Legal Certainty in Implementing the Inter-Hospital Patient Referral System under Minister of Health Regulation No. 16 of 2024

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Abstract

Minister of Health Regulation No. 16 of 2024 revoked the 2012 referral regulation and provides that referral is based on the patient's medical need and the service capability of facilities. This study analyses how the referral of patients between hospitals is regulated and how certain the law is in fulfilling patient rights through its implementation. It uses normative legal research that is descriptive and analytical, with statutory, conceptual and limited case approaches, the latter confined to policy documents and other researchers' findings. The results show that the regulation sets out the basis for choosing a destination, the types of referral, the procedure, the duties of referring and receiving facilities, and the stability of the patient and care from the moment of receipt. Legal certainty is only partly achieved. The referral criteria are left to a ministerial decree that the authors did not find, the articles read set no response deadline and no consequence if the receiving facility cannot accept, sanctions are limited to a written warning and a reduction or revocation of accreditation status without a procedure, and the competence-based referral in national health insurance still awaits a presidential regulation and has only been piloted in four regions. The study concludes that the procedural framework is clear, but certainty for patients depends on implementing regulations and alignment with health insurance.

Keywords*: legal certainty; referral system; hospital; patient rights; Minister of Health Regulation 16 of 2024*

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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]. Law No. 17 of 2023 on Health (the Health Law) divides health services into primary and advanced services (Article 26) and gives patients the right to care that matches their medical need, professional standards and quality (Article 276(c)) [2], [3]. Referral is where those two layers meet. When one facility cannot meet a patient's medical need, the patient's right depends on whether the patient can move to another facility in time, in a stable condition and without a break in care.

Minister of Health Regulation (MoH Reg.) No. 16 of 2024 on the Referral System for Individual Health Services (MoH Reg. 16/2024) was issued on November 1, 2024 and promulgated on November 12, 2024 in State Gazette No. 831. It states that it implements Article 39(7) of the Health Law and revokes MoH Reg. No. 1 of 2012 on the referral system [4]. Article 2(2) provides that referral is based on the patient's medical need and the service capability of the facility, and Article 29 gives all facilities at most one year from promulgation to adjust [4]. By the authors' calculation, that limit fell around November 12, 2025.

The problem of legal certainty arises because norms and practice move at different speeds. In November 2025 the Ministry of Health said it would abolish tiered referral for participants in National Health Insurance (JKN) and aimed to apply this in early 2026 [5], yet the Minister of Health said the change required a presidential regulation [6]. In early October 2026, news reports said that competence-based referral was only being piloted in four regions and that the presidential regulation had not yet been signed [7], [8]. Meanwhile Article 55 of Presidential Regulation No. 82 of 2018 on Health Insurance (Pres. Reg. 82/2018) still provides for tiered service [9]. In the field, a summary of a thesis in Padang reports waiting lists for referred patients and network disruptions in the integrated referral system [10], and the events in Jayapura in November 2025 involved a pregnant woman who was taken to four hospitals [11]. Both are findings or statements of others that no court has tested.

The studies on referral that the authors found are mostly managerial or empirical and do not test this regulation. The Padang thesis cites Article 3(h) of the Health Law without mentioning MoH Reg. 16/2024 [10], and the case study in East Lombok cites it only to distinguish vertical from horizontal referral [12]. Studies by lecturers of Universitas Pembangunan Panca Budi address the refusal of emergency patients, informed consent and medical disputes [13], [14], but according to their abstracts they do not address the referral procedure. This article focuses on the legal certainty of the referral procedure and the guarantee of continuity of care, not on liability for negligence, which is not examined here. The statement of novelty is limited to the sources reviewed.

This article asks two questions. First, how is the inter-hospital patient referral system regulated under MoH Reg. 16/2024? Second, how certain is the law in fulfilling patient rights through the implementation of the inter-hospital referral system? The aim is to explain that regulation, to distinguish what is already certain from what is not, and to show the points of uncertainty and how to close them.

Literature Review

Legal protection, legal certainty and patient rights

Hadjon distinguishes preventive legal protection, which gives people the chance to object 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 [15]. That formulation was made for the relation between citizens and government. In this article the authors adapt it to referral: the preventive element is the norm that sets criteria, procedures and duties before and during referral, and the repressive element is the sanction and dispute resolution after a violation. This adaptation is the authors' own choice.

Legal certainty is understood operationally, namely that patients, facilities and supervising officials can know in advance (a) when referral takes place and to where, according to criteria and a basis that can be read; (b) the duties of each party at each stage; (c) the guarantee of continuity of care for the patient and the consequence if that guarantee is breached; and (d) which norm applies during a transition and alongside other regulations, above all health insurance. These four questions are used as the test in the discussion. The patient rights used as the yardstick are those in Article 276 of the Health Law, among them the right to an adequate explanation, the right to refuse or consent to a medical act, the right to care that matches medical need, professional standards and quality, and the right to ask for the opinion of another health worker [3].

Earlier studies on referral

Edwin, Afriwardi and Pebrihariati studied the legal protection of patients' right to referral to hospitals in Padang in a master's thesis. Its summary reports minimal protection caused by service procedures that do not work well, namely disruption of the integrated referral network, waiting lists and delayed confirmation, and an example of a patient from a private hospital who was number 14 on a waiting list and died about 20 days later without being referred; the study does not discuss MoH Reg. 16/2024 [10]. Hidayatullah, Menap and Sismulyanto, in a qualitative case study at the Soedjono Selong regional hospital with ten informants in the emergency department, report that about 80 percent of the referring facilities observed still refer manually, that about 30 percent of patients still face long waits or delayed acceptance, and that some community health centres are not yet connected to the system [12]. A webinar report of Universitas Gadjah Mada records speakers' views that abolishing tiered referral is expected to improve efficiency and quality, but that hospitals in remote areas face constraints in staff, infrastructure and information systems, and that private hospitals do not yet have clear technical guidance [16]. All three are findings or views of others, not the authors' data.

Studies by lecturers of Universitas Pembangunan Panca Budi offer comparison material on patient rights and the enforcement of norms. Hasan and Aspan examine Article 438 of the Health Law on the refusal of emergency patients and conclude that facilities need internal protocols and ethical compliance [13]. Chairul, Risdawati and Aspan find that consent to treatment is now mandatory and legally well grounded but that its application is hampered by administrative formalism, patients' limited understanding and weak supervision [14], [17]. Carlos, Risdawati and Simarmata find that the Health Law gives a basis for acting without prior consent in an emergency, with obstacles in documentation and procedure [18], and Naurah examines the validity of electronic consent in hospitals [19].

Mushari, Sidi and Risdawati assess the effectiveness of mediation in disputes between patients and hospitals and propose a combined model [20], while Sinaga, Zarzani and Sahlepi find that the shift in settling medical disputes from litigation to non-litigation has not been accompanied by norms on institutional roles and technical procedure [21]. Manurung and Sidi discuss the legal relationship between doctor and patient and the doctor's liability in community health services [22]. 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 [23]. Farhan, Sahlepi and Risdawati find that policies supporting the right of patients with mental disorders to care in hospitals exist but are weakly applied [24], and Afrila, Aspan and Sahlepi show that protection for personnel working in services with limited conditions is not yet clear [25].

Legal politics, criminal policy and oversight

The analytical framework draws on Tanjung's studies with co-authors. Tanjung and Arminsyah argue that an opaque omnibus process with minimal public participation weakens legitimacy, and that the breadth of the government's power to change regulations is a risk [26]. Tanjung, Syahnan and Syahputra judge that Government Regulation in Lieu of Law No. 2 of 2022 met the requirement of a compelling emergency under Article 22(1) of the 1945

Constitution, but note concern over subjectivity and the potential abuse of authority [27]. Tanjung examines the Judicial Commission's oversight of judges and notes that other institutions also hold oversight powers [28]. In his studies of cybercrime (with Adriani) and of narcotics trafficking, he analyses penal and non-penal efforts, and the narcotics study proposes an integrated approach of prevention, enforcement, therapy and rehabilitation [29], [30]. A recent study with Arminsyah and Syam proposes a model in which an arbitration body settles disputes and a court supervises, ratifies and executes its awards, together with synchronisation of regulations [31].

Suwarto, Sutiarnoto and Magda judge that criminal law policy on digital crime remains reactive and fragmented, and recommend harmonising norms, strengthening accountability models and integrating penal and non-penal policy [32]. Mahruzar, Simarmata and Sahlepi find a conflict of norms between general criminal law and newer, more specific statutes in the legal protection of doctors, and regard criminal law as a last resort [33].

Research Method

This is normative juridical legal research that is descriptive and analytical, with statutory, conceptual and case approaches, the last confined to policy documents and the findings of other researchers. The primary legal materials are Articles 28H(1) and 28I(4) of the 1945 Constitution [1]; Articles 26, 174 and 276 of the Health Law, while Article 39(7) is cited only as the basis named in MoH Reg. 16/2024 because its wording could not be read [3]; Articles 1 to 31 of MoH Reg. 16/2024 [4]; Articles 55, 56 and 63 of Pres. Reg. 82/2018 and its third amendment [9], [34]; and Article 36(1) of MoH Reg. No. 6 of 2026 on Hospitals (MoH Reg. 6/2026), read from a secondary commentary [35]. The secondary materials are journal and proceedings articles, including the studies by lecturers of Universitas Pembangunan Panca Budi cited above, a thesis summary, a workshop report and news reports. The materials were collected through a literature and document study and analysed qualitatively, using grammatical interpretation of the wording of the articles, systematic interpretation among the statute, the presidential regulation and the ministerial regulations, and an assessment of each element against the four legal-certainty test questions.

This study has six limitations. First, the text of MoH Reg. 16/2024 was read from the file on the promulgation website through a page-reading tool that returns paraphrases and short quotations, not a copy that can be quoted word for word, so the wording of the articles should be checked against the official text; the metadata on issuance, promulgation, State Gazette No. 831 and the revocation of MoH Reg. 1/2012 were matched against the page of the Legal Documentation and Information Network of the Ministry of Health [4]. Second, the Health Law articles were read from the Pasal.id database, which contains character errors, and the content of Article 39(7) could not be read [3]. Third, the official text of MoH Reg. 6/2026 could not be read; Article 36(1) and the number of regulations revoked were read from one commentary that does not list MoH Reg. 16/2024 [35]. Fourth, the quotations of Pres. Reg. 82/2018 and Pres. Reg. 59/2024 come from scans with character-recognition errors [9], [34]. Fifth, the authors did not find the ministerial decree on referral criteria and did not find a court decision applying Article 28 of MoH Reg. 16/2024; the case approach therefore uses policy documents, news reports of officials' statements and the findings of other researchers, which are not data tested by the authors. Sixth, the reported status of JKN implementation is the position as of the latest news found, in early October 2026. This study conducted no interviews, observations or surveys.

Results and Discussion

Regulation of the referral system in MoH Reg. 16/2024

Table 1 maps the norms that regulate referral. The regulation is layered: the Constitution and the Health Law set the rights and the division of services, MoH Reg. 16/2024 sets the

system, and several important matters are left to lower instruments, namely a ministerial decree on criteria (Article 3(4)) and technical guidance for the integrated system (Article 22) [4].

Table 1. Map of the norms that regulate the patient referral system

Instrument and article	Content of the provision	Meaning for referral
1945 Constitution, Articles 28H(1) and 28I(4)	The right to health services; protection and fulfilment of human rights is the responsibility of the state, above all the government [1]	Constitutional basis of access to care
Health Law, Articles 26 and 174(2)	Services consist of primary and advanced care; facilities may not refuse patients, demand advance payment or put administrative matters first so that care is delayed [3]	Two layers connected by referral; limit on the capacity ground
Health Law, Article 276	Patient rights, among them an adequate explanation (letter b), care according to medical need, professional standards and quality (letter c), consent to or refusal of an act (letter d) and asking for another health worker's opinion (letter f) [3]	Yardstick of patient rights in the test
MoH Reg. 16/2024, Articles 2 to 6	Referral is a reciprocal transfer of duties and responsibility; destination based on medical need and service capability, which has five components; criteria set by the Minister; exceptions for emergencies, extraordinary events, epidemics, disasters and other specific circumstances [4]	Basis of destination choice; policy space in Article 6(1)
MoH Reg. 16/2024, Articles 7 to 19	Who decides on referral; vertical, horizontal and back referral; consent after explanation; duties of referrer and receiver; patient stability and ambulance [4]	Types, procedure and duties (Tables 2 and 3)
MoH Reg. 16/2024, Articles 20 to 23	Integrated system connected to the national health information system; manual back-up; technical guidance set by the Minister; recording and reporting with minimum indicators [4]	Information system as the backbone of the procedure
MoH Reg. 16/2024, Articles 24 to 28	Duties of central and regional government; funding from the national budget, regional budgets and/or other lawful sources; guidance and oversight by the Minister, governors and regents or mayors; administrative sanctions by the Minister through the Director General [4]	Layered oversight, centralised sanctions
MoH Reg. 16/2024, Articles 29 to 31	Adjustment within one year of promulgation at most; revocation of MoH Reg. 1/2012; effective on promulgation [4]	Transition; limit around November 12, 2025 by the authors' calculation
Pres. Reg. 82/2018, Article 55 (not amended by Pres. Reg. 59/2024 according to the quotation read)	Tiered service according to medical need and the competence of facilities (paragraph (1)); first-level facilities refer to advanced facilities according to case, competence and the referral system (paragraph (4)); details in a ministerial regulation (paragraph (8)) [9], [34]	Relation to JKN
MoH Reg. 6/2026, Article 36(1) (secondary commentary)	Hospitals must carry out the patient referral system in a targeted way; MoH Reg. 16/2024 is not listed among the 21 regulations revoked [35]	Relation to hospital law; official text not read
Ministerial decree on referral criteria	Article 3(4) leaves the criteria to the Minister; the report mentions decree No. 1645 of 2024 for the criteria for referring chronic disease back [4], [16]	Text of the decree not found by the authors

Note: the third column is the authors' reading. The articles of MoH Reg. 16/2024 were read through a page-reading tool from the promulgation file; MoH Reg. 6/2026 was read from a secondary commentary.

The basis for choosing the referral destination can be read as follows. Referral is defined as a reciprocal transfer of duties and responsibility between facilities (Article 2(1)). The destination is chosen according to the patient's medical need and service capability (Article 2(2)), considering accessibility, that is, the shortest distance and travel time from the referring facility, and the quality of service; the article also states that referral is not made on the basis of cost (Article 2(3) and (4)) [4]. Service capability consists of five components, namely the type of service, the type of personnel, facilities and infrastructure, pharmacy and medical devices, and capacity (Article 4), detailed in Article 5 by reference to the applicable standards [4]. In the authors' reading, what decides is what the destination facility can do, not its hospital class; the articles read do not mention class.

Article 6(1) exempts patients in an emergency, an extraordinary event, an epidemic or a disaster from the requirement that medical need match capability, and does the same for other circumstances set by the Minister [4]. The last exception is a policy space with an open wording, and in the text read no objective limit binds how it is set.

Types of referral and choice of destination

Table 2 details the types of referral. Vertical referral goes to a facility with higher service capability (Article 8). Horizontal referral goes to a facility of the same level that has a certain competence the referrer lacks, and is also permitted when staff are temporarily unavailable, facilities or equipment cannot be made to function, pharmacy supplies are unavailable in the type and quantity needed, or capacity is limited (Article 9). If no qualifying horizontal facility exists, the patient may be referred to a facility with higher capability (Article 10). Referral back is intended for patients who have been treated but still need further care at a facility with lower competence (Article 11) [4].

Table 2. Types of referral under MoH Reg. 16/2024

Type of referral	Direction and conditions under the articles	Authors' note
Vertical (Article 8)	To a facility with higher service capability [4]	What is assessed is service capability; the articles read do not mention hospital class
Horizontal (Article 9)	To a facility of the same level with a certain competence the referrer lacks; also when staff are temporarily unavailable, facilities or equipment cannot function, pharmacy supplies are unavailable in the type and quantity needed, or capacity is limited [4]	Limited capacity is not permission to refuse an emergency patient under Article 174(2) of the Health Law [3]
Horizontal unavailable (Article 10)	The patient may be referred to a facility with higher capability if no qualifying horizontal facility exists [4]	Prevents a patient being left without a destination
Back referral (Articles 11 and 18(2))	For patients who have been treated but still need further care at a facility with lower competence; chronic patients may be referred back [4]	According to the report, the criteria for referring chronic disease back lie in a ministerial decree that was not read [16]
Emergency (Articles 6 and 14(3))	The requirement that medical need match capability does not apply; covers patients who need immediate treatment and patients who need further treatment after emergency care because the facility or room is unavailable [4]	Stabilise first, then refer (Article 15(1)(d)); the authors' reading
Inpatient (Article 14(5))	Enters through the outpatient clinic or the emergency department of the receiving facility [4]	The entry route for the receiver is set

Note: the third column is the authors' reading.

The person who decides on referral is the physician in charge of care (DPJP), and if there is no medical personnel, a health worker may decide in accordance with legislation (Article 7(2) and (3)) [4]. Three notes can be added. First, the horizontal ground of limited capacity makes capacity constraints a valid reason to move a patient. In the authors' reading, that ground

must not be read as permission to refuse an emergency patient, because Article 174(2) of the Health Law prohibits facilities from refusing patients, demanding advance payment and putting administrative matters first so that care is delayed [3]. What is consistent with both norms is to help and stabilise the patient first and then refer, as implied by Article 14(3) and Article 15(1)(d) of MoH Reg. 16/2024 [4]. Second, emergency referral under Article 14(3) covers patients who need immediate treatment and patients who need further treatment after emergency care because the facility or room is unavailable [4]. Third, inpatient referral enters through the outpatient clinic or the emergency department of the receiving facility (Article 14(5)) [4].

The events in Jayapura show the two grounds meeting in one sequence. According to the Ministry of Health's statement as reported, the first three hospitals could not help because of doctors, anaesthesia or operating rooms, whereas the fourth hospital required administration and payment to be settled before treating [11]. The first tests the correctness of referral by capability, and the second tests the prohibition in Article 174(2). Both are allegations according to news reports and government statements, not facts tested in court.

Referral procedure and the duties of the parties

The referral procedure is regulated in Articles 12 to 19. Referral may be made only if at least one referral criterion in the integrated online referral system is met, and the patient or the patient's representative must consent orally and/or in writing after receiving an explanation of the diagnosis, indication, the act and its purpose, risks and complications, alternatives and their risks, the risk if the act is not performed, the prognosis and the transport (Article 12) [4]. Referral is not made if the patient cannot be transported for medical reasons, resource limits or geographic conditions, or if the patient or family refuses; in that case the referring facility may treat the patient according to its competence (Article 13) [4].

The referrer's duties before and during transfer include completing administrative and medical data, communicating with the receiving facility, issuing an electronic referral letter, ensuring that the patient is stable and ready for transport, and guaranteeing the patient's medical needs during the referral process (Article 15(1)), as well as keeping the patient stable during transport (Article 16) [4]. The receiving facility must communicate and confirm that it can serve the patient, carry out the handover, and give care according to medical indication from the moment it receives the referral (Article 18(1)), and must not repeat supporting examinations unless the receiving DPJP decides it is necessary (Article 14(6) and (7)) [4]. Patients who need continuing medical care are transported by an ambulance equipped with medical devices and accompanied by competent personnel (Article 19(2)) [4]. Table 3 arranges those duties by stage and party, together with what the articles read leave unregulated, and Figure 1 summarises the three stages.

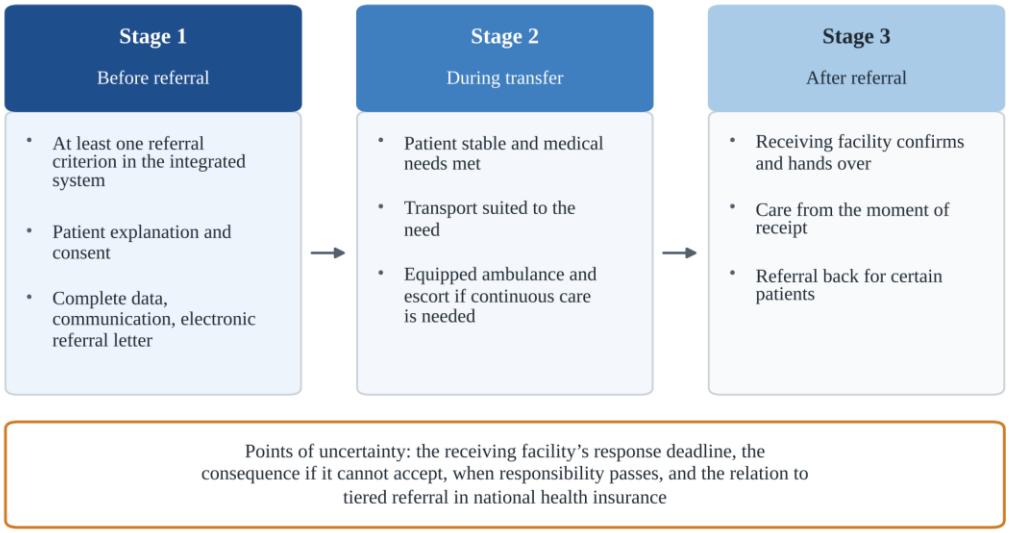


Figure 1. The three stages of the referral of a patient between hospitals and the points of uncertainty. Prepared by the authors from [4], [7], [8]; the marking of the points of uncertainty is the authors' reading.

Table 3. Duties of the parties by referral stage and matters not yet regulated

Stage and party	Duties under the articles read	Not yet regulated in the articles read
Before referral: referrer	At least one criterion in the integrated system; oral and/or written consent after eight elements of explanation (Article 12); complete administrative and medical data, communication with the receiver and an electronic referral letter (Article 15(1)) [4]	When the written form is required; an exception to consent for emergency referral
Referral not made	The patient cannot be transported for medical reasons, resource limits or geographic conditions, or the patient or family refuses; the referrer may treat according to its competence (Article 13) [4]	The measure of resource limits and who assesses it
During transfer: referrer	The patient is stable and ready for transport; medical needs guaranteed (Article 15(1)); stability kept during transport (Article 16); equipped ambulance and competent escort for continuing care (Article 19(2)) [4]	The measure of stability; the point at which responsibility passes
After referral: receiver	Communicates and confirms it can serve; carries out handover; gives care from the moment of receipt (Article 18(1)); does not repeat supporting examinations unless the receiving DPJP decides (Article 14(6) and (7)) [4]	Confirmation deadline; duty to accept a referral that meets the criteria; consequence if it cannot accept
After treatment	Back referral of chronic patients (Article 18(2)); the referrer treats a patient who cannot be referred (Article 13(2)) [4]	Criteria for back referral lie in a ministerial decree that was not read
All stages: both parties	Use of the integrated system with a manual back-up (Article 21); recording and reporting with minimum indicators, including online response time (Article 23) [4]	When a manual referral is entered into the system; response time as a binding limit

Note: the third column is the authors' reading of the articles read.

The information system is the backbone of the procedure. Referral technology must be connected to the national health information system, contain up-to-date data on the facilities' service capability, and be able to operate together with other systems (Article 20). Every facility must use the integrated referral system, with a manual back-up through a referral letter when there is no network or the system fails (Article 21). Referrers and receivers must record and report referrals with minimum indicators, namely the proportion of patients referred, the proportion of referred patients served, the proportion referred back, the most frequently referred

diseases and the online response time to a referral request (Article 23) [4]. The findings of others show a gap between norm and practice at this point: the study in East Lombok reports that most of the referrers observed still work manually [12], and the Padang thesis reports network disruptions [10]. Article 21(2) does allow the manual route and Article 23 requires recording through the health information system, but the articles read do not say when a manual referral is entered into the system [4].

Continuity of care and patient rights

The guarantee of continuity consists of several elements spread across different articles. Before departure, the patient must be stable (Article 15(1)(d)) and the referrer guarantees the patient's medical needs during the referral process (letter e). During transport, stability is maintained (Article 16) and continuing care is delivered by ambulance (Article 19). On arrival, the receiver gives care from the moment it receives the referral (Article 18(1)(c)). After treatment, a chronic patient may be referred back (Article 18(2)), and a patient who cannot be referred remains under the referrer's care (Article 13(2)) [4]. In the authors' reading, the last provision closes the possibility that a patient is left without a responsible facility.

Article 12 puts into operation two rights under Article 276 of the Health Law, namely the right to an adequate explanation (letter b) through its eight elements of explanation, and the right to consent to or refuse an act (letter d) through the consent and the refusal under Article 13(1)(b) [3], [4]. Article 12(2) allows consent orally and/or in writing without saying when the written form is required. The findings of Chairul, Risdawati and Aspan on administrative formalism in consent to treatment [14], [17] warn of the risk that a referral consent form is filled in while no real explanation is given, and Naurah's study of electronic consent [19] shows that the referral letter and the consent within the system need clear validity. Both are the authors' reading of the relevance of those findings, not findings on referral.

Three gaps in patient rights can be noted. First, the right to ask for the opinion of another health worker (Article 276(f)) [3] has no counterpart in the referral articles read. Article 2(2) makes medical need and capability the basis of the destination, so the patient's choice appears only as a refusal under Article 13 [4]. Second, the relation between consent under Article 12 and emergency referral is not explained. Carlos, Risdawati and Simarmata find that the Health Law gives a basis to act without prior consent in an emergency [18], whereas in the articles read Article 12 contains no exception for emergency referral. In the authors' reading, the explanation that can be given without delaying help still needs to be made firmer. Third, the point at which responsibility passes is unclear. Article 2(1) speaks of a reciprocal transfer of responsibility, Article 16 requires the referrer to keep the patient stable during transport, and Article 18(1)(c) burdens the receiver from the moment of receipt [4]. In the authors' reading, the referrer's responsibility lasts until handover, but the articles read do not say so expressly, and the point matters because the patient is most vulnerable in the interval between confirmation and handover. This article does not assess liability for negligence in that interval.

The guarantee of continuity also appears in instruments lower than the referral regulation. According to the Ministry of Health's release of February 11, 2026, the Director General of Advanced Health Services said that hospitals may not refuse patients merely because their JKN status is temporarily inactive, for at most three months from deactivation, and that care continues until the patient is stable and can be followed up through the referral system; the only instrument the release names is a circular letter [36]. In the authors' reading, that statement shows that continued care for JKN participants is protected by a circular letter, not by an article that can be tested, and the authors did not read the text of that circular letter.

Grouped by their standing, what the articles read permit is referring on the basis of medical need and service capability, referring horizontally when staff are temporarily unavailable, facilities do not function, pharmacy supplies are unavailable or capacity is limited, and treating a patient who cannot be referred (Articles 2, 9 and 13) [4]. What the wording of the articles does not permit is referring on the basis of cost (Article 2(3)), referring without consent after an explanation (Article 12), and, under the Health Law, refusing a patient or

demanding advance payment so that care is delayed (Article 174(2)) [3], [4]. What is unclear is an emergency referral made before an explanation can be given, whether the receiver must accept a referral that meets the criteria, and the point at which responsibility passes. This grouping is the authors' reading of the text read.

Legal certainty: a test with four questions

Table 4 tests MoH Reg. 16/2024 with the four questions formulated in the literature review. The assessment is the authors' reading of the text read.

Table 4. Legal-certainty test of the referral system with four questions

Test question	Findings in the text read	Authors' assessment
(a) When and where referral takes place	The basis for choosing the destination is clear (Articles 2 to 5); the criteria for referral and referral back are set by the Minister (Article 3(4)) and the decree was not found; exception for other specific circumstances without an objective limit (Article 6(1)) [4], [16]	Partial
(b) Duties of each party	The referrer's duties are detailed (Articles 15 to 17); the receiver's duties are thinner, with no confirmation deadline or consequence; response time is only a reporting indicator (Article 23(2)(e)) [4]	Partial: clear for the referrer, not yet for the receiver
(c) Guarantee of continuity and consequence of violation	Stability, ambulance, care from receipt, and treatment by the referrer if referral cannot be made (Articles 13, 16, 18 and 19); the point at which responsibility passes is not firm; sanction only a written warning and a reduction or revocation of accreditation status, with no procedure and no remedy for the patient (Article 28) [4]	Partial: strong up to handover
(d) Transition and relation to other regulations	One-year adjustment (Article 29); Article 55 of Pres. Reg. 82/2018 is still tiered; the Minister says a presidential regulation is needed; pilot in four regions; Article 36(1) of MoH Reg. 6/2026 read from a commentary [4], [6], [7], [9], [35]	Unclear

Note: the assessment is the authors' reading and is not based on data on referral outcomes.

On the first question, the basis for choosing the destination is clear (Articles 2 to 5), but the criteria for referral and referral back are set by the Minister (Article 3(4)) [4]. The UGM report says the criteria for referring chronic disease back are set in ministerial decree No. 1645 of 2024, which the authors did not read [16], and the Ministry of Health says that full application of competence-based referral awaits the setting of service standards and referral criteria [5]. The authors did not find the text of a decree on referral criteria. As long as those criteria cannot be read, the question of when referral is permitted or required is answered by the information system, not by a norm that can be tested. The exception for other circumstances set by the Minister in Article 6(1) adds to that uncertainty.

On the second question, the referrer's duties are clear and detailed (Articles 15 to 17), but the receiver's duties are thinner. Article 18(1) requires the receiver to communicate and confirm that it can serve the patient, but the articles read do not state a duty to accept a referral that meets the criteria, a deadline for confirmation, or a consequence if the receiver cannot accept. Response time is only a reporting indicator (Article 23(2)(e)), not a binding limit [4]. The Ministry of Health's release on the pilot says the simulated first-level referral took about 2 minutes 47 seconds against a four-minute standard [8], but that standard was not found in the articles read. This gap fits the waiting lists and delayed confirmation reported in Padang and East Lombok [10], [12].

On the third question, the guarantee of continuity is strongest on the referrer's side, but the three gaps in the previous subsection remain. The consequence of a violation is regulated in Article 28: the Minister may impose administrative sanctions on a facility that violates the provisions of the referral system, carried out through the Director General, in the form of a

written warning and/or a reduction and/or revocation of accreditation status [4]. The articles read contain no procedure, such as stages, deadlines or objection, and no remedy for the patient. In the authors' reading, an accreditation-based sanction does not directly answer the needs of an injured patient and is hard to impose proportionately on a single violation. A complaint and dispute route is not mentioned in the referral regulation. Sinaga et al.'s finding that institutional roles in non-litigation dispute resolution remain unclear [21] and Mushari et al.'s proposal of a combined mediation model [20] are relevant here as a research direction, not as findings on referral.

On the fourth question, there are three problems. First, the transition. Article 31 states that the regulation takes effect on promulgation, while Article 29 gives facilities one year to adjust [4]. The articles read do not say whether a sanction under Article 28 may be imposed before that limit passes. In the authors' reading, the safest interpretation is that sanctions could be imposed only after about November 12, 2025, but that is an interpretation, not the wording of the article.

Second, the relation to JKN. Article 55(1) of Pres. Reg. 82/2018 states that service is delivered in tiers according to medical need and the competence of facilities, paragraph (4) requires first-level facilities to refer to advanced referral facilities according to the case, competence and the referral system, and paragraph (8) leaves the details to a ministerial regulation [9]. According to the quotation read, Pres. Reg. 59/2024 does not amend Articles 55 and 56 [34]. Textually, paragraph (4), which mentions the referral system, and paragraph (8) can be read as leaving room for MoH Reg. 16/2024 to fill in the details, so there need be no conflict. Yet the Minister of Health says a presidential regulation is needed [6], the Director General of Advanced Health Services says national implementation awaits a presidential regulation that has not been signed and will be followed by a one-year transition [7], and Kontan reports that the Ministry of Health is preparing a new ministerial regulation that removes the tiered referral requirement in some cases without giving an effective date [37]. In the authors' reading, those three signals show that the government itself does not read MoH Reg. 16/2024 as a sufficient basis for competence-based referral in JKN, so for JKN participants the norm that applies during the transition is uncertain.

Third, the relation to hospital law. According to the commentary read, Article 36(1) of MoH Reg. 6/2026 requires hospitals to carry out the patient referral system in a targeted way, and the commentary does not list MoH Reg. 16/2024 among the 21 regulations revoked [35]. The authors found no conflict, but the official text could not be read, so the assessment of this element is left open.

Policy documents and field findings read

Table 5 summarises the documents read for the case approach. Three notes can be added. First, the authors found no court decision applying Article 28 of MoH Reg. 16/2024 or testing a failed referral, so a judge's test of the regulation cannot yet be read. Second, the 2025 and 2026 policy documents do not name a legal basis for applying competence-based referral in JKN: the Ministry of Health release of November 22, 2025 names no regulation [5], and neither do the release of September 26, 2026 and the news report of October 1, 2026 [7], [8]. Third, the Head of the North Sumatra Provincial Health Office said in February 2025, citing MoH Reg. 16/2024 as the basis, that referral is no longer tiered but based on hospital competence, and urged hospitals and the Social Security Agency for Health (BPJS Kesehatan) to adapt [38]. In the authors' reading, that regional official reads the regulation as having already changed referral, whereas Article 55 of Pres. Reg. 82/2018 is still tiered and the Minister says a presidential regulation is needed. The difference in reading among officials is itself a symptom of uncertainty.

Table 5. Policy documents and field findings read

Document or finding	Content read	Standing	Authors' note
Ministry of Health release, Nov. 22, 2025	Preparing to abolish tiered referral for JKN participants; full application awaits service standards and referral criteria; target of early 2026 [5]	Government statement	Names no regulation as its basis
ANTARA, Nov. 18, 2025	Minister of Health: competence-based JKN referral applies from 2026; the change requires a presidential regulation [6]	Official's statement as reported	Presidential regulation unsigned as of October 2026
Kontan, Nov. 16, 2025	The Ministry of Health is preparing a new ministerial regulation that removes the tiered referral requirement in some cases; no effective date [37]	News report on a draft	Text of the draft not read
ANTARA Sumut, Feb. 4, 2025	The Head of the North Sumatra Provincial Health Office cites MoH Reg. 16/2024 as the basis of competence-based referral and urges hospitals and BPJS Kesehatan to adapt [38]	Regional official's statement	Differs from the Minister's statement that a presidential regulation is needed
Ministry of Health release, Sep. 26, 2026, and detikHealth, Oct. 1, 2026	JKN reform pilot in Bandung, Makassar, Tulungagung and Muara Enim; national implementation awaits a presidential regulation with a one-year transition; simulated first-level referral about 2 minutes 47 seconds against a four-minute standard [7], [8]	Government statement and news report	Regulation underlying the pilot not named; four-minute standard not found in the articles read
Ministry of Health release, Feb. 11, 2026	Hospitals may not refuse temporarily inactive JKN patients for up to three months; care continues until stable and can be followed up through the referral system; basis is a circular letter [36]	Government statement	Text of the circular letter not read
Events in Jayapura, Nov. 2025	According to the Ministry of Health's statement as reported, a pregnant woman was taken to four hospitals; three could not help because of doctors, anaesthesia or operating rooms, and one required administration and payment [11]	Government statement as reported	Not tested in court
Padang thesis (executive summary), 2025	Network disruption, waiting lists and delayed confirmation [10]	Other researchers' finding	Does not discuss MoH Reg. 16/2024
Study at Soedjono Selong hospital, 2026	About 80 percent of referrers observed still manual; about 30 percent of patients face long waits or delayed acceptance [12]	Other researchers' finding	One hospital, ten informants
UGM webinar report, Dec. 31, 2024	Efficiency and quality expected to improve; constraints in remote areas; no technical guidance yet for private hospitals [16]	Others' views	Not the authors' data

Note: the third and fourth columns are the authors' classification and reading. Policy documents and news reports are not court decisions.

Legal-political perspective, oversight and dispute resolution

Tanjung's studies with his co-authors give three lenses for reading the findings above. All three are the authors' reading of the relevance of those studies, not findings on referral. The first lens is the legitimacy of the form of regulation. Tanjung and Arminsyah argue that an opaque process with minimal public participation weakens legitimacy, and that the breadth of government power to change regulations is a risk [26]. In referral, matters that decide patient rights are left to lower instruments, namely the referral criteria (Article 3(4)), technical guidance for the integrated system (Article 22) and other specific circumstances set by the Minister

(Article 6(1)) [4], while the direction of the JKN transition is announced through officials' statements and press releases [5], [6]. If those instruments are not issued, not published or changed without participation, patients and facilities cannot know in advance which norm applies.

The second lens is discretion. Tanjung, Syahnan and Syahputra judge that the requirement of a compelling emergency was met for Government Regulation in Lieu of Law 2/2022, but note concern over subjectivity and the potential abuse of authority [27]. The exception in Article 6(1) for other specific circumstances set by the Minister has a similar character on a far smaller scale: the power to set exists, but its objective limit cannot be read [4]. The third lens is oversight. Tanjung notes that oversight of judges is held by more than the Judicial Commission [28]. Article 27 of MoH Reg. 16/2024 gives guidance and oversight to the Minister, governors and regents or mayors according to their respective authority, with monitoring that covers facilities' compliance in referring according to service capability, whereas sanctions can be imposed only by the Minister through the Director General (Article 28) [4]. In the authors' reading, regional supervisors can see violations, but the articles read do not say how their findings are passed to the official with power to impose sanctions. The authors also did not find BPJS Kesehatan in the articles read, even though Article 25 asks regional governments to coordinate on health insurance financing [4].

The distinction between penal and non-penal efforts in Tanjung's studies of cybercrime and narcotics [29], [30], and Mahruzar et al.'s view that criminal law is a last resort [33], are relevant to the choice of instrument. The sanction in Article 28 is administrative, whereas the refusal of emergency patients is discussed by Hasan and Aspan as a matter of Article 438 of the Health Law [13]. The authors do not examine that criminal or civil liability. The point to note is that strengthening the administrative route in the referral system would reduce cases that the procedure could have prevented before they reach heavier sanctions. Suwarto, Sutiarnoto and Magda judge that criminal law policy on digital crime remains reactive and fragmented, and recommend harmonising norms [32]. The links among MoH Reg. 16/2024, Pres. Reg. 82/2018 and MoH Reg. 6/2026 call for similar harmonisation; this is the authors' reading of that study.

On dispute resolution, Sinaga et al. find that the shift to non-litigation settlement has not been accompanied by norms on institutional roles and technical procedure [21], and Mushari et al. propose a combined model [20]. Tanjung, Arminsyah and Syam propose a division of roles between a dispute-settlement body and a court that supervises, ratifies and executes its awards, together with synchronisation of regulations [31]. That model comes from Islamic economic disputes and has not been tested on referral. In the authors' reading, its pattern can be borrowed as a design: a tiered referral-complaint route with firm institutional roles and a court as the tester, provided it is set out in a norm that can be read.

Recommendations

The following recommendations are the authors' proposals and need to be tested by regulation makers. First, the referral criteria and the technical guidance for the integrated system should be issued and published on a clear schedule, with periodic review and a chance for public input, so that the question of when referral is permitted or required can be answered by a norm that can be read; Article 6(1) needs an objective limit for other specific circumstances. Second, an amending regulation or technical guidance should set the receiving facility's confirmation deadline, the duty to accept a referral that meets the criteria, a mechanism for alternative referral if the receiver cannot accept, and the point at which responsibility passes, which is handover. Third, Article 28 should be completed with a procedure of stages, deadlines and objection, a form of remedy for the patient, and a route for regional supervisors to pass findings to the competent official.

Fourth, the presidential regulation being prepared, or its implementing ministerial regulation, should state its relation to Article 55 of Pres. Reg. 82/2018, MoH Reg. 16/2024 and MoH Reg. 6/2026, and set the norm that applies during the transition. Fifth, patient rights need to be made firmer, namely an explanation that does not delay help in emergency referral,

consent that does not stop at a form, and the right to ask for the opinion of another health worker. Sixth, a tiered complaint and non-litigation dispute-resolution route needs to be designed in a norm. Further research should use the Article 23 indicator data and interviews, which were not done in this article.

Conclusion

MoH Reg. 16/2024 regulates the referral system with a clear framework. Referral is based on medical need and service capability, differentiated by type, carried out through consent after explanation, the duties of the referrer and the receiver, an integrated information system and reporting, and supervised by the Minister, governors and regents or mayors [4].

Legal certainty for patients is only partly achieved. The referral criteria are left to a ministerial decree that the authors did not find. The referrer's duties are clear, but the receiver's duties come without a deadline or a consequence. The guarantee of continuity is strong up to handover, but the point at which responsibility passes is not firm, and sanctions are limited to a written warning and a reduction or revocation of accreditation status without a procedure and without a remedy for the patient. The relation to JKN and MoH Reg. 6/2026 remains unclear during the transition, and the authors found no court decision applying Article 28. This conclusion is limited to the text read, part of it from secondary sources, and is not supported by data on referral outcomes.

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