Legal Certainty in Fulfilling the Rights of Healthcare Workers Against Occupational Diseases

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Abstract

Health workers face a high risk of contracting infectious diseases while performing their professional duties. The enactment of Law Number 17 of 2023 concerning Health brings a new paradigm, yet the legal certainty regarding the post-infection rights fulfillment remains critically debated. This study aims to analyze the legal certainty in fulfilling health workers' rights concerning Occupational Diseases (PAK) resulting from infectious disease transmission on duty. The research method applied is normative juridical with a statutory approach and a conceptual approach. Legal materials were analyzed through qualitative deductive doctrine. The results show that while Article 273 paragraph (1) letter c of the Health Law establishes the macro right to Occupational Health and Safety (OHS), operational clarity hinges on Government Regulation Number 28 of 2024 regarding occupational disease management. Legal certainty in rights fulfillment—encompassing full medical expenses, treatment, and rehabilitation under Article 241 paragraph (1) of the implementing regulation—is fundamentally bound by the strict mechanism of proving causal nexus. In this process, the seven-step occupational diagnosis protocol under Presidential Regulation Number 7 of 2019 serves as the primary identification instrument, whose application is not rigid but comprehensively supported by workplace epidemiological analysis and exposure records. Furthermore, the construction of corporate civil liability under tort principles and progressive administrative sanctions serve as enforcement instruments rather than absolute guarantees for labor career stability. This study outlines that legislative refinement is mandatory to transform abstract protective norms into operational certainty.

Keywords:Legal Certainty; Health Workers; Occupational Diseases; Infectious Diseases; Health Law.

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2nd International Cofference on the Epicentrum of Economic Global Framework (ICEEGLOF)
Theme: Navigating The Future: Business and Social Paradigms in a Transformative Era.
https://proceeding.pancabudi.ac.id/index.php/ICEEGLOF

INTRODUCTION

Healthcare workers play a crucial role as the spearhead in providing healthcare services to the wider community. However, the inherent nature of the medical profession places its workers in a highly vulnerable position regarding various occupational safety risks. [1] One of the most threatening is biological hazards, specifically the transmission of infectious diseases from the patients under their care. From a legal perspective, protecting the safety of healthcare workers is a pressing normative issue to enforce, as the guarantee of security within the working environment correlates directly with optimizing the quality of public healthcare services itself[2]

The enactment of Law Number 17 of 2023 concerning Health (the Health Law) utilizing the omnibus law methodology has brought a massive restructuring to Indonesia's health law landscape. This new regulation attempts to consolidate and synchronize various medical sector rules that were previously fragmented into a single, integrated codification.[3] Although this new law incorporates a cluster of comprehensive protection rights for medical and healthcare personnel, the actual implementation of the legal protection framework post-infection risk within the normative level proves to still face significant synchronization challenges.

A profound gap between written regulatory guarantees (*das Sollen*) and sociological realities on the ground (*das Sein*) is clearly visible in North Sumatra Province, which currently ranks fourth nationwide in the estimated Tuberculosis (TB) caseload. According to data from the North Sumatra Provincial Health Office, the estimated TB cases in this region are projected to reach 74,308 cases, with Medan City being one of the areas contributing the highest number of case detections. This high rate of biological exposure has a fatal impact on the medical frontline. An analysis of patient medical record data at the Technical Operation Unit (UPTD) of the Special Respiratory Hospital of the North Sumatra Provincial Government for the period from 2020 to August 2024 confirms that a person's occupation has a strong correlation with the risk of *Mycobacterium tuberculosis* infection transmission. The healthcare sector directly involved in patient diagnosis and care, such as nurses and laboratory analysts, is categorized as the group with the highest occupational vulnerability. However, in reality, when healthcare workers in Medan City's healthcare facilities are diagnosed with Occupational TB, the process of fulfilling their rights often runs into a bureaucratic wall; hospital management frequently refuses to issue a formal Occupational Disease (*Penyakit Akibat Kerja* / PAK) status under the pretext that the source of droplet transmission is ambiguous and the risk of exposure could have occurred outside the work environment.[4]

This dilemmatic condition in the North Sumatra region is further exacerbated by the operational ambiguity of the Occupational Accident Benefits (*Jaminan Kecelakaan Kerja* / JKK) claim procedures, specifically for the infectious disease category following the enactment of the new health law. Studies on occupational health policy confirm that although macro-level social protection policies have been regulated, the integration of TB screening and the formal recognition of occupational disease cases among healthcare workers still face significant implementation challenges and highly deficient monitoring. When healthcare workers become infected due to biological protection failures—such as those experienced by laboratory personnel due to inadequate environmental surveillance and personal protective equipment (PPE) compliance—they are confronted with legal uncertainty in obtaining immediate recovery benefits. Consequently, a space for bureaucratic disputes emerges, forcing sick healthcare workers to personally bear their initial medical expenses or face unfair occupational administrative sanctions.[5]

This uncertainty of protection demands specific scientific attention, given that several prior studies, such as the study by Marwiyah and Prawesthi (2023), dominantly confined themselves to the general scope of healthcare workers' immunity rights during

national health emergency periods. Meanwhile, the study by Permatasari et al. (2026) placed greater emphasis on the preventive protection aspects of first-level healthcare facilities (*Puskesmas*) regarding logistics provision. The scientific novelty of this proceeding article lies in the legal synchronization analysis following the enactment of the Health Law and Government Regulation Number 28 of 2024, which specifically dissects the operational certainty of recognizing infectious diseases as Occupational Diseases (*PAK*) in regional healthcare facilities, while simultaneously constructing a clear line of demarcation between the normative financing obligations of hospitals and the civil burden of proof.

LITERATURE REVIEW

The theoretical framework employed to analyze the legal issues in this research rests upon two primary pillars: the theory of legal liability and the theory of legal certainty

a. Theory of Legal Liability

The theory of legal liability fundamentally separates the source of legal obligations into two primary pillars: liability arising from contractual relationships (*contractual liability*) and liability arising from negligence or wrongdoing that causes harm to another party (*tort liability* or unlawful acts). Within the realm of modern law, legal liability has shifted from being purely individual-based (*personal liability*) toward the accountability of non-human legal entities, namely corporations.[6] In the dimension of health law, healthcare facilities—both hospitals and clinics—are categorized as medical corporations that independently bear the doctrine of corporate liability (*corporate liability*) by operation of law.

Referring to the doctrine of corporate liability, healthcare facilities are not only legally responsible for medical malpractice errors executed by their medical staff (*vicarious liability*), but also bear an inherent institutional obligation (*non-delegable duty*). This institutional obligation mandates management to provide facilities, infrastructure, operational standards for Infection Prevention and Control procedures, as well as a biologically safe and healthy working environment for all its workers. According to Soerjono Soekanto, the employer's failure to fulfill the obligation of providing a safe working environment legally activates the dimension of legal liability, as it violates the workers' fundamental human rights to safety protection[7]

The relationship between the Theory of Legal Liability and the object of this research serves as a conceptual foundation to analyze the boundaries of the juridical liability of healthcare facilities when biological protection in treatment rooms fails to function, resulting in healthcare workers becoming infected with dangerous pathogens. This theory is applied to reconstruct and construct a clear line of demarcation between the statutory normative obligations of medical financing under the health law and the claims for civil liability based on Unlawful Acts (*Perbuatan Melawan Hukum*) as regulated in Articles 1365 and 1367 of the Indonesian Civil Code.[8] This theoretical division is essential so that healthcare workers gain certainty regarding the most effective legal avenues to demand their rights.

b. Theory of Legal Certainty

The Theory of Legal Certainty formulated by Gustav Radbruch states that law, as a social regulating institution, must be capable of serving three core values in a balanced manner: justice (*Gerechtigkeit*), expediency or utility (*Zweckmäßigkeit*), and legal certainty (*Rechtssicherheit*). Within the discourse of legal philosophy, Radbruch asserts that legal certainty is an absolute prerequisite where positive law must be manifested in written form, drafted clearly, logically, coherently, and free from internal contradictions. This value of *Rechtssicherheit* demands that the law functions as a behavioral guideline

that generates predictability (*predictability*), allowing every legal subject to precisely predict the juridical consequences of any action they take.[9]

Within doctrinal legal research, legal certainty must not merely cease at the existence of legislative texts (formal certainty), but must encompass certainty within the realm of implementation or enforcement (substantive certainty). According to Peter Mahmud Marzuki, substantive legal certainty presupposes that the formulation of norms must not create dual interpretations or administrative ambiguities that potentially trigger the abuse of authority by policymakers. The lack of clarity in the drafting of norms or the presence of a legal vacuum in technical implementing regulations will directly collapse the pillar of utility and injure the sense of justice, which is the primary objective of the existence of the law itself.[10]

In the context of this research, Radbruch's Theory of Legal Certainty is positioned as the primary analytical tool to test the effectiveness of the synchronization between macro-level occupational safety rights in Law Number 17 of 2023 concerning Health and its implementing regulations within Government Regulation Number 28 of 2024. This theory is utilized specifically to dissect the administrative gray areas in the procedures for proving the causal nexus (cause-and-effect relationship) in infectious disease cases. Through this theoretical lens, the research will demonstrate whether current health law regulations have provided definite operational rules of the game for healthcare workers, or conversely, created bureaucratic traps at the healthcare facility level that delay the fulfillment of recovery rights for infected medical personnel.

RESEARCH METHODOLOGY

The research method applied in the writing of this scientific article is normative juridical, which is a doctrinal legal research method that positions the law as a coherently structured system of written norms. The characteristic of this proceeding research is purely doctrinal based on library research that relies on the analytical strength of regulatory texts and legal doctrines.[11]

The approach to the problem used to resolve the legal issues in this research encompasses two types of approaches, namely the statute approach and the conceptual approach. The statute approach is operated by vertically and horizontally examining the consistency of occupational safety protection norms within Law Number 17 of 2023 concerning Health, Government Regulation Number 28 of 2024, and Presidential Regulation Number 7 of 2019 concerning Occupational Diseases. Meanwhile, the conceptual approach is applied by referring to Gustav Radbruch's doctrines of legal certainty as well as the principles of civil liability of medical corporations.

The legal materials used in this research are classified into two primary sources, namely primary legal materials and secondary legal materials. Primary legal materials consist of national laws and regulations that are statutorily binding, while secondary legal materials are sourced from legal scientific journal literature, health law textbooks, and relevant academic views of legal experts. The technique for collecting legal materials is conducted through systematized document studies. Furthermore, all collected legal materials are analyzed qualitatively using the deductive reasoning method, which draws concrete conclusions from general matters in the form of statutory norms toward specific matters regarding the fulfillment of the rights of healthcare workers experiencing occupational diseases.

RESULTS

a. Legal Framework For The Protection Of Health Workers Against Occupational Diseases

Law Number 17 of 2023 concerning Health performs a fundamental codification by placing occupational safety guarantees as a statutory right of healthcare workers. Through Article 273 paragraph (1) letter c, this law explicitly mandates that healthcare workers have the right to occupational safety, health, and legal protection.[12] If tested using Gustav Radbruch's Theory of Legal Certainty, particularly on the value of written legal certainty (rechtssicherheit), the placement of this macro right has met the formality requirements of positive law, which must be written and explicit. However, Radbruch emphasizes that formal certainty will be meaningless without operational predictability.[13] Therefore, in order to transform these abstract norms into operational certainty, the regulation hands down a statutory obligation for healthcare facilities through Article 100 paragraph (1) of Law Number 17 of 2023 concerning Health, which requires the provision of a healthy, safe, and clean working environment. In the dimension of biological risks, this obligation is realized through the provision of standard Personal Protective Equipment and Infection Prevention and Control protocols.

The structuring of this obligation is doctrinally linear with the Theory of Legal Liability, specifically the doctrine of corporate liability. Based on this doctrine, healthcare facilities bear an inherent institutional obligation (non-delegable duty) as the primary workplace safety controller.[14] Therefore, forms of violations against this normative obligation are specifically analyzed through three classifications of corporate negligence:

- Material logistical violations: Actions by the management of healthcare facilities that provide Personal Protective Equipment below medical specification standards (for instance, providing ordinary surgical masks for negative pressure isolation rooms that require N95 respirator masks), or delays in the distribution of protective logistics during a surge in biological exposure.[15]
- Operational systemic violations: The institution's failure to maintain the reliability of biohazard protection infrastructure, such as leaving the air ventilation systems of infectious wards broken, failing to calibrate air filtration equipment, or mixing the evacuation routes of infectious medical waste with general waste.
- Supervisory managerial violations: The absence of drafting up-to-date Infection Prevention and Control operational standards, alongside the lack of periodic oversight by the hospital's occupational health and safety committee regarding healthcare workers' compliance in using protective equipment.[16]

Based on the provisions of Article 853 paragraph (1) juncto Article 856 of Government Regulation Number 28 of 2024 concerning the Implementing Regulation of Law Number 17 of 2023 concerning Health, hospital healthcare facilities that neglect to meet the standardization of working environment maintenance and the provision of Personal Protective Equipment are subject to progressive administrative sanctions by the Central Government, ranging from oral warnings, written warnings, administrative fines, to the permanent revocation of business licenses.

From the perspective of the Theory of Legal Liability, the integration of these progressive administrative sanctions proves that the state does not rigidly apply the concept of absolute liability without fault (strict liability) within the realm of operational sanctions for medical governance. If the concept of strict liability were to be extremefully forced upon every event of biological infection among workers, it would conversely undermine the value of legal utility (zweckmassigkeit) as it could trigger the forced closure of medical facilities and paralyze the continuity of large-scale public healthcare services. Instead, non-compliance with normative occupational health and safety standards is positioned as a strong indication or valid initial evidence (prima facie evidence) that shifts the burden of proof (shifting-burden of proof).[17] The management of healthcare facilities is obligated to prove that they have implemented the maximum

principle of prudence (due diligence) in protecting their workers to be able to exonerate themselves from the imposition of such state administrative sanctions.

b. Proof Of Occupational Diseases As The Basis For Fulfilling Health Workers' Rights

The formal recognition of an infectious disease as an Occupational Disease is a juridical gateway (legal gateway) that activates further statutory protection rights for healthcare workers. When analyzed using Gustav Radbruch's Theory of Legal Certainty, the mechanism for proving the cause-and-effect relationship (causal nexus) in biological infection cases requires an instrument possessing substantive legal certainty to prevent administrative ambiguities that disadvantage medical workers.[18] Indonesian positive law manifests this value of rechtssicherheit (legal certainty) through a systematically regulated 7 (seven)-step occupational diagnosis protocol under Presidential Regulation Number 7 of 2019 concerning Occupational Diseases. This protocol functions to provide scientific predictability to screen, identify, and strictly demarcate between professional risks (professional risk) inherent to medical service duty units and personal exposures (personal exposure) acquired from the social interactions of healthcare workers outside healthcare facilities.

- Workplace Risk Identification: The initial stage to specifically map the biological hazards present within the healthcare worker's environment. This process examines the characteristics of the duty unit (such as infectious isolation wards, microbiology laboratories, or emergency departments) and conducts an audit of the availability and reliability of biological protection systems.
- Exposure Analysis: Delving deeply into the frequency, duration, intensity, and transmission pathways of biological contact between the healthcare worker and the pathogen. This stage examines whether there is a history of direct contact with infectious patients or biological specimens during the execution of official duties that corresponds with the disease's incubation period.
- Clinical Diagnosis: Establishing the validity of the disease's pathology through physical examination, supporting tests (such as thoracic X-rays), and laboratory gold standard tests to ensure the healthcare worker medically suffers from a specific infectious disease (such as Occupational Tuberculosis).
- Causal Nexus Verification: Integrating the three aforementioned pieces of data to draw a final occupational diagnosis conclusion. This process is conducted through the elimination method, which logically proves that workplace exposure is the primary determinant factor triggering the infection, while eliminating the possibility of social exposure risk factors outside the healthcare facility.[19]

In constructing such legal causal relationships, placing identical pathogen genetic strains (for instance, through Whole Genome Sequencing testing) as an absolute, sole prerequisite constitutes a fatal error in legal reasoning and lacks authoritative support. Neither Presidential Regulation Number 7 of 2019 concerning Occupational Diseases nor the international standards of the International Labour Organization have ever established genetic proof as a single requirement. If strain identicalness is strictly enforced as an absolute condition, the value of legal utility will collapse, as healthcare workers will consistently fail to obtain their rights due to the limitations of regional laboratory equipment. Therefore, a legal causal relationship is declared valid and proven by operation of law if supported by other authentic evidence, such as medical record visualizations of the healthcare worker's interaction with infectious patients, epidemiological analyses of transmission clusters in wards, and concrete evidence of ventilation system failures or biological containment breaches within the healthcare facility.

The contextualization of this risk verification also serves as a theoretical foundation in providing rigid scope boundaries for the rights of healthcare workers to refuse medical actions that endanger themselves based on Article 273 paragraph (1) letter i of Law Number 17 of 2023 concerning Health. The Theory of Legal Certainty demands a clear separation of context so that this right of refusal is not abused and does not disrupt service operations:

- Emergency Conditions (Force Majeure): The right of refusal cannot be exercised if the healthcare facility is within a situation of a public health emergency, biological disaster, or regional mass outbreak. Based on the public safety doctrine (salus populi suprema lex esto) and professional codes of ethics, healthcare workers bear a legal obligation to continue performing rescue service actions by optimizing the maximum available protection.[20]
- Non-Emergency Conditions: The right to refuse medical actions can be lawfully executed in routine service situations, if the healthcare facility is tangibly proven to have neglected the provision of standard Personal Protective Equipment (for instance, assigning a nurse to an active tuberculosis ward without an adequate respirator mask), so that the healthcare worker's refusal is protected by law as a form of legitimate self-defense against the management's omission of fatal danger.

c. Legal Liability Of Health Facilities For Health Workers Suffering From Occupational Diseases

The legal liability of healthcare facilities for losses suffered by healthcare workers due to Occupational Diseases requires a strict doctrinal separation between the realm of statutory obligations and the domain of pure civil lawsuits. The Theory of Legal Liability, particularly through the doctrines of corporate liability and non-delegable duty, positions healthcare facilities as medical corporate entities that bear an inherent institutional responsibility to ensure workplace safety. The obligation to facilitate complete medical treatment and rehabilitation for healthcare workers, as regulated in Article 100 paragraph (1) of Law Number 17 of 2023 concerning Health juncto Article 241 paragraph (1) of Government Regulation Number 28 of 2024, constitutes a form of normative obligation arising from the law (obligatione ex lege). [21] The fulfillment of this health recovery right is inherent and active by operation of law once the occupational risk status is medically confirmed through the seven-step diagnosis, without requiring proof of an element of fault (schuld) at the management level. Conversely, civil liability is a secondary legal regime that can only be activated if healthcare workers claim damages for specific losses outside the scope of regular social security compensation.[22]

In order to construct a civil lawsuit over the healthcare facility's failure to mitigate biological risks, the fulfillment of the elements of an Unlawful Act (Perbuatan Melawan Hukum) as regulated in Article 1365 of the Indonesian Civil Code (KUHPerdata) must be dissected cumulatively. The element of an unlawful act is fulfilled when there is a tangible violation of the employer's positive legal obligation to implement Infection Prevention and Control (PPI). The element of fault (fault/schuld) manifests through corporate negligence, such as omitting repairs on mechanical ventilation systems in negative-pressure isolation rooms or distributing Personal Protective Equipment (PPE) below standard respiratory specifications. The element of damage (schade) encompasses material losses in the form of uncovered real medical expenditures, alongside immaterial losses for physical suffering and the reduction of the worker's bodily functional capacity. Lastly, the element of causal nexus demands linear proof that the transmission of pathogens such as Mycobacterium tuberculosis occurred due to a systemic defect in the healthcare facility, rather than external exposure outside the work environment.

The dimension of healthcare facility accountability is expanded by the doctrine of vicarious liability accommodated in Article 1367 of the Indonesian Civil Code, wherein a medical corporation is held responsible for damages arising from the allocated commands or supervisory negligence of its subordinates, such as the occupational health and safety committee or the hospital's operational management. Nonetheless, a rigid legal boundary exists stating that the event of infectious disease transmission to a healthcare worker cannot automatically be utilized as a basis for an absolute legal presumption of the healthcare facility's negligence.[23] The invisible and dynamic characteristics of biological agents place the initial burden of proof on the healthcare worker as the plaintiff to demonstrate where the healthcare facility's breach of duty against PPI standards lies. If the healthcare facility is empirically capable of proving that it has implemented the principle of maximum prudence (due diligence) and complied with all safety protocols, the transmission is then categorized as an inherent professional risk, thereby invalidating the healthcare facility's element of fault by operation of law.

From the perspective of labor law, the stability of the employment relationship of healthcare workers who experience a decline in health significance due to Occupational Diseases is strictly protected to prevent unilateral termination of employment. The imperative prohibition for healthcare facilities to terminate healthcare workers suffering from illness is explicitly regulated in Article 81 number 43 of Law Number 6 of 2023 concerning Job Creation, which amends Article 153 paragraph (1) letter a of Law Number 13 of 2003 concerning Labor. This article prohibits termination of employment on the grounds that the worker is unable to report for work due to illness according to a doctor's statement for a continuous period not exceeding 12 months. [24] A violation of this provision results in the termination being null and void by operation of law (void ab initio) and the healthcare facility is obligated to reinstate the healthcare worker concerned.

If the illness period has exceeded the time limit of 12 consecutive months, the assumption stating that termination can be executed automatically by operation of law (ipso jure) remains a legal reasoning error. The legitimacy of healthcare facilities to propose termination only opens based on Article 81 number 45 of Law Number 6 of 2023, which inserts Article 154A paragraph (1) letter m of Law Number 13 of 2003, stating that termination may be carried out if the worker experiences prolonged illness or disability due to an occupational accident after exceeding the 12-month limit. However, its execution must still proceed through formal industrial relations dispute procedures and the fulfillment of full compensation rights.[25] The healthcare facility is legally obligated to pay the normative rights of the healthcare worker in the form of severance pay at 2 (two) times the statutory provision, long-service appreciation pay at 1 (one) time the statutory provision, and rights compensation pay as regulated in Article 55 paragraph (1) of Government Regulation Number 35 of 2021 concerning Specific Time Employment Agreements, Outsourcing, Working Hours and Rest Times, and Termination of Employment.

d. Legal Certainty In Fulfilling Health And Employment Rights Of Health Workers

Legal certainty in the fulfillment of health and labor rights for healthcare workers substantially rests upon the regulatory capability to provide predictive and concrete legal protection. Referring to the value of legal certainty (rechtssicherheit) within the triad of Gustav Radbruch's legal philosophy, a legal norm must not merely cease at the level of formal certainty in the form of legislative texts alone (formal certainty), but must manifest into the realm of implementation or enforcement (substantive certainty). The value of rechtssicherheit demands that the law functions as a behavioral guideline that generates predictability, allowing legal subjects to precisely project the rights they receive when professional risks occur.[26] In the context of healthcare worker protection, substantive

legal certainty demands operational clarity regarding claim procedures, financing mechanisms, and employment status protection, so that the macro right to occupational safety does not merely become an abstract regulatory ornament but rather an efficacious protective instrument.

However, a critical evaluation reveals a profound gap between written regulatory guarantees (das Sollen) and sociological realities at the practical level (das Sein). The failure to achieve this substantive legal certainty is concretely visible within the administrative gray areas of the verification process for Occupational Accident Benefits claims, specifically for the infectious disease category following the enactment of the new health law. Although Article 100 paragraph (1) of the Health Law juncto Article 241 paragraph (1) of Government Regulation Number 28 of 2024 explicitly establishes the obligation of healthcare facilities to facilitate complete medical treatment and rehabilitation, the absence of technical regulations at the Ministerial of Health Regulation level governing provisional funding schemes creates a fatal impact on the ground. Healthcare workers infected by pathogen droplets while on duty are frequently forced to face recovery delays because the management of healthcare facilities refuses to issue a formal Occupational Disease status under the pretext of an ambiguous source of transmission, thereby forcing sick workers to personally bear their initial medical expenses or confront prolonged bureaucratic disputes.

This dilemma of legal uncertainty becomes further complicated when confronted with the construction of the norm in Article 277 letter a of Law Number 17 of 2023 concerning Health, which prohibits patients or service users from providing false or manipulative clinical data. A premature interpretation that categorizes this provision as a purely imperfect norm (lex imperfecta) solely due to the absence of an internal sanction clause within the body of the Health Law constitutes a fundamental error in legal reasoning. In legal dogmatics, the binding force (gelding) of a norm must not be assessed partially but must be viewed within the unity of an integrated legal system (legal system coherence). The absence of direct criminal sanctions or specific administrative sanctions within the Health Law does not mean that Article 277 letter a loses its enforcement teeth. The characteristic of this norm actually functions as a referential norm that establishes a standard of conduct which, if unlawfully violated, automatically activates legal liability through an external legal regime residing outside the sectoral health law.

The activation of external legal consequences for violations of Article 277 letter a of the Health Law can be solidly enforced through the integration of the prevailing national civil and criminal laws. From the dimension of civil law, the act of a patient intentionally manipulating medical history, thereby causing a healthcare worker to contract a fatal infectious disease, is qualified as a form of fault that fulfills the elements of an Unlawful Act based on Article 1365 of the Indonesian Civil Code. Meanwhile, from the dimension of contemporary criminal law, the manipulation of clinical data by a patient has fulfilled the elements of actus reus (criminal act) and mens rea (criminal intent or awareness of risk) that can be prosecuted using the provisions of Law Number 1 of 2023 concerning the Criminal Code.

Specifically, if a patient consciously conceals their active infection status, thereby transmitting dangerous biological substances to a healthcare worker, such action fulfills the elements of the material offense in Article 330 of Law Number 1 of 2023 regarding the act of spreading dangerous materials that can pose a danger to the life or health of others. Furthermore, if the deception is carried out under the conscious awareness that their actions could harm the healthcare worker treating them, the legal construction can be drawn into Article 421 of Law Number 1 of 2023 related to criminal offenses that intentionally endanger the safety or life of another person. The existence of this new criminal law codification provides a highly rigid coercive force (dwang), thereby proving

that Article 277 letter a of the Health Law is not a void norm, but rather a statutory norm whose enforcement efficacy rests upon cross-sectoral law enforcement.

4. CONCLUSION

Legal certainty regarding the protection of health workers experiencing Occupational Diseases (PAK) has been formally accommodated under Article 273 paragraph (1) letter c of Law No. 17 of 2023 concerning Health, implemented through Government Regulation No. 28 of 2024, which mandates healthcare facilities to fully fund medical expenses and complete rehabilitation. However, substantive legal certainty in field implementation remains hindered by administrative ambiguities, particularly in proving the causal nexus using the seven-step protocol under Presidential Regulation No. 7 of 2019. This uncertainty is exacerbated by errors in legal reasoning among regional healthcare facilities that strictly demand genetic strain verification of pathogens as a mandatory absolute requirement, whereas legally, the causal link is proven valid when supported by other authentic evidence like medical interaction records and workplace epidemiological analysis. In terms of liability, a facility's non-compliance with occupational safety standards serves as *prima facie evidence* of corporate negligence, yet it does not automatically trigger *strict liability* in civil torts; given the dynamic nature of biological agents, infections are classified as inherent professional risks if the facility empirically demonstrates the exercise of *due diligence*. Finally, employment legal certainty provides rigid safeguards for health workers' career stability post-12-month illness under Law No. 6 of 2023 concerning Job Creation, which dictates that termination of employment never occurs automatically (*ipso jure*), but strictly requires formal industrial dispute procedures and full severance pay fulfillment.

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