REGULATORY AND IMPLEMENTATION MISMATCH: A CRITIQUE OF EXISTING HEALTH LAW POLICIES

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ABSTRACT

This study critically examines the inconsistencies between regulation and implementation in health law policy in Indonesia, and how these gaps hinder the fulfillment of constitutional rights to health. Although Indonesia has a comprehensive legal framework rooted in Article 28H of the 1945 Constitution and supported by the Health Law and the National Health Insurance (JKN) program the reality of implementation in the field is still far from expectations. This study uses a qualitative approach with empirical legal research, combining primary data from interviews and field observations with secondary data in the form of regulatory documents, institutional reports, and academic literature. The results of the study show a clear gap between normative expectations and practice, such as unequal access to services, concentration of medical personnel in urban areas, limited infrastructure, and regulatory fragmentation between central and local governments. Case studies in Surakarta and Boyolali show that local capacity, technology adoption, and institutional coordination greatly influence the effectiveness of implementation. Surakarta has been relatively successful in integrating JKN and utilizing health information systems, while Boyolali still faces major challenges through manual referral systems, limited facilities, and uneven distribution of medical personnel. These findings confirm that effective health policies require not only comprehensive regulations, but also harmonization, institutional synergy, fiscal redistribution, and consistent law enforcement. The novelty of this study lies in its attempt to link normative constitutional principles with practical implementation challenges, thereby offering improvement strategies for realizing fairer, more effective, and sustainable health governance.

Keywords: Health law, Regulation, Implementation, Constitutional rights, Public policy

BACKGROUND

Health generally refers to a state of well-being that encompasses physical, emotional, and social aspects, enabling everyone to lead a productive life both socially and economically. Health includes an individual's balance and ability to adapt to their environment, as well as the capacity to perform daily activities well. In a broader view, health is also influenced by various determinants, such as environmental conditions, access to health services, genetic factors, lifestyle, and socio-economic circumstances. Therefore, efforts to achieve and maintain health are not only a personal responsibility, but also involve the role of society and government through supportive policies and services. In Indonesia, the right to health is clearly stated in the 1945 Constitution, especially in article 28H paragraph (1) which reveals that every individual has the right to live in physical and mental well-being,

including the right to obtain health services. In addition, a more detailed explanation is provided in Law No. 36/2009 on Health and its derivative regulations. These regulations should be the basis for ensuring access to fair, quality and affordable health services for all levels of society. The challenges that arise include the unequal distribution of medical personnel, the limited number of health facilities, financing issues, and overlapping regulations that create legal uncertainty. This situation results in difficulties in fulfilling the community's right to health as a whole. Therefore, research on the discrepancy between regulation and implementation in health law policy is very important. Criticism from academics on the policies implemented can provide an opportunity for improvements to the health law system that is more responsive, efficient, and in accordance with the needs of the community.

Health is a fundamental concept that has been broadly defined by various important figures in the field of public health. Basically, health is not only understood as a condition free from disease, but also as a universal right that includes social, environmental and systemic dimensions. As such, health must be viewed within a multidimensional framework that brings together biological, social, economic, and public policy aspects.

One of the early figures to provide a comprehensive definition of health was C.E.A. Winslow (1920). He emphasized that public health is the result of organized community efforts. This definition emphasizes the importance of collective action, focusing not only on disease prevention and life extension, but also on organizing society to create a decent standard of living for all individuals. Winslow's perspective asserts that the success of a health system depends largely on the active involvement of the community in managing the factors that affect collective well-being.

Meanwhile, Henrik L. Blum (1974) deepened the discourse on health by introducing a model of health determinants known as the force-field paradigm. According to Blum, there are four main pillars that interact with each other in determining the degree of health of a person or community, namely environmental factors, heredity, lifestyle, and health services. This model suggests that an effective health policy must consider all four aspects in an integrated manner, as the dominance of one factor without regard to the others will result in inequality in the achievement of public health.

The implementation of health law policy in Indonesia still faces serious challenges, although normatively there is a fairly comprehensive regulatory basis. One of the fundamental problems is the gap in access to health services between urban and rural areas. Communities in cities are relatively easy to obtain quality services due to the availability of more adequate hospital facilities, health centers, and medical personnel. In contrast, people in remote areas often have to face limited facilities, high costs, and long distances to access basic health services. This condition is further exacerbated by the uneven distribution of health workers, where the majority of doctors and nurses are concentrated in big cities, leaving a void of services in rural areas.

On the other hand, health policy implementation is often hampered by overlapping regulations and authorities between agencies, such as between the Ministry of Health, BPJS Kesehatan, and local governments. The lack of coordination across agencies makes the decision-making process slow and often out of sync with the real needs of the community. This situation shows that the existence of comprehensive regulations is not enough without the support of infrastructure, strong institutional mechanisms, and effective coordination. Therefore, a more integrated, equitable, and inclusive implementation of health policies is needed so that the people's constitutional right to health can be guaranteed in real terms.

The implementation of health services in Indonesia is not only faced with the complexity of regulations, but also with disharmony between organizing institutions. Institutions such as the Ministry of Health, BPJS Kesehatan, and local governments often lack solid coordination in policy formulation and implementation. This lack of synchronization can be seen in various aspects, one of which is related to differences in health service claim rates and budget management. For example, the Ministry of Health sets certain service standards and tariffs, but BPJS Kesehatan has its own provisions that are not always in line, while local governments face budget constraints in implementing them. As a result, these overlapping policies confuse health facilities and medical personnel in providing compliant services. On the other hand, weak supervision and law enforcement mechanisms exacerbate the situation. Many administrative violations or non-compliance with legal provisions are not sanctioned, creating the impression that rules can be ignored without consequences. This condition causes a sharp gap between regulations that are normative on paper and real practices in the field. Furthermore, this gap shows the real limitations of the government in guaranteeing the right to health as part of the constitutional rights of citizens. When people witness inconsistencies and uncertainties in health policy, their trust in the government in realizing social justice decreases significantly.

There is a clear gap between the normative expectations of the law and the reality of health policy implementation in Indonesia. Legally, the Health Law and its derivative regulations, such as the National Health Insurance (JKN), are intended to guarantee the equitable distribution of health services, improve service quality, and strengthen inter-agency coordination. Constitutionally, the state is obligated to ensure every citizen obtains the right to health as regulated in Article 28H of the 1945 Constitution. However, field implementation shows significant differences. Urban community access is far better compared to rural or remote areas, which still experience infrastructure limitations, shortages of medical personnel, and difficult access to referral facilities.

Furthermore, the provision of health services is also marked by a lack of harmony between institutions such as the Ministry of Health, BPJS Health, and local governments, leading to policy overlaps, including differences in claim tariffs and budget management. This condition is worsened by weak monitoring and law enforcement mechanisms, which allow many violations or non-compliances to go unaddressed consistently. Consequently, there is a wide chasm between normative regulations and on-the-ground reality. This disparity not only shows the government's limitations in fulfilling citizens' constitutional right to health but also reduces public trust in the government's ability to achieve social justice in the health sector.

This research presents novelty through a critical analysis of regulatory misalignment as the root of fundamental problems in health law, which is often overlooked. Unlike studies that usually focus on technical operational issues like shortages of facilities or medical personnel, this research deeply examines vertical (central-regional) and horizontal (inter-agency) regulatory differences that cause legal uncertainty, overlapping authority, and inefficiency. Its main contribution lies in connecting the constitutional normative dimension (the right to health based on the 1945 Constitution) with the reality of field implementation, so the constructed criticism is theoretical, empirical, and contextual. With this approach, this research is expected not only to identify problems but also to provide strategic recommendations for creating a more harmonious, consistent, and implementable regulatory framework to realize health justice for all Indonesian people.

This research has a very high level of urgency because the discrepancy between health policy regulations and implementation has direct consequences for the fulfillment of the public's constitutional rights. The formulated regulations are essentially intended to guarantee equal and quality access to health services, but in practice, they often do not function as intended. This is reflected in the still wide access gap between urban and rural communities, where population groups in remote areas face limitations in facilities, medical personnel, and adequate infrastructure. This situation not only reduces

the overall quality of health services but also reinforces legal uncertainty that can lead to injustice in fulfilling citizens' basic rights. If this problem is allowed to persist, the risk that arises is the erosion of legal legitimacy and the weakening of public trust in the government as the state administrator, potentially hindering the achievement of national health development goals.

Furthermore, this issue of regulatory misalignment and health policy implementation cannot be viewed merely as an administrative or technical problem alone; it also concerns the sustainability of the entire health legal system. The ineffectiveness of health policy enforcement can increase the potential for social instability, especially when the public perceives injustice in obtaining public services that are their constitutional right. It is in this context that this research becomes highly relevant, as it seeks to identify the root problems causing the weak alignment between legal norms and field implementation. Additionally, this research also aims to formulate strategic recommendations that can strengthen the effectiveness and integrity of the health legal system in Indonesia. With this approach, this research is expected not only to provide a theoretical contribution to the development of health law science but also to offer practical solutions that can be implemented by policymakers in efforts to realize a more just, transparent, and sustainable national health system

RESEARCH METHOD

This research uses a qualitative approach with an empirical juridical research type to analyze the incompatibility of health law regulations and policy implementation. The empirical juridical approach was chosen because it not only examines the normative aspects of health regulations but also explores how these regulations are implemented in practice in the field. Primary data was obtained through in-depth interviews with policy makers, health service providers and the community as service recipients, as well as field observations in areas experiencing limited access to health. Secondary data was collected through document studies of health-related laws and regulations, annual reports of government agencies, court decisions, and related journal articles and news. The collected data were analyzed interactively with data reduction, data presentation, and conclusion drawing, as well as using content analysis to identify key themes such as regulatory disharmony, implementation ineffectiveness, and the impact of implementation weaknesses on the fulfillment of public health rights. Through this method, the research is expected to provide a holistic picture of the root of the problem and recommend appropriate solutions to improve the effectiveness of health law policies.

RESEARCH FINDINGS

1. What are the forms of discrepancies between the regulation and implementation of health law policies in Indonesia in ensuring equitable access to health services?
2. What factors cause differences in regulations and overlapping authority between agencies in the implementation of health law policies?
3. Why is the implementation of health law policies often inconsistent and weak in law enforcement, even though regulations have mandated the protection of health rights?

DISCUSSION

1. Discrepancies in Regulation and Implementation in Ensuring Access to Health Services

Normatively, Indonesia has built a legal framework through the National Health Insurance (JKN) policy that is intended to ensure the fulfillment of the community's right to obtain equitable and fair health services. This regulation is rooted in the constitutional mandate of Article 28H paragraph (1) of the 1945 Constitution which affirms the right of every person to live in physical and mental prosperity, including obtaining health services. Within this legal framework, the state has an obligation to guarantee

universal access to health as part of a human rights-based approach. As stated by Thomas R. Dye in his theory of policy implementation, a policy is not only measured by the quality of its formulation, but also by the success of its implementation in responding to community needs.

However, the reality on the ground shows that there is an implementation gap between the substance of the regulation and its practice. Many National Health Insurance (JKN) participants, especially socioeconomically vulnerable groups, still have to bear the burden of additional costs. This burden arises both in the form of purchasing medicines that are not listed in the national formulary and transportation costs to health facilities that are located far from the place of residence. This fact confirms that although health regulations in Indonesia are normatively inclusive, their effectiveness in ensuring truly equal access for all levels of society is still limited. This condition is in line with Van Meter and Van Horn's view of the policy implementation gap, which emphasizes that differences between written policies and their implementation are often caused by various structural barriers. In the context of health policy in Indonesia, these barriers include limited fiscal and human resources, weak coordination across actors involved, and disparities in institutional capacity at the regional level. Thus, the success of health policy implementation is not only determined by the quality of regulations, but also by the ability of the bureaucratic system and implementing actors to translate these regulations into concrete actions that reach the entire community.

Another factor that widens the gap is the non-uniformity of local government fiscal capacity in allocating health budgets. National regulations stipulate minimum allocation requirements, but not all regions are able to fulfill these requirements. This results in disparities in service quality between regions with high resources and regions that are still dependent on central transfers. In practical terms, urban communities have easier access to quality health services, while rural communities or 3T areas still face limited infrastructure and medical personnel. This structural injustice is consistent with Michael Lipsky's analysis of street-level bureaucracy, where policy implementation is often affected by limited bureaucratic resources at the implementing level.

Although health regulations in Indonesia have provided progressive policy direction, the technical translation into practice in the field still shows significant misalignment. Many normative provisions have actually emphasized the importance of equitable access to health, but implementation is often hampered by limited resources, weak coordination between agencies, and not optimal distribution of health workers and facilities. These conditions have a direct impact on the achievement of the objectives of the National Health Insurance (JKN), which is ideally expected to provide equal health services for all levels of society, both in urban and rural areas.

The misalignment between regulation and implementation indicates a structural gap that requires more comprehensive policy intervention. Harmonization can be realized through increasing fiscal capacity at the regional level so that the health budget is not solely dependent on the central government, equitable distribution of health facilities and personnel so that remote areas are not left behind, and strengthening the supervisory system to ensure accountability of program implementation. With a more structured mechanism and continuous supervision, health policies will not only stop at the formal level, but can actually be implemented effectively. If these steps can be taken consistently, the principle of social justice as mandated by the constitution can be realized in the health sector. Furthermore, this will also

strengthen public confidence in the national health legal system, as regulations are not only seen as written rules, but as instruments that truly protect and fulfill the health rights of citizens.

2. Regulatory differences and overlapping authority in policy implementation

Health law in Indonesia suffers from serious problems due to weak inter-agency coordination in the regulatory process. A phenomenon known as “hyper-regulation” has emerged, characterized by the abundance of regulations in the form of laws, government regulations, and ministerial regulations governing the health sector. Although these numerous regulations are supposed to strengthen the health legal system, in reality they lead to overlaps and unsynchronization between rules. This has led to multiple interpretations in implementation in the field. Health workers, regional bureaucrats, and managers of health care facilities are often confused in determining which regulations should be used as the main reference. A clear example of this is the discrepancy between the Health Law and the Hospital Law, each of which has a different approach to service standards and health worker competencies. This disharmony is further exacerbated by ministerial regulations that sometimes do not refer to or even contradict the regulations above them. As a result, the effectiveness of health policy is hampered and potentially detrimental to public services.

Lack of harmonization among regulations in the health sector is one of the root causes of weak health policy effectiveness in Indonesia. This cannot be separated from the existence of sectoral ego among regulatory agencies, where each agency tends to emphasize its institutional interests without considering the need for cross-sectoral coordination. The Ministry of Health, Ministry of Manpower, and local governments often issue policies or regulations related to health services unilaterally, resulting in overlapping legal norms. For example, in regulating the employment of medical personnel, there are differences in focus between the protection of workers' rights, public service obligations, and the need for distribution of health workers in remote areas. This lack of clarity not only creates an administrative burden for health workers, but also has a direct impact on the quality of services received by the community. In a legal context, this condition shows weak regulatory integration, resulting in legal uncertainty that ultimately harms the community as the main beneficiary of health policy.

In addition, overlapping authority is increasingly evident in the relationship between the central and local governments. The implementation of regional autonomy, which aims to improve the effectiveness of public services, often creates a dilemma in health policy implementation. Regulations from the central government are often not in line with the resource capacity and specific needs in the regions, so local governments have to choose between following central directives or adjusting to local conditions. This situation slows down the implementation process and creates inconsistencies in various regions. The case of handling the COVID-19 pandemic is a concrete example, where differences in policies between the center and regions regarding social restrictions, quarantine rules, and vaccine distribution caused confusion in the community. This lack of coordination has resulted in a slow response to health emergencies, reducing the effectiveness of response efforts and exposing the fragile synergy of health policies in Indonesia.

Thus, the main factors behind regulatory disharmony and overlapping authority are excessive regulatory fragmentation, sectoral ego between agencies, and weak coordination between the center and regions. These conditions create legal uncertainty that directly affects access, quality, and equity of health services. If not addressed immediately, this disharmony has the potential to reduce the legitimacy of health policies in the eyes of the public, hinder the achievement of national health development, and ultimately widen social disparities. Therefore, a mechanism is needed to strengthen regulatory harmonization, improve cross-sectoral coordination, and synergize the relationship between the central

and local governments. These steps are important not only to ensure the consistency of health policy implementation, but also to guarantee the fulfillment of the community's constitutional rights to effective, equitable, and sustainable health services.

3. Why is Health Law Policy Implementation Often Inconsistent and Weak in Enforcement, Despite Regulations Mandating the Protection of Health Rights?

Weaknesses in health law implementation and enforcement in Indonesia can be analyzed through three main domains, namely fiscal-organizational, technical-operational, and regulatory and accountability. These three domains do not stand alone, but are interrelated and form a complex chain of problems. In the fiscal-organizational domain, problems arise from limited regional budget capacity, which makes it difficult for regulations to be implemented optimally. In the technical-operational domain, obstacles can be seen from the unpreparedness of resources, both in the form of the availability of drugs, health workers, and supporting infrastructure, so that service standards are not achieved. Meanwhile, in the regulatory and accountability domain, weak supervisory mechanisms, sanctions, and overlapping regulations lead to inconsistencies in policy implementation. The interaction of these three aspects then creates a real gap between formal regulations that are normatively designed and implementation practices in the field, so that the main goal of realizing equitable and equitable access to health has not been fully achieved.

From a fiscal-organizational perspective, the main obstacle arises from the inequality of fiscal capacity between regions. National health regulations, such as those governing Minimum Service Standards (MSS) and subsidy obligations, are essentially binding. However, the reality is that not all regions have sufficient fiscal capacity to allocate budgets as needed. Regions with low fiscal capacity are often only able to cover basic operations, while the financing of broader health services still depends on central transfers. As a result, the burden of service costs shifts to households and increases the risk of catastrophic health expenditure in vulnerable groups. This suggests that while regulations are in place, limited local fiscal capacity undermines their implementation (Fattah et al., 2023; Laksono et al., 2023).

On the technical-operational aspect, the biggest challenges lie in the availability of essential drugs, the distribution of medical personnel, and the readiness for digital transformation. Many puskesmas are not always able to provide drugs listed in the formulary, so patients are often forced to buy drugs outside the health facility. In addition, the distribution of health workers, especially specialists, is still unequal between urban and rural areas. This extends the referral chain and reduces the effectiveness of services. Digital transformation through e-health and electronic medical records (EMR) has actually begun to be implemented, but its adoption has not yet reached the highest level. In addition, the distribution of health workers, especially specialists, is still unequal between urban and rural areas. This extends the referral chain and reduces service effectiveness. Digital transformation through e-health and electronic medical records (EMR) has already begun, but adoption is uneven. Facilities in big cities are relatively better prepared, while remote areas are constrained by network infrastructure and digital literacy of health workers. These factors show that unequal technical readiness is a serious obstacle in realizing the effectiveness of health regulations (Fanda et al., 2024; Hossain et al., 2025).

Meanwhile, from the perspective of governance and accountability, the problem arises not in the absence of regulation, but in weak oversight and inconsistencies between policies. Regulations on service standards, claim rates, and subsidy mechanisms are available, but implementation is often inconsistent. Administrative sanction mechanisms are weak, while supervision of institutional compliance is not carried out on an ongoing basis. Inter-subregulatory inconsistencies, such as differences between national claims tariff policies and regional procurement, create legal loopholes that are exploited for local interests. Administrative barriers in the BPJS claims process also worsen the situation as they slow down hospital payments and add to operational costs (Ahsan et al., 2025).

Overall, the weakness of health law implementation and enforcement in Indonesia cannot be viewed as a stand-alone issue, but rather is the result of a complex interaction between fiscal limitations, technical

barriers, and weak institutional governance. Fiscal constraints are reflected in the limited health budget allocation, which has led to uneven provision of health services, especially in rural and remote areas. Technical barriers can be seen in the low availability of fairly distributed medical personnel, limited infrastructure, and a health information system that is not yet fully integrated. Meanwhile, the governance aspect shows that there are overlapping regulations, ineffective coordination between agencies, and weak monitoring mechanisms for the implementation of existing health policies.

These conditions emphasize that improving the health system cannot rely solely on drafting new regulations, but also requires an integrated and comprehensive strategy. The strategy includes fiscal redistribution to ensure equitable health financing, strengthening technical capacity through improving the quality of human resources and the use of information technology, as well as harmonizing regulations so as not to cause norm conflicts in the field. Consistent and sustainable supervision is also an important key to ensure that policy implementation is in line with the initial objectives, namely improving the quality and accessibility of health services for the entire community.

Thus, challenges in health law implementation and enforcement in Indonesia should be viewed as structural issues that require long-term solutions. Social justice-oriented policy formulation, cross-sector collaboration, and strong political commitment from the central to local governments will determine the success of health reform efforts. If these strategies can be implemented consistently, then the goal of equal access to health services will not only stop at the normative level, but can be achieved in real terms and felt by all levels of society.

Table 1: Interview Data

Responden	Kecamatan	Statement
A	**Surakarta**	A private sector worker mentioned that the hospital's online registration system facilitates access to services, but there are still many people, especially the elderly, who have difficulty utilizing the technology. She emphasized the importance of mentoring to make digital services more equitable.
B	**Boyolali**	A farmer in the countryside is more likely to utilize the services of a midwife or mantri because of the distance to the puskesmas. These services are quite helpful, but limited facilities mean that patients must still be referred to the hospital, which is an obstacle for people without private vehicles.
C	**Surakarta**	Access to health services is easier because facilities are available quite complete and close by, the JKN program helps reduce costs, although there are still constraints on waiting times for specialists.
D	**Boyolali**	Access to health services is difficult, especially in mountainous areas due to long distances to hospitals, slow referral processes, so the benefits of health regulations have not been felt equally.

CASE STUDY

Comparison of Health Policy Implementation: Surakarta vs Boyolali

The implementation of health policies in Surakarta City has shown good achievements, especially in terms of the implementation of the National Health Insurance (JKN) and efforts to achieve Universal Health Coverage (UHC). This success is shown by the high level of JKN membership and the awareness of the community to utilize available health services. Important factors supporting this include the commitment of the local government in integrating central policies into local programs, active involvement of health facilities such as puskesmas and hospitals, and community participation through health cadres. With a good coordination pattern, Surakarta is able to minimize the distance between formal regulations and real implementation in the field.

In addition to institutional support, Surakarta has also started to utilize health information technology. The implementation of systems such as PCare and information management at puskesmas is an important step in strengthening basic service governance. These systems allow for more structured patient data collection and facilitate monitoring of JKN implementation at the primary care level. Although still in the evaluation phase, these efforts show that the city government is serious about improving service efficiency and reducing potential administrative barriers. However, challenges remain, particularly in the availability of specialized medical personnel and certain medications that cannot always be procured at the primary healthcare level.

In contrast, the situation in Boyolali district shows a different dynamic. Although the region is within the same Greater Solo region, Boyolali faces major challenges in the health referral system. The patient referral process is still mostly done manually via telephone without the support of an integrated electronic information system. This results in delays in patient handling, especially in emergency conditions, and reduces the effectiveness of coordination between health facilities. This condition confirms the large gap between national regulations that emphasize the importance of an integrated referral system and the operational reality on the ground.

Another challenge faced by Boyolali lies in the limited infrastructure and distribution of medical personnel. Health facilities in rural areas, especially in mountainous areas, are still inadequate. The number of medical personnel is also uneven, making it difficult for people in remote areas to access quality health services. This situation further widens the disparity between urban and rural communities in obtaining equal health services. Thus, although normatively health regulations apply equally, the capacity of regions in carrying out implementation is the main differentiating factor.

The comparison between Surakarta and Boyolali shows that regional characteristics greatly influence the effectiveness of health policy implementation. Surakarta, with the support of technology, institutional capacity, and public awareness, has succeeded in bringing regulations closer to implementation. In contrast, Boyolali still faces significant gaps due to limited infrastructure, distribution of medical personnel, and lack of integration of health information technology. This shows that the success of health policy is not only determined by formal regulations, but is also strongly influenced by regional readiness in fiscal aspects, technology, and institutional coordination. Therefore, a more adaptive strategy in accordance with the local context is needed to ensure equitable access to health services in both regions.

Table 2: Comparison of health policy Implementation: Surakarta and Boyolali

Aspek	Surakarta	Boyolali
Determinants of Succes	Information technology, ıstitutional capacity, ommunity participation	Limited regional capacity, distribution of medical personnel, lack of technology
Key challenges	Availability of specialists & certain drugs	Manual referral system, limited infrastructure, distribution of medical personnel
Institutionalizati on & Coordination	Good coordination between puskesmas, hospitals, and health cadres	Coordination between facilities is still manual, referrals via telephone, less effective
Information Technology Utilization	Has implemented PCare & information system puskesmas for JKN monitoring	No information system yet integrated referral, still manual
Medical Personnel	Fairly available, however is still lacking for specific specialists & drugs	Distribution of medical personnel is not even, shortages in rural & mountainous areas
Health infrastructure	Facilities are relatively adequate and well integrated	Facilities in rural/mountainous areas limited, widening disparities city village
Service efficiency	More efficient thanks to technology support & governance	Less efficient due to limited infrastructure & technology

CONCLUSION

This study shows that although Indonesia has a relatively comprehensive health regulatory framework, its implementation in the field is far from optimal. Rules that normatively guarantee people's right to health are often inconsistent due to overlapping regulations, weak coordination between agencies, and limited infrastructure and distribution of health workers. This situation creates a significant gap between urban and remote areas in terms of access to health services. Thus, the main objective of health policy to provide fair and equitable protection for all citizens has not been fully realized in practice.

The mismatch between regulation and implementation also has implications for the declining level of public trust in the health legal system. The right to health, which is actually part of human rights, often cannot be enjoyed proportionally due to systemic structural and technical barriers. Therefore, solving this problem requires a serious commitment from the government to strengthen cross-sectoral coordination, harmonize regulations so that they do not contradict each other, and ensure that every health policy is designed with implementation aspects in all regions of Indonesia in mind. These efforts must be complemented by a continuous monitoring mechanism so that regulations do not stop at the normative level, but are truly effective in improving the quality of health services nationally.

REFERENCE

Affandi, H. (2019). Implementation of the right to health under the 1945 Constitution: between regulation and realization of state responsibility. Positum Law Journal, 4(1), 36-56.

Annisa, F. N. (2023, March). Analysis of Article 28 H of the 1945 Constitution (Health Services) through BPJS. In Proceeding Legal Symposium (Vol. 1).

Arief, B. (2023). Medical waste management in Indonesia: The gap between regulation and implementation. Journal of Public Health, 12(1), 45-58.

Arliman, L. (2014). Protection of Children's Rights in Obtaining Health Services. Journal of Advocacy, 5(1).

Asmi, A. S., & Haris, A. (2020). Analysis of health worker performance on the quality of health services to the community. Scientific Journal of Health Sandi Husada, 9(2), 953-959.

Fatharani, N. (2024). Access to health services in remote areas.

Fauzan, A. (2020). The role of Law No. 32 of 2009 in medical waste management. Journal of Health Law, 8(2), 15-27.

Karim, M. I. T., Moenta, A. P., & Riza, M. (2018). Implementation of local government policies in the field of public health through the National Health Insurance. Amanna gappa, 53-63.

Karwur, C. E. T. (2024). Fulfillment of the right to health in terms of article 28 h paragraph 1 of the 1945 constitution of the republic of indonesia. Lex privatum, 13(2).

Member, G. (2025). Critical review of important decisions related to legal protection of medical personnel and patients in Indonesia. Berajah Journal, 5(1), 13-20.

Nugroho, A. (2025). Legal framework for health data protection: Safeguarding patient privacy and institutional needs. Indonesian Journal of Health and Law Governance Policy, 1(1), 35-47.

Putri, S., Wardani, A. R., Jasinta, I., Puspita, A. A., & Stogmuller, K. (2025). A critical review of Indonesia's health law and its implementing regulations: Strengths and challenges. South-East Asian Journal of Advanced Law and Governance, 2(1), 1-19.

Ridwan, R., Sadewa, I., & Sutoto, K. A. S. (2024). COVID-19 pandemic and mental health law in Indonesia: A review of regulations and implementation challenges. Siber Nusantara of Law and Politic Review, 1(1), 1-8.

Shalihah, A., & Nury, M. (2024). Implications of the Omnibus Health Law for the welfare of the public and medical personnel. De Recht: Journal of Police and Law Enforcement, 2(2), 77-90.

Sheikh, K., Saligram, P. S., & Hort, K. (2015). What explains regulatory failure? Analyzing the architecture of health care regulation in two Indian states. Health policy and planning, 30(1), 39-55.

Siti, D., & Nugroho, A. (2021). Legal challenges of telemedicine in Indonesia: A study of regulation and implementation. Journal of Indonesian Health Law, 5(2), 45-60.