JURNAL AKTA
Volume 13 No. 2, June 2026
SINTA 2,
Decree No. 164/E/KPT/2021

Comparison of Civil Legal Responsibility in BPJS Health Services in Indonesia and National Health Service in England

Helma Widya[1)] & Angga Aldilla Gussman[2)]

[1)]Universitas Islam Sumatera Utara, Indonesia, E-mail: helmawidya140969@gmail.com

[2)]Universitas Jambi, Indonesia, E-mail: anggagussman8686@gmail.com

Abstract. *This study examines and compares civil legal liability in the provision of health services between the Social Security Administration for Health (BPJS Kesehatan) in Indonesia and the National Health Service (NHS) in the United Kingdom. Both health insurance systems represent concrete forms of state intervention in fulfilling citizens' basic rights to health, but have fundamentally different legal foundations, institutional structures, and civil legal liability mechanisms. Using a normative-comparative legal research method, this study analyzes the legal construction of civil liability, dispute resolution mechanisms, and legal protection for participants in both systems. The results show that Indonesia still relies on a liability approach based on the Civil Code (KUHPerdata) and sectoral regulations with high institutional fragmentation, while the United Kingdom has established an integrated NHS Resolution system with a mature negligence doctrine and an efficient compensation mechanism. This study recommends structural reforms to the BPJS Kesehatan civil legal liability system towards a more integrated, transparent, and participant-protection-oriented model.*

Keywords: *BPJS Health; Civil Legal Liability; Comparative Health Law; Malpractice; NHS.*

1. Introduction

The right to health is a universally recognized human right, as affirmed in Article 25 of the 1948 Universal Declaration of Human Rights (UDHR) and Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). In the context of modern nations, the fulfillment of the right to health is realized through various models of health insurance systems organized by the state, both through social insurance mechanisms and direct provision of health services. Two of the most significant models and those that have attracted global attention are the National Health Insurance (JKN) system managed by BPJS Kesehatan in Indonesia, and the National Health Service (NHS) in the United Kingdom, which was established in 1948.

BPJS Health was established based on Law Number 24 of 2011 concerning the Social Security Administration Agency,(Undang-Undang Nomor 24 Tahun 2011 Tentang Badan Penyelenggara Jaminan Sosial, 2011, p. 24). as a transformation of PT Askes

(Persero). The establishment of BPJS Kesehatan is a direct mandate of Law Number 40 of 2004 concerning the National Social Security System (SJSN),(Undang-Undang Nomor 40 Tahun 2004 Tentang Sistem Jaminan Sosial Nasional, 2004). which outlines the state's responsibility for providing social security for all Indonesians. By the end of 2022, BPJS Kesehatan had covered more than 248 million participants, or approximately 90% of Indonesia's total population, making it the world's largest social health insurance program by number of participants (Siregar et al., 2025).

On the other hand, the UK NHS was established through the National Health Service Act 1946 and currently operates under the NHS Act 2006 and its amendments,(NHS Act 2006, 2006) One of the oldest and most comprehensive tax-funded health systems, the NHS provides universal health coverage to all UK residents, regardless of financial ability. With an annual budget of over £180 billion, the NHS has become an international benchmark for rights-based healthcare delivery.

The legal issues that arise in the implementation of these two systems, particularly those related to civil liability, are complex. In the Indonesian context, the fundamental question of who is civilly responsible for losses to participants—whether it is BPJS Kesehatan as the provider, partner health facilities (faskes), or individual health workers—does not yet have a uniform and comprehensive answer in existing laws and regulations (Siswati, 2013). This fragmentation of legal responsibility creates legal uncertainty for injured participants. Unlike Indonesia, the UK has a more established legal liability system through the NHS Resolution mechanism (formerly known as the NHS Litigation Authority), which acts as the central body for handling clinical negligence claims against NHS Trusts. Civil law doctrines developed through jurisprudence, such as the Bolam test and its modification in the Bolitho case, provide a clear framework for determining legal liability in NHS healthcare.

Comparative law research between the BPJS Kesehatan and NHS systems in the context of civil legal liability is highly relevant and urgent, given that Indonesia is still striving to refine the JKN legal framework. The results of this study are expected to provide scientific contributions as well as policy recommendations for the development of a more effective, equitable, and optimally protecting participant rights for the BPJS Kesehatan civil legal liability system. Based on this background, this study formulates two main questions. First, how is the legal construction of civil liability in the provision of health services by BPJS Kesehatan in Indonesia and the NHS in the UK? Second, what are the fundamental similarities and differences between the civil legal liability systems of the two systems, and what are the implications and lessons that can be learned for the development of Indonesian health law?

2. Research Methods

This research is normative legal research with a comparative law approach. Normative legal research is research conducted by examining library materials or secondary data (Soekanto & Mamudji, 2011).This study covers legislation, legal doctrine, jurisprudence, and relevant legal literature from the two jurisdictions studied: Indonesia and the United Kingdom. The approach used in this study includes three complementary approaches. First, the statute approach, which examines all regulations related to BPJS Kesehatan, starting from Law Number 40 of 2004, Law Number 24 of 2011, and Presidential Regulation Number 82 of 2018 concerning Health Insurance (Peraturan Presiden Nomor 82 Tahun 2018 Tentang Jaminan Kesehatan, 2018). to the

technical regulations below it as well as NHS regulations in England, especially the NHS Act 2006, the Health and Social Care Act 2012, and the NHS Constitution. Second, the conceptual approach, which examines relevant civil law concepts such as unlawful acts (onrechtmatige daad), breach of contract (toerekenbare tekortkoming), vicarious liability, and tortious liability. Third, the comparative approach, which identifies similarities and differences between the two legal systems studied to find the best model (best practices) for the development of Indonesian law.

The legal materials used in this study consist of primary, secondary, and tertiary legal materials. Primary legal materials include Indonesian and English laws and regulations, as well as court decisions (jurisprudence) from both countries relevant to civil legal liability in healthcare services. Secondary legal materials include legal textbooks, scientific journals, articles, and various previous research results related to healthcare law, civil law, and the healthcare insurance system. Tertiary legal materials consist of legal dictionaries, legal encyclopedias, and other reference sources that serve as complements. The analytical method used is qualitative analysis with descriptive-analytical techniques. The collected legal materials are analyzed systematically and in-depth to answer the established problem formulation (Marzuki, 2016). The analysis process is carried out in stages: (1) inventory of legal materials; (2) identification and classification of relevant legal norms; (3) systematic and contextual analysis of these norms; and (4) comparative synthesis to produce conclusions and recommendations that can be scientifically justified.

3. Results and Discussion

3.1. Legal Construction of Civil Liability in BPJS Health Services in Indonesia

Civil legal liability in the BPJS Kesehatan system in Indonesia cannot be separated from the general civil legal framework derived from the Civil Code (KUHPerdata), specifically Book III on Contracts. In this context, there are two basic constructions of civil liability that can be applied: first, liability based on breach of contract (Article 1243 of the Civil Code) which stems from the contractual relationship between the parties; and second, liability based on unlawful acts or onrechtmatige daad (Article 1365 of the Civil Code) which does not require a prior contractual relationship. The legal relationship in the BPJS Kesehatan system is tripartite and complex, involving at least three main parties: BPJS Kesehatan as the organizer of the JKN program, health facilities (faskes) as providers of health services, and participants/patients as beneficiaries (Khairandy, 2013). The relationship between BPJS Kesehatan and health facilities is realized through a contractual cooperation agreement (PKS) (Charisso, 2026). Meanwhile, the relationship between health facilities and participants/patients is therapeutic in nature, which in law is known as in spanning sverbintenis (an agreement to make efforts) not result aatsverbintenis (an agreement to produce results), which means that health workers are obliged to provide the best efforts, not to guarantee healing results.

In the event of a loss experienced by a BPJS Health participant, the most common basis for a civil lawsuit is Article 1365 of the Civil Code concerning unlawful acts, which requires the fulfillment of four elements: (1) the existence of an unlawful act (onrechtmatige daad); (2) the existence of a mistake (schuld) from the perpetrator; (3) the existence of a loss (schade) experienced by the victim; and (4) the existence of a causal relationship (oorzakelijk verband) between the act and the loss that arises (Fuady, 2013). Fulfilling these four elements in health care disputes often presents a

challenge for participants who feel they have been harmed, particularly in proving the elements of fault and causality in the context of technical medical actions.

The Indonesian Supreme Court's jurisprudence, in several important decisions, has affirmed civil legal liability for BPJS Kesehatan services. In Decision Number 1416 K/Pdt/2018,(Putusan Nomor 1416 K/Pdt/2018) The Supreme Court affirmed that hospitals as institutions can be held liable for losses suffered by patients due to the negligence of their healthcare workers, based on the principle of respondeat superior, which in Indonesian law is analogous to the provisions of Article 1367 of the Civil Code concerning responsibility for the actions of others. Within the sectoral legal framework, civil legal responsibility in BPJS Kesehatan services is also regulated by several specific laws. Law Number 29 of 2004 concerning Medical Practice (Undang-Undang Nomor 29 Tahun 2004 Tentang Praktik Kedokteran, 2004, p. 29) establishes professional standards for doctors and dentists, and regulates civil sanctions for violations of these standards. Law Number 44 of 2009 concerning Hospitals (Undang-Undang Nomor 44 Tahun 2009 Tentang Rumah Sakit, 2009,) expressly regulates the responsibility of hospitals, particularly in Article 46 which states that hospitals are legally responsible for all losses caused by negligence by health workers in the hospital.

Law Number 36 of 2009 concerning Health in Article 58 gives every person the right to demand compensation from health workers and/or health providers who cause losses due to errors or negligence in health services. This provision strengthens the position of patients/participants as legal entities with the right to sue (locus standi) in healthcare disputes. The fundamental issue that arises concerns the legal standing of BPJS Kesehatan itself in the context of civil liability. BPJS Kesehatan is a public legal entity established by law with the primary function of managing funds and administering the National Health Insurance (JKN) program, not directly providing healthcare services (Koeswadji, 2002). The function of providing health services is carried out by BPJS Kesehatan partner health facilities, both primary health care facilities (FKTP) and advanced referral health care facilities (FKRTL) (Sudiari, 2022). Thus, when losses occur due to inadequate health services, BPJS Kesehatan cannot be held directly responsible for medical actions carried out by partner health facilities (Peraturan Menteri Kesehatan Nomor 28 Tahun 2014 Tentang Pedoman Pelaksanaan Program Jaminan Kesehatan Nasional, 2014). However, BPJS Kesehatan can be held responsible for aspects directly related to its administrative functions, such as: rejection of invalid claims, delays in payment of claims resulting in health facilities refusing to provide services to participants, or policies that limit participants' access to health services that should be guaranteed.

Another important aspect is the dispute resolution mechanism within the BPJS Kesehatan system. Based on Presidential Regulation Number 82 of 2018 and BPJS Kesehatan regulations, there are several available resolution mechanisms: (1) internal complaints through BPJS Kesehatan offices; (2) mediation through the Indonesian Medical Disciplinary Honorary Council (MKDKI) for disputes related to medical discipline; (3) mediation through the Consumer Dispute Resolution Agency (BPSK) if the participant is a consumer; and (4) civil lawsuits through the district court (Purwoleksono, 2014). However, this fragmentation of dispute resolution mechanisms creates confusion and legal uncertainty for participants. No single body has full authority to comprehensively resolve disputes involving all aspects of BPJS Kesehatan services. Aggrieved participants must navigate multiple dispute resolution forums with

limited competence in specific areas, making the process of obtaining justice extremely lengthy, tedious, and expensive.

Another weakness in the BPJS Kesehatan civil liability system is the lack of a responsive and systemic compensation mechanism. Unlike tort law systems in common law countries, which have no-fault compensation mechanisms for several categories of medical losses, in Indonesia, injured participants are almost entirely dependent on proving fault (fault-based liability), which is practically very difficult given the technical complexity of medical procedures and the information asymmetry between patients and healthcare providers (Pohan, 1985). Supreme Court of the Republic of Indonesia in Decision Number 3666 K/Pdt/2017 (*Putusan Nomor 3666 K/Pdt/2017*, 2017) affirms that the legal relationship between patients and healthcare facilities contains a fiduciary dimension, placing the healthcare facility in a position of obligation to prioritize the patient's interests over its own commercial interests. This ruling aligns with the views of Indonesian healthcare law scholars who emphasize the importance of the ethical dimension in medical relationships as a basis for legal responsibility (Komalawati, 1989).

The provisions of Article 32 of Law Number 44 of 2009 concerning Hospitals guarantee patient rights This includes the right to receive humane, fair, and non-discriminatory services, which serve as a normative basis for BPJS Kesehatan participants to defend their rights in legal relations with health facilities. In its 2020 report, the National Commission on Human Rights (Komnas HAM) noted that discrimination against BPJS Kesehatan participants in health services persists, particularly PBI (Premium Assistance Recipients) from poor communities (Komnas HAM, 2020). Overall, the legal framework for civil liability within the Indonesian BPJS Kesehatan system can be concluded to be fragmented, fault-based, and lacking an integrated mechanism. Although various legal norms, scattered across various laws and regulations, exist that, in principle, provide protection to participants, their implementation in practice is far from optimal. Comprehensive reform, encompassing not only normative but also institutional aspects, is needed to establish an effective civil liability system within the BPJS Kesehatan ecosystem (Hernoko, 2010).

3.2. Legal Construction of NHS Civil Liability in England and Comparative Analysis with BPJS Health

The UK's National Health Service (NHS) operates under a common law legal system that is fundamentally different from Indonesia's civil law system. The NHS's philosophical foundation as a tax-funded universal healthcare provider informs the construction of its civil legal responsibilities. The NHS Constitution, established under the Health and Social Care Act 2008 and updated in 2019 (United Kingdom, 2019), affirms patient rights and the NHS's obligations to provide safe, effective, and patient-centered healthcare. In the English common law system, civil liability in NHS healthcare is built on the foundation of the tort of negligence, which requires the fulfillment of three elements: (1) the existence of a duty of care from the service provider to the patient; (2) the existence of a breach of that duty; and (3) the existence of damage caused causally by the breach of that duty (Health and Social Care Act 2012, 2012). Unlike the Indonesian system, which relies heavily on written codification, the English system relies heavily on judicial precedents developed gradually through court decisions over more than a century.

The most important milestone in the development of medical negligence law in England was the case of Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582 (Bolam v Friern Hospital Management Committee, 1957). In this decision, Judge McNair formulated the Bolam test, which has become the gold standard for assessing whether a healthcare professional has met the required standard of care. The Bolam test states that a physician is not considered negligent if his or her actions are in accordance with accepted practice by a responsible body of medical men skilled in that particular art.

The Bolam test was later significantly modified by the House of Lords in the case of Bolitho v. City and Hackney Health Authority [1998] AC 232 (Bolitho v City and Hackney Health Authority, 1998). The House of Lords affirmed that while peer acceptance standards of medical practice remain relevant, the courts have the power to overrule medical opinions that are not logically sound, even if they are supported by a group of competent doctors (Yen, 2022). This modification introduces a dimension of legal rationality into the assessment of medical negligence, preventing doctors from overprotecting themselves on the basis of professional solidarity. In terms of duty of care, the test in the NHS context refers to the three-stage test developed in the case of Caparo Industries plc v. Dickman [1990] 2 AC 605: (Caparo Industries plc v Dickman, 1990) (1) foreseeability of harm, namely whether the harm that occurs can be reasonably estimated; (2) proximity of relationship, namely whether there is a sufficiently close relationship between the service provider and recipient; and (3) whether it is fair, just and reasonable to impose a duty, namely whether it is just and proper to establish such a legal obligation. In the context of NHS patients, these three elements are generally easily met given the direct relationship between the NHS and the patients who use its services.

The aspect of causality in NHS medical negligence law is determined through the but-for test, as developed in the case of Barnett v. Chelsea and Kensington Hospital Management Committee [1969] 1 QB 428, (Barnett v Chelsea and Kensington Hospital Management Committee, 1969) which asks: "but for" the defendant's negligence, would the harm suffered by the plaintiff have occurred? If the answer is that the harm would have occurred even without the negligence, then causation is not proven. While this causation test often presents evidentiary difficulties in complex medical cases, English courts have developed various modifications to accommodate the uncertainties of medical science. One of the most significant legal developments in recent decades was the English Supreme Court's decision in Montgomery v. Lanarkshire Health Board [2015] UKSC 11 (Montgomery v Lanarkshire Health Board, 2015). This ruling revolutionized informed consent law in the UK by shifting the standard for risk disclosure from the doctor's perspective (the Bolam test) to that of a reasonable patient. Post-Montgomery, doctors were obligated to disclose any risks a reasonable patient might consider material in their circumstances, not just those risks a reasonable medical practitioner would normally disclose. This represented a paradigmatic shift that placed patient autonomy as a central value in the therapeutic relationship.

The legal accountability mechanism within the English NHS is also supported by the NHS Resolution system (formerly the NHS Litigation Authority), a dedicated body tasked with managing legal claims against NHS Trusts and Foundation Trusts (NHS Resolution, 2023). NHS Resolution operates through the Clinical Negligence Scheme for Trusts (CNST), (Cooke-Hurle, 2023) A mutuality-based clinical negligence insurance system. Through the CNST, NHS Trusts pay an annual premium, and NHS Resolution

covers claims for clinical negligence occurring within their Trusts. In the 2022/23 financial year, NHS Resolution handled claims with a total estimated liability value of over £83 billion, reflecting the scale of the clinical negligence problem facing the NHS (Cooke-Hurle, 2023).

The NHS Resolution system offers several advantages over the existing system in Indonesia. First, centralized claims handling allows for consistency in the application of legal standards and compensation amounts. Second, the availability of a specialized team of legal and medical experts ensures that each claim is handled with adequate competence. Third, this system encourages systemic learning from cases of negligence to prevent recurrence, in line with patient safety principles (Healthcare Safety Investigation Branch (HSIB), 2023). In addition to NHS Resolution, the UK also has the Parliamentary and Health Service Ombudsman (PHSO), which serves as an alternative dispute resolution body that is more accessible to patients. The PHSO can investigate complaints not resolved through the NHS and recommend remedial action and compensation (Parliamentary and Health Service Ombudsman, 2022). NHS Patient Advice and Liaison Service (PALS) (Cooke-Hurle, 2023) is also available in every NHS Trust to assist patients experiencing service issues. This layered yet integrated structure provides NHS patients with a range of complementary resolution pathways.

The Care Quality Commission (CQC) is an independent regulator of healthcare services in the UK (Care Quality Commission (CQC), 2023). also plays a crucial role in the NHS legal liability ecosystem. The CQC has the authority to conduct inspections, issue warnings, and even revoke the operating licenses of healthcare facilities that fail to meet standards. The CQC provides a layer of regulatory oversight that complements the litigation liability system, creating incentives for NHS Trusts to continually improve the quality of care. Regarding vicarious liability, the NHS system in England has developed this principle more comprehensively. Based on the case of Lister v. Hesley Hall Ltd [2001] UKHL 22, (Lister v Hesley Hall Ltd, 2001) NHS Trusts are liable for negligent acts committed by their healthcare professionals acting as employees or agents of the Trust. This doctrine provides patients with assurance that the relevant NHS Trust will indemnify them for clinical negligence, without the patient needing to separately prove the liability of each healthcare professional individually.

The concept of Chester v. Afshar [2004] UKHL 41 (Chester v Afshar, 2004)extends the obligation for NHS doctors to disclose information about the risks of a medical procedure. The House of Lords ruled in this case that a doctor's failure to disclose subsequent risks could give rise to legal liability, even if the patient might have undergone the procedure had they been fully informed. This approach differs significantly from the Indonesian system, which is still struggling to establish consistent standards for informed consent within the context of BPJS Kesehatan services (Wulandari, 2020).

A comprehensive comparison of the two systems reveals a number of fundamental similarities and differences. These similarities include: (1) both are based on the principle that the state is responsible for the health of its citizens; (2) both recognize the patient's right to compensation for losses caused by negligence in healthcare services; and (3) both have out-of-court dispute resolution mechanisms as an alternative to litigation. The fundamental differences cover several aspects. In terms of institutional structure, Indonesia relies on a plurality of dispersed bodies and mechanisms (BPJS Kesehatan, partner healthcare facilities, MKDKI, BPSK, courts),

while the UK has NHS Resolution as a central, integrated institution (Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan, 2023). From a legal perspective, Indonesia uses a codification approach with regulations spread across various laws, while England relies on a combination of legislation and common law (jurisprudence) that has developed over hundreds of years.

In terms of evidentiary standards, Indonesia still relies heavily on a fault-based approach that places the burden of proof entirely on the patient, while the UK, particularly post-Montgomery, has moved towards an approach that prioritizes patient autonomy and information (Peraturan Menteri Kesehatan Nomor 4 Tahun 2018 Tentang Kewajiban Rumah Sakit Dan Kewajiban Pasien, 2018). In terms of compensation, the UK, through NHS Resolution, provides a more standardized and predictable mechanism, while Indonesia still relies heavily on case-by-case court decisions with large disparities in the amount of compensation awarded. Finally, in terms of transparency and accountability, the NHS system in England regularly publishes claims data, negligence trends, and systemic learning through NHS Resolution reports, while Indonesia does not yet have an adequate centralized reporting system for BPJS Kesehatan service disputes. This lack of comprehensive data makes it difficult to evaluate system performance and plan evidence-based reforms (Poernomo, 1985).

4. Conclusion

The legal construction of civil liability within the Indonesian BPJS Kesehatan system remains fragmented, fault-based, and scattered across various laws and regulations without an efficient, unified mechanism. Legal responsibility is divided between BPJS Kesehatan as the program administrator, partner health facilities as service providers, and individual health workers, with multi-layered but unintegrated dispute resolution mechanisms creating significant obstacles for participants seeking justice. The NHS system in the UK demonstrates a much more mature level of development in its legal construction of civil liability, supported by a rich jurisprudential doctrine of negligence, an integrated NHS Resolution institution as a centralized claims manager, and various complementary alternative dispute resolution mechanisms. Landmark decisions such as Bolam, Bolitho, Montgomery, and Chester v. Afshar have established a clear, predictable, and responsive legal framework to evolving social values regarding patient rights. A comparison between the two systems provides valuable lessons for the development of the BPJS Kesehatan civil liability system in Indonesia. Indonesia needs to consider establishing a dedicated, integrated JKN service dispute resolution body (analogous to NHS Resolution), developing more operational standards for medical negligence through consistent jurisprudence, expanding patients' right to information towards standards oriented towards patient autonomy, and developing a data-based reporting and learning system to prevent similar losses from recurring. The main recommendations that can be conveyed are as follows: (1) the government and the House of Representatives need to conduct a comprehensive revision of Law Number 24 of 2011 and Law Number 40 of 2004 to clarify the construction of BPJS Kesehatan civil liability; (2) it is necessary to establish a dedicated JKN dispute resolution body that is independent, competent, and easily accessible to participants; (3) the development of a no-fault compensation scheme for certain categories of medical losses needs to be studied as an alternative to the fault-based system that relies entirely on proving fault; and (4) strengthening the informed consent mechanism in the context of BPJS

Kesehatan services that recognizes and respects patient autonomy as a fundamental principle.

5. References

Journals:

Charisso, L. (2026). Hukum Rumah Sakit terhadap Pengembalian Klaim BPJS dalam Perspektif Asas Proporsionalitas. Locus: Jurnal Konsep Ilmu Hukum, 6(1), 44–51. https://doi.org/10.56128/jkih.v6i1.778

Siregar, W., Siregar, M. H., & Nasution, M. I. P. (2025). Pengaruh Telecompliance dalam Peningkatan Kolektibilitas Iuran JKN BPJS Kesehatan Segmen PPU BU Cabang Padangsidimpuan. Al Qalam: Jurnal Ilmiah Keagamaan Dan Kemasyarakatan, 19(1), 464–490. https://doi.org/10.35931/aq.v19i1.4419

Sudiari, M. (2022). Pemilihan Fasilitas Kesehatan Tingkat Pertama Pada Pasien Perserta Bpjs Kesehatan: First Level Health Facilities Selection In Bpjs Kesehatan Participants. Bali Medika Jurnal, 9(1), 99–106. https://doi.org/10.36376/bmj.v9i1.237

Wulandari, S. (2020). Analisis Yuridis Tanggung Jawab Hukum BPJS Kesehatan dalam Sengketa Pelayanan Kesehatan. Jurnal Hukum Dan Peradilan, 9(2).

Yen, L. D. (2022). Uji Kelalaian Medis: Sebuah Kajian Literatur. 412283, 12(1). https://doi.org/10.24843/IJLFS.2022.v12.i01.p02

Books:

Fuady, M. (2013). Perbuatan Melawan Hukum: Pendekatan Kontemporer. Citra Aditya Bakti.

Hernoko, A. Y. (2010). Hukum Perjanjian: Asas Proporsionalitas dalam Kontrak Komersial. Kencana Prenada Media Group.

Khairandy, R. (2013). Hukum Kontrak Indonesia dalam Perspektif Perbandingan. FH UII Press.

Koeswadji, H. H. (2002). Hukum untuk Perumahsakitan. Citra Aditya Bakti.

Komalawati, V. (1989). Hukum dan Etika dalam Praktik Dokter. Sinar Harapan.

Marzuki, P. M. (2016). Penelitian Hukum (Edisi Revisi). Kencana Prenada Media Group.

Poernomo, B. (1985). Asas-Asas Hukum Pidana. Ghalia Indonesia.

Pohan, M. (1985). Tanggunggugat Advocaat, Dokter, dan Notaris. Bina Ilmu.

Purwoleksono, D. E. (2014). Hukum Pidana. Airlangga University Press.

Siswati, S. (2013). Etika dan Hukum Kesehatan dalam Perspektif Undang-Undang Kesehatan. Raja Grafindo Persada.

Soekanto, S., & Mamudji, S. (2011). Penelitian Hukum Normatif: Suatu Tinjauan Singkat. Raja Grafindo Persada.

Regulations:

Health and Social Care Act 2012, C. 7 (2012).

Law Number 24 of 2011 concerning the Social Security Administering Body, State Gazette of the Republic of Indonesia 2011 Number 116 (2011).

Law Number 29 of 2004 concerning Medical Practice, State Gazette of the Republic of Indonesia 2004 Number 116 (2004).

Law Number 40 of 2004 concerning the National Social Security System, State Gazette of the Republic of Indonesia 2004 Number 150 (2004).

Law Number 44 of 2009 concerning Hospitals, State Gazette of the Republic of Indonesia 2009 Number 153 (2009).

Minister of Health Regulation Number 28 of 2014 concerning Guidelines for the Implementation of the National Health Insurance Program (2014).

Minister of Health Regulation Number 4 of 2018 concerning Hospital Obligations and Patient Obligations (2018).

NHS Act 2006, C. 41 (2006).

Presidential Regulation Number 82 of 2018 concerning Health Insurance, State Gazette of the Republic of Indonesia 2018 Number 165 (2018).