PANORAMIC

HEALTHCARE REGULATION

Indonesia



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Healthcare Regulation

Contributing Editor

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ORGANISATION, FINANCING AND STRUCTURE OF THE HEALTHCARE SYSTEM

Organisation

How is healthcare in your jurisdiction organised? What is the role of government?

At the national level, the Ministry of Health (MOH) is the main authority responsible for setting health policy, developing national standards, issuing technical regulations and coordinating the overall health system. Indonesia's health administration is significantly decentralised: provincial and district/city governments are responsible for managing most public health facilities and health services within their territories, supervising local healthcare delivery and implementing regional health policies.

Healthcare services are provided through a combination of public and private providers, including community health centres, clinics, hospitals, pharmacies and specialist facilities. A defining feature of the Indonesian healthcare system is the National Health Insurance scheme (JKN), administered by the Indonesian Health Social Security Agency (Health BPJS). JKN covers approximately 280 million members – roughly 98% of Indonesia's population. Health BPJS manages enrolment, collects contributions and reimburses providers. Insured patients must generally access care through a designated primary facility first and obtain a referral for hospital or specialist treatment, except in emergencies. Patients can access services at both public and private facilities with Health BPJS cooperation agreements. Approximately 66% of contracted hospitals are private. Providers outside JKN serve private-pay patients and those with private insurance.

In recent years, the government has prioritised digital integration to address fragmentation in the decentralised health system. The national health information platform (SATUSEHAT) is intended to enable interoperable exchange of health data across Indonesia's public and private healthcare facilities, supporting coordination of care and policy oversight across regional boundaries.

Law stated - 2 October 2026

Key legislation

What key legislation governs the provision of healthcare services in your jurisdiction?

The principal legislation governing the provision of healthcare services in Indonesia is Law No. 17 of 2023 on Health as amended by Law No. 1 of 2026 (the Health Law). The Health Law is omnibus legislation that consolidated and replaced eleven prior laws in the healthcare sector, including the former laws on health, medical practice, hospitals and health workers. It serves as the main legal framework for regulating healthcare service delivery, healthcare facilities, medical and healthcare personnel, pharmaceuticals, medical devices, health information systems, and health sector supervision. The implementation of the Health Law is further regulated by Government Regulation No. 28 of 2024 on the Implementing Regulation of the Health Law (GR 28/2024), which provides more detailed provisions on the organisation of healthcare services and related matters. Implementing regulations under the

Health Law are still being progressively issued, meaning that healthcare providers should monitor regulatory developments for new or amended requirements.

In addition, the administration of the national health insurance programme and its implementing body is governed by Law No. 40 of 2004 on the National Social Security System as last amended by Law No. 4 of 2023 (the SJSN Law) and Law No. 24 of 2011 on the Social Security Administering Body as last amended by Law No. 1 of 2026 (the BPJS Law).

Moreover, certain aspects of the healthcare system are regulated under Presidential Regulation No. 82 of 2018 as last amended by Presidential Regulation No. 59 of 2024 (PR 82/2018), including the national health insurance scheme and the financing of healthcare services.

At the ministerial level, the MOH issues technical regulations covering specific aspects of healthcare services and facilities, including licensing standards, hospital governance and classification, accreditation, service standards, healthcare personnel, medical records, telemedicine and health data systems. These regulations are updated frequently and should be checked against the applicable business classification and facility type.

Law stated - 2 October 2026

Financing

How is the healthcare system financed in the various patient care sectors?

Healthcare financing in Indonesia operates on a mixed model, drawing from state and regional budgets, JKN contributions, private insurance, employer benefits and out-of-pocket payments. This framework is grounded in the Health Law, the SJSN Law and the BPJS Law. JKN contributions for formal employees are shared between employer and employee, while self-employed workers pay tiered contributions directly. Low-income individuals are covered through the government-subsidised contribution assistance recipient (PBI) scheme, a key mechanism for near-universal coverage.

For hospital inpatient care, services within the JKN benefit package are financed by Health BPJS when provided by contracted public or private facilities; in emergencies, non-contracted facilities may also be used, subject to applicable emergency criteria. Health BPJS reimburses healthcare providers under the INA-CBGs (Indonesia Case Base Groups) prospective payment system, which sets predetermined tariffs based on diagnosis groupings rather than individual service fees. INA-CBGs tariffs are typically lower than the rates charged to private-pay patients, and this differential can affect service delivery economics for providers participating in the JKN programme. JKN participants are generally entitled to standard class inpatient care, although higher-class accommodation may be obtained through supplementary health insurance or by self-paying the difference in room charges. For outpatient care, JKN financing is available for covered services provided by health facilities that have cooperation agreements with Health BPJS. Ancillary services, including medicines and consumable medical supplies, may also be financed under JKN to the extent they form part of the benefit package. Services outside the JKN benefit scope remain payable directly by the patient or through private insurance.

Law stated - 2 October 2026

Delivery structures

What are the basic structures for the delivery of care to patients in your jurisdiction?

Healthcare delivery follows a tiered model comprising primary healthcare and advanced (referral) healthcare. Primary healthcare is provided through over 10,000 public community health centres nationwide, plus primary clinics and independent practices. Advanced services are delivered through hospitals and specialist clinics. Private hospitals constitute approximately 65% of the hospital sector and play a significant role in serving both JKN and private-pay patients.

Law stated - 2 October 2026

Access and coverage

What rules govern access to treatment and emergency services? Which items and services are covered and which are not covered?

Access to healthcare under Indonesia's national health insurance programme or JKN is principally governed by the BPJS Law and PR 82/2018.

JKN participants are entitled to both medical and supporting non-medical benefits. Covered services are organised into primary healthcare (non-specialistic services including health promotion, basic examinations, procedures, medicines and diagnostic support) and advanced healthcare (specialist consultations, advanced diagnostics, rehabilitation, blood services and intensive care). Non-medical benefits include ambulance services for emergency referrals and accommodation for participants requiring distant treatment.

Emergency services are covered under JKN provided that the applicable emergency criteria are met. However, JKN does not cover all healthcare services. Key exclusions include treatment for aesthetic purposes, infertility treatment, orthodontic treatment, services rendered outside Indonesia, complementary or traditional treatments not proven effective, experimental procedures, contraceptive devices and cosmetics, and treatment for conditions arising from drug or alcohol dependence or self-harm. Services already covered under other programmes are also excluded, including work-related injuries covered by Employment BPJS work accident insurance and traffic accidents covered by the mandatory traffic accident compensation scheme. Services provided at non-cooperating healthcare facilities are generally not covered except in emergencies.

Law stated - 2 October 2026

Exclusions from statutory coverage

Are any groups excluded from statutory coverage? Are any groups covered under alternative schemes?

JKN is designed as a universal coverage programme. All Indonesian residents, including foreigners who have resided in Indonesia for at least six months, are required to participate by registering as Health BPJS participants. Participants are classified into PBI, whose

contributions are subsidised by the government, and non-PBI participants, including salaried workers, non-salaried workers and non-workers who pay contributions according to their respective tiers.

While JKN coverage is broad, certain healthcare needs are addressed through other social security programmes. Work-related injuries and occupational illnesses for Employment BPJS participants are covered under the Work Accident Insurance programme. Traffic accidents are covered under the mandatory traffic accident compensation scheme. Individuals may also obtain private health insurance or employer-provided benefits as supplementary protection.

Law stated - 2 October 2026

Gaps in cost coverage

Are there any gaps in cost coverage?

JKN participants may be subject to modest cost-sharing for certain healthcare services that have a potential for misuse, though this does not apply to PBI or residents registered by regional governments. Cost-sharing takes the form of fixed co-payments for outpatient visits and a percentage-based contribution (capped at 10% of the applicable INA-CBGs tariff) for inpatient care, both subject to periodic and absolute caps.

Participants who choose to upgrade their inpatient class or level of care above their entitlement must pay the difference between the amount covered by Health BPJS and the cost of the upgraded service. These upgrade costs are also subject to regulatory caps.

Law stated - 2 October 2026

HEALTHCARE PRICING AND REIMBURSEMENT

Pricing

How are prices for healthcare services set and paid for in your jurisdiction? To what extent is the cost of healthcare services governed by law or regulation?

For JKN services, prices are highly regulated. The MOH determines the standard tariffs used by Health BPJS to pay healthcare facilities. Primary healthcare facilities are paid through capitation (a fixed periodic payment per registered participant) and non-capitation mechanisms, while hospitals and other advanced referral facilities are paid through INA-CBGs (a case-based payment system linked to diagnosis and procedure) and non-INA-CBGs mechanisms for separately claimable items such as certain medicines, devices and ambulance services.

For medicines, the MOH publishes the National Formulary (FORNAS), which lists medicines covered under JKN based on clinical evidence and cost-effectiveness. Healthcare facilities procure JKN medicines through the government's e-Catalogue system, which sets price ceilings. Medicines not listed in FORNAS or procured outside the e-Catalogue may not be reimbursable or may result in losses for the facility if procurement prices exceed the applicable reimbursement rates.

Outside the JKN scheme, pricing is generally determined by the provider, patient, insurer or payer arrangement, subject to general transparency, consumer protection, professional, licensing and contractual rules. For example, hospitals must set service tariffs based on the national tariff pattern determined by the MOH and the maximum tariff ceiling determined by the relevant governor where the hospital is located, as provided under the Health Law and MOHR 6/2026. If the governor has not yet determined the maximum tariff ceiling, the hospital tariff should refer to the national tariff pattern.

Law stated - 2 October 2026

Reimbursement
How is reimbursement for healthcare services structured?

Under the JKN public scheme, healthcare facilities submit claims to Health BPJS based on the standard tariffs determined by the MOH. Claims are generally processed and paid within statutory timelines, though facilities bear the risk of claim rejection or underpayment if coding, documentation or tariff compliance issues arise.

Under private health insurance, reimbursement is governed by the insurance policy and agreement between the policyholder and insurer, including covered benefits, policy limits, claim procedures and any coordination of benefits with JKN. Recent regulatory reforms require private health insurers to offer coordination of benefits features, allowing policyholders to use private insurance to cover amounts not reimbursed by Health BPJS.

Law stated - 2 October 2026

Adjudication
If applicable, what is the competent body for decisions regarding the pricing and reimbursement of healthcare services?

Under the JKN scheme, the MOH is the competent authority for establishing standard tariffs for healthcare services, which are set out in MOHR 3/2023. The National Formulary Committee advises on which medicines should be covered under JKN. Health BPJS implements these tariffs through its payment mechanisms and processes facility claims accordingly. For private health insurance, the Financial Services Authority (OJK) oversees insurers and has issued regulations on product standards, including coordination of benefits with JKN.

Law stated - 2 October 2026

HEALTHCARE ORGANISATIONS AND BUSINESS STRUCTURES

Legal authorisation
What steps are necessary to authorise the provision of healthcare services, and what laws govern this?

The authorisation to provide healthcare services begins with determining the type of facility to be established, as each type is subject to different licensing requirements. Under the Health Law, healthcare facilities must fulfil the applicable business licensing requirements administered through the risk-based licensing regime under GR 28/2025. Depending on the business classification and risk level, the provider may be required to obtain a business identification number, standard certificate, or specific licence before commencing operations.

In addition, medical personnel and healthcare workers must hold a Registration Certificate and, where applicable, a Practice Licence for the relevant place of practice under the Health Law, GR 28/2024 and MOHR 13/2025. Accordingly, healthcare services may only be provided after the provider has obtained the relevant business licence, satisfied facility and service standards, and ensured its professionals hold the required credentials.

Law stated - 2 October 2026

Legal structures
What types of legal entities can offer healthcare services?

In Indonesia, healthcare services may be provided by public entities, private legal entities, and licensed individual professionals, depending on the facility type and licensing requirements.

Public healthcare services are provided by the central government, provincial governments, regency/municipal governments, and other authorised public institutions. Private healthcare services may be provided by legal entities established to engage in healthcare, as well as licensed individual health professionals such as doctors, dentists, midwives and nurses, subject to the scope of practice permitted by law and applicable facility licensing rules.

Law stated - 2 October 2026

Foreign companies
What further steps are necessary for foreign companies to offer healthcare services?

If foreign companies intend to offer healthcare services, they must generally establish or invest through an Indonesian company, subject to compliance with the foreign investment rules under Presidential Regulation No. 10 of 2021 on Investment Business Fields, as amended by Presidential Regulation No. 49 of 2021, and the applicable minimum capital and investment requirements. Foreign investment in healthcare facilities is subject to restrictions that limit participation to larger-scale operations, such as hospitals meeting minimum bed and classification requirements and higher-tier clinics. Primary healthcare facilities remain reserved for domestic enterprises. The Indonesian entity must then obtain the relevant business licences and health-sector-specific approvals applicable to foreign investment healthcare facilities.

If the arrangement involves foreign medical personnel or healthcare workers, additional requirements apply under the Health Law and GR 28/2024. Foreign professionals are generally limited to specialists and sub-specialists, must meet competency and registration

requirements, and may only practice through a healthcare facility for a prescribed period. The use of Indonesian professionals remains the priority.

Law stated - 2 October 2026

Healthcare arrangements

What regulatory and legal issues commonly arise in relation to healthcare arrangements? What are the main rules and principles that apply to extraterritorial participation in these arrangements?

Common issues include business licensing, scope of permitted services, clinical governance, professional credentialing, records management and JKN cooperation. Healthcare facilities must comply with the licensing and standards requirements under the Health Law regulatory framework and its implementing regulations.

The Health Law does not have explicit extraterritorial reach. Foreign entities providing healthcare services to Indonesian patients in Indonesia must generally do so through a licensed Indonesian healthcare facility and comply with the foreign personnel framework under the Health Law and GR 28/2024. Where services are delivered through digital platforms or involve cross-border data transfers, the Personal Data Protection Law applies extraterritorially to any processing of Indonesian health data, and Indonesia's electronic system and sectoral health data rules must also be observed.

Law stated - 2 October 2026

COMPETITION, ANTI-CORRUPTION AND TRANSPARENCY RULES

Authority enforcement

Are infringements of competition law by healthcare providers pursued by national authorities?

Yes. Competition law in Indonesia is governed by Law No. 5 of 1999 concerning the Prohibition of Monopolistic Practices and Unfair Business Competition (Competition Law) and enforced by the Indonesian Competition Commission (KPPU). Enforcement may be initiated on KPPU's own initiative or upon a report filed by a party. Under the Competition Law, KPPU may take action against healthcare providers that enter into anticompetitive agreements (such as price-fixing, market allocation or bid-rigging), engage in abuse of dominant position or fail to comply with merger notification requirements. Where KPPU finds a violation, it may impose administrative sanctions including fines, behavioural orders and recommendations to revoke business licences. Since its establishment in 2000, KPPU has handled several matters involving healthcare market participants, including late merger notification cases, a price-fixing and abuse of dominant position case involving pharmaceutical companies, bid-rigging cases in healthcare-related procurement and a partnership supervision case regarding arrangements between general practitioners and pharmaceutical companies.

Law stated - 2 October 2026

Private enforcement

Is follow-on private antitrust litigation against healthcare providers possible?

Follow-on private antitrust litigation against healthcare providers is possible. A party claiming damages arising from an anticompetitive practice may request compensation during KPPU proceedings or, following a KPPU decision, bring a civil lawsuit to the commercial courts using the KPPU decision as the legal basis. The civil claim is typically brought on the basis of an unlawful act under article 1365 of the Indonesian Civil Code, which requires the claimant to establish: an unlawful act; fault; causation; and actual loss. Historically, follow-on damages actions in civil courts faced challenges in establishing legal standing and causation. However, in a February 2026 ruling (Decision No. 04/KPPU-L/2025), KPPU awarded damages to a claimant for the first time in decades in a case involving misuse of confidential business information and collusion under article 23 of the Competition Law, signalling that seeking compensation through KPPU proceedings is now a viable path where financial losses are properly documented and can be substantiated.

Law stated - 2 October 2026

Anti-corruption and transparency

What are the main anti-corruption and transparency rules applicable to healthcare providers?

The principal anti-corruption legislation in Indonesia is Law No. 31 of 1999 on the Eradication of Corruption Crimes, as amended. The law applies across all sectors, including healthcare, and prohibits, among others, bribery, unlawful gratuities, procurement-related corruption and the misuse of state funds, with penalties including imprisonment of up to 20 years and substantial fines. In addition, Law No. 11 of 1980 on the Criminal Act of Bribery, as amended, addresses bribery in the private sector, covering owners, employees and directors of private companies. Depending on the circumstances, healthcare institutions and healthcare professionals may fall within the scope of these laws.

In addition, the Health Law imposes a set of transparency, accountability, and integrity rules that function as anti-corruption safeguards, including obligations to provide accurate information to patients, maintain proper medical records and report services through the health information system, and are subject to supervision and sanctions for unlawful practice.

More specifically, Minister of Health Regulation No. 58 of 2016 regulates sponsorship for healthcare professionals, requiring it to be transparent, accountable, non-inducive of conflicts of interest, and not to affect professional independence, including disclosure and reporting obligations. Furthermore, Minister of Health Regulation No. 16 of 2019 requires healthcare providers participating in Indonesia's National Health Insurance system to implement fraud prevention measures and provides for administrative sanctions in cases of fraud.

Law stated - 2 October 2026

REGULATION OF HEALTHCARE SERVICES

Licensing authority and process

Which authorities are charged with licensing and regulating patient care facilities and healthcare professionals? What licensing processes apply?

Licensing and regulation of patient care facilities and healthcare professionals are principally divided between the Ministry of Health (MOH) and regional governments. The applicable framework is the Health Law and its implementing regulations, including MOHR 11/2025 on risk-based business licensing standards in the health sub-sector and MOHR 13/2025 on health human resources management. For facilities, the licensing process involves obtaining business identification and a business licence through Online Single Submission, followed by the specific operational health licence and any technical approval.

For healthcare professionals, the licensing process begins with obtaining a Registration Certificate (STR), which is issued by the relevant Council on behalf of the MOH through the national Health Information System. Under the Health Law, STR is now valid for lifetime, replacing the previous five-year renewal requirement. Only after obtaining a valid STR may the practitioner apply for a Practice Licence (SIP), which is issued by the regency/city regional government or the MOH. While the STR is lifetime, healthcare professionals must continue to accumulate professional credit units (SKP) through continuing education as a condition for maintaining or renewing their SIP.

Law stated - 2 October 2026

Cross-border regulation

What requirements and restrictions govern the mobility of licensed health professionals across borders?

The regulation of cross-border practice is governed by the Health Law, which distinguishes between Indonesian citizens and foreign nationals who graduated from foreign educational institutions. Indonesian overseas graduates must undergo a competency evaluation (administrative and practical assessments), followed by healthcare service adaptation, and must obtain an STR and SIP. An exemption applies to those who graduated from a recognised foreign institution and have at least two years of practice experience abroad, or to certain priority-field experts holding professional certification.

For foreign nationals who graduated from foreign institutions, practice is permitted only for specialist and sub-specialist medical personnel and certain healthcare workers, subject to competency evaluation, adaptation and possession of an STR and SIP. Exemptions apply to those with recognised qualifications and at least five years of practice experience, or certified priority-field experts with five years of experience. Practice may only be upon request of a healthcare facility, for technology and knowledge transfer purposes, for a maximum of two years (renewable once for two years). Indonesian personnel must remain the priority.

Law stated - 2 October 2026

Collaboration between healthcare professionals

What authorisations are required for collaboration between healthcare professionals? How is this regulated?

No separate collaboration licence is required for routine collaboration. Medical personnel and health personnel may practise provided each holds a valid STR and SIP. Supporting health workers collaborating with medical personnel, health personnel, or facility heads must have education or training appropriate to the required qualifications.

Separate approval may be required if the collaboration changes the service type, facility licence, research activity or telemedicine model.

Law stated - 2 October 2026

Collaboration between patient care facilities and healthcare professionals

What authorisations are required for collaboration between patient care facilities and healthcare professionals? How is this regulated?

Collaboration between patient care facilities and healthcare professionals is generally permitted provided it complies with applicable facility licensing, professional licensing and governance requirements, and the scope of services is covered under the respective licences. Collaboration should be structured around each professional's competence, authority, STR/SIP, applicable standards and the facility's licensed scope of services.

For example, a hospital may be designated as a teaching hospital under MOHR 6/2026 if it meets specific requirements, including valid business licensing, accreditation, a university cooperation agreement, sufficient case volume and variation, qualified educators, appropriate medical technology, routine research programmes, institutional commitment to education, and owner approval. A teaching hospital must also meet standards on education management, human resources, educational support facilities and clinical education programmes. Healthcare services must be integrated, patient-centred and provided through interprofessional collaboration, with students practising only within their competence and under clinical educator supervision.

Law stated - 2 October 2026

Training of healthcare professionals

What educational and training requirements must physicians and healthcare professionals satisfy to obtain the right to practise in your jurisdiction?

Physicians and healthcare professionals must complete the relevant education and professional qualifications for their field. To obtain an STR, they must hold the relevant diploma and competency certificate and satisfy registration requirements under the Health Law and implementing regulations.

To obtain an SIP, the applicant must hold a valid STR and satisfy requirements for the relevant practice location and competency. The STR confirms professional registration and eligibility

to practise, while the SIP authorises practice at a specific place. Both are required before a professional may lawfully provide healthcare services.

Continuing professional development, credentialing, privileging and facility-level competence assessment may also apply. Foreign graduates and professionals are subject to additional evaluation, adaptation, experience and authorisation requirements.

Law stated - 2 October 2026

Discipline and enforcement

What civil, administrative or criminal sanctions, penalties, corrective measures and related tools may be imposed on patient care facilities and healthcare professionals for regulatory non-compliance?

For non-compliance, Indonesian law provides a layered enforcement regime for both health facilities and healthcare professionals. Under health law, administrative measures may include written warnings, administrative fines, suspension and revocation of licences or approvals, depending on the severity and nature of the breach. Health facilities may also be subject to corrective orders, service restrictions or closure measures under the licensing and supervision framework. Criminal sanctions apply to healthcare facilities or persons who employ practitioners without a valid SIP.

For individual practitioners, violations of professional standards, service standards or discipline may trigger proceedings before the Professional Disciplinary Council, which may recommend administrative follow-up including practice restrictions or licence-related consequences. Civil exposure may arise through tort or breach-of-obligation claims where a patient suffers loss, and criminal sanctions may apply where the conduct meets the elements of a criminal offence under Health Law and the Indonesian Penal Code, particularly in cases involving negligence causing serious injury or death, unlawful practice, falsification or serious patient harm.

Law stated - 2 October 2026

Patient complaints

How are patient complaints processed and adjudicated?

Patient complaints are generally handled first at the facility level, where health facilities are expected to maintain complaint-handling and patient-safety mechanisms in line with their service governance obligations under Health Law. Where the complaint concerns alleged professional misconduct or discipline, the matter may be brought before the Professional Disciplinary Council, which is authorised to examine suspected breaches of professional discipline by medical and health personnel. Depending on the subject matter, complaints may also be submitted to the MOH, the relevant regional health office, or another competent authority.

For disputes involving alleged medical mistakes, Health Law requires the matter to be resolved through alternative dispute resolution (such as mediation or arbitration through the Indonesian Medical and Health Mediation-Arbitration Institution) before proceedings may

be brought in court. Separately, patients retain the right to pursue civil claims for loss, and criminal proceedings remain available where the facts indicate a criminal offence.

Law stated - 2 October 2026

DATA PROTECTION, PRIVACY AND DIGITAL HEALTH

Responsible authorities and applicable legislation

Which authorities are responsible for compliance with data protection and privacy, and what is the applicable legislation?

Compliance with data protection and privacy in Indonesia is primarily overseen by the Ministry of Communication and Digital Affairs, which acts as the de facto supervisory authority pending the establishment of the dedicated Personal Data Protection Agency mandated by the PDP Law. The Ministry of Health (MOH) regulates medical records and health information systems in the health sector.

The main applicable framework is Law No. 27 of 2022 on Personal Data Protection as amended by Law No. 1 of 2026 (PDP Law), together with Law No. 11 of 2008 on Electronic Information and Transactions as lastly amended by Law No. 1 of 2024 (EIT Law) and Government Regulation No. 71 of 2019 (GR 71/2019). For health-sector data, additional obligations arise under the Health Law and Government Regulation No. 28 of 2024 (GR 28/2024), which require confidentiality of patient information and medical records, and mandate that health information systems store and process data in data centres located within Indonesian territory.

Law stated - 2 October 2026

Requirements

What basic requirements are placed on healthcare providers when it comes to data protection and privacy? Is there a regular need for qualified personnel?

Healthcare service providers must ensure the protection of health data by maintaining confidentiality, security, and restricted access to patient data. Health service facilities must keep patients' personal health information confidential and safeguard the security, integrity and availability of data contained in medical records. Medical and health personnel are required to prepare and retain medical records and to maintain patient confidentiality, even after the patient's death. In the context of health information systems, system operators must process data within Indonesia, implement system reliability measures, and establish data access controls.

In regard to dedicated personnel, the PDP Law requires appointment of a Data Protection Officer (DPO) where any of the following applies: (1) processing is for public service purposes; (2) core activities involve regular and systematic monitoring of personal data on a large scale; or (3) core activities involve large-scale processing of specific personal data (including health data) or data related to criminal acts. Following Constitutional Court Decision No. 151/PUU-XXII/2024, these criteria are alternative – meeting any one triggers the DPO

requirement. Since health data constitutes specific personal data, many healthcare providers will require a DPO. The DPO must be appointed based on professionalism, legal knowledge and ability to fulfil the required duties.

Law stated - 2 October 2026

Regulatory guidance

Have the authorities issued specific guidance or rules for data protection and privacy in the healthcare sector?

Yes. Minister of Health Regulation No. 24 of 2022 on Medical Records (MOHR 24/2022) is the key sector-specific regulation and requires all healthcare facilities to maintain electronic medical records. The regulation establishes core data-security principles of confidentiality, integrity and availability, limits access through role-based controls granted by the facility head, and imposes confidentiality obligations on all persons involved in patient care (including after the patient's death). The retention period for medical records in a healthcare facility is prescribed at least 25 years from the patient's last visit. The MOH has developed the SATUSEHAT platform as the national health data integration ecosystem. All healthcare facilities were required to implement electronic medical records by 31 December 2023 and integrate with SATUSEHAT by 31 March 2024, with non-compliance potentially affecting accreditation status. The Indonesian Code of Medical Ethics also includes ethical obligations regarding patient confidentiality.

Law stated - 2 October 2026

Common infringements

What are the most common data protection and privacy infringements committed by healthcare providers?

There are no widely reported cases of regulatory enforcement against individual healthcare providers (such as hospitals or clinics) for data protection violations in Indonesia. The most prominent incidents have involved government entities rather than healthcare providers per se. Notable examples include data leaks at Health BPJS (Indonesia's national health insurance administrator) and patient data from MOH's integrated digital health platform.

In May 2021, an alleged data leak involving Health BPJS participants came to light, with approximately 279 million records reportedly offered for sale on an online forum. The Ministry of Communication and Information coordinated investigations with Health BPJS and the National Cyber and Encryption Agency (BSSN). In 2022, MOH reportedly faced an alleged data leak involving covid-19 patient data, including identity data and medical-record information, with around 6 million medical records and 720 GB of sample documents labelled "Centralized Server of Ministry of Health of Indonesia" appearing on a dark web forum. Both incidents occurred before the PDP Law took effect (October 2022), so no PDP Law-based penalties were imposed; investigations were conducted under the then-applicable electronic information and transaction laws.

These incidents illustrate the need for healthcare data controllers to strengthen access controls, security monitoring, and vendor/system governance. Under the current framework

(following the PDP Law's full effect), similar incidents would be assessed under personal data protection obligations, including maintaining confidentiality, preventing unauthorised access, and notifying data protection failures within 3 x 24 hours to personal data subjects and the supervisory authority. The Health Law and GR 28/2024 further strengthen healthcare data protection by imposing sector-specific operational obligations on healthcare facilities, including securing medical records, protecting patient personal health secrets, controlling access and transfers of health data, maintaining system reliability, conducting audits, and responding to cybersecurity incidents.

Law stated - 2 October 2026

Digital health services

Which authorities regulate the provision of digital health services and what is the applicable legislation? What basic requirements are placed on healthcare providers when it comes to digital health services?

Digital health is regulated mainly by the MOH from a healthcare service perspective, and the Ministry of Communication and Digital Affairs from an electronic systems perspective. Depending on the business model, other sectoral rules may also apply, including for medicines, medical devices, insurance, payment services and consumer protection. The key framework includes the Health Law, GR 28/2024, MOHR 24/2022, Minister of Health Regulation No. 20 of 2019 on Telemedicine Services Between Healthcare Facilities (MOHR 20/2019), GR 71/2019, and PDP Law. MOHR 20/2019 originally regulated only facility-to-facility telemedicine (such as teleradiology, tele-electrocardiography, and clinical teleconsultation between healthcare facilities). The Health Law and GR 28/2024 have since expanded the framework to permit healthcare facilities to provide telemedicine services between healthcare facilities and the public, independently or through cooperation with registered electronic system providers (digital platforms), provided the clinical services are carried out by appropriately licensed medical or healthcare professionals (ie, having valid STR and SIP).

Where a healthcare facility cooperates with a digital platform, the platform must be registered as an electronic system operator under GR 71/2019, but the clinical services must still be performed by the facility's licensed personnel. Providers must also maintain proper medical records, obtain patient consent, protect patient data, and use secure electronic systems. Electronic medical records should comply with MOH requirements, including integration with SATUSEHAT where applicable.

From an electronic systems, privacy and operational perspective, providers must maintain secure and reliable systems, privacy notices, lawful processing basis, data retention arrangements, breach-handling procedures and cross-border transfer documentation where relevant, noting that health data is treated as specific personal data. Providers should also have clear procedures for patient identification, clinical assessment, referrals, emergency escalation, prescriptions, follow-up care and the limits of remote care, while additional sector-specific rules may apply if the service involves medicines, medical devices, insurance, payment services or consumer-facing platform services.

Law stated - 2 October 2026

UPDATE AND TRENDS

Key developments

Are there any current or foreseeable legislative initiatives, court cases, laws or other rules that affect the regulation of healthcare? What has recently changed (or will likely change), and what steps need to be taken in preparation?

The main recent development is the continued implementation of the Health Law and GR 28/2024. Healthcare providers should review licences, governance, staffing, service standards and reporting duties against the new framework. Risk-based business licensing changed in 2025 under GR 28/2025 and MOHR 11/2025.

For hospitals, MOHR 6/2026 consolidates hospital-specific rules on establishment, licensing, classification, governance, quality and patient safety, recording, reporting and sanctions. Hospitals should review their licences, service scope, classification, governance structure, quality systems and accreditation status under the new framework.

Professional regulation changed under MOHR 3/2025 on professional discipline and MOHR 13/2025. National Health Insurance scheme (JKN) inpatient policy continues moving toward a standard class system; hospitals should monitor implementing rules on tariffs and bed standards under amended PR 82/2018. Digital health is also a key development, with the SATUSEHAT platform launching on 1 September 2026.

On healthcare financing, the government is transitioning from INA-CBGs to iDRG (Indonesia Diagnosis Related Groups), which provides more granular case classification based on diagnosis, procedures, severity and comorbidities for more accurate tariff determinations. As at September 2026, INA-CBGs remains operative under MOHR 3/2023, while iDRG is undergoing phased pilot implementation. Healthcare providers should monitor Ministry of Health and Health BPJS announcements regarding the transition timeline and prepare for potential changes to coding, documentation and claims processes.

Law stated - 2 October 2026