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Specialized Health Courts for National Health Insurance Disputes in Indonesia

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Abstract: Indonesia's National Health Insurance (Jaminan Kesehatan Nasional, JKN) has integrated healthcare financing and administration into a single national system, yet the institutions responsible for resolving healthcare disputes remain divided across multiple jurisdictions. This institutional divergence has become increasingly significant as healthcare disputes now extend beyond medical negligence and insurance reimbursement to encompass administrative decision-making, contractual relationships, professional accountability, and the constitutional right to health. This article examines whether Indonesia's existing judicial framework remains capable of adjudicating disputes generated by an integrated healthcare system. It first analyses the legal characteristics of disputes arising under JKN and the fragmentation of their resolution across existing institutions. It then evaluates the institutional limitations of the current framework through doctrinal and comparative legal analysis. The article argues that the principal challenge lies not in the absence of legal remedies but in the allocation of adjudicatory jurisdiction. Although existing institutions perform legitimate statutory functions, no single forum possesses the institutional capacity to resolve the interconnected legal and technical issues presented by contemporary healthcare disputes. It concludes that a specialized health court represents a constitutionally compatible institutional response to the evolving demands of Indonesia's healthcare governance and access to justice.

Keywords: National Health Insurance, Health Court, Healthcare Dispute Resolution, Healthcare Governance, Access to Justice.

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1. Introduction

Indonesia's National Health Insurance (Jaminan Kesehatan Nasional, JKN) has transformed healthcare delivery by integrating nearly the entire population into a single social health insurance system. Yet the judicial framework governing healthcare disputes has not evolved at the same pace. While healthcare financing and administration have become increasingly centralized, dispute resolution remains fragmented across multiple institutions. The result is an institutional mismatch

between an integrated system of healthcare governance and the judicial architecture responsible for resolving healthcare disputes.

This mismatch reflects the changing character of disputes arising from JKN (Romero et al., 2023; Zainuddin & Simarmata, 2025). Healthcare disputes increasingly encompass issues beyond medical negligence and insurance reimbursement. A single dispute may simultaneously implicate patients' rights, medical judgment, administrative discretion, contractual obligations, professional accountability, and constitutional guarantees of the right to health. Such disputes resist conventional legal classifications (Zainuddin & Simarmata, 2025). They routinely traverse the boundaries separating civil, administrative, and professional law, requiring institutions to address legal and technical issues within the same proceeding.

Indonesia currently resolves these disputes through a variety of forums, including the general courts, the State Administrative Court, professional disciplinary bodies, the Ombudsman, mediation mechanisms, and internal complaint procedures administered by Indonesia's Social Security Administering Body for Health (*Badan Penyelenggara Jaminan Sosial Kesehatan*, BPJS Kesehatan) (Law No. 17 on Health, 2023; Law No 24 on the Social Security Administering Body, 2011; Law No 40 on the National Social Security System, 2004; Law No. 48 on Judicial Power, 2009; Zainuddin & Simarmata, 2025). Each institution performs a legitimate regulatory function, yet none possesses comprehensive jurisdiction over disputes arising from JKN. Jurisdiction therefore becomes a threshold issue before the merits of a claim can even be considered. Similar disputes may be characterized differently depending upon the forum selected, exposing litigants to overlapping procedures, inconsistent legal standards, and potentially conflicting outcomes.

Fragmentation carries consequences that extend beyond institutional efficiency. It undermines legal certainty, increases litigation costs, prolongs dispute resolution, and weakens effective access to justice (Cappelletti & Garth, 1978, pp. 8–10). Patients, who frequently occupy the weakest position within the healthcare system, bear a disproportionate share of these burdens. Their ability to obtain legal protection often depends less upon the strength of their substantive claims than upon their capacity to navigate a fragmented adjudicatory system. Under such circumstances, procedural complexity becomes an obstacle to the realization of legal rights.

Reform efforts have largely focused on strengthening individual institutions through improved complaint mechanisms, professional accountability, and alternative dispute resolution (Zainuddin & Simarmata, 2025, pp. 335–337). While these measures may enhance institutional performance, they leave a more fundamental question unresolved: whether the existing judicial framework remains capable of resolving

disputes generated by an integrated national health insurance system. The central challenge may therefore lie not in institutional performance alone, but in the distribution of adjudicatory jurisdiction.

Comparative experience suggests that this question is neither novel nor uniquely Indonesian. Several jurisdictions have responded to the increasing complexity of healthcare disputes by adopting specialized adjudicatory mechanisms, including administrative compensation systems, specialized tribunals, and proposed health courts that integrate legal and medical expertise. (Mello et al., 2006, pp. 476–484). Although their institutional designs differ, these models reflect a common recognition that healthcare disputes possess characteristics distinct from ordinary civil or administrative litigation (Mello et al., 2006, pp. 388–391). Judicial specialization has therefore emerged not simply as an administrative innovation but as an institutional response to increasingly specialized systems of healthcare governance.

Despite the rapid development of Indonesia's health law regime, legal scholarship has focused primarily on substantive issues, including patient rights, hospital liability, medical malpractice, professional responsibility, and the implementation of JKN (Khalid et al., 2026, pp. 1–18; Romero et al., 2023, pp. 31–36; Zainuddin & Simarmata, 2025). Comparatively little attention has been devoted to the institutional organization of healthcare dispute resolution. As a result, the relationship between institutional design, legal certainty, and access to justice remains underexplored.

This article examines healthcare dispute resolution from an institutional perspective. Rather than evaluating existing dispute resolution mechanisms in isolation, it argues that fragmentation constitutes a structural weakness within Indonesia's judicial system. It further assesses whether the establishment of a specialized health court could provide a more coherent framework for resolving disputes arising from JKN while strengthening legal certainty, judicial consistency, and access to justice.

Accordingly, this article addresses three questions. First, what are the characteristics of disputes arising under Indonesia's National Health Insurance (JKN), and how are they fragmented across existing dispute resolution mechanisms? Second, what institutional limitations characterize the current framework for resolving healthcare disputes in Indonesia? Third, what are the legal and institutional prospects for establishing a specialized health court to adjudicate disputes arising under JKN.

2. Method

This article employs normative legal research to examine whether Indonesia's existing judicial framework is institutionally capable of resolving disputes arising from the JKN.

Because the inquiry concerns the adequacy of legal institutions rather than the operation of individual cases, the analysis integrates three complementary approaches. A statutory approach examines the constitutional, legislative, and regulatory framework governing judicial power, health law, and the administration of JKN. A conceptual approach develops the analytical framework by drawing upon legal scholarship on judicial specialization, institutional design, legal certainty, and access to justice. Finally, a comparative approach considers selected jurisdictions that have adopted specialized health courts or analogous adjudicatory mechanisms to identify institutional principles that may inform legal reform in Indonesia. The analysis relies on primary legal materials, including legislation and judicial decisions, as well as secondary legal materials comprising scholarly literature and policy documents. These materials are analyzed qualitatively through doctrinal legal analysis to assess whether a specialized health court offers a coherent institutional response to the fragmentation of healthcare dispute resolution in Indonesia.

3. Result & Discussion

3.1. The Fragmented Landscape of National Health Insurance Disputes in Indonesia

Healthcare disputes in Indonesia have undergone a fundamental transformation following the implementation of the JKN. While disputes concerning medical negligence, professional discipline, informed consent, and liability remain an important part of healthcare litigation, the operation of JKN has substantially expanded the legal relationships underlying healthcare dispute (Zainuddin & Simarmata, 2025, p. 340). Contemporary disputes increasingly involve not only patients and healthcare providers, but also BPJS Kesehatan, healthcare facilities, government regulators, and other institutional actors whose rights and obligations are governed by overlapping contractual, administrative, and statutory frameworks. Consequently, healthcare disputes increasingly extend beyond the conventional patient-provider relationship to encompass financing claims, regulatory compliance, contractual performance, and the protection of patients' statutory rights within the national health insurance system (Andira et al., 2026).

The implementation of the JKN has fundamentally reshaped healthcare governance in Indonesia. Healthcare now operates through interconnected legal relationships involving BPJS Kesehatan, healthcare providers, patients, and government regulators. Healthcare disputes increasingly engage overlapping contractual, administrative, and statutory obligations rather than isolated patient-provider relationships (Khalid et al., 2026, pp. 2–10; Zainuddin & Simarmata, 2025, p. 330).

The operation of JKN illustrates this institutional transformation. Disputes over Indonesia Case Base Groups (INA-CBG) reimbursement, claim verification, referral obligations, and provider agreements have become an integral feature of healthcare governance under the JKN scheme (Law No 24 on the Social Security Administering Body, 2011; Law No 40 on the National Social Security System, 2004). In 2025, for example, the Ombudsman of the Republic of Indonesia investigated the accumulation of pending INA-CBG claims involving hundreds of hospitals in East Java and concluded that prolonged verification and delayed reimbursement disrupted hospital financing, procurement of medicines and medical devices, and the continuity of healthcare services (*Ombudsman RI Soroti Potensi Maladministrasi Pada Pending Claim BPJS Kesehatan, Ini Lima Poin Perbaikannya - Ombudsman RI*, n.d.; Zainuddin & Simarmata, 2025, pp. 335–336). Yet the controversy did not present a single legal question. It engaged contractual obligations arising from provider agreements with BPJS Kesehatan, administrative accountability in the delivery of public services, and the statutory entitlement of patients to healthcare under the JKN framework (Khalid et al., 2026, pp. 8–9; Law No. 17 on Health, 2023, Preprint 6; Law No 24 on the Social Security Administering Body, 2011, p. arts. 10-15).[3] A single dispute thus generated multiple legal relationships, illustrating why contemporary healthcare disputes can no longer be understood through a single doctrinal lens.

Healthcare disputes have become increasingly shaped by digital technologies and global health innovation. Pharmaceuticals, medical devices, artificial intelligence, and digital health technologies raise interconnected questions of regulatory approval, product liability, data governance, reimbursement, and intellectual property (*Global Strategy on Digital Health 2020-2025*, 2021, pp. 8, 11–12, 23–25). Pharmaceutical innovation likewise engages patent protection and the flexibilities recognized under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), including compulsory licensing and technology transfer in the interest of public health (*WTO | Ministerial Conferences - Doha 4th Ministerial - TRIPS Declaration*, 2001, paras. 4–7). Contemporary healthcare disputes therefore increasingly require the concurrent application of health law, administrative law, consumer protection, intellectual property law, and international trade law.

These developments reflect a broader shift in healthcare law from adjudicating individual claims to governing population health (*Global Strategy on Digital Health 2020-2025*, 2021, pp. 8, 10–13). JKN functions not only as a mechanism for financing healthcare but also as an instrument for allocating finite resources across the population (Law No 24 on the Social Security Administering Body, 2011; Law No 40 on the National Social Security System, 2004). Decisions concerning reimbursement, benefit design, procurement, regulatory approval, and access to innovative therapies

therefore affect both individual rights and the sustainability of the healthcare system.[3] Healthcare disputes consequently require legal institutions to reconcile competing interests involving patient safety, fiscal sustainability, fraud, technological innovation, equitable access, and broader public health objectives (Kartika et al., 2025).

The consequences of fragmentation extend beyond jurisdictional complexity. A single healthcare dispute may engage parallel contractual, administrative, civil, disciplinary, or criminal processes, each operating under distinct legal frameworks and procedural rules (Khalid et al., 2026, pp. 8–9, 14; Zainuddin & Simarmata, 2025, p. 335). Such institutional fragmentation increases the cost and complexity of dispute resolution and may delay the resolution of disputes involving continuing treatment, access to essential medicines, or the allocation of limited public resources (Cappelletti & Garth, 1978, pp. 8–10). In healthcare, where delay may affect access to care, procedural design becomes integral to the effective realization of the constitutional right to health (Constitution of the Republic of Indonesia, 1945, Article 28H(1), 34(3); General Comment No. 14: The Right to the Highest Attainable Standard of Health UN Doc E/C.12/2000/4, 2000, paras. 11–17).

3.2. Existing Dispute Resolution Mechanisms: Between Jurisdictional Fragmentation and Institutional Incoherence

The fragmentation identified above is not accidental. It reflects the way judicial authority is allocated within Indonesia's legal system. Law No. 48 of 2009 on Judicial Power distributes jurisdiction among separate court systems according to established branches of law rather than according to the substantive characteristics of healthcare disputes (Law No. 48 on Judicial Power, 2009). None, however, was designed to resolve healthcare disputes whose legal dimensions simultaneously extend across multiple jurisdictions. Civil claims arising from medical treatment, contractual relationships, or compensation fall within the jurisdiction of the general courts. Challenges to administrative decisions, including licensing, regulatory enforcement, or decisions taken by public authorities in the health sector, belong before the State Administrative Court. Criminal liability arising from healthcare activities is adjudicated through the criminal courts. Outside the judiciary, healthcare professionals remain subject to disciplinary proceedings before the Professional Discipline Council (*Majelis Disiplin Profesi*), allegations of maladministration may be investigated by the Ombudsman, while BPJS Kesehatan administers complaint mechanisms concerning the implementation of the National Health Insurance scheme (Law No. 17 on Health, 2023). Each institution exercises authority conferred by statute and performs a distinct institutional function.

That institutional design assumes that legal disputes can be classified into discrete legal categories before adjudication begins. Healthcare disputes increasingly defy that assumption. A single reimbursement dispute within the JKN system, for example, may simultaneously require judicial review of an administrative determination by BPJS Kesehatan, interpretation of contractual obligations between BPJS and healthcare providers, assessment of compliance with clinical standards, and determination of a patient's statutory entitlement under Law No. 17 of 2023 on Health (Khalid et al., 2026, pp. 2–4). The rapid digitalization of healthcare further dissolves these doctrinal boundaries. Clinical decision-making is now embedded within overlapping regulatory frameworks governing healthcare services, health data protection, electronic medical records, digital health systems, and artificial intelligence (Gulo, 2026, pp. 66–69). As healthcare becomes increasingly data-driven and technologically mediated, disputes no longer arise within a single legal regime but across several simultaneously. Yet judicial jurisdiction remains organized around disciplinary boundaries that assume precisely the opposite.

The dispute over pending INA-CBG claims in East Java illustrates how a single healthcare controversy may generate multiple legal relationships while remaining institutionally fragmented. In early 2025, the Ombudsman of the Republic of Indonesia investigated the accumulation of unresolved reimbursement claims submitted by hundreds of hospitals to BPJS Kesehatan. The Ombudsman found that prolonged claim verification and delayed reimbursement disrupted hospitals' operational cash flow, constrained the procurement of medicines and medical devices, and threatened the continuity of healthcare services (*Ombudsman RI Soroti Potensi Maladministrasi Pada Pending Claim BPJS Kesehatan, Ini Lima Poin Perbaikannya - Ombudsman RI*, n.d.). Hospitals approached the dispute primarily as one concerning contractual rights arising under their provider agreements with BPJS Kesehatan. The Ombudsman, by contrast, examined the same controversy through the framework of maladministration in public service delivery (*Ombudsman RI Soroti Potensi Maladministrasi Pada Pending Claim BPJS Kesehatan, Ini Lima Poin Perbaikannya - Ombudsman RI*, n.d.). The consequences inevitably extended beyond the contracting parties, as disruptions in hospital financing had the potential to affect the continuity of services provided to patients (Zainuddin & Simarmata, 2025, pp. 336–339). A single controversy therefore generated distinct questions of contractual performance, administrative accountability, and the protection of patients' statutory interests, yet no single institution possessed jurisdiction to resolve those issues within an integrated proceeding.

The consequences of institutional fragmentation are practical as well as doctrinal. As disputes arising from the JKN system increasingly implicate contractual obligations, administrative oversight, and the continuity of healthcare services, parties may be

required to pursue different institutional processes depending on the legal character of each issue (Zainuddin & Simarmata, 2025, pp. 336–339). A dispute concerning delayed reimbursement may simultaneously generate contractual claims between hospitals and BPJS Kesehatan, administrative scrutiny of reimbursement decisions, allegations of maladministration in public service delivery, and questions concerning the protection of patients' rights (Khalid et al., 2026, pp. 6–8). None of these institutions possesses jurisdiction to determine every legal issue arising from the same controversy. Fragmentation therefore becomes more than a question of jurisdiction. It becomes a question of institutional capacity.

The problem is especially acute because healthcare disputes differ from ordinary commercial or administrative litigation. Courts are required to evaluate not only legal rights and procedural compliance, but also evolving scientific evidence, clinical standards, public health objectives, and increasingly sophisticated regulatory frameworks. Decisions concerning the safety of medical devices, the allocation of scarce healthcare resources, access to innovative therapies, or the secondary use of health data may carry implications extending far beyond the immediate parties to the litigation. Access to justice and legal certainty are therefore shaped not only by substantive law but also by institutional design.

3.3. Existing Dispute Resolution Mechanisms: Between Jurisdictional Fragmentation and Institutional Incoherence

Comparative experience offers no single institutional model for resolving healthcare disputes (Kachalia et al., 2008, pp. 388–393; Mello et al., 2006, pp. 476–484). Different jurisdictions have adopted different approaches, ranging from administrative compensation schemes to proposals for specialized health courts (Mello et al., 2006, pp. 476–484; Widman, 2006, pp. 58–63). Despite these institutional differences, the comparative literature reflects a common concern that conventional negligence litigation often struggles to deliver timely, consistent, and technically informed resolution of medical injury claims (Kachalia et al., 2008, p. 388; Mello et al., 2006, p. 476). The resulting reforms have therefore focused not on creating a uniform model, but on developing adjudicatory mechanisms capable of integrating legal and medical expertise into the resolution of healthcare disputes (Mello et al., 2006, p. 480; Widman, 2006, p. 60).

The proposal to establish specialized health courts reflects a broader recognition that medical injury disputes present institutional challenges that conventional courts may not always address effectively. Rather than relying exclusively on generalist judges and jury determination, the proposed model envisions adjudication by judges with specialized expertise in healthcare, supported by court-appointed medical experts and

a modified standard for determining compensable injuries. Its proponents contend that specialization would produce greater consistency, technical accuracy, and predictability in medical adjudication. Yet the same institutional features have generated substantial constitutional controversy, with critics arguing that replacing ordinary civil adjudication with a specialized forum fundamentally alters long-established guarantees of jury trial, judicial review, and access to the civil justice system (Widman, 2006, pp. 58–63).

The United Kingdom has integrated healthcare adjudication into its tribunal system rather than establishing a standalone health court. The Health, Education and Social Care Chamber of the First-tier Tribunal exercises jurisdiction over designated health service and mental health cases under specialized procedural rules (*Health, Education and Social Care Chamber Tribunal Rules*, 2025). Separate adjudicatory mechanisms also exist for the regulation of medical professionals, with doctors' fitness to practise determined by the Medical Practitioners Tribunal Service (*Guidance for MPTS Tribunals*, n.d.). These institutions illustrate an incremental model of specialization in which healthcare disputes are allocated according to subject matter while remaining embedded within the broader judicial framework.

Institutional diversity should not obscure the broader comparative lesson. Healthcare adjudication has become increasingly specialized because healthcare itself has become increasingly specialized. The jurisdictions surveyed here differ in history, constitutional design, and judicial organization, yet they converge on the same institutional judgment. General jurisdiction remains indispensable, but it is no longer sufficient for disputes arising from contemporary healthcare governance. Specialized adjudication is therefore best understood not as an exception to ordinary judicial administration, but as an institutional adaptation to the growing complexity of healthcare regulation. That development offers an important reference point for evaluating whether Indonesia's judicial system remains aligned with the legal demands of the National Health Insurance era.

3.4. Specialized Health Court

The preceding analysis does not suggest that every healthcare dispute should be removed from the ordinary courts. General jurisdiction remains an indispensable feature of Indonesia's judicial system, and many healthcare disputes can be resolved effectively through existing civil, criminal, or administrative procedures. The institutional question is narrower. Certain disputes arising from the National Health Insurance system simultaneously engage regulatory governance, contractual relationships, scientific evidence, and constitutional guarantees in ways that transcend conventional jurisdictional categories. In such cases, adjudication depends not only

upon the application of legal rules but also upon the capacity of the decision-maker to evaluate complex medical and scientific issues within a coherent legal framework (Skrypnyk et al., 2024, p. 1264). The case for a specialized health court therefore rests not on replacing the ordinary judiciary, but on providing an institutional forum capable of resolving legally and scientifically integrated disputes through a single adjudicatory process.

The defining feature of a specialized health court should therefore be its jurisdiction rather than its institutional label. Jurisdiction should be determined by the nature of the dispute, not merely by the identity of the parties. Disputes involving reimbursement under JKN, provider agreements, patient access to insured services, healthcare financing, regulatory decisions concerning health technologies, product safety, and the interaction between healthcare regulation and patients' statutory rights present common institutional characteristics despite arising under different branches of law, as in Fuller's policentricity (Fuller, 1978, p. 394). Their resolution frequently requires simultaneous consideration of medical evidence, administrative decision-making, contractual obligations, and technical regulation (Skrypnyk et al., 2024, p. 1264). Assigning such disputes to a single adjudicatory forum would enable the court to evaluate the controversy in its entirety rather than requiring litigants to pursue fragmented proceedings before multiple institutions.

This does not imply that every issue connected with healthcare should fall within the jurisdiction of a specialized court. Criminal liability for corruption, offences against the person, or other crimes should remain within the ordinary criminal courts. Accordingly, the proposed jurisdiction should not extend to disputes having only a remote or incidental connection with healthcare merely because one of the parties is a healthcare provider. Judicial specialization is warranted only where healthcare issues constitute the central legal controversy and where fragmented jurisdiction risks inconsistent or incomplete adjudication. The objective is therefore functional specialization rather than institutional expansion.

The case for a specialized health court is ultimately defined by the nature of the disputes it is expected to resolve rather than by its institutional designation. Disputes arising from Indonesia's National Health Insurance system are inherently polycentric, involving interdependent questions of medical evidence, contractual obligations, administrative decision-making, and constitutional guarantees of the right to health. As Fuller observed, conventional adjudication is not always institutionally equipped to resolve disputes whose interconnected elements cannot readily be separated into discrete legal issues (Fuller, 1978, p. 394). The evolution of specialized adjudicatory institutions similarly reflects the broader access to justice movement, which recognizes

that effective protection of rights may require procedural and institutional adaptation to the distinctive characteristics of particular categories of disputes (Cappelletti & Garth, 1978, p. 184). A specialized health court therefore represents not a departure from the ordinary judicial system, but an institutional response to the legal and factual complexity of healthcare disputes that demand consistent, expert, and integrated adjudication.

Procedural gatekeeping also promotes institutional legitimacy. Early judicial assessment enables the court to distinguish disputes requiring integrated healthcare adjudication from those more appropriately resolved through ordinary civil, criminal, or administrative proceedings. Jurisdictional clarity at the outset reduces unnecessary duplication, limits procedural uncertainty, and enhances predictability for patients, healthcare providers, regulators, and insurers. Admissibility thus functions not merely as a jurisdictional threshold but as an institutional safeguard, preserving the coherence of the broader judicial system while ensuring that specialized adjudication remains confined to disputes for which its expertise is genuinely required.

4. Conclusion

The expansion of Indonesia's National Health Insurance system has transformed not only the delivery of healthcare but also the nature of healthcare disputes. Contemporary disputes extend far beyond medical negligence or insurance reimbursement. They increasingly involve interconnected questions of public administration, contractual obligations, professional accountability, product regulation, consumer protection, intellectual property, digital technologies, and the constitutional right to health. The legal relationships generated by the JKN ecosystem have become progressively more integrated, while the institutions responsible for resolving those disputes remain organized according to conventional jurisdictional boundaries.

This article has argued that the resulting fragmentation is institutional rather than doctrinal. Indonesian law already provides multiple legal avenues through which healthcare disputes may be pursued. General courts, administrative courts, disciplinary bodies, the Ombudsman, and internal BPJS mechanisms each perform functions assigned by statute. The difficulty arises because no single institution possesses jurisdiction to address the legal, regulatory, technical, and scientific dimensions that increasingly converge within the same healthcare dispute. As healthcare governance evolves, the institutional architecture of dispute resolution has remained largely unchanged.

Comparative experience does not prescribe a uniform institutional model. It nevertheless demonstrates a common recognition that increasingly complex healthcare disputes require specialized adjudicatory expertise, whether through specialized courts, tribunals, or administrative mechanisms. Indonesia need not replicate any particular foreign design. Any institutional reform must remain consistent with the constitutional framework governing judicial power and the organization of the national court system. The comparative lesson is more fundamental. Judicial institutions should evolve alongside the legal systems they are intended to serve.

Rather than advocating institutional transplantation, this article argues that the appropriate design of a specialized health court must emerge from Indonesia's own constitutional framework, judicial structure, and healthcare governance system. The question, therefore, is not whether Indonesia should create another forum for healthcare disputes. It is whether the existing judicial architecture remains capable of administering justice within an integrated healthcare system. If the answer is increasingly uncertain, then the establishment of a specialized health court deserves consideration not as an institutional experiment, but as a logical development in the continuing evolution of Indonesia's healthcare governance and the realization of the constitutional right to health

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