



Redesigning State Liability in Healthcare Provision: A Comparative Legal Framework of Indonesia, Malaysia, and the Netherlands

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Abstract:

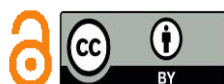
While the right to healthcare is recognized as an internationally binding obligation, existing legal frameworks often fail to translate state duties into enforceable legal liability when healthcare facility delivery collapses. To address this critical enforcement gap, this study proposes a novel legal framework to redesign state liability in healthcare provision, establishing how state responsibility should be structurally reconfigured in Indonesia through a comparative synthesis with Malaysia and the Netherlands. Utilizing a normative juridical method with conceptual and comparative approaches, this research analyzes how distinct legal traditions shape state legal accountability. The findings reveal that Indonesia relies on an explicit constitutional entitlement with a direct administrative-fault model, which currently suffers from enforcement bottlenecks and budgetary retrogressions. Conversely, Malaysia operates under an implicit statutory right managed through an operational vicarious liability model, limiting state claims strictly to civil torts within public facilities. Meanwhile, the Netherlands adopts an instructional social-right approach implemented through a supervisory-systemic regulatory model, where the state acts strictly as a system guardian within a managed competition framework. By synthesizing these divergent systems, this study reconstructs a balanced state liability model for Indonesia that integrates direct constitutional mandates, operational vicarious compensation, and independent supervisory enforcement. Ultimately, this redesigned framework offers a transformative legal blueprint to strengthen judicial enforceability and guarantee equitable access to healthcare facilities.

Keywords:

healthcare; right to health; state liability; state responsibility.

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Introduction

The right to healthcare is a fundamental social right that imposes an affirmative duty on the state to guarantee accessible, available, acceptable, and quality healthcare facilities. In Indonesia, this mandate is explicitly anchored in Article 28H (1) and Article 34(3) of the 1945 Constitution, as well as the newly enacted the Indonesian Health Law of 2023.¹ However, structural enforcement bottlenecks exacerbated by the recent removal of mandatory health spending have exposed a critical gap between constitutional guarantees (*das Sollen*) and

¹ Mei Rita et al., "Implementasi Kebijakan Program Jaminan Kesehatan (JKN) Dalam Meningkatkan Akses Pelayanan Kesehatan," *Jurnal Administrasi Pemerintahan Desa* 07, no. 01 (2025): 1–18, <https://doi.org/10.47134/villages.v7i1.363>; Syamsul Bachri Nurnaeni, "Kesehatan Masyarakat Dan Tanggung Jawab Hukum Negara" *Jurnal Berita Kesehatan* 18, no. 2 (2025): 265–280, <https://doi.org/10.58294/jbk.v18i2.329>

judicial enforceability (*das Sein*) when healthcare delivery fails. To address this liability-design flaw, a comparative legal analysis of Malaysia and the Netherlands provides a compelling functional blueprint. The selection of Malaysia and the Netherlands as comparative benchmarks is grounded in their distinct legal traditions, health system typologies, and opposing state liability mechanisms. Malaysia represents a Common Law framework utilizing a centralized, public-tier model where state accountability is operationalized through vicarious liability (*Government Proceedings Act 1956*), providing a clear model for compensatory remedies in public facilities while insulating macro-budgetary policies.² Conversely, the Netherlands offers a Civil Law, managed-competition model under the *Zorgverzekeringswet*, where direct state provision is privatized and state liability is transformed into supervisory, systemic regulatory oversight via the Health Inspectorate and non-adversarial dispute resolution.³ Comparing Indonesia's hybrid model against Malaysia's operational vicarious system and the Netherlands' supervisory-regulatory framework is essential to extract transferable legal mechanics for redesigning an enforceable state liability model in Indonesia.

Despite these normative frameworks appearing sound, their empirical implementation in all three countries faces serious structural challenges. Indonesia has regional access problems, lack of facilities in remote areas, and service restrictions in its National Health Insurance (*Jaminan Kesehatan Nasional - JKN*) program,⁴ including clear benefit package exclusions, severe tiered referral capacity, and patient quota caps. Malaysia has chronic overcrowding in public tertiary hospitals, long waiting times for specialized care, and too much reliance on a lightly regulated private sector.⁵ The Netherlands has high mandatory insurance premiums, high out-of-pocket deductibles (*eigen risico*), long waiting times for non-emergency hospital admissions, and slow implementation of all healthcare models. This empirical breakdown underscores the need to differentiate between state responsibility, which is the state's constitutional and statutory responsibility to regulate, fund, and provide access to healthcare facilities in the country, and state liability, which is the legal means by which the state is held to account when it fails to do so. Understanding how these three jurisdictions navigate the tension between principal duty (responsibility) and actual legal fault (liability) is key to addressing structural failures in healthcare facility provision in practice.

² Yusniliyana Yusof and Kazi Arif Uz Zaman, "Towards Equitable Healthcare Provision: Convergence of Public Health Spending and the Role of Decentralization in Malaysia," *Journal of the Asia Pacific Economy* 30, no. 2 (April 2025): 359–75, <https://doi.org/10.1080/13547860.2023.2285579>; Mohammad Zahid Zamaludin et al., "Malaysia's Primary Healthcare Public private Partnership Venture: The Medical Equipment Enhancement Tenure (MEET) Initiative," *BMC Health Services Research* 25, no. 1 (August 2025): 1041, <https://doi.org/10.1186/s12913-025-13146-1>.

³ Frédérique Franken et al., "Price Transparency in the Dutch Market-Based Health Care System: Did Price Dispersion for Similar Hospital Services Reduce over Time?," *The European Journal of Health Economics* 26, no. 7 (September 2025): 1137–47, <https://doi.org/10.1007/s10198-025-01759-6>; Ewald Engelen, Mayra Mosciaro, and Maria Kaika, "Seeing like an Economist: Using the Case of Dutch Healthcare Reform to Bring Professions and Their Epistemologies Back in the Field of New Economic Sociology," *Socio-Economic Review* 21, no. 2 (June 2023): 909–34, <https://doi.org/10.1093/ser/mwado05>.

⁴ Afifah Rohadatul 'Aisy, Ratu Puanurani Anggitya Abdillah, and Riswandy Wasir, "Evaluasi Strategi Pembelian Jasa Kesehatan Dalam JKN: Tantangan Dan Arah Kebijakan," *Indonesian Journal of Health Science* 5, no. 3 (May 2025): 547–52, <https://doi.org/10.54957/ijhs.v5i3.1534>; Desi Sintyasari and Irsyam Risdawati, "Urgensi Reformasi Hukum Kesehatan Di Era Digital: Antara Etika, Privasi Data, Dan Perlindungan Hak Pasien," *Indonesia of Journal Business Law* 4, no. 2 (2025): 1–14, <https://doi.org/10.47709/ijbl.v4i2.5878>.

⁵ Samsiah Awang et al., "Development of the National Policy for Quality in Healthcare for Malaysia," *Health Research Policy and Systems* 21, no. 1 (November 2023): 119–24, <https://doi.org/10.1186/s12961-023-01063-w>; Muhamad F. Zainudin et al., "A Path Analysis of the Healthcare Utilization and Services Satisfaction among Community-Dwelling Individuals with Spinal Cord Injury in Malaysia," *Journal of Rehabilitation Medicine* 57, no. 2 (February 2025): 20–29, <https://doi.org/10.2340/jrm.v57.40621>.

In our study, we formulate the framework for a social rights-based welfare state and social rights-based services. This suggests that the government should do what it can to meet all our needs under the banner of social rights.⁶ The right to health is a social right, and it is the federal government's responsibility to provide health services through regulation, funding, and service delivery. The theory of state responsibility holds that the government can be held legally responsible for failures in public services, whether due to administrative failures, poor facilities, or structural deficiencies.⁷ This doctrine has been developed in civil and common law systems. Thus, it provides a framework for comparison with countries like Indonesia, Malaysia, and the Netherlands. The right to health is based on four basic principles: services must be available, accessible, acceptable, and of high quality. Thus, this overall arrangement indicates a country's health care performance and how it fulfills its responsibilities.⁸

This study builds on the social rights-based welfare state and social rights-based services. It shows that governments have a responsibility to ensure that, in the name of social rights, we have what we need. The right to health is a social right, and the federal government's responsibility for providing health care is through regulation, funding, and service delivery. The theory of state responsibility says governments can be legally liable for failures in public service, whether because of administrative failure, poor facilities, or structural flaws. This doctrine has developed in civil and public legal systems. So it provides a framework for comparison with nations like Indonesia, Malaysia, and the Netherlands. The idea holds that governments can be legally liable for failures in public service, whether due to the right to health rests on four basic tenets: services should be available, accessible, acceptable to those who need them, and high quality. This arrangement then serves as a measure of the state's performance in health care and how it fulfills its responsibilities.

Normatively (*das Sollen*), Indonesia asserts the right to health through constitutional provisions and the Health Law; Malaysia through the constitution and administrative regulations; and the Netherlands through national legislation mandating basic health insurance.⁹ All demonstrate a state commitment to fulfilling health rights in accordance with welfare state principles. However, empirically (*das Sein*), significant gaps remain. Indonesia faces challenges in service equity, limited public financing, and incomplete inclusivity in National Health Insurance implementation.¹⁰ Malaysia experiences an imbalance between public facility capacity and service demand, as well as a high burden on the primary care

⁶ Khudzaifah Dimiyati et al., "Indonesia as a Legal Welfare State: A Prophetic-Transcendental Basis," *Heliyon* 7, no. 8 (August 2021): 1–8, <https://doi.org/10.1016/j.heliyon.2021.e07865>; Hs. Tisnanta, James Reinaldo, and Fathoni Fathoni, "The Dilemma of Indonesia Welfare State Challenge of Realizing Social Welfare in the Global Era," *FIAT JUSTISIA: Jurnal Ilmu Hukum* 11, no. 3 (February 2018): 231, <https://doi.org/10.25041/fiatjustisia.v11n03.936>.

⁷ Yuhui Guo and Zexun Zhang, "How Open Government Data Enhances Public Service Delivery: A Quasi-Natural Experiment from Government Data Platforms," *Systems* 14, no. 4 (2026), <https://doi.org/10.3390/systems14040408>.

⁸ Alicia Ely Yamin, "Chapter 9: The Right to Health," in *The Right to Health. Research Handbook on Economic, Social and Cultural Rights as Human Rights* (Edward Elgar Publishing, 2020), 159–179, <https://doi.org/10.4337/9781788974172.00017>.

⁹ Anne Willemsen et al., "Preparing for the EU HTA Regulation: Insights from the Dutch Perspective," *Journal of Market Access & Health Policy* 13, no. 3 (July 2025): 35–46, <https://doi.org/10.3390/jmahp13030035>.

¹⁰ M. N Faiz, R. S. R Kandau, and F. P Gurning, "Evaluasi Implementasi JKN Dalam Peningkatan Akses Pelayanan Kesehatan Di Medan," *Jurnal Kolaboratif Sains* 8, no. 7 (2025): 4095–4103, <https://doi.org/10.56338/jks.v8i7.8206>; Rita et al., "Implementasi Kebijakan Program Jaminan Kesehatan (JKN) Dalam Meningkatkan Akses Pelayanan Kesehatan."

system.¹¹ The Netherlands faces challenges regarding financial sustainability, waiting times, and dissatisfaction with mandatory private insurance premiums.¹²

Recent studies on the right to health in Indonesia, Malaysia, and the Netherlands have mainly focused on health economics, financing mechanics and quality assurance, not on the structural dimensions of state legal liability. Huber et al., for example, examined the Dutch healthcare system but did not consider the legal mechanisms that trigger state accountability during systemic service delivery failures.¹³ Similarly, Nurnaeni and Bachri argued that health services in Indonesia are a constitutional obligation rather than a discretionary policy, but their data remained domestic and lacked a cross-country perspective.¹⁴ Mohamad et al. investigated public expenditure and fiscal decentralization in Malaysia and advocated spatial equity in facility distribution but did not address the legal doctrine of state liability.¹⁵ In order to bridge the gap, the authors have chosen Indonesia, Malaysia, and the Netherlands as comparisons because they represent three distinct legal families and structural types of state liability in health care: Indonesia is a Civil Law social code, and the constitution gives its legal obligations in terms of the law of Indonesia; Malaysia is a Common Law system with centralized public welfare based on vicarious operational liability; and the Netherlands is a Civil Law regulated market model in terms of supervisory system and guardian liability. Comparing these jurisdictions matters because it helps identify transferable legal mechanisms for state liability, moving beyond legal theory to enable the introduction of a new conceptual model for designing an enforceable state liability model in Indonesia.

Clarifying these legal pathways is increasingly urgent given the rising prevalence of healthcare disputes between service recipients, healthcare providers, and state authorities, often triggered by systemic failures in healthcare infrastructure delivery. To address this enforcement crisis, this study addresses two central research questions: How do the constitutional frameworks and statutory laws of Indonesia, Malaysia, and the Netherlands define state responsibility for healthcare facility provision? How does each legal system operationalize state liability when healthcare delivery collapses, and to what extent is actionable state fault judicially recognized? Moving beyond mere descriptive comparison, this article argues that no single system is universally superior; rather, each offers distinct functional mechanisms that must be synthesized. While Indonesia's explicit constitutional mandate provides a strong basis for public policy litigation, enforcement bottlenecks and fiscal retrogressions severely hamper its real-world efficacy. Conversely, Malaysia's operational vicarious liability model delivers direct compensatory remedies for clinical torts but insulates macro-budgetary policy from judicial scrutiny. Meanwhile, the Netherlands' supervisory regulatory framework optimizes system quality through independent oversight

¹¹ Awang et al., "Development of the National Policy for Quality in Healthcare for Malaysia"; Zainudin et al., "A Path Analysis of the Healthcare Utilization and Services Satisfaction among Community-Dwelling Individuals with Spinal Cord Injury in Malaysia."

¹² J Wammes et al., "The Dutch Health Care System," *International Profiles of Health Care Systems* 137, no. 6 (2020): 137–47; Maura Leusder et al., "Patient-Level Cost Analysis of Subfertility Pathways in the Dutch Healthcare System," *The European Journal of Health Economics* 26, no. 6 (August 2025): 927–43, <https://doi.org/10.1007/s10198-024-01744-5>.

¹³ Huber, Machteld, Hans Peter Jung, *The Dutch Health Care System. In: Handbook Positive Health in Primary Care* (Houten: Bohn Stafleu van Loghum, 2021), https://doi.org/https://doi.org/10.1007/978-90-368-2729-4_3.

¹⁴ Nurnaeni, "Kesehatan Masyarakat Dan Tanggung Jawab Hukum Negara Nurnaeni."

¹⁵ Mohamad Iqbal Bin Kunji Mohamad et al., "Third-Party Consent To Medical Treatment in Malaysia: A Critical Analysis from Ethical and Malaysian Legal Perspectives," *Health Care Analysis* 2, no. 1 (July 2025): 1–20, <https://doi.org/10.1007/s10728-025-00531-4>.

and non-adversarial dispute resolution, though it shifts financial risks to individual citizens. Ultimately, this study contends that Indonesia must redesign its legal framework by synthesizing its strong constitutional mandate with Malaysia's direct vicarious compensation mechanics and the Netherlands' supervisory enforcement oversight, thereby creating a balanced, judicially enforceable model of state liability.

Method

This study employs a doctrinal (normative juridical) legal research method, utilizing statutory, conceptual, and comparative approaches to evaluate and reconstruct the legal frameworks governing state responsibility for healthcare facility provision across Indonesia, Malaysia, and the Netherlands. To address the specific comparative mechanics, this research adopts the Functionalist Comparative Legal Method (*praesumption similitudinis*). Rather than merely contrasting formal statutory texts, the functionalist approach identifies how fundamentally distinct legal traditions (Indonesia's Civil Law hybrid, Malaysia's Common Law system, and the Netherlands' regulated market) solve the identical social and legal problem (*tertium comparationis*): namely, determining state legal liability when healthcare facility delivery fails.¹⁶ In accordance with the standards of doctrinal research, primary reliance is placed on secondary data comprising primary legal materials (constitutional texts, statutes, and regulatory orders such as the 1945 Indonesian Constitution, the Indonesian Health Law of 2023, the Federal Constitution of Malaysia, the Fees (Medical) Order 1982, and the Dutch *Zorgverzekeringswet*, alongside secondary legal materials (authoritative legal scholarship), judicial precedents, and international health standards.¹⁷ Rather than focusing on empiric data collection procedures, this study concentrates on how legal materials are systematized, categorized, and critically processed. The primary and secondary legal sources were classified using a three-tier qualitative framework:

1. Normative Identification: Decoding formal statutory parameters and constitutional allocations of duty;
2. Functional Classification: Categorizing liability rules based on their operational mechanism (direct policy-mandate, vicarious-tort, or supervisory-regulatory); and
3. Constructive Synthesis: Evaluating systemic flaws to reconstruct a cohesive state liability model.¹⁸

The reliability and evaluative rigor of this doctrinal study are grounded in two theoretical foundations, which provide an analytical framework for moving beyond descriptive analysis toward a prescriptive approach to reconfiguring state liability in Indonesia:

¹⁶ K Zweigert, H Kötz, and J. A Weir, *Introduction to Comparative Law* (US: Oxford University Press, 1998).

¹⁷ Majeed, Nasir et al., "Doctrinal Research in Law: Meaning, Scope and Methodology." *Bulletin of Business and Economics (BBE)* 12, no. 4 (2012): 135–42 <https://doi.org/10.61506/01.00167>.

¹⁸ Hans Maarse and Patrick Jeurissen, "Healthcare Reform in the Netherlands: After 15 Years of Regulated Competition," *Health Economics, Policy and Law*, 21, no. 1 (2024), 121–32, <https://doi.org/10.1017/S1744133123000385>.

1. Internal Legal Foundations: Derived from internal measures of law, including the hierarchy of statutes, judicial precedents, the doctrine of Unlawful Act by Public Authority (*Onrechtmatige Overheidsdaad*), vicarious liability, and the General Principles of Good Public Governance (*Algemene Beginselen van Behoorlijk Bestuur*).
2. External Theoretical Foundations: This analysis draws on interdisciplinary concepts from political philosophy and public policy, focusing on Welfare State Theory and the international human rights framework on the Right to Health (the 4A framework: Availability, Accessibility, Acceptability, and Quality).

Discussion

1. *Scope and Limits of State Responsibility in the Constitution and Primary Legislation of Indonesia, Malaysia, and the Netherlands*

a. *Normative Framework on State Liability in the Provision of Healthcare Services*

The right to health has shifted from a moral aspiration to a binding legal obligation in global human rights discourse, serving as a supreme social contract that defines state responsibility toward its citizens. However, a comparative analysis of the constitutional foundations in Indonesia, Malaysia, and the Netherlands reveals a divergent spectrum of legal archetypes: from explicit constitutional guarantees and implicit rights derived from the right to life to instructional social rights embedded in a regulated market. Evaluating these constitutional models requires examining not only their theoretical design but also their empirical effectiveness and the legal gaps that emerge between normative ambition (*das Sollen*) and practical implementation (*das Sein*).

In Indonesia, following the constitutional amendments to the 1945 Constitution, the right to health secured a fundamental position, marking the nation's transition toward a modern welfare state (*Verzorgingsstaat*). Enshrined explicitly under Article 28H paragraph (1), which guarantees individual entitlement to medical care, and Article 34 paragraph (3), which mandates that the state is responsible for proper medical and public service facilities, the Constitution creates a dual obligation of conduct and result.¹⁹ Placing these provisions within the chapters on Human Rights and Social Welfare confirms that healthcare infrastructure is a constitutionally protected public good, not a mere commercial commodity.²⁰ Goal Attainment and Efficacy: This explicit constitutional framing provides robust theoretical justiciability, allowing citizens to challenge state inaction before the Constitutional Court and use Citizen Lawsuits. Despite these strong normative foundations, the legal framework fails to achieve its stated goals due to severe structural implementation gaps.²¹ In practice, regional health

¹⁹ Sri Ayu Astuti, "Human Rights and People's Sovereignty from the Perspective of Article 28 Chapter XA of the 1945 Constitution: A Case Study of the Struggle for Jobs by Foreign Workers," *Jurnal Hukum Dan Keadilan* 2, no. 6 (October 2025): 39–47, <https://doi.org/10.61942/jhk.v2i6.446>.

²⁰ S Isra, *Pergeseran Fungsi Legislasi: Menguatnya Model Legislasi Semu Dalam Sistem Presidensial Indonesia* (Jakarta : Rajawali Pers, 2020).

²¹ M El-Muhtaj, *Hak Asasi Manusia Dalam Konstitusi Indonesia* (Jakarta : Prenada Media Group, 2017); M. Yasser and Y.S Desiandri, "Konsep Hak Asasi Manusia Dalam Konstitusi Indonesia," *Iuris Studia: Jurnal Kajian Hukum* 4, no. 3 (2023): 164–72, <https://doi.org/10.55357/is.v4i3.413>.

access disparities remain acute, remote health facilities lack basic infrastructure, and operational service restrictions such as daily patient quota caps and strict referral bottlenecks within the National Health Insurance (*Jaminan Kesehatan Nasional - JKN*) scheme routinely restrict access. Furthermore, the enactment of the Indonesian Health Law of 2023 introduced a significant normative retrogression by repealing the mandatory health spending allocation (previously set at 5% of the national budget). This creates a severe enforceability gap: while the state bears an explicit constitutional duty, citizens lack effective administrative mechanisms to enforce state liability when healthcare facilities fail or lack adequate operational resources.

Malaysia, the Implicit Rights Model and the Policy Immunity Barrier. In contrast to Indonesia, Malaysia adopts an implicit constitutional approach. The Federal Constitution of Malaysia contains no explicit clause guaranteeing a "right to health" or mandating state provision of facilities, reflecting a Common Law tradition that places socio-economic rights outside rigid constitutional texts.²² Instead, Malaysian jurisprudence links health protection to Article 5(1) of the Federal Constitution, "liberty of the person". Through progressive judicial interpretation, Malaysian courts have expanded the "right to life" to include living with human dignity, which inherently necessitates access to basic healthcare.²³ Goal Attainment and Efficacy: Malaysia's statutory framework, driven by primary legislation such as the Fees (Medical) Order 1982 and Ministry of Health directives, has successfully established a highly subsidized, two-tiered public health infrastructure that delivers broad foundational population coverage. Gap Between Theory and Practice: Because health is framed as a statutory right rather than an explicit constitutional guarantee, state responsibility is treated as an administrative public service rather than a judicially enforceable right.²⁴ In practice, Malaysia faces severe overcrowding in public tertiary facilities, prolonged waiting lists for specialized surgeries, and a growing brain drain of medical personnel to the private sector. The primary legal gap stems from policy immunity: judicial avenues directly challenging state macro allocation decisions or hospital capacity failures remain virtually non-existent unless a failure directly results in actionable medical negligence under tort law (*Government Proceedings Act 1956*).²⁵ Thus, while the public system functions practically, constitutional state legal liability for system failure remains largely dormant.

Under Article 22 of the Dutch Constitution (*Grondwet*), health promotion is an instructional social duty (*instructienorm*), not a directly enforceable subjective right. Consequently, citizens cannot litigate against the state for structural infrastructure omissions. Instead, the Dutch state acts as a system guardian (*systeemverantwoordelijkheid*) under a managed-market model via the

²² A Harding, *The Constitution of Malaysia* (New York : Bloomsbury Publishing, 2022).

²³ Khairil Azmin Mokhtar, "Health and Human Rights Within the Context of International Human Rights Laws and the Malaysian Constitution Hak Kesihatan Dan Manusia Dalam Konteks Undang-Undang Hak Asasi Manusia Antarabangsa Dan Perlembagaan Malaysia Abstrak," *Iium Law Journal* 29, no. 1 (2021): 104–27, <https://doi.org/10.31436/iiumlj.v29i1.536>.

²⁴ Mohamad et al., "Third-Party Consent To Medical Treatment in Malaysia: A Critical Analysis from Ethical and Malaysian Legal Perspectives."

²⁵ Mohamad et al.

Zorgverzekeringswet and *Wet kwaliteit, klachten en geschillen zorg* (*Wkkgz*). State liability shifts to supervisory, systemic oversight enforced by the Inspectorate, while citizens and insurers bear operational and financial risks.

Representing the Western European Civil Law tradition, the Netherlands operationalizes state responsibility through a regulated market instead of direct state provision. Under Article 22(1) of the Dutch Constitution (*Grondwet*), the right to health is framed as a social right rather than a directly enforceable liberty right. Article 22 functions as an instruction norm (*instructienorm*) directed at the legislature and executive, rather than granting an actionable subjective right (*subjectief recht*) for individual litigation upon service deficits. Consequently, citizens cannot sue the state under Article 22 alone for facility omissions. This design reflects judicial restraint in macro-allocating resources. The state acts as a system guardian (*systeemverantwoordelijkheid*) through primary legislation like the *Zorgverzekeringswet* and *Wkkgz*. State liability becomes a supervisory-systemic obligation, guaranteeing solidarity, affordability, and safety while leaving operational delivery to private entities under strict Health and Youth Care Inspectorate (*Inspectie Gezondheidszorg en Jeugd - IGJ*) oversight.

Synthesizing these three jurisdictions reveals a distinct structural spectrum in how healthcare rights sit within the legal hierarchy, each carrying trade-offs between judicial enforceability and executive policy flexibility: Indonesia chooses the most textually progressive path through a Strong Constitutional Entitlement (Articles 28H and 34 of the Indonesian Constitution of 1945). This model maximizes theoretical justiciability but creates a severe *enforceability gap* when systemic resource constraints and statutory retrogressions (such as the Indonesian Health Law of 2023) impede operational delivery. Malaysia relies on an Implicit/Statutory Entitlement derived from the right to life (Article 5 of the Federal Constitution) paired with primary statutes. While this model provides high executive discretion and a functional public safety net, it insulates macro allocation policies from judicial scrutiny (*the policy immunity gap*), restricting state legal liability to individual clinical torts under vicarious liability. The Netherlands adopts an Instructional/Social Entitlement (Article 22 *Grondwet*), translating state duty into comprehensive statutory regulation (*systeemverantwoordelijkheid*). This approach minimizes direct constitutional litigation while maximizing quality control and coverage, though it shifts financial risks (*eigen risico*) to citizens and transforms state liability into regulatory enforcement.

b. Limitations of Responsibility in Primary/ Health Legislation

While the constitution lays the idealistic foundation for the right to health, health legislation serves as the operational instrument that establishes parameters, mechanisms, and, crucially, the limitations of that responsibility. No state has unlimited resources; therefore, primary health legislation in Indonesia, Malaysia, and the Netherlands includes “limitation clauses” that restrict state liability. These limitations vary from fiscal caps and delegation of authority to the private sector to insurance

mechanisms that share the cost burden with citizens. An analysis of primary legislation in these three countries shows how “rights” translate into “limitedly available services.” Consequently, the state evades Unlawful Act by Public Authority (*Perbuatan Melawan Hukum oleh Penguasa*) lawsuits regarding budget allocation ratios, provided basic health programs nominally persist. However, abolishing statutory spending floors breaches the international Non-Retrogression Principle, which prohibits social rights degradation. Executive discretionary budgeting thus shields macro-fiscal decisions from judicial scrutiny, shifting financial deficits onto regional entities, local facilities, and citizens under the Indonesian Health Law of 2023.²⁶ Decentralization also serves as a limitation mechanism; the central government delegates most healthcare service responsibilities to regional governments, which often creates service disparities due to differences in regional fiscal capacity.

Malaysia operates a dual-tiered healthcare system with heavily subsidized public services still functionally constrained by capacity limits and waiting lists. Legislation such as the Private Healthcare Facilities and Services Act 1998 (Act 586) creates a clear legal division between public and private care. By encouraging higher-income patients to use private facilities, the government acknowledges its delivery limits and shifts its role in that sector to quality regulation.²⁷ Furthermore, state responsibility under Malaysia’s Fees (Medical) Order is explicitly citizenship-centric, imposing full cost recovery on non-citizens while offering highly subsidized care for nationals. Fiscal constraints are managed through implicit temporal rationing, where public subsidization causes prolonged waiting times. Because statutory frameworks omit speed guarantees for non-emergency care, citizens cannot seek legal redress for service delays, legally constraining state liability.²⁸

The Netherlands delineates state responsibility through the *Zorgverzekeringswet* (*Zvw*), delegating direct provision and financing to privatized structures. The state limits its obligation to systemic governance and defining basic benefit packages (*basisverzekering*). By statutorily mandating individual private insurance coverage, the Dutch framework transfers primary financial exposure from the state budget to insurance risk pools funded by citizen premiums and taxes.²⁹ Under Dutch law, state responsibility is strictly bounded by statutory mechanisms like the *eigen risico* (*deductible*), which mitigates moral hazard by requiring initial individual out-of-pocket contributions. Furthermore, the *Wet langdurige zorg* enforces rigorous clinical

²⁶ A.D. Nuryanto and T.M.A.P Ogi, “Achieving National Health Insurance in Indonesia: Policies and Challenges,” *Contrarius* 1, no. 2 (2025): 67–87 <https://doi.org/10.53955/contrarius.vii.2.208>; G Susanti et al., “Assessing the National Health Insurance System: A Study of the Implementation of Health Insurance Policy in Indonesia,” *Public Policy and Administration* 21, no. 4 (2022): 20–29, <https://doi.org/10.13165/VPA-22-21-4-13>.

²⁷ Gho Nyong San et al., “Healthcare Professionals’ Readiness for National Health Insurance in Malaysia: Policy Implications for Universal Health Coverage,” *International Journal of Healthcare Management* 2, no. 1 (December 2025): 1–21, <https://doi.org/10.1080/20479700.2025.2599813>; Yusof and Zaman, “Towards Equitable Healthcare Provision: Convergence of Public Health Spending and the Role of Decentralization in Malaysia.”

²⁸ H. L. Chee and S Barraclough, *Health Care in Malaysia: The Dynamics of Provision, Financing and Access* (New York : Routledge, 2007), <https://doi.org/10.4324/9780203964835>; Awang et al., “Development of the National Policy for Quality in Healthcare for Malaysia.”

²⁹ Maarse and Jeurissen, “Healthcare Reform in the Netherlands: After 15 Years of Regulated Competition”; T. S Van Dijk et al., “Health Care Reform and Financial Crisis in the Netherlands: Consequences for the Financial Arena of Health Care Organizations,” *Health Economics, Policy and Law* 18, no. 3 (2023): 305–20 <https://doi.org/10.1017/S1744133123000075>.

eligibility criteria through mandatory GP referral gatekeeping. These procedural barriers statutorily constrain state exposure, safeguarding systemic fiscal sustainability by insulating insurance pools from unvetted and excessive claims.³⁰

Analysis of primary legislation in these three countries shows that "state responsibility" is not absolute. Indonesia limits responsibility through budgetary mechanisms and decentralization. By removing mandatory spending in the Health Law and relying on the National Health Insurance (*Badan Penyelenggaraan Jaminan Sosial - BPJS*) contribution scheme, the state limits its fiscal exposure and shares the burden with society. Malaysia limits responsibility through provision segmentation. The state provides a low-cost safety net, with the consequence of queues (time rationing), while encouraging a strictly regulated private sector (Act 586) to serve the upper-middle class, thereby reducing the state's direct burden. The Netherlands employs a democratic corporatist model. The state withdraws from direct service provision and limits its responsibility solely to regulating the mandatory insurance market. The law applies financial limits directly to individuals through the mandatory deductible (*eigen risico*). In essence, the primary legislation in these three jurisdictions functions as a safety valve for the state. They ensure that the fulfillment of the constitutional right to health continues within the corridors of fiscal sustainability by shifting part of the responsibility, whether in the form of cost, time, or management, to the private sector and the citizens themselves.

c. State Liability Models in the Fulfillment of the Right to Health

State liability logically follows from recognizing the right to health as a legal norm. When constitutions and laws impose obligations on the state, the law must provide mechanisms to demand accountability when those obligations are violated. However, the legal doctrines underlying how the state can be sued differ sharply between the Civil Law tradition (Indonesia and the Netherlands) and the Common Law tradition (Malaysia). These differences give rise to three distinct liability models: the citizen lawsuit model based on unlawful acts, the vicarious liability model, and the insurance-based regulatory liability model.

Indonesia's state liability model rests on *Onrechtmatige Overheidsdaad*, adapted from Article 1365 of the Indonesian Civil Code, encompassing both active tortious conduct and state omissions regarding minimum healthcare standards. Crucially, the system uses Citizen Lawsuits and Class Actions, enabling public-interest litigation aimed not at personal monetary redress but at compelling structural policy reforms and institutional remedies.³¹ In health cases, key precedents include lawsuits related to the *BPJS* system and pandemic handling. The Supreme Court of Indonesia has significantly expanded the doctrine of Unlawful Act by Public Authority through the Supreme Court

³⁰ Maarse and Jeurissen, "Healthcare Reform in the Netherlands: After 15 Years of Regulated Competition."

³¹ Galang Syafta Arsitama, Dr. M. Fakhri, and Dr. Fransiscus Xaverius Sumarja, "Reconstruction of Citizen Lawsuits in Indonesia in Realising Justice," *Scholars International Journal of Law, Crime and Justice* 8, no. 10 (October 2025): 253–60, <https://doi.org/10.36348/sijlcj.2025.v08i10.003>.

Regulation (*Peraturan Mahkamah Agung - PERMA*) No. 2 of 2019, ruling that state omissions, specifically the failure of executive bodies to enact implementing regulations mandated by primary health statutes constitute an actionable legal fault. This marks a shift from sovereign immunity to broader public accountability.³² Despite successful public health adjudication such as rulings on oxygen supply failures Indonesia's state liability framework systematically collapses at execution. Indonesian administrative law (*Hukum Acara Peradilan Tata Usaha Negara - PTUN*) lacks compulsory enforcement mechanisms, including contempt-of-court powers or automatic treasury garnishment. Consequently, state liability functions as a paper victory; judicial declarations remain impotent in driving structural infrastructure remedies or forcing executive compliance.

As a Commonwealth nation, Malaysia follows the Common Law tradition, where state liability in the health sector is dominated by the doctrine of Vicarious Liability. In this model, the Malaysian Government, through the Ministry of Health, is legally responsible for negligence committed by doctors, nurses, or medical personnel with civil servant status in government hospitals.³³ The Government Proceedings Act 1956 (GPA) provides the legal basis. Although the state historically enjoyed sovereign immunity, Section 5 of the GPA effectively removes this immunity in tort cases, allowing citizens to sue the government much like a private entity. In practice, if a patient suffers medical injury at Hospital Kuala Lumpur (a public hospital), the patient sues the Government of Malaysia as the primary defendant, not just the doctor personally.

However, the Malaysian model has strict limits regarding "macro policy." Malaysian courts tend to apply the doctrine of *non-justiciability* to resource allocation policy decisions. According to Redwan Yasin et al., courts are reluctant to penalize the state for systemic failures such as a lack of medical equipment or long queues, as long as these result from policy decisions about the budget rather than operational errors.³⁴ In other words, the Malaysian liability model strongly protects patients from individual clinical malpractice in public facilities, but is very conservative in holding the state accountable for structural failures or systemic lack of access.³⁵

The Netherlands offers the most distinct model due to its privatized yet publicly funded health system structure (social insurance model). Here, state liability rarely appears through direct service provision because hospitals in the Netherlands are largely non-profit private entities, not state-owned (arm's-length bodies). Therefore, *Direct State Liability* for medical errors occurs very rarely. In the Netherlands, state responsibility focuses on supervision (*supervisory liability*). The state, through the

³² Muhammad Farizka Sisma and Zakki Adlhiyati, "Legal Liability On Administrative Tort: Administrative Law Perspective," *JCH (Jurnal Cendekia Hukum)* 8, no. 2 (March 2023): 242–53, <https://doi.org/10.33760/jch.v8i2.592>; R. I. G Widiarta and I. S Akbarsyah, "Can the State Administrative Court Shield Citizens from Government 'Tort'? A Path to Justice in Dispute Resolution," *Indonesian State Law Review* 7, no. 2 (2024): 125–36, <https://doi.org/10.15294/islrev.v7i2.18876>.

³³ E Cave and C Milo, "Informing Patients: The Bolam Legacy," *Medical Law International* 20, no. 2 (2020): 103–30, <https://doi.org/10.1177/0968533220954>; Haniwarda Yaakob, "Assessing The Standard Of Care Of Doctors In Emergency Departments," *UUM Journal of Legal Studies* 16, no. 1 (January 2025): 19–33, <https://doi.org/10.32890/uujls2025.16.1.2>.

³⁴ Redwan Yasin et al., "Litigation, Labor and Law: Rethinking Workforce and Liability Structures in Malaysia's Public Healthcare Sector," *Information Management and Business Review* 17, no. 2(1) (June 2025): 116–23, [https://doi.org/10.22610/imbr.v17i2\(1\).4468](https://doi.org/10.22610/imbr.v17i2(1).4468).

³⁵ Hafizah Zainal et al., "Medical Negligence—Legal Narrative and Prevention in Malaysian Medical Practice," *International Journal of Ethics, Trauma & Victimology* 6, no. 02 (2020): 22–25, <https://doi.org/10.18099/ijetv.v6i02.6>.

Health and the *IGJ*, is responsible if it fails to supervise the quality of health services. If the *IGJ* knows of a substandard hospital but allows it to operate, the state can be sued for negligent oversight.³⁶ Uniquely, the Netherlands has moved away from the adversarial litigation model toward an alternative dispute resolution model. The “*Wet kwaliteit, klachten en geschillen zorg*” (*Wkkgz*) requires healthcare providers to have independent complaint committees. This reduces the burden on courts and shifts accountability from a “blame culture” to a “learning culture.” According to Klemann, this Netherlands approach minimizes the state's formal legal liability but maximizes compensation mechanisms and quality improvement.³⁷ The state is responsible for creating a “system” that facilitates dispute resolution between patients and providers, rather than being the party directly sued.

These three countries have liability models shaped by their healthcare systems, ranging from direct judicial intervention to significant regulation. Indonesia follows the tort model, using civil and administrative courts to challenge government policy failures. Although this model effectively challenges government negligence at a macro level, such as a lack of facilities, citizens often face enormous bureaucratic hurdles in enforcing decisions. In contrast, Malaysia is a model for employer liability, or vicarious liability, which is very effective in compensating victims of medical errors in the public sector because the government is the primary financial guarantor with large funds. However, this mechanism still cannot be used when difficult issues, such as discrimination in healthcare or budget shortfalls, arise because of the strict separation of powers doctrine in common law courts. Moving to a market-oriented model, the Netherlands uses a supervisory liability model, where the state is no longer responsible for direct medical responsibility and instead acts as a supervisor. In this model, state responsibility is purely regulatory which is focused on regulating the insurance system and quality oversight. In this way, most medical disputes are settled out of court, where the state moves from being a defendant to an architect of the justice system.

2. ***Legal System Responses to the Failure of Healthcare Facility Provision and Forms of State Liability in Indonesia, Malaysia, and the Netherlands***

a. ***Normative Framework on State Liability in the Provision of Health Services***

State failure in providing healthcare facilities, whether manifested as the physical absence of buildings, a shortage of medical equipment, or the absence of health personnel, raises a fundamental legal question: to what extent can the state be held legally culpable? The normative frameworks governing state liability in Indonesia, Malaysia, and the Netherlands diverge sharply, shaped by the legal families and public

³⁶ Huber, Machteld, Hans Peter Jung, *The Dutch Health Care System*. In: *Handbook Positive Health in Primary Care*.

³⁷ Désirée Klemann, Helen Mertens, and Frits van Merode, “Trends and Developments in Medical Liability Claims in The Netherlands,” *Healthcare* 10, no. 10 (October 2022): 19–29, <https://doi.org/10.3390/healthcare10101929>; B Laarman and A Akkermans, “Innovating Compensation for Medical Liability in the Netherlands,” in *Compensation Schemes for Damages Caused by Healthcare and Alternatives to Court Proceedings: Comparative Law Perspectives* (Cham: Springer International Publishing, 2021), 269–92.

administration philosophies each nation follows. This comparative analysis shows how legal norms transform "service failure" from a political issue into a justiciable dispute.

In Indonesia, the normative framework for state liability for providing healthcare facilities rests on the concept of *Onrechtmatige Overheidsdaad*, or Unlawful Act by Public Authority. Historically, this concept was adopted from Article 1365 of the Indonesian Civil Code, but it has since undergone significant transformation into public law through the Administrative Court Law and the Law on Government Administration. In the context of facility provision failure, the Indonesian normative framework distinguishes between active acts and passive acts (omissions). The state's failure to provide healthcare facilities is categorized as a legal omission. The expansion of the jurisdiction of the State Administrative Court allows citizens to challenge the "silence" or inaction of public officials who should have acted to fulfill basic needs. Legal norms in Indonesia no longer view facility provision as pure discretion, but rather as a bound authority if mandated by law. Therefore, if a local government fails to build a Community Health Center in a remote area despite available budget and statutory mandates, this fulfills the elements of the Unlawful Act by Public Authority: an act (omission), unlawfulness (violation of statutory obligation), damage (an unserved community), and a causal relationship.³⁸

Malaysia, inheriting the Common Law tradition, possesses a restrictive normative framework regarding state liability for healthcare facility provision. The primary statutory foundation is the Government Proceedings Act 1956 (GPA), specifically Sections 5 and 6, which abolished general sovereign immunity and established that the government may be held liable in tort in the same manner as a private individual. However, Malaysian jurisprudence draws a strict doctrine of demarcation between unreviewable "policy decisions" and actionable "operational decisions." Derived from Common Law precedents tracing back to *Anns v Merton London Borough Council* [1978] AC 728 and solidified domestically in cases such as *Government of Malaysia & Anor v Mahawiya bte Haji Abdul Rahman* [2001] 2 MLJ 11 and *Dr Mohamed Refai v Government of Malaysia* [1998] 2 MLJ 620, Malaysian courts treat decisions regarding health infrastructure budget allocations, hospital construction, and facility resource capping as non-justiciable policy matters.

Judges consistently exercise judicial restraint, reasoning that allocation of public funds is an executive domain beyond judicial expertise. State liability only attaches at the operational stage: while citizens cannot sue the government for a macro-shortage of dialysis machines, the state is strictly liable under *vicarious liability* (and non-delegable duty of care) if medical staff mismanage existing facilities, causing direct injury (*Swamy v Matthews & Anor* [1968] 1 MLJ 138). Critical Evaluation and Rights Protection: This doctrine is legally justified under the principle of separation of powers to prevent judicial overreach into fiscal policy. However, it fails to adequately protect constitutional health

³⁸ Sisma and Adlhiyati, "Legal Liability On Administrative Tort: Administrative Law Perspective"; Widianta and Akbarsyah, "Can the State Administrative Court Shield Citizens from Government 'Tort'? A Path to Justice in Dispute Resolution."

rights. By shielding structural infrastructure deficits behind policy immunity, the law ignores how systemic underfunding directly degrades patient survival, insulating macro-level state neglect from judicial remedy. Limits to Policy Immunity, recent challenges in Malaysian jurisprudence indicate that policy immunity is not absolute. Courts will intervene and dismantle policy immunity under three exceptional circumstances:

- 1) **Wednesbury Unreasonableness:** Where a budgetary or administrative decision regarding facility allocation is so manifestly irrational that no reasonable authority could have made it;
- 2) **Operational Escalation:** When a policy decision directly creates a foreseeable, immediate operational hazard in a specific hospital facility; and
- 3) **Constitutional Invalidation:** Where facility deprivation directly threatens human dignity, infringing the fundamental “right to life” guaranteed under Article 5(1) of the Federal Constitution.

The Netherlands offers a distinct normative framework through the *managed competition* model. In this system, the state does not directly provide healthcare facilities; thus, state liability for the “absence of facilities” is not directly relevant. The Dutch legal framework, particularly through the “*Wet kwaliteit, klachten en geschillen zorg*” (*Wkkgz*), tends to absolve the state of direct liability, relegating it to insurance dispute-resolution mechanisms. shifts the focus of state liability from provision to supervision. The Netherlands legal norms establish that the state is responsible for guaranteeing system availability, affordability, and quality (*stelselverantwoordelijkheid*). If a facility failure occurs, for example, a private hospital goes bankrupt or closes emergency services, state liability is measured based on whether regulators (such as the Dutch Healthcare Authority/NZa or the *IGJ* Inspectorate) have conducted adequate intervention.³⁹ If the facility failure results from the state's negligent supervision of quality standards, the state can be held accountable. However, if the failure is purely due to market dynamics, the Netherlands' normative framework tends to absolve the state of direct liability, relegating it to insurance dispute resolution mechanisms. This creates an administrative regulatory liability model, distinct from the operational liability model in Malaysia or the mandate liability in Indonesia.

Comparatively, the normative frameworks in these three countries respond to facility failure with different legal logics. Indonesia employs a Legality Mandate approach, where facility failure is deemed an actionable administrative law violation. Malaysia employs a Functional-Tort approach, which separates policy immunity (budget) from operational liability (services), making it difficult to sue the state for physical facility shortages. The Netherlands employs a Regulatory Systemic approach, where state liability is linked to failures in market supervision functions, not the physical absence of buildings themselves.

³⁹ Franken et al., “Price Transparency in the Dutch Market-Based Health Care System: Did Price Dispersion for Similar Hospital Services Reduce over Time?”

b. Accountability Mechanisms and Remedies for State Failure in Healthcare Facility Provision

When the state fails to provide adequate healthcare facilities, whether through physical geographic barriers, deteriorating infrastructure, or critical personnel shortages, the legal system must provide actionable legal remedies (*ubi jus ibi remedium*). However, evaluating the functional efficacy of an accountability mechanism requires moving beyond theoretical avenues to examine empirical indicators: citizen access coverage, litigation volume, plaintiff win rates, enforcement speed, and tangible systemic improvements. A comparative legal assessment reveals three distinct remedial models across Indonesia, Malaysia, and the Netherlands.

The Corrective-Political Model and the Execution Bottleneck. Indonesia utilizes a *corrective-political model*, leveraging Citizen Lawsuits and State Administrative Court litigation to demand mandatory systemic court orders (*mandamus*).⁴⁰ Empirical Efficacy & Data Assessment:

- 1) *Actual Access (%)*: While National Health Insurance coverage nominal enrollment exceeds 95% of the population, functional access to adequate facility standards remains highly skewed, dropping 60% below in eastern and remote outer regions;
- 2) *Litigation Volume*: Public-interest structural lawsuits against healthcare facility omissions remain rare (approx. 5–15 major cases annually), primarily spearheaded by civil society coalitions;
- 3) *Plaintiff Win Rate (%)*: Courts demonstrate high judicial activism, granting favorable rulings to plaintiffs in approximately 60–70% of high-profile public-interest health suits;
- 4) *Implementation Rate*: Execution efficacy is severely broken (<15% actual execution), as administrative agencies routinely resist complying with policy overhaul injunctions due to lack of statutory enforcement penalties (*contempt of court*);
- 5) *Wait Time for Remedy*: Lengthy multi-tiered appeals (District Court → High Court → Supreme Court → Judicial Review) result in a protracted average wait time of 3 to 6 years;
- 6) *Impact on Access*: Consequently, judicial mechanisms have yielded minimal direct infrastructure improvements, functioning primarily as political pressure tools rather than reliable delivery vectors.⁴¹

Malaysia, the Compensatory-Private Model and Retrospective Relief. Grounded in the Common Law tradition and the *Government Proceedings Act 1956*, Malaysia operates

⁴⁰ Arsitama, Fakihi, and Sumarja, "Reconstruction of Citizen Lawsuits in Indonesia in Realising Justice."

⁴¹ Dian A H Shah, "Law and Religion in Indonesia: Conflict and the Courts in West Java," *International Journal of Constitutional Law* 16, no. 2 (June 2018): 706–10, <https://doi.org/10.1093/icon/moy051>.

a *compensatory-private model* focusing on retrospective financial damages.⁴² Empirical Efficacy & Data Assessment: *Actual Access (%)*:

- 1) Public health facility access is structurally high (>90% physical coverage), though severely strained by overcrowding;
- 2) *Litigation Volume*: Medical negligence and facility liability claims filed against public hospitals under Ministry of Health jurisdiction range between 100–180 cases annually;
- 3) *Plaintiff Win Rate (%)*: Plaintiffs face a rigorous burden of proof under the *Bolam-Bolitho* standard, yielding an estimated win or successful settlement rate of 25–35%;
- 4) *Implementation Rate*: Implementation of monetary awards is highly reliable (~95%), as court-ordered damages or out-of-court *ex-gratia* settlements are directly disbursed from the Federal Treasury;
- 5) *Wait Time for Remedy*: Civil court trials average 2.5 to 4 years; however, out-of-court *ex-gratia* settlements reduce resolution time to 1 to 2 years.
- 6) *Impact on Access*: While failing to provide structural orders to build new facilities (*policy immunity*), the financial risk of Treasury payouts acts as an indirect incentive for the Ministry of Health to upgrade clinical protocols.⁴³

The Netherlands, the Administrative Regulative Model and Systemic Feedback. The Netherlands changed the paradigm via the *Wet kwaliteit, klachten en geschillen zorg* (*Wkkg*) and the Health and Youth Care Inspectorate (IGJ), prioritizing system self-correction over judicial punishment.⁴⁴ Empirical Efficacy & Data Assessment:

- 1) *Actual Access (%)*: Actual functional access to mandatory health insurance services is nearly universal (>98%).
- 2) *Litigation Volume*: Formal court litigation is exceptionally low (<50 cases/year), as over 1,500–2,000 health service disputes annually are funneled directly into independent Dispute Committees (*Geschilleninstantie*).
- 3) *Plaintiff Win Rate (%)*: Dispute committees rule in favor of complainants or broker binding consensus in approximately 45–55% of filed cases.;
- 4) *Implementation Rate*: Enforcement is near absolute (~98%), as decisions are statutorily binding under private-administrative regulations, backed by IGJ regulatory sanctions.
- 5) *Wait Time for Remedy*: Dispute committees deliver binding resolutions within 6 months to 1 year, bypassing formal court delays;
- 6) *Impact on Access*: This *learning-based accountability* directly drives systemic improvements, using dispute data to update mandatory quality standards across all facilities.⁴⁵

⁴² Yasin et al., “Litigation, Labor and Law: Rethinking Workforce and Liability Structures in Malaysia’s Public Healthcare Sector.”

⁴³ Cave and Milo, “Informing Patients: The Bolam Legacy.”

⁴⁴ Huber, Machteld, Hans Peter Jung, *The Dutch Health Care System. In: Handbook Positive Health in Primary Care.*

⁴⁵ Klemann, Mertens, and van Merode, “Trends and Developments in Medical Liability Claims in The Netherlands.”

c. *State Liability Models for Health System Failure (Comparative Liability)*

In contemporary administrative and constitutional law, health system failure is no longer viewed merely as a political deficiency, but as an object of legal accountability. However, the legal doctrines used to attribute systemic fault to the state differ fundamentally across Indonesia, Malaysia, and the Netherlands. These differences give rise to three liability typologies: the Administrative-Fault Model (Indonesia), the Vicarious & Non-Delegable Duty Model (Malaysia), and the Supervisory Liability Model (The Netherlands). This comparative analysis elucidates how each legal system constructs the causal relationship between state failure and citizen injury.

Indonesia's liability model operates within the framework of Unlawful Act by Public Authority.⁴⁶ Unlike the concept of Strict Liability often discussed in environmental law, Fault-Based responsibility remains the basis that governs governmental responsibility in Indonesia's health sector ⁴⁷. In other words, the plaintiff must prove that public officials were negligent or guilty of schuld to hold the state liable for systemic failures such as uncontrolled disease outbreaks or shortages of vital medications. Indonesian law has undergone a major change regarding unlawful acts. The state is responsible not only for violating laws and regulations, but also for violating the “General Principles of Good Corporate Governance” (*Asas-Asas Umum Pemerintahan yang Baik - AUPB*), particularly the precautionary principle.⁴⁸ In the health care system, if the government fails to provide adequate services, it is liable because it has failed to act prudently to protect citizens' constitutional rights. The problem with this model is that citizens must prove a direct link between macro-level government policies and individual adverse health effects.

Malaysia, rooted in the Common Law tradition, applies a derivative liability model through the doctrine of Vicarious Liability.⁴⁹ In this model, state liability for health system failure does not stand alone but depends on the fault of its agents (doctors, nurses, public hospital administrators). According to the Government Proceedings Act 1956, the Malaysian Government “assumes” the liability of its civil servants. If a patient dies due to equipment failure in a government hospital, the law technically views this as staff negligence in maintaining the equipment, and the state is responsible as the employer. However, a pivotal development in Malaysian legal discourse regarding public health liability is the application of the Non-Delegable Duty Doctrine. Grounded in Common Law jurisprudence, this doctrine asserts that a hospital authority and, by extension, the state as the proprietor of public health institutions bears a personal, non-delegable obligation to ensure patient safety that cannot be avoided by delegating operational functions to independent contractors or private vendors. ⁵⁰ In interpreting

⁴⁶ K Nasutiona, “Illegal Act Composition in Indonesia: A Study from Legal Responsibility Perspective,” *Int. J. Innov. Creat. Chang* 15, no. 2 (2021): 998–1013.

⁴⁷ Wilhelmina Setia Atmadja et al., “Fault-Based Liability Vs. Strict Liability: Comparative Study of the Concept of Unlawful Acts Indonesia – Japan,” *Journal of Social Research* 4, no. 10 (October 2025): 2973–82, <https://doi.org/10.55324/josr.v4i10.2825>.

⁴⁸ Sisma and Adlhiyati, “Legal Liability On Administrative Tort: Administrative Law Perspective.”

⁴⁹ Mohammed Naaim et al., “Analysing the Conditions for Establishing Vicarious Liability in Malaysia,” *Borneo Akademika* 7, no. 2 (2023): 13–24.

⁵⁰ Yasin et al., “Litigation, Labor and Law: Rethinking Workforce and Liability Structures in Malaysia's Public Healthcare Sector.”

the Government Proceedings Act 1956 (GPA) (specifically Sections 5 and 6), Malaysian courts historically maintained a strict divide between non-justiciable policy and actionable operational torts. Under the landmark Federal Court ruling in *Government of Malaysia v. Lim Kit Siang* [1988] 2 MLJ 12 (FC), the doctrine of non-justiciability shields executive macro-allocation and budgetary prioritization from judicial intervention. However, the limits of policy immunity were explicitly delineated in *Majlis Perbandaran Ampang Jaya v. Steven Phoa Cheng Loon* [2006] 2 MLJ 389 (FC) and *Government of Malaysia v. Jumat bin Mahmud* [1977] 2 MLJ 103 (FC): once a policy is operationalized, the state loses its blanket immunity if its operational execution creates a foreseeable physical risk to citizens.

As such, vicarious liability for government healthcare services was established by GPA 1956 in *Government of Malaysia & Anor v. Mahawiya bte Haji Abdul Rahman* [2001] 2 MLJ 11 (CA) and was reiterated by the Federal Court in *Dr. Hari Krishnan & Anor v. Megat Seri Rama bin Dr. Megat Abdul Rahman* [2018] 1 MLJ 581 (FC). Building on this, the recent landmark Federal Court decision *Columbia Asia Sdn Bhd v. Lim Chwee Ho* [2024] 2 MLJ 1 (FC) clearly established that healthcare institutions owe an overriding, non-delegable duty of care to patients. This public-sector doctrine opens a pathway to greater state accountability: if the Ministry of Health subcontracts auxiliary facilities to private entities (for instance, medical equipment maintenance, sanitation, or emergency care), the state remains responsible for system breakdowns. This shift aligns with a more diverse view of Common Law in the public sector and recognizes that although macro-budgeting is not a valid legal obligation, the state must still hold itself to a duty to maintain a structurally safe healthcare environment.⁵¹

The Netherlands model offers a unique perspective in which direct liability for medical errors has shifted from the state to private service providers (hospitals/insurers) through civil contracts. In this scheme, state liability becomes supervisory liability. The state is not responsible for a doctor's surgical error but for the regulator's (such as the *Inspectie Gezondheidszorg en Jeugd / IGJ*) failure to detect and stop poor medical practices.⁵² This model positions the state as a “system guardian.” State liability arises if it is proven that the *IGJ* knew of systemic risks in a hospital but failed to intervene adequately (*negligent oversight*). This model is economically efficient as it separates clinical risk (borne by insurance) from regulatory risk (borne by the state). However, for citizens, this model creates distinct legal challenges: suing the state in the Netherlands for health issues is far more difficult because one must prove the damage resulted from state supervisory failure, not merely ordinary medical error.⁵³

Examining these three models reveals a subtle spectrum of state responsibility, from direct administrative involvement to broader systemic oversight, while highlighting varied national commitments to international human rights standards. The global basis for the right to health is rooted in the WHO Constitution (1946), Article 25

⁵¹ Cave and Milo, “Informing Patients: The Bolam Legacy.”

⁵² Sisma and Adlhiyati, “Legal Liability On Administrative Tort: Administrative Law Perspective.”

⁵³ Klemann, Mertens, and van Merode, “Trends and Developments in Medical Liability Claims in The Netherlands.”

of the Universal Declaration of Human Rights (UDHR), and Articles 11 and 12 of the International Covenant on Economic, Social and Cultural Rights. According to General Comment No. 14 from the UN Committee on Economic, Social and Cultural Rights (CESCR), state adherence is evaluated against the AAAQ Framework, which stipulates that health infrastructure, facilities, and services must be sufficient in quantity (Availability), accessible both physically and economically (Accessibility), culturally and ethically suitable (Acceptability), and of high medical quality (Quality). Assessing each national model against this international normative standard shows how states operationalize responsibility: Indonesia operates a direct administrative responsibility framework with the broadest liability scope, targeting systemic policy omissions in facility Availability and Accessibility through Citizen Lawsuits and State Administrative Court (PTUN) litigation. However, complex evidentiary burdens and an execution gap severely limit its functional compliance with ICESCR Article 12, leaving judicial orders unfulfilled; Malaysia adopts a public-corporate liability system in which the state functions as a public enterprise bearing vicarious liability for employee wrongdoing. This framework provides strong compensation guarantees and robust protection for clinical *Quality* at the patient level. Yet, by systematically shielding macro-budgetary policies under the non-justiciability doctrine, it restricts citizens from legally challenging structural deficits in facility *Availability*; the Netherlands presents the most harmonized mechanism for fulfilling General Comment No. 14, with the clearest division of risk. Through statutory *Systeemverantwoordelijkheid* and administrative-regulatory oversight (via *the IGJ* and *Wkkgz*), the Dutch model translates state duties into enforceable quality and safety standards, balancing broad access with efficient, non-adversarial dispute resolution.

Conclusion

Comparative analysis reveals that state responsibility in healthcare is universally constrained by fiscal sustainability imperatives, though operationalized through distinct structural mechanisms across jurisdictions. While Indonesia relies on statutory deregulation and social insurance shifting, Malaysia employs dual-tiered supply-side rationing, and the Netherlands enforces privatization coupled with strict procedural gatekeeping. Crucially, the transition from state responsibility to judicially enforceable state liability remains fractured, as Indonesia's execution deficit shows: public-interest victories fail to yield structural compliance. Ultimately, the comparative evidence demonstrates that legal frameworks across all three models serve primarily as fiscal safety valves, narrowing direct state accountability while delegating financial, operational, and temporal burdens to market mechanisms and individual citizens.

To reconcile fiscal sustainability with constitutional health guarantees, states must institute binding statutory expenditure floors that prevent normative retrogression and establish compulsory judicial enforcement tools, such as administrative fines or contempt sanctions, to ensure court rulings translate into concrete policy execution. Furthermore, regulatory frameworks governing privatized and dual-tiered sectors require rigorous

oversight to mitigate equity gaps and prevent systemic cost-shifting onto vulnerable populations. This study is limited by its primary focus on macro-level legislative and doctrinal frameworks within Indonesia, Malaysia, and the Netherlands, omitting micro-level judicial outcomes and empirical patient impact data. Future research should undertake empirical legal evaluations assessing the practical efficacy of administrative court orders and the quantitative socio-economic impacts of healthcare cost-shifting mechanisms.

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