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No-Fault Compensation System and Restorative Justice in Medical Dispute Resolution: A Lesson from New Zealand for Indonesia

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Abstract

Medical dispute resolution in Indonesia relies on a fault-based litigation model, which burdens patients with high evidentiary standards, stigmatizes physicians, and hinders systemic learning in healthcare. This article aims to explore the potential of integrating a no-fault compensation system with restorative justice as an alternative framework. The research adopts a normative juridical method combined with comparative legal analysis, using New Zealand's accident compensation corporation as a primary comparative model. Findings indicate that Indonesia's mechanism fails to ensure equitable remedies and often results in defensive medicine. New Zealand's no-fault compensation system demonstrates efficiency and patient-centeredness. However, the no-fault compensation system alone may lack the relational repair component that restorative justice provides. The proposed hybrid no-fault restorative justice model combines material justice (compensation without proof of negligence) with relational justice (acknowledgement, apology, and trust restoration). This integrated approach is normatively consistent with Indonesia's constitutional commitment to social justice and resonates with cultural values of deliberation. The hybrid no-fault restorative justice model could transform Indonesia's health law from a punitive, adversarial paradigm into a preventative, restorative, and patient-centered system.

Keywords

Health Law, Hybrid Model, Medical Dispute Resolution, No-Fault Compensation, Restorative Justice.

1. Introduction

The relationship between a patient and a healthcare provider is unique, founded upon a profound imbalance of power, vulnerability, and trust. The patient entrusts their physical integrity to the provider's expertise, operating under the shared expectation of safety, diligence, and healing (Beauchamp & Childress, 2019; WHO, 2019). When this relationship is fractured by an adverse event, particularly one perceived by the patient or their family as resulting from medical negligence, the legal system is invoked to provide a remedy and restore balance. In Indonesia, the primary mechanism for this remedy remains anchored in a traditional, fault-based litigation model. This adversarial paradigm, inherited from classical tort law, mandates that a patient must prove negligence, causation, and damages to secure compensation (Maulana et al., 2023).

This reliance on adversarial litigation, however, has proven to be systemically problematic and deeply unsatisfying for all parties involved. From the patient's perspective, the system is often inaccessible and re-traumatizing (Vento et al., 2018). The patient, already bearing the physical and emotional trauma of a medical injury, is saddled with the onerous burden of proof (*onus probandi*). They must navigate a complex procedural labyrinth, secure expert testimony (often from peers of the physician they are suing), and finance a legal battle that is both costly and protracted (Kusworo & Fauzi, 2023). For many, justice becomes an illusion, an unreachable luxury, fostering deep-seated frustration and a corrosive cynicism towards both the medical and legal professions (Karjoko et al., 2021; Rahman et al., 2025).

From the provider's perspective, the system is perceived as a direct threat to their professional integrity and personal reputation (Mello et al., 2004). The "fault" model inherently seeks a "guilty" party, a framework that is ill-suited to the complex, high-risk, and often uncertain nature of modern medicine. The ever-present fear of legal reprisal fosters a pervasive culture of "defensive medicine." In this paradigm, clinical decisions are increasingly driven not by the patient's optimal interest, but by the physician's desire to mitigate legal risk. This leads to ordering superfluous diagnostic tests, avoiding high-risk but necessary procedures, and a breakdown in transparent communication with patients (Studdert et al., 2005). This defensive posture not only inflates healthcare costs but, paradoxically, can place patients at greater risk while fundamentally eroding the physician-patient trust it purports to protect (Hussaini & Varon, 2023; Lakoro et al., 2025).

This academic anxiety surrounding Indonesia's failing model is not new. The legal and medical professions have long recognized the system's inadequacies. Since the enactment of the 1992 Health Law and the 2004 Medical Practice Law, patients have been formally recognized as rights-holders. Yet, the institutional mechanisms for vindicating these rights remain fragmented. The Indonesian Medical Council (*Konsil Kesehatan Indonesia*/KKI) is empowered to adjudicate ethical and disciplinary matters but lacks the authority to grant material compensation to patients. Consequently, the civil and criminal courts remain the *de facto* arena for redress, perpetuating the adversarial cycle. The passage of the new omnibus Law Number 17 of 2023 concerning Health, which introduces elements of mediation and restorative justice, signals a crucial legislative acknowledgment that the old paradigm is broken. However, it does not, by itself, dismantle the fault-based structure or provide a comprehensive alternative.

This domestic dissatisfaction compels a comparative turn. In stark contrast to the Indonesian model, New Zealand pioneered a revolutionary alternative with its No-Fault Compensation System (NFCS), institutionalized through the Accident Compensation Act of 1974 and managed by the Accident Compensation Corporation (ACC). This system effectively abolishes the right to sue for personal injury, including medical injury, in exchange for a state-run compensation scheme. Patients

receive rehabilitation, financial support, and medical aid based on the fact of the injury itself, not on proof of provider negligence (Paterson, 2013). This paradigm shift moves the focus from "fault" to "recovery" and from "punishment" to "systemic learning" (Bismark & Paterson, 2006).

While the New Zealand model is lauded for its efficiency and patient-centeredness, it is not without critique. Some research argues that by eliminating "fault," the NFCS may inadvertently weaken provider accountability and, crucially, fail to address the patient's profound relational and emotional needs, the need for an explanation, an apology, and the restoration of trust. This is where the burgeoning field of restorative justice offers a powerful conceptual supplement. Restorative which has gained traction in Indonesian criminal law, shifts the focus of justice from retribution (punishment) to restoration (repairing harm) (Zehr, 2015). It prioritizes a mediated dialogue where the harmed party can express their pain and the responsible party can acknowledge their role, fostering accountability and relational healing.

This article identifies a critical gap in Indonesian health law scholarship. While many have critiqued the litigation model and a few have begun to explore restorative justice, there has been no systematic attempt to integrate the material, structural efficiency of a No-Fault Compensation System (the New Zealand model) with the relational, procedural, and cultural depth of restorative justice (the *musyawarah* model) (Karjoko et al., 2021; Maskanah, 2023; Mustika et al., 2023). The novelty of this research lies in this precise synthesis. It moves beyond a simple critique of the current system and beyond a simple proposal to "copy" New Zealand. It argues for the creation of a Hybrid No-Fault Restorative Justice (H-NFRJ) Model tailored to the Indonesian legal and cultural context. This model posits that true justice for medical injury requires a dual approach: first, a no-fault mechanism to provide rapid, material justice (compensation and rehabilitation) to the patient; and second, a restorative justice process to provide relational justice (acknowledgment, apology, and restored trust).

This study contributes to the fact that a hybrid model is not only normatively superior but also practically feasible. It aligns with the constitutional mandate for social justice (*keadilan sosial*) and resonates deeply with the Indonesian cultural preference for deliberation (*musyawarah*) and consensus (*mufakat)* over adversarial confrontation. This study aims to proceed by first deconstructing the systemic failures of Indonesia's current fault-based model; second, providing a deep comparative analysis of the New Zealand NFCS; and third, constructing the proposed H-NFRJ model as a transformative and culturally resonant solution for the future of Indonesian health law.

2. Methods

This research employs a normative juridical methodology, which is fundamentally doctrinal and qualitative in nature. The study is designed to analyze legal norms, principles, and structures, rather than to measure empirical phenomena. The research design integrates three specific approaches: the statutory and doctrinal approach, the comparative law approach, and the conceptual approach. Statutory and doctrinal approach involves a systematic analysis (law as it is written) of the primary legal materials governing medical disputes in Indonesia, principally Law Number 17 of 2023 (Health), Law Number 29 of 2004 (Medical Practice), the Civil Code (*Kitab Undang-Undang Hukum*/KUHPerdata), and relevant regulations concerning the KKI and mediation. This is contrasted with the foundational legislation of the New Zealand model, the Accident Compensation Act.

The comparative law approach employs a macro-level, functional comparative analysis (Zweigert et al., 1998). It compares two distinct legal systems (Indonesia and New Zealand) by focusing on the function of medical dispute resolution. New

Zealand was selected as the primary comparative model because its No-Fault Compensation System (NFCS) represents one of the most mature, comprehensive, and empirically evaluated alternatives to fault-based medical injury mechanisms worldwide. The system's long-standing implementation since 1974 provides a robust body of evidence on institutional design, efficiency, and patient-centered outcomes, making it an ideal benchmark for assessing Indonesia's structurally fragmented and litigation-oriented model. Moreover, the NFCS offers a paradigmatic contrast, shifting from fault to recovery which enables a clear analytical examination of whether such structural principles could be adapted to Indonesia's legal and sociocultural context.

This study seeks to understand how each system solves the same problem (medical injury) and to draw lessons from the differences in their approaches (fault-based vs. no-fault). By a conceptual approach, this study analyzes the core concepts of "justice" that underpin each model. It deconstructs the retributive/corrective justice of the fault-based system and contrasts it with the material/distributive justice of NFCS and the relational/procedural justice of restorative justice (Zehr, 2015). This conceptual analysis provides the theoretical foundation for proposing the hybrid H-NFRJ model.

Data collection is based on library research, sourcing secondary data from primary legal materials (statutes), secondary legal materials (academic journals, textbooks, scholarly commentary), and tertiary legal materials (legal dictionaries). Sources were identified from databases (Google Scholar, HeinOnline, Scopus) and Indonesian legal repositories. The analysis is descriptive, critical, and prescriptive, moving from an analysis of the current law (*das Sollen*) to a critique of its in-practice failures (*das Sein*), and culminating in a proposal for legal reform (*ius constituendum*).

3. Results and Discussion

3.1 The Systemic Failure of Indonesia's Fault-Based Litigation Model

The "fault-based" system is grounded in classic tort theory, which requires a plaintiff to prove four elements: a duty of care was owed, that duty was breached (negligence), the breach caused an injury, and damages resulted. Scholars have long argued that this model is a poor fit for the healthcare context (Weiler, 1991). The "breach of duty" is notoriously difficult to prove due to the complexity of medicine and the "conspiracy of silence" among medical professionals. This leads to a dual injustice: a high number of legitimate claims are never filed or never succeed, while a significant number of non-meritorious claims proceed, creating a "lottery" effect (Mello et al., 2004). The high administrative costs of litigation (legal fees, court time, expert witnesses) consume a disproportionate amount of the funds that could otherwise go to injured patients. Furthermore, this body of literature extensively documents the system's toxic side effect: the rise of "defensive medicine," which undermines the quality of care and inflates costs (Studdert et al., 2005). The current Indonesian framework for resolving medical disputes is a relic of 19th-century tort law, fundamentally ill-equipped for the 21st-century healthcare environment. Its reliance on proving fault, creates a system that is inefficient, inaccessible, and ultimately antithetical to the core goals of both patient safety and access to justice. This systemic failure can be deconstructed into three interconnected domains: the profound burden on the patient, the corrosive effect on the medical profession, and the fragmentation of institutional response (Utama et al., 2024).

First, the procedural and evidentiary burden on the patient is arguably the system's most significant moral failing. When a patient suffers a medical injury, they are immediately placed in an adversarial position against a well-funded, highly organized, and information-rich institution (the hospital) and its expert (the physician). To secure a remedy under the Civil Code (*Kitab Undang-Undang Hukum*

/KUHPerdata) for an unlawful act, the patient-plaintiff must prove, by a preponderance of the evidence, that the physician breached the professional standard of care and that this breach directly caused their injury. This is a near-insurmountable task. The evidence required, complex medical records, expert testimony is almost exclusively in the control of the very parties being sued. Patients face what is commonly known as the "conspiracy of silence," where physicians are culturally and professionally reluctant to testify against a colleague. This information asymmetry transforms the legal process from a search for justice into a war of attrition. As litigation drags on for years, the patient's financial and emotional resources are exhausted (Kusworo & Fauzi, 2023). The result is a system that filters out the vast majority of legitimate claims, leaving injured patients with no remedy, no compensation, and a profound sense of injustice.

Second, the corrosive impact on the medical profession is equally damaging. The fault-based model operates on the principle of public blame and punishment (Deffains & Fluet, 2014). For a physician, a malpractice suit is not just a financial risk; it is an existential threat to their professional reputation and personal integrity (Mello et al., 2004). This culture of fear breeds precisely the opposite of what patient safety requires. Instead of open disclosure, it encourages secrecy and the concealment of errors. Instead of collaborative problem-solving, it fosters tribalism and defensiveness. The most well-documented outcome of this fear is the proliferation of defensive medicine. Physicians, operating under the shadow of the law, armor themselves against potential lawsuits by ordering a barrage of medically unnecessary but procedurally defensible tests and consultations (Studdert et al., 2005). This practice not only drives up national healthcare costs, siphoning resources from Social Security Agency for Health *(Badan Penyelenggaran Jaminan Sosial/*BPJS*)*, but it also exposes patients to iatrogenic risks from the unnecessary procedures themselves (Garattini & Padula, 2020). The law, in its clumsy attempt to assign blame, actively undermines the quality of care.

Third, the institutional framework is fragmented and ineffective. Indonesia lacks a single, coherent body for resolving medical injury claims. A patient faces a confusing array of options, each with a different purpose. They can file a complaint with the Indonesian Medical Council, but the KKI's mandate is limited to professional discipline and ethics. It can sanction the doctor (e.g., with a warning or suspension), but it has no power to order compensation for the patient. The patient's need for material justice is left unaddressed (Small, 2019). Alternatively, the patient can pursue criminal charges (*pidana*), a path that intensifies the adversarial nature of the dispute and is rarely successful, as it requires proving a higher burden of *mens rea* (criminal intent) or gross negligence. Finally, they can pursue the civil claim (*perdata*) as discussed. While the new Law Number 17 of 2023 encourages mediation, this is often seen as a preliminary step before the inevitable litigation, lacking the structural support to be a genuine alternative. This fragmentation means there is no central repository for adverse event data. Each case is treated as an isolated incident, a "one-off" failure, rather than a data point indicating a systemic flaw. Consequently, the system is prevented from learning from its mistakes.

The Indonesian fault-based model is a failing paradigm. It is adversarial, inefficient, economically wasteful, and procedurally inaccessible to the vast majority of those it is meant to serve. It punishes physicians for errors that are often systemic, rather than personal, and in doing so, it creates a culture of fear that is toxic to patient safety. It fails the patient by denying them accessible compensation, and it fails the public by hindering the systemic improvements that could prevent future harm.

3.2. Comparative Analysis of No-Fault Compensation's New Zealand Model

The locus classicus for No-Fault Compensation System (NFCS) model is New Zealand. Scholarship in this area, led by figures like Bismark and Paterson (2006)

and Paterson (2013) analyzes the New Zealand Accident Compensation Corporation (ACC) as a case study. This literature highlights the system's profound advantages: it dramatically improves access to compensation, reduces administrative costs, and, most importantly, creates a "data-rich" environment. By decoupling compensation from negligence, the ACC encourages open disclosure of adverse events, transforming "mistakes" from sources of legal peril into invaluable data for systemic patient safety improvements (Wallis, 2017). However, this literature also raises critical questions, debating whether the absence of "fault" leads to a corresponding erosion of individual provider accountability and whether the standardized compensation schedules adequately address the full spectrum of patient suffering, particularly non-economic harm.

In 1974, New Zealand embarked on one of the 20th century's boldest social-legal experiments. Based on the recommendations of the Woodhouse Report, the government passed the Accident Compensation Act, effectively abolishing the entire common law regime of personal injury tort law. In its place, it erected a comprehensive, state-run no-fault compensation system administered by the accident compensation corporation. This decision fundamentally redefined the concept of justice for injury, moving it from the private law domain of "fault and liability" to the public law domain of "community responsibility and rehabilitation." For medical disputes, this shift was revolutionary (Triana & Sulistyorini, 2021).

The operation of the ACC system is elegant in its simplicity. When a patient suffers an injury as a result of medical treatment (a "treatment injury"), they do not sue the doctor. Instead, they file a claim directly with the ACC. The central question for the ACC is not "Was the doctor negligent?" but "Did the injury result from the treatment, rather than the patient's underlying condition?" Proof of causation is required, but proof of negligence is irrelevant. If the claim is accepted, the patient receives a comprehensive, state-funded package of benefits. This includes not only 100% coverage of all medical and rehabilitation costs but also earnings-related compensation for lost income and lump-sum payments for permanent impairment. The entire process is administrative, not judicial. It is inquisitorial, not adversarial (Walis et al., 2017; Kasuri et al., 2024).

The benefits of this model are profound and multifaceted. The primary beneficiary is the patient. Access to compensation is transformed from a "legal lottery" into an administrative entitlement. The process is swift, typically resolving in months, not years. It is "no-cost" to the patient, removing the financial barriers that define the Indonesian system. Most importantly, its focus is not on a one-time financial payout but on long-term rehabilitation. The ACC's "social contract" is to do everything possible to restore the patient's quality of life (Paterson, 2013). This patient-centeredness stands in stark relief to the adversarial combat of a fault-based system.

The benefits for physicians and the healthcare system are equally significant. The ACC model acts as a "lightning rod" for disputes, de-escalating conflict. By removing the threat of personal financial ruin and professional stigma, it dismantles the primary driver of defensive medicine (Wallis, 2017). Physicians are no longer the "enemy" in a legal battle. This, in turn, fosters a culture of open disclosure. New Zealand's health system has become a world leader in patient safety precisely because the ACC model encourages providers to report adverse events without fear of punishment. The ACC itself becomes a massive, centralized repository of data on medical injury. As Bismark and Paterson (2006) have documented, the ACC analyzes this data to identify systemic trends, such as a specific surgical technique proving high-risk or a particular hospital having poor infection control and then uses this information to drive national patient safety initiatives. The system learns from its failures.

However, the New Zealand model is not a panacea, and a critical analysis reveals its limitations. By "de-personalizing" the dispute, the ACC model is sometimes criticized for being "too" administrative. A patient receives a check and rehabilitation, but they may never receive an explanation, an acknowledgment of their suffering, or an apology from the provider. The system is efficient at material justice but can be deficient at relational justice. It compensates for the injury but does not always heal the relationship (Paterson, 2013). Furthermore, the elimination of "fault" as a legal concept has raised persistent concerns about accountability. If a doctor is consistently incompetent, the ACC model will compensate their victims, but it does not, by itself, remove the doctor from practice. That responsibility remains with the (separate) medical disciplinary bodies. This potential "accountability deficit," combined with the lack of relational repair, demonstrates that while the NFCS is a massive improvement, it may not be the complete solution. It perfects the "compensation" function of justice but leaves the "restorative" function largely unaddressed.

3.3. H-NFRJ Model: Integrating No-Fault and Restorative Justice

This critique of NFCS's potential "relational deficit" leads directly to the restorative justice. Pioneered in criminology by scholars like Zehr (2015), restorative justice is a paradigm that views wrongdoing not as a violation of a rule, but as a violation of relationships. Its goal is not to assign blame or mete out punishment, but to address the needs of the harmed party and hold the responsible party accountable through a process of mediated dialogue, acknowledgment, and reparation. In recent years, legal scholars in Indonesia have begun to explore the applicability of restorative justice, arguing that its principles align strongly with indigenous legal traditions and the Pancasila philosophy of deliberation (*musyawarah)* (Karjoko et al., 2021; Maskanah, 2023). When applied to medicine, RJ directly addresses the relational and emotional trauma of an adverse event, the patient's need for an explanation, an apology, and a restored sense of trust that both litigation and NFCS models tend to overlook (Mustika et al., 2023).

The analysis of Indonesia's failing model and New Zealand's successful but incomplete model provides the necessary foundation for this paper's core prescriptive proposal: the Hybrid No-Fault Restorative Justice (H-NFRJ) Model. A simple "copy-paste" of the New Zealand ACC is neither feasible nor desirable in Indonesia. The costs would be astronomical, and its purely administrative, non-relational nature would clash with Indonesian cultural values that prioritize harmony and consensus. The Indonesian legal culture, embodied in Pancasila's fifth *sila* ("Social Justice for all...") and the tradition of deliberation and consensus (*mufakat*), demands a solution that not only compensates but also heals (Karjoko et al., 2021; Putri, 2023).

The H-NFRJ model is a bespoke synthesis designed for this context. It integrates the material efficiency of NFCS with the relational healing of restorative justice. This proposal moves beyond the binary choice of "litigation vs. no-fault" and creates a "third way" that leverages the strengths of both reformist paradigms. The model is built on three essential pillars.

Pillar 1, The no-fault compensation fund (material justice), is the structural mechanism for compensation. This paper proposes the creation of a national Medical Injury Compensation Fund (MICF). This fund would operate on a no-fault basis, similar to the ACC. A patient who suffers a "medical treatment injury" (a term to be legally defined, distinguishing it from the natural progression of an illness) would apply directly to this fund. The key is to sever the link between compensation and negligence. Financially, this MICF could be structured as a new, specialized branch within the existing BPJS framework. It could be funded by a combination of sources: a small, dedicated levy on all healthcare providers (hospitals and clinics), a contribution from the state budget (*Anggaran Pendapatan Belanja Negara*/APBN),

and perhaps a fractional re-allocation of the BPJS premium. By collectivizing the risk across the entire population and provider network, the system becomes financially sustainable. The patient would receive rapid administrative payouts for medical costs, rehabilitation, and lost earnings, thus satisfying the constitutional demand for social justice and removing the primary driver of litigation (Ardi et al., 2023).

Pillar 2 states that the restorative justice process (relational justice). This second pillar is the H-NFRJ model's crucial innovation and what distinguishes it from the standard NZ model. Accessing the MICF (Pillar 1) would be procedurally linked to a mandatory, but non-coercive, restorative justice Process. This is where the relational harm is addressed, in a manner perfectly aligned with deliberation. This process would be managed by a new cadre of trained, independent mediators within the MICF or under the auspices of the KKI (Munandar et al., 2025). Once a claim is validated, the patient and their family would be invited (but not forced) to participate in a facilitated dialogue with the physician(s) and a hospital representative. The principles of restorative justice, as articulated by Zehr (2015), would govern this meeting. This is not a trial; it is a human-to-human encounter. The patient is given a voice to express their pain, anger, and questions. The physician, legally protected by the no-fault structure (anything said in this dialogue would be inadmissible in any future disciplinary hearing), is empowered to provide a full explanation, express empathy, and, where appropriate, offer a sincere apology. Research on medical disclosure overwhelmingly shows that what patients desire most is not money, but an acknowledgement of their suffering and an assurance that "it will not happen again" (Mustika et al., 2023). This pillar provides the "justice" that money cannot buy: the restoration of dignity, accountability, and trust.

Pillar 3, the systemic learning loop (systemic justice) ensures the model is not just reactive but proactive. The fault-based system hides data; the H-NFRJ model harvests it. All data from both the MICF claims (Pillar 1) and the restorative justice dialogues (Pillar 2) would be anonymized and aggregated by a central body, for example, the National Patient Safety Committee (*Komite Keselamatan Pasien*/KKP). This body's sole function would be systemic analysis. This "learning loop" transforms every adverse event into a lesson. Through this process, the KKP can identify patterns, such as repeated surgical site infections in a specific hospital, consistent failures of a new medical device, or recurring breakdowns in communication protocols during patient handoffs.

These insights would then be used to generate binding national patient safety guidelines, update medical education curricula, and mandate specific quality improvements. This achieves the highest form of justice: preventative justice, where the harm suffered by one patient is used to protect all future patients. This H-NFRJ model thus moves Indonesia away from a punitive, adversarial, and fragmented system. It creates a single, integrated pathway that is materially just (compensation), relationally just (restoration), and systemically just (learning). It is an approach that is efficient, compassionate, and culturally resonant, offering a truly transformative vision for Indonesian health law.

4. Conclusion

The Indonesian legal system for resolving medical disputes is anchored in an archaic, fault-based litigation model that has proven to be inefficient, inaccessible, and profoundly adversarial. It fails injured patients by erecting insurmountable barriers to compensation, and it fails the medical profession by fostering a culture of defensive medicine that is toxic to patient safety. This study argues that the persistent reliance on this punitive paradigm is no longer tenable. A comparative analysis of New Zealand's successful NFCS demonstrates that a non-adversarial, patient-centered alternative is not only possible but highly effective at providing material justice and facilitating systemic learning. However, the New Zealand model,

in its purely administrative form, may lack the capacity for the deep relational repair that patients and providers both require.

This research proposes a novel synthesis that the H-NFRJ Model. This integrated framework satisfies the three crucial dimensions of justice. It provides material justice through a no-fault compensation fund (similar to the ACC), relational justice through a mandatory restorative dialogue (aligned with deliberative processes), and systemic justice through a "learning loop" that uses adverse-event data to prevent future harm. This hybrid model is normatively superior, as it aligns with Pancasila's mandate for social justice, and it is culturally resonant, offering a solution that values consensus and restoration over conflict. Adopting this model would be a transformative step, moving Indonesian health law from a punitive past to a preventative, restorative, and truly patient-centered future.

A key limitation of this analysis is its reliance on secondary literature and cross-jurisdictional comparisons, which may not fully capture the institutional, fiscal, and cultural constraints that could shape Indonesia's real-world implementation of an H-NFRJ model. Future research would benefit from empirical studies, such as cost-modelling, pilot-program evaluations, and stakeholder interviews, to assess feasibility, refine operational design, and identify context-specific barriers.

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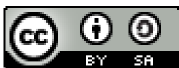
Data Disclosure Statement
The data that support the findings of this study are available from the corresponding author upon reasonable request.



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