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# Implementation of Health Law at a Remote Community Health Center in Indonesia: Challenges and Strategies

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## Abstract

Community health centers serve as the frontline of primary health care in Indonesia, yet their ability to deliver quality services in remote areas is often limited by gaps between legal mandates and daily practice. This study examines the implementation of health law at Health Center, and identifies practical strategies to improve service quality and legal compliance. The research combined juridical-normative analysis of relevant national laws and regulations with empirical data collected through observation, in-depth interviews with the head of the health center, staff, and patients, and document review at the health center. Thematic analysis was applied to assess alignment between legal standards and actual practice. Findings reveal that the health center consistently applies standard operating procedures, maintains active promotive-preventive-curative-rehabilitative programs, and provides accessible complaint mechanisms. However, persistent personnel shortages, inadequate infrastructure, and low legal awareness among staff and community members continue to hinder full compliance with minimum service standards. Management responds through regular internal training, gradual infrastructure improvement using operational funds, and cross-sectoral collaboration with local leaders and village cadres. These efforts demonstrate that service quality in remote areas can be strengthened through continuous capacity building and community involvement.

**Keywords:** Community Health Center, Health Law, Health Service, Remote Area, Service Quality.

## 1. Introduction

The attainment of health is a fundamental human right, as affirmed in Article 28H of the 1945 Constitution, which guarantees every person's right to physical and mental well-being, a healthy environment, and access to health services. This constitutional mandate requires the state to ensure adequate healthcare infrastructure and strong legal protections (Kuntardjo, 2020). The right to health thus represents an integrated set of individual, social, and cultural entitlements.

In Indonesia, the state's duty to provide health services is reinforced by Law No. 36 of 2009 and Law No. 29 of 2004, which affirm health as a human right, to be realized through accessible, high-quality interventions for all (Komalawati, 2017). Health services must be available, comprehensive, continuous, integrated, appropriate, acceptable, quality-assured, accessible, and affordable (Ministry of Health of the Republic of Indonesia, 2019). Meeting these standards simultaneously is essential to ensure equitable access to quality and economically feasible healthcare (Triwibowo, 2017).

Despite this strong legal foundation, achieving equitable health services in Indonesia remains difficult, particularly due to its archipelagic geography and uneven population distribution. Data from Statistic Indonesia in 2024 shows that 27.34% of Indonesians experienced health complaints in the previous month (Statistic Indonesia, 2024). A key contributor is the limited effectiveness and efficiency of healthcare delivery. Health services must uphold fundamental human rights principles, such as dignity, equality, respect, fairness, and autonomy (Sunarto, 2009; Group, 2019). Patient rights, including access to care, self-determination, and the right to information, are legally protected, notably under Law Number 8 of 1999 on Consumer Protection (Republik Indonesia, 1999; Sunarto, 2009). Healthcare providers are legally and professionally required to meet core dimensions of service quality: reliability, responsiveness, assurance, and empathy (Notoatmodjo, 2019).

The community health center serves as the vanguard of Indonesia's primary healthcare system (Wulandari et al., 2023; Firma et al., 2025). According to the recently promulgated Regulation of the Minister of Health of the Republic of Indonesia Number 19 of 2024 on the Operation of community health centers are primary healthcare institutions responsible for organizing and coordinating promotive, preventive, curative, rehabilitative, and/or palliative services, with a priority on promotive and preventive efforts within their working area. Community health centers are instrumental in achieving the Minimum Service Standards (*Standar Pelayanan Minimal*/SPM) in the health sector, as outlined in Regulation of the Minister of Health Number 6 of 2024 on the Technical Standards for Fulfilling Minimum Health Service Standards.

However, challenges in the operationalization of primary healthcare services remain substantial. Nationally, many frontline health facilities still struggle to meet the minimum service standards mandated by current regulations (Dewi & Ayuningtyas, 2023). Key problems include shortages of medical personnel, inadequate infrastructure, and a persistent gap between regulatory provisions and their practical implementation (Luthfiyah & Rahmawati, 2022; Batubara, 2025). These structural deficiencies raise important legal questions about institutional liability in public health service delivery and the extent of the legal protection guaranteed to patients receiving essential care.

This study focuses on the implementation of primary health services at the Lemo Community Health Center in North Barito Regency, Central Kalimantan. Situated in a remote area, this facility provides an important case for evaluating the effectiveness of national health law enforcement under geographical and resource constraints. The research is driven by the need to assess whether the Lemo Health Center fulfills its legal obligations to deliver high-quality, non-discriminatory, and

standard-compliant services, and to examine how legal implementation influences public health outcomes for vulnerable communities (Handayani & Sholihah, 2022).

The specific research questions of this study are; (1) to examine the status of health law implementation in health services at Lemo Community Health Center, North Barito, in relation to improving public health service quality; (2) to identify the challenges and mitigation strategies in the implementation of these services from a health law perspective; and (3) to analyze the development of mitigation strategies aimed at enhancing the overall quality of public health services. This research aims to provide a comprehensive picture of the alignment between service practices and applicable legal provisions, and to determine the extent to which the implementation of law supports the enhancement of public health quality in the North Barito region. The findings are expected to provide targeted recommendations to strengthen legal compliance and service quality in primary healthcare, especially in remote areas.

## **2. Methods**

This study used a mixed-method approach that combined juridical-normative analysis and juridical-empirical (socio-legal) analysis. The juridical-normative part examined the main laws and regulations that govern health services at community health centers in Indonesia, namely Law Number 36 of 2009 on Health, Law Number 29 of 2004 on Medical Practice, Law Number 25 of 2009 on Public Services, Minister of Health Regulation Number 19 of 2024 on the Operation of Community Health Centers, and Minister of Health Regulation Number 6 of 2024 on Technical Standards for Fulfilling Minimum Health Service Standards. These regulations became the legal benchmark to assess compliance at the field level.

The juridical-empirical part focused on real practice at Lemo Community Health Center, North Barito Regency, Central Kalimantan. Primary data were collected through direct observation of daily services, in-depth interviews, and review of official documents such as Standard Operating Procedures (SOPs), service reports, and quality meeting minutes. Interviews were conducted with key informants, including the head of the health center, several medical and non-medical staff (nurses and midwife/program coordinator), and several patients or community members who represented service recipients. All interviews were recorded with permission and later transcribed for analysis.

Data analysis was carried out qualitatively using thematic analysis. The process began by repeatedly reading all transcripts and documents, then coding the data into three major themes: level of legal compliance in daily services, obstacles faced, and strategies applied by the health center. The coded data were grouped, compared with the legal norms identified earlier, and interpreted to produce findings that reflect both legal aspects and empirical reality in the field. The results of this analysis form the basis for practical recommendations in accordance with applicable health law.

## **3. Results and Discussion**

### **3.1. Implementation of Health Services from a Health Law Perspective**

Health services at community health centers in Indonesia are regulated primarily by Law No. 36 of 2009 on Health and Law No. 29 of 2004 on Medical Practice. These laws state that every citizen has the right to obtain safe, quality, and non-discriminatory health services. The government and local governments share responsibility for making this right a reality through adequate facilities and human resources (Suwanda & Suryana, 2020; Prajany et al., 2025). Minister of Health Regulation Number 19 of 2024 on the Operation of Community Health Centers further explains that community health center must carry out promotive, preventive, curative, rehabilitative, and palliative services with priority on promotive and preventive efforts. Meanwhile, Minister of Health Regulation Number 6 of 2024 on

Technical Standards for Fulfilling Minimum Health Service Standards requires local governments to guarantee quantity and quality of services, human resources, and clear technical guidelines. Law Number 25 of 2009 on Public Services also binds public health to provide transparent, accountable, and non-discriminatory services so that the community can easily submit complaints or obtain information.

At Public Health Lemo, the application of these regulations is evident in daily operational practices. All health services adhere to established Standard Operating Procedures (SOPs) that are regularly monitored by the head of the health center and the District Health Office (Anita et al., 2016). These procedures are not only technical guidelines but also serve as legal protection for both patients and health workers. Promotive efforts include education on clean, healthy living and dental health counseling in villages. Preventive programs cover complete immunization for children, iron tablets for pregnant women, and early detection of disease risks (Sahabuddin et al., 2023). Curative services are provided through general polyclinics and emergency units, while rehabilitative services include home visits for patients who need follow-up care. All these activities follow the concept of a comprehensive health service required by national regulations.

The head of the health center explained that supervision from the District Health Office helps ensure consistency in applying the rules (Asyari & Azka, 2024). Internal monitoring is also conducted monthly through quality meetings, where service indicators such as immunization coverage and patient visits are evaluated (Ulumiyah, 2018; Nurvidyaning et al., 2025). A patient complaint mechanism already exists in the form of a suggestion box and direct access to management. Every complaint receives follow-up, either internally or through coordination with higher authorities when the case is serious. This practice demonstrates awareness of the accountability requirements under Law Number 25 of 2009 (Aini & Purboyo, 2021).

Health workers at various levels understand that SOPs must be followed not only for administrative order but also to protect patient rights, including the right to information and safety (Lavey & Loomba, 2017). Training on health law is routinely conducted, although not all staff have received the same intensity of training. The quality team continuously collects data on key performance indicators and uses the results to make improvements. These steps align with Minister of Health Regulation Number 6 of 2024, which emphasizes continuous quality evaluation at the primary health care level.

Despite limited resources, Lemo Community Health Center maintains documentation of medical actions and patient records in accordance with standards (Harjanti & Wariyanti, 2023). Medical record confidentiality is guarded as part of patient rights protection (Putra & Rahmadhani, 2021; Agustinus et al., 2023). Informed consent is applied to procedures that carry risk, although written documentation is sometimes minimal due to workload (Gunawan & Sugiarti, 2024). The existing commitment to non-discriminatory service is reflected in equal treatment for all patients regardless of economic background or place of residence. Patients from remote villages receive the same attention as those living near the health center.

The role of public health as the gatekeeper of the national health system is carried out through strict implementation of the referral system (Subawati, 2023). Patients who need further treatment are provided with appropriate referral letters to hospitals in the district capital. This practice follows the Ministry of Health's hierarchy and prevents overload at the primary level. At the same time, community health efforts through Integrated Service Posts (*Pos Pelayanan Terpadu/Posyandu*) and village-level cadres remain active, bringing services closer to the population.

The implementation of the health law at Lemo Community Health Center already shows good compliance with major regulations. SOPs are used consistently, the complaint mechanism functions, and quality monitoring is conducted regularly. The

four main pillars of service (promotive, preventive, curative, rehabilitative) are carried out even though facilities and number of personnel are still limited. The spirit to continue improving service quality in accordance with legal standards is clearly visible in management policy and daily practice of health workers. This condition provides a strong foundation for further enhancing public health services in North Barito Regency.

### **3.2. Challenges in the Implementation of Health Services**

Despite the strong legal framework and clear management commitment, the implementation of health law principles at Lemo Community Health Center still faces serious obstacles from structural, human resource, and cultural factors. These barriers make it difficult to fully achieve the standards required by national regulations. The most frequent and dominant challenge is the severe limitation of resources, both human and infrastructure, which directly contradicts the legal mandate that health services must be available, accessible, and of assured quality at all times (Triwibowo, 2017). This situation is especially felt in remote areas like North Barito.

The shortage of human resources remains the main concern of almost all health workers. The number of staff is very limited, so when one person is on leave, attending training, or performing duties outside the health center, services are delayed, and the workload for the remaining staff increases significantly. This condition is a national phenomenon, particularly in remote regions, and has created what is known as “healthcare deserts” in many parts of Indonesia (Mangoma & Sulistiadi, 2024). A heavy workload can lead to fatigue, reduced concentration, and an increased risk of medical errors or deviations from SOPs. More importantly, such a shortage directly weakens the ability to provide comprehensive, continuous, and non-discriminatory services as mandated by Law Number 36 of 2009 on Health, particularly the principle of prioritizing patient safety in Article 53.

Inadequate facilities and infrastructure are equally critical. The building and supporting equipment are still far from ideal. The waiting room is cramped, the elderly service area is uncomfortable, and several examination rooms lack the privacy needed for certain procedures. Medical devices are often outdated or incomplete, making it difficult to provide services in accordance with the latest technical standards. These physical limitations clearly violate the requirements for the safety, security, and comfort of the service environment as set out in Minister of Health Regulation Number 6 of 2024. For patients, poor facilities reduce feelings of assurance and empathy, which are important indicators of service quality (Notoatmodjo, 2019). In the end, this structural deficit becomes a real obstacle to achieving the Minimum Service Standards that must be met by every public health.

Another equally serious challenge is the low level of legal literacy among health workers themselves. Although compliance with SOPs is always emphasized, a deeper understanding of health law is still lacking, especially among newer staff and non-medical personnel. Many workers still focus solely on clinical actions without fully understanding the legal weight of informed consent, medical record confidentiality, patient autonomy, and professional responsibility in the event of negligence. This condition shifts the focus of service from patient rights and dignity to a purely technical approach, thereby increasing the risk of legal problems and patient dissatisfaction (Sunarto, 2009). The legal protection that health workers should receive under Article 57 of Law Number 36 of 2009 is also weakened because of this knowledge gap.

Low legal awareness is not only found among health workers but also among the community as service users. Many patients do not understand or deliberately ignore established procedures. They often come directly to the public health without going through Posyandu or village health posts first, demand service without queuing, or do not bring referral letters when required. Such behaviour disrupts the systematic

and accountable flow of services and adds unnecessary burden to the limited resources available (Batubara, 2025). Law Number 25 of 2009 on Public Services requires the public to comply with procedures, but in reality, legal literacy regarding rights and obligations in health services remains very low among the community. This lack of understanding also prevents the community from fulfilling its supervisory role over service quality, as mandated by Law Number 36 of 2009.

The implementation of health law at Lemo Community Health Center involves a complex interplay between strong management commitment on the one hand and resource scarcity and legal literacy gaps on the other. These challenges are not only administrative but also structural and cultural in nature, so they cannot be overcome merely through the health center's internal efforts. Systemic intervention and support from various parties at the district and higher levels are absolutely necessary to close the gap between written regulations and daily reality in the field (Luthfiyah & Rahmawati, 2022).

### **3.3. Mitigation Strategy and Improvement of Public Health Service Quality**

The Lemo Community Health Center does not remain passive in the face of the various obstacles identified. Management and staff have implemented several concrete and sustainable strategies that combine internal strengthening with external collaboration to maintain service continuity and legal compliance, even under limited conditions. The main strategy focuses on continuous capacity building for health workers, especially in understanding health law and SOPs. Regular internal training is held by inviting resource persons from the District Health Office or from more advanced public health. These activities are not limited to technical-clinical matters but also cover patient rights, informed consent, professional responsibility, and confidentiality of medical records (Sunarto, 2009). The training is expected to close the legal literacy gap so that every action taken by staff is not only medically correct but also legally protected. In addition, SOPs are evaluated and updated periodically in line with the latest regulations, particularly Minister of Health Regulation Number 19 of 2024, to ensure daily practices always comply with current legal standards.

To address the shortage of personnel and inadequate facilities, the health center actively coordinates with the District Health Office to request additional staff and gradually uses the Health Operational Assistance (Bantuan Operasional Kesehatan/BOK) fund for infrastructure improvements. Management also encourages Posyandu cadres to play a more active role in basic services and community education. These steps are a form of leveraging the legal responsibility of local government to provide resources and ensure equitable services, as mandated by Article 54 of Law Number 36 of 2009 on Health (Dima et al., 2024). Although improvements cannot be made all at once due to budget constraints, the gradual, prioritized approach demonstrates realistic efforts to meet the technical standards required by Minister of Health Regulation Number 6 of 2024.

Another equally important strategy is cross-sectoral coordination with village heads, sub-district heads, and community leaders to increase public legal awareness. Through regular meetings and joint activities, the community is continually educated on proper service procedures, the importance of the referral system, queuing discipline, and their rights as service recipients. Socialization is also carried out to ensure that people understand the complaint mechanism if they feel their rights are not being fulfilled (Batubara, 2025). Integrated health post cadres are given additional roles as agents of health and legal information at the village level, making the dissemination of knowledge more effective and culturally acceptable to the community.

This combination of strategies, internal training, and legal strengthening, smart resource management, and intensive community education demonstrates a comprehensive and proactive approach. All efforts are directed not only at

overcoming daily operational difficulties but also at building a stronger foundation for long-term legal compliance and service quality. The synergy among the health center, local government, and the community is key to gradually realizing optimal primary health services that truly meet constitutional mandates and health law in remote areas such as North Barito Regency (Handayani & Sholihah, 2022).

These local strategies also carry broader implications for national policy and capacity building. The experience of Public Health Lemo underscores the need for more adaptable regulatory standards for remote-area conditions and highlights the importance of institutionalizing capacity-building programs, particularly in legal literacy, managerial skills, and workforce development. By linking these local initiatives to national regulatory frameworks, this case helps strengthen governance, accountability, and quality assurance within Indonesia's primary healthcare system.

#### **4. Conclusion**

The juridical-empirical analysis shows that Lemo Community Health Center, North Barito, has succeeded in implementing most of the health law's provisions in its daily services. SOPs are consistently applied, the four main pillars of service (promotive, preventive, curative, and rehabilitative) are carried out, the complaint mechanism's function is maintained, and quality monitoring is conducted regularly. This condition reflects strong management commitment and awareness that compliance with the law is not only an administrative obligation but also legal protection for both patients and health workers in a remote area with limited resources.

However, full implementation remains constrained by structural problems, including a shortage of personnel and inadequate facilities, as well as low legal literacy among staff and the community. The strategies currently applied, internal training, gradual use of operational funds, and cross-sectoral coordination with village officials and cadres, have proven effective in reducing gaps but still need stronger and more sustainable support from the district government. For primary health services in remote areas to truly meet constitutional mandates and Minimum Service Standards, continuous investment in human resources, infrastructure, and public legal education remains the key that cannot be postponed.

The implications of this study underline that legal compliance at the primary health level cannot be separated from adequate resource support and active community participation. The main limitation of this research is that it was only conducted at one health center, so the findings cannot be generalized to all remote public health in Indonesia. Policymakers and district health authorities are encouraged to prioritize structured capacity-building, allocate targeted budgets for legal literacy and infrastructure improvement, and strengthen monitoring systems to ensure consistent regulatory implementation in remote health facilities. These measures will help narrow the gap between regulatory expectations and on-the-ground realities in remote regions. Future studies are suggested to involve more health centers across different provinces, include quantitative measurements of service quality indicators, or examine the effectiveness of cross-sectoral coordination models in increasing community legal literacy.

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The authors declare that there is no conflict of interest.

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Ethical approval was obtained for this study. The manuscript represents original work and has not been previously published, nor is it under consideration by another journal.

### ***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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