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Original Research Article

HOSPITAL-BASED MEDICINE DELIVERY SERVICES IN BALI: A JURIDICAL ANALYSIS OF HOSPITAL AUTHORITY AND PATIENT SAFETY

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ABSTRACT

Introduction. Access to health services is a constitutional right, yet geographic and demographic barriers, distance to referral hospitals, traffic congestion, and a large chronic-disease population, continue to constrain access in Bali. Government hospitals have responded with home medicine delivery services, but this innovation raises an unresolved question in Administrative Law regarding the validity of hospital authority to organize service outside the health facility. **Method.** This study uses normative legal research, combining statute, conceptual, and limited case approaches. Primary, secondary, and tertiary legal materials were analyzed descriptively-qualitatively and prescriptively to evaluate the legal basis for medicine delivery and its implications for patient safety. **Result & Analysis.** Regional Public Service Agency (BLUD) hospitals hold broader flexibility for third-party cooperation than Non-BLUD hospitals, yet neither possesses explicit attributive authority to delegate medicine handover to non-medical couriers. This delegation shifts a professional pharmaceutical act into a mere factual act, bypassing mandatory Drug Information Services and compounding risks to medication quality, patient data confidentiality, and institutional accountability. Two 2026 Ministerial Regulations reorganizing hospital and health-supply governance leave this authority gap unresolved. **Discussion.** These findings indicate that legal certainty and patient safety in third-party medicine delivery cannot rest on institutional flexibility alone. A dedicated Ministerial Regulation of Health or Governor Regulation of Bali is needed to establish operational standards, ensuring hospital authority and patient safety advance together as this service model expands.

Keywords: Health Access, Hospital Authority, Hospital Pharmacy Service, Medicine Delivery, Patient Safety

INTRODUCTION

Access to health services is a constitutional right guaranteed under Article 28H paragraph (1) and Article 34 paragraph (3) of the 1945 Constitution of the Republic of Indonesia. The state is thereby obliged to ensure the availability of adequate health facilities for every citizen. Fulfilling this right requires more than the physical presence of facilities; it also demands accessibility, ease of service, and minimal bureaucratic friction. Geographic accessibility is an especially decisive factor in a country as topographically diverse as Indonesia. Ramadhani *et al.* (2025), examining accessibility and acceptability of services in remote rural areas, found that infrastructure gaps continue to depress patient satisfaction even where formal coverage policies are already in place.

This challenge is visible in Bali. Although the province has achieved a comparatively high rate of Universal Health Coverage, physical and geographic accessibility remain uneven. Advanced referral hospitals, including RSUP Prof. Dr. I.G.N.G. Ngoerah and RSUD Wangaya, are concentrated in South Bali, particularly Denpasar and Badung. North, East, and Central Bali, including parts of Buleleng, Karangasem, and Bangli, are hillier and lie farther from these referral centers. This distributional imbalance compounds a workforce and facility problem that is not unique to Bali. Meilianti *et al.* (2025), in a national review of Indonesia's pharmacy workforce, reported chronic shortages and uneven distribution of pharmacists, meaning that hospitals in lower-resourced regions face a double constraint of both distance and staffing capacity.

Two further pressures intensify the access problem. First, chronic traffic congestion within the Sarbagita metropolitan area (Denpasar, Badung, Gianyar, and Tabanan) already consumes substantial time for a routine pharmacy visit. Second, Bali's outpatient population skews toward older adults managing non-communicable diseases such as diabetes, hypertension, and cardiovascular conditions, all of which require monthly medication refills that this group is often physically unable to queue for. International evidence supports treating home delivery as a legitimate response to precisely this combination of constraints: Abu-Farha *et al.* (2022) found that community pharmacists regard home medicine delivery as a meaningful way to preserve continuity of care for patients with limited mobility, while Meilyana *et al.* (2024), studying diabetes patients in Kasembon, linked poor medication adherence directly to barriers in obtaining refills.

It is against this backdrop that home medicine delivery has emerged as a strategic policy instrument for expanding outreach in Bali. RSUD Wangaya's “Si Bos” (Siap Bantu Antar Obat Sampai Rumah) program and a parallel delivery initiative for outpatients at RSUP Prof. Dr. I.G.N.G. Ngoerah are the clearest local examples. The pattern is not confined to Bali. Comparable schemes now operate at RSUP Nasional Dr. Cipto Mangunkusumo Jakarta through its “Smart RSCM” platform, RSJPD Harapan Kita Jakarta for chronic cardiac patients, RSUD Dr. Moewardi Surakarta in partnership with PT Pos Indonesia, RSUD Cengkareng Jakarta, RSUD dr. Soedirman Kebumen, RSUD Ali Manshur Tuban through its “Taromah” program, and RSUD Brigjend. H. Hasan Basry Kandangan in South Kalimantan. This national replication mirrors a broader

shift toward distance-based health service delivery already documented in platform-based digital health practice across Indonesia (Widhiastuty, Dewi and Dinar, 2024).

When government hospitals execute this expansion, whether as Regional Public Service Agencies (Badan Layanan Umum Daerah, BLUD) or as vertical institutions under the Ministry of Health, a foundational problem arises within Administrative Law. Public institutions may not undertake legal or factual acts without clear attribution, delegation, or mandate from statute. This is the principle of *nulla actio sine lege*: even a well-intentioned expansion of public service must rest on valid legal authority, or it risks a defect of competence (*onbevoegdheid*) that can later be challenged administratively. The problem is sharpened by the differing institutional status of government hospitals in Bali. BLUD hospitals, such as RSUD Wangaya and RSUD Bali Mandara, hold broader flexibility to enter private-law cooperation under Government Regulation No. 23 of 2005 jo. Minister of Home Affairs Regulation No. 79 of 2018, a flexibility rooted in local government's attributive authority to establish BLUD entities for improved public service (Hadi, 2023). Yet a systematic review of BLUD implementation across regional hospitals shows that, even after two decades, this flexibility remains beset by structural and regulatory gaps at the operational level (Basabih and Widhakuswara, 2024). Non-BLUD hospitals, meanwhile, remain bound by rigid public procurement rules, facing the same equity demands with fewer administrative tools to meet them.

The legal ambiguity deepens once the delivery mechanism is examined at the level of professional practice. Under prevailing pharmaceutical law, medicine handover must be performed directly by a pharmacist, accompanied by Drug Information Services (Pelayanan Informasi Obat, PIO), precisely because this information exchange safeguards patient safety. When that handover is instead entrusted to a non-medical courier, the same shift from a professional legal act (*rechtshandeling*) into a mere factual act (*feitelijk handeling*) that concerns delegation scholarship elsewhere becomes directly relevant here: Tronconi *et al.* (2025), analyzing the delegation of health tasks to non-healthcare personnel in Italy, show that such delegation is legally sound only where supervision and scope of practice are explicitly regulated, conditions that Indonesian medicine-delivery practice has not yet met. The information gap in medicine delivery, in Semarang's own experience, appears to have already been linked to reduced patient understanding (Setianingrum *et al.*, 2024). A related risk concerns the transfer of patient data, including diagnosis and medication history, to logistics couriers operating outside the hospital's organizational structure; Ramadhanty *et al.* (2022) emphasize that release of medical information to any third party must follow strict confidentiality procedures, and Baines *et al.* (2024), in a systematic review of patient attitudes toward third-party data sharing, found that willingness to share is conditional on clear safeguards that current courier arrangements do not provide.

Prior legal scholarship on this subject remains underdeveloped. Existing normative work has examined distance-based health regulation largely at a macro level: Andrianto and Athira (2022), assessing pandemic-era telemedicine policy, found that regulatory vacuums of

this kind tend to generate legal disputes between providers and patients in the absence of prompt national standards. Institutional studies of BLUD, meanwhile, have concentrated on financial and asset flexibility rather than on the boundary of clinical authority beyond the physical facility. This is the precise gap this study addresses, and its novelty: whether the administrative-economic flexibility of BLUD hospitals, or the corresponding limitations faced by Non-BLUD hospitals, can lawfully justify delegating the factual act of medicine delivery, given the boundaries that Administrative Law places on clinical-pharmaceutical authority.

Based on this background, the study addresses two research problems. First, within Administrative Law: how valid is the authority of government hospitals in Bali to organize medicine delivery services outside health facilities? Second, within Health Law and patient protection: what forms of legal protection and patient safety assurance, including drug-quality standardization and medical data confidentiality, apply to medicine delivery mechanisms carried out by third parties?

METHOD AND ANALYSIS

This study uses normative legal research, a doctrinal method that treats law as a system of written norms and evaluates it against the standard of what the law prescribes (*das sollen*) rather than what occurs empirically in practice (Soekanto and Mamudji, 2010). This method was chosen because the central question, whether government hospitals hold valid authority to delegate medicine delivery to non-medical couriers, concerns the internal coherence and completeness of statutory norms rather than the observed behavior of patients or providers. For readers more familiar with clinical or public-health research designs, the closest analogue is a structured document-based policy analysis: the "data" are legal instruments, and the "findings" are conclusions about legal validity and normative gaps, rather than measured health outcomes.

Three approaches were combined. The statute approach examined the relevant legal instruments directly, namely Law No. 17 of 2023 on Health, Law No. 44 of 2009 on Hospitals, Government Regulation No. 51 of 2009 on Pharmaceutical Work, Government Regulation No. 23 of 2005 jo. Minister of Home Affairs Regulation No. 79 of 2018 on Regional Public Service Agencies (BLUD), Minister of Health Regulation No. 72 of 2016, and Law No. 27 of 2022 on Personal Data Protection. The conceptual approach was used to unpack the doctrines of attribution, delegation, mandate, and *feitelijk handeling* within Administrative Law. A case approach was applied on a limited, illustrative basis, drawing on the medicine delivery practices at RSUD Wangaya, RSUP Prof. dr. I.G.N.G. Ngoerah, and other government hospitals identified earlier, to ground the normative analysis in observable policy practice rather than treating the legal question in the abstract.

Legal materials were drawn from three tiers. Primary materials comprised the statutes and regulations listed above. Secondary materials included books, peer-reviewed journal articles, and prior research relevant to hospital authority, pharmaceutical practice, and health-service delegation. Tertiary materials, namely legal dictionaries and encyclopedic references, were used to clarify technical terminology where needed. Materials were collected through library-based research and

analyzed using descriptive-qualitative and prescriptive techniques: legal materials were classified, organized into a coherent system of norms, and then interpreted grammatically, systematically, and teleologically to answer the two research questions set out in the Introduction.

As a normative-legal study, this research does not incorporate empirical field triangulation, such as direct review of hospital standard operating procedures, structured interviews with hospital pharmacists, or patient-experience data on delivery safety. This is an intentional methodological boundary rather than an oversight: the study's aim is to establish the legal validity of current practice before any empirical evaluation of it is warranted. Readers assessing patient-safety claims made later in this paper should therefore treat those claims as doctrinal risk assessments grounded in statutory and professional-standard analysis, not as findings from observed clinical or operational data. This limitation also defines a clear direction for future research, discussed further in the Conclusion, namely an empirical study of hospital compliance with delivery standards and patient perceptions of delivery safety in Bali.

RESULTS

Legal Validity of Hospital Authority to Organize Off-Site Medicine Delivery

The principle of legality (*legaliteitsbeginsel*) is the foundation of Administrative Law: every act of government, whether a formal legal act (*rechtshandeling*) or a factual act (*feitelijke handeling*), must rest on valid authority conferred by statute, through attribution, delegation, or mandate. Government hospitals, as technical implementing units of regional government or as vertical institutions of the Ministry of Health, derive their authority to provide health services attributively from Law No. 17 of 2023 on Health. That attributive authority is, however, explicitly confined to services delivered inside the health facility. Extending service beyond the facility, through home medicine delivery, is not addressed as part of this attribution, leaving a normative vacuum that hospital management could easily misread as unrestricted discretion.

This vacuum is not unique to pharmaceutical delegation. Putra *et al.* (2024), examining legal protection for pharmacists performing electronic pharmaceutical services after the enactment of the new Health Law, found that any transformation in how pharmaceutical care is delivered, whether electronically or through an intermediary, still requires explicit implementing regulation if professional accountability is to remain enforceable once direct pharmacist-patient contact is reduced. The same logic applies to medicine delivery: the pharmacist's attributive authority should, in principle, remain attached to the process even where physical handover is performed by another party. Clinical authority, moreover, is inherently tied to the competence and training of the specific health worker who holds it; it cannot be transferred to a party without equivalent qualification unless clear supervisory mechanisms are put in place. On this basis, the authority of government hospitals to organize medicine delivery in Bali sits in a doctrinally unsettled position, one this paper returns to directly in the Conclusion once the patient-safety findings below have also been weighed.

Government hospitals in Bali fall into two institutional categories, and each carries distinct legal implications for third-party cooperation. Hospitals with Regional Public Service Agency (Badan Layanan Umum Daerah, BLUD) status, including RSUD Wangaya and RSUD Bali Mandara, gain financial-management and private-cooperation flexibility under Government Regulation No. 23 of 2005 jo. Minister of Home Affairs Regulation No. 79 of 2018. Regional government holds discretionary, attributive authority to establish a BLUD specifically to improve public-service quality (Hadi, 2023), and this flexibility allows BLUD hospitals to enter operational partnerships with third parties without the rigidity of standard government procurement. That administrative-financial flexibility, though, does not automatically extend into clinical-pharmaceutical authority. A systematic review of BLUD implementation across regional hospitals found that, despite more than two decades of practice, structural gaps in regulatory capacity and oversight persist (Basabih and Widhakuswara, 2024), which suggests that BLUD flexibility remains instrumental to asset and revenue management rather than a license to shift health-profession functions to non-professional actors such as logistics couriers. Non-BLUD hospitals, including several district-level RSUD in North and East Bali, face the opposite constraint: rigid procurement rules slow down third-party cooperation even as they face the same public pressure to expand access. This asymmetry produces a form of institutional inequality in which access to delivery-based innovation tracks a hospital's administrative status rather than the actual health needs of the surrounding community.

The medicine-delivery practices introduced earlier, spanning RSUD Wangaya's “Si Bos” program through to the seven national examples already listed in the Introduction, show that operational demand has outpaced the readiness of sectoral legal norms. This is not a new pattern in Indonesian health law. A parallel dynamic occurred earlier in distance-based telehealth regulation, where implementation grew rapidly across regions in the absence of a binding national standard, generating legal uncertainty for both providers and recipients of care (Bonsapia and Jumiran, 2025). Projected onto medicine delivery, each hospital effectively drafts its own internal standard operating procedure, without a uniform implementing reference from the Ministry of Health. The result is meaningful variation across hospitals in who is authorized to hand over medicine, how patient identity is verified, and how accountability is assigned when delivery goes wrong. Left unresolved, this fragmented practice will keep expanding on legal ground that has not yet been tested.

Post-2026 Regulatory Reorientation

The normative gap identified above warrants re-examination following two implementing regulations issued under Law No. 17 of 2023 and Government Regulation No. 28 of 2024: Minister of Health Regulation No. 6 of 2026 on Hospitals and Minister of Health Regulation No. 5 of 2026 on Health Supplies. Regulation No. 6 of 2026 is an omnibus instrument that revokes and consolidates no fewer than twenty-one sectoral hospital regulations into a single framework covering licensing, classification, corporate governance, and clinical governance, including explicit confirmation that government-owned

hospitals may adopt public-service-agency financial management. This consolidation was a natural opportunity to close the authority gap this study has identified.

Regulation No. 5 of 2026 comprehensively governs the planning, production, supply, circulation, control, and oversight of health supplies, including price-reporting obligations and a prohibition on gratuities in drug circulation, in service of availability and affordability. Neither regulation, however, contains an explicit provision governing the delegation of medicine handover to non-medical couriers in off-facility delivery. Regulation No. 6 of 2026 is oriented toward institutional governance and clinical classification, while Regulation No. 5 of 2026 governs the upstream supply chain, from production through wholesale distribution to the health facility, rather than the last-mile segment from facility to individual patient. Rather than closing the gap this study identifies, both regulations leave the authority question in the same juridical grey zone, reinforcing the case for a dedicated Ministerial Regulation or Governor Regulation of Bali.

Patient Safety and Legal Protection in Third-Party Medicine Delivery

Under Government Regulation No. 51 of 2009 on Pharmaceutical Work and Minister of Health Regulation No. 72 of 2016 on Hospital Pharmaceutical Service Standards, medicine handover is a professional legal act that must be performed directly by a pharmacist, or by a pharmaceutical technician under a pharmacist's supervision, together with Drug Information Services (PIO). This obligation is imperative precisely because it protects patient safety. Sidabuke (2023) frames this duty broadly: legal protection of patients in general hospital care requires that every patient-facing action be preceded by adequate understanding on the patient's part, reflecting a health worker's commitment to public welfare.

When medicine is instead handed to a non-medical courier for home delivery, without a pharmacist physically present, the act shifts character from a professional legal act (*rechtshandeling*) into a mere logistical, factual act (*feitelijk handeling*). This shift matters because the PIO that should accompany handover, dosage information, drug interactions, and side effects, can no longer be adequately conveyed by a courier without pharmaceutical competence. Sagita *et al.* (2023) examined criminal liability arising from a hospital's failure to guarantee patient safety in nursing care rather than in pharmaceutical practice, so the analogy requires an explicit bridge: the doctrine they describe rests on an institutional duty to prevent foreseeable harm during service delivery, a duty that is not confined to a single health profession. That same duty of care applies with equal force when a hospital delegates medicine handover to a party outside its clinical structure, since in both cases the patient is not present to supervise the process on their own behalf. Responsibility for harm arising from this shift does not disappear. Under the corporate liability doctrine codified in Article 193 of Law No. 17 of 2023, a hospital remains legally responsible for patient harm caused by negligence in organizing health services, including negligence in selecting and supervising a third-party courier partner (Abdurrohman *et al.*, 2024). Delegating the factual act of delivery to a third party therefore broadens, rather than discharges, the hospital's scope of corporate accountability.

Drug quality is a second dimension of risk. Storage and handover standards for pharmaceutical preparations are governed under PKPO 3 (Storage), one of the seven pharmaceutical-service standards within the National Hospital Accreditation Standard, and an accreditation-based evaluation of pharmaceutical service found that storage, prescribing, and handover form an interdependent chain that must be consistently satisfied to preserve service quality (Rezkyah, Ervianingsih and Yusnidar, 2023). When delivery is instead outsourced to a commercial courier without temperature-controlled storage or training in pharmaceutical handling, drug quality risks deteriorating before it reaches the patient, particularly for cold-chain products such as insulin. This gap between internal hospital accreditation standards and the operational reality of third-party couriers creates a genuine oversight blind spot, since accreditation instruments are designed to measure processes occurring inside the facility rather than distribution occurring beyond the direct control of the pharmacy installation (Muharani *et al.*, 2026). Responsibility for this quality failure, in turn, returns to the hospital's corporate accountability rather than transferring fully to the courier provider (Abdurrohman *et al.*, 2024), since the hospital remains the principal party obligated to ensure that its delivery partner meets minimum pharmaceutical standards, including temperature control, packaging, and delivery time, before the cooperation is scaled up to the wider public.

A third dimension concerns personal data. Medicine delivery inevitably involves exchanging a patient's name, home address, contact number, diagnosis history, and medication regimen with a courier provider that sits outside the hospital's organizational structure. Ramadhanty *et al.* (2022) found that release of medical information to any third party must follow strict confidentiality procedures precisely because such information is protected by law and professional ethics; the same caution should extend to non-medical logistics partners who receive a portion of that information in the course of delivery. A comparable concern has already surfaced in telehealth practice, where protecting patient privacy is treated as a foundational ethical obligation for every party in the service chain, including non-medical technical intermediaries (Fakih, 2022). More broadly, patients' willingness to share personal health data with third parties is not unconditional: Baines *et al.* (2024), in a systematic review of patient attitudes toward third-party data sharing, found that this willingness depends on clear safeguards, an accountable data controller, and a defined purpose for the disclosure, conditions that current courier cooperation arrangements do not yet formally provide. Under Law No. 27 of 2022 on Personal Data Protection, the hospital remains the data controller and therefore bears legal responsibility for any breach occurring within this cooperation, which means every medicine-delivery scheme should be accompanied by a contractual clause specifying data-access limits, retention periods, and a remedy mechanism should a breach occur.

Beyond these Administrative Law and pharmaceutical-practice concerns, drug quality across the delivery chain also falls within the technical oversight of the National Agency of Drug and Food Control (BPOM), the authority responsible for ensuring the safety, efficacy, and quality of medicine throughout distribution. The relevant technical standard is BPOM

Regulation No. 20 of 2025 on Good Distribution Practice (CDOB), which superseded BPOM Regulation No. 9 of 2019 and its amendment under BPOM Regulation No. 6 of 2020. CDOB regulates twelve technical aspects, from quality-management systems and temperature-controlled storage requirements for cold-chain products, to documentation obligations covering recipient identity, storage conditions, and courier-personnel identification whenever a third party is used for delivery.

These CDOB provisions already anticipate third-party involvement in the drug-distribution chain, as reflected in the requirement to record courier-personnel identity and storage conditions on delivery documentation, a requirement that reinforces the drug-quality risk identified above regarding commercial couriers lacking temperature-controlled storage (Rezkyah, Ervianingsih and Yusnidar, 2023; Muharani *et al.*, 2026). Institutionally, however, CDOB was designed primarily to regulate business-to-business distribution, from pharmaceutical manufacturers and wholesalers through to health facilities, and has not yet specifically extended to the retail, business-to-consumer segment running from a health facility directly to an individual patient's home.

This coverage gap is itself a distinct problem. CDOB's underlying commitment to drug quality across the distribution chain should, in principle, extend to hospital-run medicine delivery as well; yet without explicit scope language to that effect, hospital compliance with CDOB in home-delivery practice remains voluntary and inconsistent across facilities. This reinforces the need to harmonize hospital administrative authority, the Ministry of Health's pharmaceutical technical standards, and BPOM's quality-oversight standards, so that patient-safety assurance in third-party medicine delivery rests not only on each hospital's internal compliance but on a consistent, cross-institutional oversight framework.

DISCUSSION

The most original contribution of this study is the finding that hospital-organized medicine delivery, once handover passes from a pharmacist to a non-medical courier, undergoes a juridical transformation from a professional legal act (*rechtshandeling*) into a mere factual act (*feitelijk handeling*). This distinction does more than describe a legal technicality. It identifies the precise mechanism by which a well-intentioned access innovation can quietly strip away the professional safeguards, principally Drug Information Services, that Indonesian pharmaceutical law treats as inseparable from the act of dispensing itself. Read against the broader literature this study opened with, the finding both confirms and complicates what earlier work has shown.

On geographic access, the findings support the direction of Ramadhani *et al.* (2025), who linked accessibility gaps in remote areas to persistent patient dissatisfaction despite formal coverage. This study extends that line of research by showing that the policy response to geographic access barriers, home delivery, carries its own governance cost. Ramadhani et al. treated accessibility as an outcome to be improved; this study shows that the instrument used to improve it can itself generate a new patient-safety liability if deployed without a clear legal basis. In that sense, the present findings do not contradict the access literature so much as expose a

blind spot within it: studies of accessibility rarely ask whether the fix is itself lawful, and this study suggests that question deserves equal weight.

On institutional flexibility, the findings extend rather than confirm the assumptions (Hadi, 2023; Basabih and Widhakuswara, 2024). Both treated BLUD flexibility as primarily a financial and administrative matter, useful for procurement and asset management but not examined for its clinical implications. This study's finding, that BLUD flexibility does not extend to clinical-pharmaceutical authority, is a distinction the earlier BLUD literature did not need to draw, because it was not asking a clinical-authority question. The present analysis therefore sharpens, rather than overturns, the earlier institutional picture: BLUD status remains exactly as flexible as Hadi (2023) described for private-law cooperation, but that flexibility stops precisely at the boundary this study identifies, a boundary the institutional literature had left unmarked.

On regulatory pattern, the findings are directly consistent with Andrianto and Athira (2022) and Bonsapia and Jumiran (2025), both of whom found that Indonesian distance-based health services tend to outpace their governing norms, producing legal uncertainty for providers and recipients alike. What this study adds is a second data point for that same structural pattern, this time in medicine logistics rather than teleconsultation, which strengthens the broader claim that Indonesia's distance-health regulatory gap is systemic rather than confined to any single service type. Where this study meaningfully departs from that prior work is in showing that the 2026 omnibus hospital and health-supply regulations, despite being a clear opportunity to close exactly this kind of gap, did not do so. That is a more pessimistic finding than the earlier telehealth literature would have predicted, since both implied that national standardization was simply a matter of time; this study suggests the gap can persist even through a major regulatory overhaul if the specific service in question is not named in the drafting process (Andrianto and Athira, 2022; Bonsapia and Jumiran, 2025).

On delegation of clinical tasks, the findings partially contradict what a reader might expect from Tronconi *et al.* (2025). Their analysis of Italy's nursing-assistant reform found that delegation to non-healthcare personnel can be legally sound where supervision, training, and scope of practice are formally regulated. Indonesian medicine delivery has none of those formal conditions in place. The contrast is instructive precisely because it is a contrast: it is not that delegation of health-adjacent tasks is inherently unsafe, the Italian case shows it can be structured safely, but that Indonesian practice has adopted the delegation without adopting the safeguards that made the Italian model defensible. The same caution applies to Meilianti *et al.* (2025), whose review of Indonesia's pharmacy workforce shortage helps explain why hospitals reach for courier delegation in the first place, understaffed pharmacy installations have a practical incentive to offload logistics, but a staffing shortage is not, by itself, a legal basis for reassigning a professional act to an unqualified party.

The clinical and access-oriented literature this study drew on for justification, Abu-Farha *et al.* (2022) on community pharmacists' generally positive view of home delivery, and Meilyana *et al.* (2024) on the link between refill access and adherence in diabetes patients, is not contradicted by these findings, but it is put

in a different light. Both studies evaluated home delivery on its operational and adherence merits, and reasonably concluded it helps patients. This study does not dispute that conclusion; it shows that the same service, evaluated through a legal-authority lens rather than an adherence-outcome lens, carries risks that adherence research is not designed to detect. The two bodies of evidence are therefore complementary rather than competing: one measures whether delivery works for the patient in the short run, the other asks whether the hospital is authorized to provide it and whether it remains safe once professional oversight is removed from the point of handover.

Turning to the health-relevant significance of these findings, the clearest connection is to patient safety and medication-related harm. Drug Information Services exist because omitting them is associated with predictable clinical consequences: missed contraindications, incorrect self-administration, and delayed recognition of adverse effects, risks that are especially material for the chronic-disease population, largely elderly and managing conditions such as diabetes and hypertension, that this delivery model is meant to serve. When handover shifts to a courier without pharmaceutical competence, the counseling function does not simply move to a different provider; it is effectively lost for that encounter, and it is this loss, not the delivery mechanism itself, that constitutes the health risk this study is describing. The drug-quality findings carry a parallel implication: cold-chain products such as insulin degrade predictably outside temperature-controlled conditions, so a courier arrangement lacking such conditions is not a hypothetical risk but a foreseeable one, particularly for a home-delivery population that skews toward insulin-dependent diabetic patients.

A second health-relevant dimension concerns equity rather than individual safety. Because BLUD status, not clinical need, currently determines which hospitals can move quickly on third-party delivery partnerships, the institutional asymmetry identified in the Results risks reproducing a new axis of health inequality within Bali: patients in areas served by Non-BLUD hospitals, often the same North, East, and Central Bali regions already facing the geographic access disadvantage Ramadhani *et al.* (2025) documented, may be the least likely to benefit from a service designed specifically to correct that disadvantage. In that sense, an unregulated legal gap does not just create abstract legal risk; it threatens to concentrate a genuine health-access improvement in precisely the hospitals whose patients already have comparatively better geographic access, undermining the equity rationale that motivated the innovation in the first place.

It is worth being explicit about the limits of this reasoning, consistent with the scope boundary already noted in the Method section. These health-relevant implications are derived doctrinally, from statutory obligations and professional-standard analysis, rather than measured directly through clinical or patient-outcome data. The direction of the argument, that removing a professional legal safeguard plausibly increases clinical risk, is well supported by the pharmaceutical-practice literature this study relies on, but the magnitude of that risk in Bali specifically has not been quantified here. This is precisely the empirical gap the Method section flagged and the gap this paper's

recommendations, discussed next, are designed to help close.

CONCLUSION

This study finds that the authority of government hospitals in Bali to organize medicine delivery outside health facilities occupies an unsettled legal position: the practice carries clear public-policy legitimacy as a response to geographic and demographic access barriers, yet it lacks an explicit attributive basis in current legislation, leaving both BLUD and Non-BLUD hospitals to rely on institutional flexibility that was never designed to reach clinical-pharmaceutical delegation. Compounding this authority gap, the mechanism through which delivery is typically carried out, handover by a non-medical courier rather than a pharmacist, shifts what should be a professional legal act into a mere factual act, stripping away the accompanying Drug Information Service and exposing patients to compounded risks in medication quality, medical data confidentiality, and accountability once something goes wrong.

Addressing this gap does not require an entirely new regulatory architecture, but it does require the Ministry of Health and the Bali Provincial Government to treat medicine delivery as a distinct object of regulation rather than an incidental extension of existing hospital or BLUD rules. A dedicated Ministerial Regulation should define the operational standards and the precise limits of permissible delegation to third parties, while a complementary Governor Regulation could harmonize BLUD flexibility with uniform patient-safety expectations across hospitals of differing institutional status. At the level of individual cooperation, every hospital-courier partnership should be underpinned by a formal agreement specifying data-confidentiality obligations, temperature-controlled storage requirements, and a mechanism for remote pharmacist supervision, so that continuity of pharmaceutical care is preserved even when physical handover is performed by someone outside the profession.

These conclusions are drawn from normative legal analysis rather than empirical fieldwork, and this boundary itself points to the natural next step for this line of research: an empirical study examining hospitals' actual compliance with delivery standards, alongside patients' own perceptions of safety and trust in this expanding model of care, would test the doctrinal risks identified here against real-world practice and give policymakers a firmer evidentiary basis for the regulatory reforms this study recommends.

REFERENCES

Abdurrohman, R. *et al.* (2024) "Tanggung Jawab Hukum Rumah Sakit Berdasarkan Doktrin Corporate Liability Menurut Pasal 193 Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan," *Jurnal Cahaya Mandalika ISSN 2721-4796 (online)*, pp. 2635–2647. Available at: https://doi.org/10.36312/jcm.v3i3.3659.

Abu-Farha, R. *et al.* (2022) "Home delivery of medications: Community pharmacists' perspectives on the pros and cons of the service," *Frontiers in Public Health*, 10. Available at: https://doi.org/10.3389/fpubh.2022.966145.

Andrianto, W. and Athira, A.B. (2022) "Telemedicine (Online Medical Services) Dalam Era New Normal Ditinjau Berdasarkan Hukum Kesehatan," *Jurnal Hukum &*

Pembangunan, 52(1). Available at: https://doi.org/10.21143/jhp.vol52.no1.1314.

Baines, R. *et al.* (2024) "Patient and Public Willingness to Share Personal Health Data for Third-Party or Secondary Uses: Systematic Review," *Journal of Medical Internet Research*, 26, p. e50421. Available at: https://doi.org/10.2196/50421.

Basabih, M. and Widhakuswara, I. (2024) "Opportunities and Challenges in Implementing Regional Public Service Agency Policy in Regional Hospitals: Systematic Review," *Jurnal Ilmu Kesehatan Masyarakat*, 15(1), pp. 1–20. Available at: https://doi.org/10.26553/jikm.2024.15.1.1-20.

Bonsapia, M. and Jumiran (2025) "ASPEK HUKUM TELEMEDICINE DI INDONESIA," *The Juris*, 9(1), pp. 259–268. Available at: https://doi.org/10.56301/juris.v9i1.1636.

Fakih, M. (2022) "Telemedicine in Indonesia During the Covid-19 Pandemic: Patient's Privacy Rights Protection Overview," *Fiat Justisia: Jurnal Ilmu Hukum*, 16(1), pp. 83–102. Available at: https://doi.org/10.25041/fiatjustisia.v16no1.2583.

Hadi, S. (2023) "Pembentukan Badan Layanan Umum Daerah Oleh Pemerintah Daerah," *DiH: Jurnal Ilmu Hukum*, pp. 179–186. Available at: https://doi.org/10.30996/DIH.V19I1.8966.

Meilianti, S. *et al.* (2025) "A narrative review of pharmacy workforce challenges in Indonesia," *Human Resources for Health*, 23(1), p. 10. Available at: https://doi.org/10.1186/s12960-024-00967-0.

Meilyana, B.D. *et al.* (2024) "ANALYSIS OF FACTORS RELATED TO MEDICATION ADHERENCE IN PATIENTS WITH DIABETES MELLITUS AT RSUI MADINAH KASEMBON," *Journal of Scientific Health*, pp. 421–430. Available at: https://doi.org/10.56943/jsh.v3i4.683.

Muharani, D. *et al.* (2026) "Tinjauan Literatur Tentang Penerapan Standar Pengendalian Mutu Obat Di RS Pemerintah," *RIGGS: Journal of Artificial Intelligence and Digital Business*, 5(1), pp. 4264–4273. Available at: https://doi.org/10.31004/riggs.v5i1.6284.

Putra, I.M.A.S.P. *et al.* (2024) "Perlindungan Hukum Bagi Apoteker dalam Melakukan Pelayanan Kefarmasian Secara Elektronik Pasca Pemberlakuan Undang-Undang Kesehatan," *JUNCTO: Jurnal Ilmiah Hukum*, 6(1), pp. 151–164. Available at: https://doi.org/10.31289/JUNCTO.V6I1.3912.

Ramadhani, M. *et al.* (2025) "The Accessibility and Acceptability of Health Services in Remote Rural Areas," *Asia Pacific Journal of Health Management* [Preprint]. Available at: https://doi.org/10.24083/apjhm.v20i1.3989.

Ramadhanty, A. *et al.* (2022) "Pelepasan Informasi Medis Kepada Pihak Ketiga Di Rumah Sakit (Literature Review)," *SEHATMAS: Jurnal Ilmiah Kesehatan Masyarakat*, 1(1), pp. 16–24. Available at: https://doi.org/10.55123/sehatmas.v1i1.30.

Rezkyah, N., Ervianingsih, E. and Yusnidar, Y. (2023) "Evaluasi Pelayanan Kefarmasian dan Penggunaan Obat Berbasis Standar Akreditasi di Instalasi Farmasi RSUD Sawerigading Kota Palopo," *Jurnal Kesehatan Komunitas*, 9(1), pp. 76–84. Available at: https://doi.org/10.25311/keskom.Vol

9.Iss1.1444.

Sagita, A.W. *et al.* (2023) "Tanggung Jawab Pidana Rumah Sakit Terhadap Penerapan Patient Safety Dalam Pelaksanaan Asuhan Keperawatan dari Perspektif Hukum Pidana," *Unes Journal of Swara Justisia*, 7(3), pp. 845–853. Available at: https://doi.org/10.31933/ujsj.v7i3.378.

Setianingrum, R.Y. *et al.* (2024) "IMPLEMENTATION OF PROVIDING MEDICINES INFORMATION TO PATIENTS AT THE SEMARANG CITY SUB-PRIMARY HEALTH CENTERS," *Journal of Scientific Health*, 3(4), pp. 399–409. Available at: https://doi.org/10.56943/jsh.v3i4.647.

Sidabuke, M.T.R. (2023) "Perlindungan Hukum Terhadap Pasien Dalam Pelayanan Medis Di Rumah Sakit Umum," *Doktrin: Jurnal Dunia Ilmu Hukum dan Politik*, 1(1), pp. 01–07. Available at: https://doi.org/10.59581/doktrin.v1i1.343.

Soekanto, S. and Mamudji, S. (2010) *Penelitian Hukum Normatif: Suatu Tinjauan Singkat*. Edisi 1 Cet. 12. Jakarta: Raja Grafindo Persada.

Tronconi, L. Pietro *et al.* (2025) "Nursing Assistant in Italy: The Principle of Delegation of Health Activities and Liability Profiles," *Nursing Reports*, 15(12), p. 443. Available at: https://doi.org/10.3390/nursrep15120443.

Widhiastuty, N.P.A.A., Dewi, A.A.S.L. and Dinar, I.G.A.A.G.P. (2024) "Perlindungan Hukum Terhadap Kesalahan Diagnosis Penyakit Melalui Platform Telemedicine," *Jurnal Analogi Hukum*, 6(3), pp. 356–363. Available at: https://doi.org/10.22225/JAH.6.3.2024.356-363.