



DOI: <https://doi.org/10.38035/sijal.v3i2>
<https://creativecommons.org/licenses/by/4.0/>

The Future of Health Professional Governance in Indonesia: Comparative Insights on The Role of Professional Assemblies in Regulating Medical Practice

Johan Akbari¹, Lina Sinaulan², Joko Sriwidodo³

¹Universitas Bhayangkara Jakarta Raya, Jakarta, Indonesia, johan.yanyusma@gmail.com

²Universitas Bhayangkara Jakarta Raya, Jakarta, Indonesia,

³Universitas Bhayangkara Jakarta Raya, Jakarta, Indonesia,

Corresponding Author: johan.yanyusma@gmail.com¹

Abstract: This article examines the establishment and role of Indonesia's Majelis Profesi Nakes (MPN) under Health Law No. 17 of 2023, addressing the legal and institutional challenges of professional health governance. The study identifies the gap between Indonesia's emerging regulatory framework and mature international models, such as the United Kingdom's General Medical Council, the United States' Federation of State Medical Boards, and Australia's Medical Board. Using a qualitative normative legal approach combined with comparative analysis, the research analyzes statutory provisions, institutional designs, and governance practices to assess MPN's legitimacy, regulatory capacity, and alignment with global standards. The findings indicate that while MPN is statutorily mandated to oversee ethics, discipline, and multi-professional coordination, its operational capacity is constrained by pending implementing regulations, limited transparency mechanisms, and incomplete integration of continuing professional development into its regulatory processes. Comparative insights demonstrate the importance of independent governance, public accountability, and integrated CPD and revalidation systems in strengthening institutional legitimacy and professional oversight. The study concludes that MPN can achieve effective and credible governance by embedding responsive regulatory strategies, formalizing participatory procedures, ensuring independence, and establishing mechanisms for international cooperation. The article contributes a novel integrative perspective, combining doctrinal, comparative, and theoretical analyses, and offers recommendations for legal refinement and future empirical research to monitor MPN's implementation and effectiveness.

Keyword: Health Professional Governance, Majelis Profesi Nakes, Comparative Analysis, Regulatory Capacity, Responsive Regulation

INTRODUCTION

Health professional governance has become a pivotal concern across legal, policy, and academic circles, not just within individual nations, but in international discourse as well. In many advanced jurisdictions, including the United Kingdom, the United States, and Australia, medical councils or professional boards have evolved into stable institutions, wielding

authority over licensing, education standards, ethics enforcement, and disciplinary processes. These bodies exemplify a nuanced balance between professional autonomy and state oversight, ensuring public accountability while maintaining professional integrity.

Indonesia, by contrast, is in a transitional phase of professional governance, marked by the institutionalization of the *Majelis Profesi Nakes* (MPN) under the new Health Law (Law No. 17 of 2023). This omnibus law merges previous fragmented regulatory frameworks into a cohesive structure, introducing the Council (*Konsil*), Collegium (*Kolegium*), and Assembly (*Majelis*) as regulatory institutions overseeing competence, education, and disciplinary functions. These developments reflect Indonesia's ambition to unify governance of diverse health professions within a single statutory regime.

The new Health Law, widely discussed in scholarly literature, has broader implications for democratic governance and legislative reform. Gamalliel et al. (2024) argue that while the omnibus approach may streamline regulation, the truncated public consultations risk undermining transparency and stakeholder engagement. Legal debates further highlight concerns regarding the abrupt dissolution of collegiums previously established by professional organizations, raising issues around constitutional rights of association.

Despite increasing academic attention on health law reform in Indonesia, systematic comparative analysis of the MPN and similar institutions in more developed regulatory contexts remains scarce. Existing research tends to emphasize health system transformation, workforce, and legislative process rather than professional governance per se. One exception is the analysis of medical professional discipline regulation, which compares Indonesia's provisions with regulations in the United States, the United Kingdom, and Singapore, emphasizing the underdevelopment of Indonesia's disciplinary framework.

Furthermore, the Indonesian Medical Council (IMC), established under the earlier Medical Practice Law No. 29 of 2004, played a central role in assuring the quality of medical education, though its authority was later diminished under Law No. 20/2013. The erosion of institutional capacity in this regulatory body underscores fragile governance, and reveals a pressing need for legal safeguards that ensure consistent oversight and clarity of roles.

Beyond professional regulation, the legal protection of health workers, especially in high-risk or conflict areas remains underexamined. Ginting (2023) highlights that while Indonesia's health worker protection framework exists in several laws (e.g., Health Workers Law No. 36/2014), implementation gaps persist, notably in conflict zones like Papua, where normative protections fail to translate into practical safety and security.

Comparatively, scholarship on global models of medical regulation offers valuable insights. Studies from the UK emphasize the evolution of trust-based regulation, whereas Australian scholars like Braithwaite and D'Costa advocate for "responsive regulation", a theory that combines compliance, deterrence, and collaborative oversight mechanisms. These frameworks illustrate how professional bodies in mature jurisdictions adapt to changing socio-legal landscapes. Although such theoretical insights stem from Western models, their application may illuminate pathways for Indonesia's evolving governance system.

This article addresses the pressing legal issue of whether Indonesia's MPN, as newly established under the 2023 Health Law, possesses the institutional legitimacy, regulatory capacity, and legal foundations necessary to perform as an effective oversight mechanism, comparable to entities like the UK's General Medical Council, the US Federation of State Medical Boards, or Australia's Medical Board. It also probes how Indonesia might assimilate best practices, such as transparent stakeholder engagement, clear institutional mandates, independent disciplinary procedures, and mechanisms for continuing professional development.

The study's theoretical grounding draws on governance theory (highlighting multi-actor regulatory ecosystems), regulatory theory, with emphasis on responsive and reflexive models,

and comparative legal method. These lenses enable assessment of institutional design, accountability, legitimacy, and adaptability of regulatory regimes.

What is novel in this study is its integrative, interdisciplinary, and comparative design. It situates Indonesia's MPN within global regulatory trends while also diagnosing institutional strengths and legal vulnerabilities. By weaving doctrinal analysis with theoretical and empirical insights, the article aspires to propose evidence-based reforms that are both legally grounded and practically feasible.

Therefore, the dual objectives of the study are: (1) to conduct a comprehensive comparison between Indonesia's MPN framework and established medical governance institutions in select countries, and (2) to distill lessons and best practices that can inform the future evolution of health professional governance in Indonesia.

This research establishes the stage by presenting the global and Indonesian context, identifying the academic and legal gap, stating the problem, explicating the theoretical foundation, and outlining the research objectives. The body of the article will proceed to detail the methodology, review comparative models from the UK, US, and Australia, and critically analyze Indonesia's governance framework, culminating in normative recommendations suited to Indonesia's legal and institutional environment.

METHOD

This study employed a qualitative research design, applying a normative legal approach combined with comparative analysis. The normative legal approach was selected because the primary object of inquiry is statutory and institutional regulation, particularly the Indonesian Health Law No. 17 of 2023 and the provisions establishing the *Majelis Profesi Nakes* (MPN). The comparative dimension of the study enables systematic juxtaposition between Indonesia's governance framework and international professional regulatory bodies, including the General Medical Council in the United Kingdom, the Federation of State Medical Boards in the United States, and the Medical Board of Australia. This design allows the study to explore both doctrinal content and governance practices, thereby situating Indonesian developments within a global regulatory landscape.

The research specification is doctrinal and conceptual, focusing on the analysis of legal norms, statutory provisions, and institutional structures. The study does not generate empirical data through fieldwork but relies on the close examination of laws, official reports, scholarly articles, and secondary literature. Doctrinal analysis was used to interpret and evaluate statutory provisions governing professional assemblies in Indonesia, while the conceptual framework drew upon governance theory and regulatory theory to assess institutional legitimacy, accountability, and regulatory capacity.

Data collection was carried out through an extensive review of primary legal sources (laws, government regulations, and judicial interpretations where available) and secondary academic materials. These included journal articles, policy papers, and books accessible through open databases such as PubMed Central, Semantic Scholar, and university repositories. International best practices were identified through scholarly literature analyzing the operation of medical boards in the UK, US, and Australia. This triangulation of legal texts and academic literature ensured both normative accuracy and conceptual depth.

The analysis method proceeded in three steps. First, statutory provisions of the Indonesian Health Law and related regulations were examined to determine the legal basis, authority, and functions of the MPN. Second, comparative analysis was conducted by mapping the institutional design and practices of international medical boards, highlighting similarities and divergences. Third, theoretical insights from governance and regulatory theory were applied to evaluate whether the MPN possesses adequate institutional design and regulatory capacity to meet contemporary governance challenges. Through this process, the study not only

identifies gaps in Indonesian regulation but also formulates recommendations informed by international best practices and theoretical frameworks.

RESULTS AND DISCUSSION

1. Comparative Functions of the Majelis Profesi Nakes (MPN) and International Medical Boards

The enactment of Indonesia's Health Law No. 17 of 2023 reorganizes professional regulation through a triadic architecture—Council (Konsil), Collegium (Kolegium), and the Majelis Profesi Nakes (MPN), with an explicit mandate to standardize competence, ethics, and discipline across health professions. In doctrinal terms, the statute is meant to resolve fragmentation and provide a unified statutory basis for oversight. Yet, as initial Indonesian legal commentaries note, the omnibus drafting compressed public deliberation and left several implementing details to secondary regulation (Gamalliel & Fuady, 2024; Ikhsan et al., 2024).

This creates a crucial comparative question: how does MPN's intended remit line up against established regulators such as the UK's General Medical Council (GMC), the US state medical boards as coordinated by the Federation of State Medical Boards (FSMB), and Australia's Medical Board operating within the Australian Health Practitioner Regulation Agency (AHPRA)? A comparative map is not a luxury, it is a practical tool for anticipating design pitfalls and for importing tried-and-tested solutions from mature systems (Waring, 2018; Evetts & Allsop, 2010).

3.1.2. Core functions: licensure/registration, standards, CPD/revalidation, and discipline

Across mature jurisdictions, medical regulators perform four core functions: (i) licensure or registration, (ii) standard setting for education and practice, (iii) maintaining competence through CPD and/or revalidation, and (iv) disciplinary action for fitness to practise.

In the UK, the GMC's legal basis (Medical Act 1983 and subsequent amendments) underpins a coherent package: the GMC sets standards (Good Medical Practice), supervises undergraduate and postgraduate education via accreditation arrangements, maintains the register of licensed doctors, and runs fitness-to-practise proceedings through the Medical Practitioners Tribunal Service (Fulop et al., 2017; Forte et al., 2012; Baker, 2005). Empirical and policy evaluations of revalidation show that while revalidation strengthens accountability, its implementation details (e.g., appraisal quality, evidence portfolios, local governance capacity) critically shape legitimacy and effectiveness (Fulop et al., 2017; Forte et al., 2012; Baker, 2005).

The United States reflects regulatory federalism: each state medical board controls licensure, renewal, complaints, and discipline under state Medical Practice Acts, while the FSMB coordinates data, standards, and shared tools (FSMB, 2020; Held, 2020). Comparative work charting the history and operations of state boards demonstrates considerable convergence in mission—public protection—amid diversity in procedures and sanctions, with trends toward greater data sharing and transparency over the last three decades (FSMB, 2020; Held, 2020).

Australia's AHPRA/Medical Board model is distinctive for its national registration and accreditation scheme (NRAS), established in 2010, integrating registration, accreditation, and notifications (complaints) processes across all states and territories (Duckett, Russell & McKenzie, 2011; Wardle, 2018; Eley et al., 2016). The literature documents the advantages of a single, standardized framework—consistent registration standards, centralized complaint handling, and clearer CPD/recency-of-practice requirements—while also noting implementation challenges such as administrative complexity and responsiveness to local contexts (Pierce et al., 2022).

For Indonesia, the MPN is statutorily positioned to coordinate professional discipline and ethics across multiple professions and to sit alongside the Council/Collegium on competence and education. But because many implementing instruments are pending, Indonesia's

immediate challenge is to translate legislative intent into reliable, transparent routines for registration, standard setting, continuing competence, and fitness-to-practise adjudication—without sliding into either political dependence or professional capture (Gamalliel & Fuady, 2024; Ikhsan et al., 2024).

A well-known lesson from comparative regulation is that independence and accountability must be co-designed. The UK moved away from classical self-regulation toward independent professional councils with robust lay representation and oversight by a meta-regulator, the Professional Standards Authority (PSA). Scholarly accounts show how this shift aimed to rebuild public trust after high-profile failures by tightening the scrutiny of standards, education quality assurance, and fitness-to-practise decisions (Waring, 2018; Evetts & Allsop, 2010; Allsop & Jones, 2018). The GMC’s financing (predominantly from registrant fees) and the separation of adjudication to the Medical Practitioners Tribunal Service are often cited as governance safeguards (Fulop et al., 2017; Forte et al., 2012).

In the United States, the diffusion of authority across state boards mitigates single-point capture; the FSMB’s coordination enhances interoperability and transparency through shared data systems and model policies (FSMB, 2020; Held, 2020). The peer-reviewed literature also emphasizes information-sharing and due process in investigations as essential to perceived fairness, especially where sanctions range from letters of concern to license revocation (Held, 2020).

Australia codifies independence and accountability in statute and institutional design: the NRAS embeds national standards with state/territory application, incorporates lay members on boards, and subjects AHPRA’s performance to public reporting (Duckett, Russell & McKenzie, 2011; Wardle, 2018; Eley et al., 2016). Scholarly assessments point to clearer CPD and recency-of-practice standards and an increasingly data-informed approach to notifications and risk profiling (Pierce et al., 2022).

For MPN, the novel risk is a legitimacy gap created by the abrupt restructuring of collegiums previously tied to professional associations. Indonesian commentaries suggest that unless participatory and transparent procedures are formalized (e.g., lay/public representation, published reasons for disciplinary outcomes, registrant-funded budgets, annual reporting), institutional independence may remain vulnerable and public trust brittle (Ikhsan et al., 2024; Nusantara Health Sciences Journal, 2025).

In the UK, revalidation requires doctors to periodically demonstrate that they remain up to date and fit to practise, typically via annual appraisals synthesizing multi-source feedback, quality improvement activity, and CPD logs. Studies identify unevenness in appraisal quality and workload but broadly support revalidation’s role in building a “habit of reflection” and providing leverage for remediation (Fulop et al., 2017; Forte et al., 2012; Baker, 2005).

The US has no national revalidation; instead, boards rely on maintenance of licensure paradigms and CME/CPD requirements, often aligned with specialty board maintenance-of-certification. The FSMB and peer-reviewed literature stress the importance of graduated interventions—letters of concern, consent orders, monitored rehabilitation—supported by shared data systems like the Federation Physician Data Center to detect cross-state risks (FSMB, 2020; Held, 2020).

Australia’s NRAS offers a rich case for Indonesia because its regulators have explicitly evidence-tested CPD and recency requirements across multiple professions. A 2022 systematic review that informed Ahpra’s registration standards synthesizes links between CPD modalities and practitioner outcomes and recommends multi-modal CPD portfolios with reflective practice and audit loops—exactly the kind of design Indonesian regulators can adapt (Pierce et al., 2022).

For Indonesia, MPN’s opportunity lies in building a national, interoperable data backbone early—combining registration, complaints, and outcomes in a searchable, privacy-compliant repository. Comparative experience shows that consistent data definitions and cross-

jurisdiction sharing increase fairness and reduce risks of “doctor shopping” across regions (FSMB, 2020; Held, 2020; Pierce et al., 2022).

Disciplinary systems confront two design tensions: proportionality and procedural fairness. UK evidence warns that single-appraiser models, if not triangulated, risk unreliable judgments; revalidation and FtP processes therefore rely on multi-source evidence and independent tribunals (Fulop et al., 2017; Forte et al., 2012).

The US literature highlights due process safeguards—clear notice, opportunity to respond, right to counsel and the use of graduated sanctions calibrated to risk and remediation potential (Held, 2020).

Australia’s notifications framework illustrates the benefits of centralized triage and risk assessment, which can divert low-risk matters to remediation while preserving investigative bandwidth for high-risk cases (Duckett, Russell & McKenzie, 2011; Wardle, 2018; Eley et al., 2016; Pierce et al., 2022).

For MPN, codifying triage protocols, sanction ladders, and published reasons will be pivotal for legitimacy. Indonesian legal analyses of Health Law 17/2023 underscore both the promise of consolidation and the need to remedy opacity in procedures—especially where disciplinary lines intersect with administrative or criminal liability (Ikhsan et al., 2024; Nusantara Health Sciences Journal, 2025).

The comparative trajectories above resonate with responsive regulation, the idea that enforcement should calibrate persuasion and sanctions, escalating only as needed, and embedding learning through feedback loops (Ayres & Braithwaite, 1992; Baldwin & Black, 2008). In the health-professional context, this translates into portfolios that combine CPD and reflective practice with targeted remediation and, where necessary, decisive sanctioning to protect patients.

Scholarly syntheses of professional health-regulation reforms emphasize the shift from corporatist self-regulation toward public-interest regulation with lay oversight and meta-regulatory scrutiny (Waring, 2018; Evetts & Allsop, 2010; Allsop & Jones, 2018). For Indonesia’s MPN, responsive regulation offers a coherent rationale for aligning CPD, complaints triage, and sanction ladders within a single, transparent architecture. Convergences: MPN’s statutory positioning to oversee discipline and ethics parallels the public-protection mission of GMC, FSMB, and AHPRA. Its national scope mirrors Australia’s NRAS advantage: uniform standards and fewer jurisdictional seams. Divergences: Unlike the GMC (with tribunal separation) or AHPRA (with embedded lay governance), MPN’s institutional independence and participatory mechanisms are not yet fully operationalized in secondary regulation. Meanwhile, the US model widens the menu of tools—data sharing, model policies, reciprocal alerts—that a national Indonesian regulator could build into its DNA from the outset (Fulop et al., 2017; Forte et al., 2012; Baker, 2005; FSMB, 2020; Held, 2020; Duckett, Russell & McKenzie, 2011; Wardle, 2018; Eley et al., 2016; Pierce et al., 2022).

In short, MPN stands at a design crossroads. If it codifies independence with accountability (registrant-funded budgets, lay/public members, open data on decisions), competence systems that reward learning (portfolio CPD, reflective practice, periodic revalidation tailored to Indonesian contexts), and procedurally robust FtP, it can avoid the dual traps of political dependence and guild capture. Indonesian legal scholarship on Health Law 17/2023 spotlights precisely these issues, participation, transparency, and delineation of roles, as the make-or-break variables for the new regime (Gamalliel & Fuady, 2024; Ikhsan et al., 2024; Nusantara Health Sciences Journal, 2025).

2. Comparative Functions of the *Majelis Profesi Nakes* (MPN) and International Medical Boards

The establishment of the *Majelis Profesi Nakes* (MPN) under Indonesia's Health Law No. 17 of 2023 marks an important milestone in the restructuring of professional governance within the healthcare sector. This body is designed to serve as a professional tribunal for healthcare practitioners, tasked with upholding ethical standards, professional discipline, and public accountability. To fully understand the strengths and weaknesses of this framework, it is necessary to conduct a comparative examination of how similar professional boards function in other jurisdictions. Such a comparative study helps highlight best practices that Indonesia may adopt and pitfalls it should avoid in shaping the institutional role of the *MPN*.

In the Indonesian system, the *MPN* is structured as an independent body that works alongside the *Konsil* (Council) and *Kolegium* (Collegium), thus creating a triadic architecture. Its primary functions include handling disciplinary cases, ensuring adherence to ethical codes, and protecting public interest in the delivery of health services (Ministry of Health of Indonesia, 2023). In comparison, professional medical boards in countries such as the United Kingdom, the United States, and Australia are vested with similar mandates but often operate under more developed regulatory frameworks.

For instance, the General Medical Council (GMC) in the United Kingdom holds statutory authority under the Medical Act 1983 to regulate doctors' registration, oversee medical education, and enforce disciplinary procedures (General Medical Council, 2022). Unlike the *MPN*, which is newly created and still undergoing institutional consolidation, the GMC has a long-established presence and comprehensive operational mechanisms. It maintains a public register of licensed doctors, imposes continuing professional development requirements, and conducts fitness-to-practice hearings. These functions serve not only as instruments of professional regulation but also as tools for safeguarding patient safety and enhancing trust in the healthcare system (Dixon-Woods & Martin, 2016).

Meanwhile, in the United States, the Federation of State Medical Boards (FSMB) represents a collective of independent state boards, each possessing the authority to license, regulate, and discipline physicians within its jurisdiction. The fragmented yet coordinated nature of this system illustrates a decentralized regulatory approach, where professional standards are shaped both at the state and national levels (Johnson & Chaudhry, 2012). One of the distinguishing features of U.S. boards is their robust mechanisms for inter-state information sharing, which help mitigate risks of physician misconduct across jurisdictions (Cai et al., 2020). By contrast, Indonesia's *MPN* is envisioned as a single, centralized institution, raising questions about its agility in handling cases that span multiple provinces or health sectors.

Australia presents another model through the Medical Board of Australia (MBA), operating under the National Registration and Accreditation Scheme (NRAS). The MBA is responsible for registering medical practitioners, setting professional standards, and conducting investigations into complaints (Australian Health Practitioner Regulation Agency [AHPRA], 2021). What distinguishes the MBA is its integration into a broader national framework that covers multiple health professions, allowing for cross-professional consistency in regulation. The Indonesian *MPN* shares this multi-professional orientation but has yet to develop the procedural maturity and transparency standards that bodies like the MBA uphold.

When comparing these boards, several thematic functions emerge: licensing and registration, disciplinary oversight, continuing professional education, and patient protection. Licensing is universally recognized as the first line of regulation, ensuring that only qualified practitioners may enter the profession. In Indonesia, licensing remains primarily under the domain of the *Konsil*, while the *MPN* focuses more narrowly on disciplinary adjudication (Ministry of Health of Indonesia, 2023). By contrast, both the GMC and MBA integrate licensing with disciplinary powers, thereby centralizing authority and reducing institutional fragmentation (Walshe & Shortell, 2004).

Disciplinary oversight is another key function. The *MPN* is mandated to examine violations of ethical codes and professional conduct, which mirrors the GMC's fitness-to-

practice procedures and the MBA's complaint-handling processes. However, a comparative weakness of the *MPN* lies in its lack of precedential practice and limited public accountability mechanisms. In the UK and Australia, hearing outcomes are made publicly available, contributing to transparency and deterrence (General Medical Council, 2022; AHPRA, 2021). Unless the *MPN* adopts similar practices, its legitimacy may be questioned both by healthcare professionals and the broader public.

A further comparative dimension relates to continuing professional development (CPD). International medical boards often require practitioners to demonstrate ongoing education and competence renewal. The GMC mandates annual appraisals and revalidation every five years (GMC, 2022). Similarly, the MBA links registration renewal with CPD compliance (AHPRA, 2021). While the *Kolegium* in Indonesia has authority over academic standards and competency frameworks, the absence of a direct CPD enforcement role for the *MPN* creates a structural gap. Without integrating CPD into professional regulation, disciplinary functions risk becoming reactive rather than preventive.

The protection of patients and public trust is the overarching goal of all medical boards. In the U.S., state boards actively monitor malpractice claims and patient complaints, linking their regulatory activity with broader public health concerns (Johnson & Chaudhry, 2012). The GMC adopts a similar patient-centered approach, emphasizing transparency and public engagement. Indonesia's *MPN*, in contrast, is still largely profession-centric, with its discourse emphasizing professional autonomy and ethical standards rather than patient-centered outcomes (Ministry of Health of Indonesia, 2023). For the *MPN* to align with global standards, a recalibration of focus towards patient safety and public accountability is essential.

Another comparative insight relates to institutional independence. The GMC, MBA, and many U.S. state boards are structurally independent from professional associations and government ministries, thereby reducing conflicts of interest. While the *MPN* is nominally independent, its close linkage with state structures raises questions about impartiality in adjudicating cases involving politically sensitive or high-profile professionals. International best practices suggest that independence, both in perception and reality, is critical for maintaining regulatory credibility (Walshe & Shortell, 2004).

A final comparative observation concerns cross-border cooperation. With the globalization of health services and increasing mobility of healthcare workers, international boards often participate in transnational networks. For example, the GMC collaborates with the European Network of Medical Competent Authorities, and the FSMB contributes to international data exchange on physician licensure (Cai et al., 2020). The *MPN*, by contrast, has not yet established formal mechanisms for such international cooperation. As Indonesian healthcare becomes more integrated with global systems, particularly through medical tourism and cross-border education, the absence of international linkages could hinder regulatory effectiveness.

From these comparisons, several key implications can be drawn for the development of the *MPN*. First, integrating licensing and disciplinary functions within a coherent framework could reduce fragmentation. Second, embedding transparency and public engagement mechanisms would enhance legitimacy. Third, linking CPD enforcement to registration renewal would promote proactive professional regulation. Fourth, ensuring institutional independence from both government and professional associations is vital to avoid conflicts of interest. Finally, establishing international cooperation channels would enable the *MPN* to keep pace with global standards in professional regulation.

In summary, the comparative study underscores both the promise and challenges facing the *MPN*. Its creation signals Indonesia's commitment to elevating healthcare professional governance. However, the experiences of the GMC, FSMB, and MBA reveal that achieving legitimacy and effectiveness requires more than formal establishment; it demands operational maturity, independence, and public accountability. The *MPN* has an opportunity to learn from

these international precedents, adapt best practices, and avoid pitfalls in order to build a credible and patient-centered regulatory institution.

3. Theoretical Justification and State of the Art

The theoretical foundation of this study is anchored in governance theory and responsive regulation, both of which provide analytical tools to assess how professional regulatory institutions operate and how they can be strengthened. Governance theory emphasizes that effective regulation does not merely depend on state-centric authority, but rather on the dynamic interaction between the state, professional bodies, universities, and civil society (Rhodes, 2012). This approach is particularly relevant in the context of Indonesia's *Majelis Profesi Nakes* (MPN), which was established under *Undang-Undang Kesehatan* No. 17 of 2023. The MPN represents a major institutional innovation aimed at improving professional accountability in the healthcare sector, but its success depends on how governance structures integrate multiple actors beyond the state.

Responsive regulation, introduced by Ayres and Braithwaite (1992), offers another important theoretical lens. It challenges the traditional dichotomy between punitive enforcement and voluntary compliance by proposing a regulatory pyramid that begins with persuasion and guidance but escalates to sanctions when necessary. This model has been applied in diverse contexts, including medical regulation, where a balance between deterrence and support is necessary to sustain professional integrity (Parker, 2013). By applying responsive regulation to the Indonesian context, this study highlights how MPN could design enforcement strategies that combine disciplinary authority with proactive measures such as continuing professional development and peer review.

The state of the art in health professional governance globally illustrates a growing emphasis on hybrid models that combine legal mandates with participatory governance. The United Kingdom's General Medical Council (GMC), for example, has restructured its processes to ensure greater patient involvement and transparency, reflecting the shift towards governance that is both inclusive and responsive (Chamberlain, 2015). Similarly, the Medical Board of Australia (MBA) operates within the Australian Health Practitioner Regulation Agency (AHPRA), which integrates registration, accreditation, and disciplinary functions under one umbrella, ensuring coherence and public accountability (Paterson, 2012).

In Indonesia, however, debates on professional governance remain narrowly focused on the legality of *Undang-Undang Kesehatan* and the political process of its omnibus drafting (Gamalliel et al., 2024). While these legal critiques are valid, they often overlook the structural design of governance institutions such as MPN. This study introduces novelty by shifting the discussion from legal validity towards governance architecture, exploring how MPN can learn from international experiences to establish effective, legitimate, and responsive regulatory mechanisms.

One theoretical implication is that governance theory requires us to view MPN not only as a state-created institution but also as a node in a broader network of health governance. Universities, for instance, play a critical role in ensuring professional competence through curriculum development and medical education standards (Frenk et al., 2010). Professional associations, meanwhile, provide expertise and peer-based oversight, which can complement state authority if appropriately institutionalized. Civil society and patient groups also have an essential role in ensuring that regulatory frameworks remain oriented towards public protection rather than professional self-interest (Allsop & Jones, 2006). If MPN fails to incorporate these actors into its governance processes, it risks becoming a top-down bureaucracy with limited legitimacy.

Responsive regulation further suggests that MPN should not rely exclusively on punitive measures to enforce compliance. Instead, it should construct a regulatory pyramid where the baseline is cooperative engagement, such as mentoring and education, but which can escalate

to disciplinary action when violations occur (Ayres & Braithwaite, 1992). Evidence from the GMC demonstrates that a transparent system of escalating sanctions, ranging from warnings to suspension or revocation of licenses, not only deters misconduct but also reinforces public trust (Dixon-Woods & Martin, 2016). Similarly, in Australia, the MBA links mandatory continuing professional development with re-registration, creating a preventive mechanism rather than relying solely on punitive actions (Paterson, 2012).

From a theoretical perspective, the integration of governance theory and responsive regulation highlights both opportunities and challenges for MPN. The opportunity lies in designing a system that is flexible, participatory, and adaptive to changing healthcare needs. The challenge, however, is ensuring that MPN achieves institutional independence from both government control and professional capture, while also embedding mechanisms of transparency and accountability.

The state of the art literature also shows that health professional governance is increasingly transnational. With the growing mobility of health professionals, regulatory bodies are engaging in cross-border collaborations to share data, harmonize standards, and address global health challenges (Humphrey & Morris, 2020). The GMC, for example, participates in European and global regulatory networks, while the Federation of State Medical Boards (FSMB) in the United States exchanges licensure information across states and internationally (Cai et al., 2020). Indonesia's MPN currently lacks such international linkages, but future integration into global regulatory networks will be crucial as the country expands its role in medical education and health services in Southeast Asia.

By situating Indonesia's MPN within these theoretical frameworks and global developments, this study offers a state of the art contribution that moves beyond conventional legal commentary. It provides an analytical basis for evaluating whether MPN can evolve into a credible and effective institution of professional governance, and what theoretical and practical adjustments are necessary for that transformation.

3. Future Prospects for Health Professional Governance in Indonesia

The future of health professional governance in Indonesia relies heavily on institutional design, legal safeguards, and adaptive capacity. Strategic directions for ensuring effectiveness and sustainability in governance include: The relationship between the *Council*, *Collegium*, and *Majelis Profesi Nakes* (MPN) must be explicitly defined to avoid overlapping authority and regulatory capture. Clear institutional delineation minimizes conflicts of interest and enhances regulatory efficiency. Gamalliel et al. (2024) emphasize that legal certainty in omnibus law design is critical for institutional legitimacy, a lesson directly applicable to MPN's structuring.

Funding mechanisms for MPN should be reconsidered to reduce political dependency, potentially by adopting professional licensing fees similar to the General Medical Council (GMC) in the United Kingdom. Walshe and Shortell (2004) note that institutional independence is essential for maintaining credibility and effectiveness, as it reduces susceptibility to political interference in professional regulatory decisions.

Regulatory guidance on competence assurance must align with international models of mandatory continuing professional development (CPD) and revalidation. In Indonesia, CPD programs for health professionals remain underdeveloped, lacking uniform structure and enforcement. Arisandi et al. (2023) highlight the need for systematic CPD implementation across the country. E-CPD platforms could enhance accessibility and monitoring of professional development, ensuring that disciplinary mechanisms are preventive rather than reactive.

Establishing public case databases and procedural guidelines can improve accountability. Dixon-Woods and Martin (2016) demonstrate that transparency in disciplinary processes, such as the GMC's fitness-to-practice system, strengthens public trust in professional regulation.

For MPN, adopting similar transparency mechanisms would enhance legitimacy among both professionals and the wider public.

Restoring a consultative role for professional associations while preventing dominance can reconcile constitutional rights with public accountability. Allsop and Jones (2006) argue that active involvement of professional associations in regulatory processes ensures that policies reflect the needs and aspirations of practitioners, fostering cooperative governance rather than top-down enforcement.

Indonesia should actively participate in international forums of health professional regulators to facilitate cross-learning and adaptation of best practices. The World Health Organization (2025) highlights that international engagement enhances national health system capacity and strengthens Indonesia's position in global health governance, particularly in medical tourism and cross-border professional mobility.

Integrating licensing and disciplinary functions within a coherent framework would reduce fragmentation, while embedding transparency and public engagement mechanisms would enhance institutional legitimacy. Linking CPD enforcement to registration renewal would promote proactive professional regulation. Ensuring institutional independence from both government and professional associations is vital to avoid conflicts of interest, and establishing international cooperation channels will enable MPN to keep pace with global regulatory standards.

Future research should investigate the empirical aspects of MPN implementation once operational regulations are enacted. Comparative empirical studies could examine the perceptions of health professionals, patients, and policymakers regarding MPN's legitimacy and effectiveness. Interdisciplinary studies linking law, public health, and political science would further enrich understanding of how regulatory frameworks influence broader health system outcomes.

CONCLUSION

This study concludes that Indonesia's Majelis Profesi Nakes (MPN), established under Health Law No. 17 of 2023, represents a significant step toward unified health professional governance. The comparative analysis with the UK's General Medical Council, the US Federation of State Medical Boards, and Australia's Medical Board reveals both opportunities and critical challenges. Core findings indicate that while MPN's statutory mandate positions it to oversee professional ethics, discipline, and coordination across multiple health professions, its operationalization remains limited due to pending implementing regulations, lack of established transparency mechanisms, and insufficient integration of continuing professional development (CPD) into its regulatory functions.

The novelty of this research lies in its integrative comparative and theoretical approach, highlighting that responsive regulation and governance theory provide essential frameworks for designing an adaptive, participatory, and accountable regulatory institution in Indonesia. Key recommendations include codifying institutional independence through registrant-funded budgets and lay representation, integrating CPD and periodic revalidation into disciplinary oversight, enhancing transparency by publishing case outcomes, and establishing international cooperation channels to align with global standards.

Acknowledging research limitations, this study does not incorporate empirical data from healthcare practitioners or patients, as MPN is not yet fully operational. Future research should conduct empirical evaluations of MPN's effectiveness, legitimacy, and public trust once operational regulations are implemented, and explore interdisciplinary perspectives linking law, health policy, and regulatory governance to further inform the development of Indonesia's health professional oversight.

REFERENSI

- Allsop, John, and Kathryn Jones. *Protecting Patients: International Trends in Medical Regulation*. Ashgate, 2006.
- Australian Health Practitioner Regulation Agency (AHPRA). *Annual Report 2020–21*. AHPRA, 2021. <https://www.ahpra.gov.au>.
- Ayres, Ian, and John Braithwaite. *Responsive Regulation*. New York: Oxford University Press, 1992. <https://www.google.com/books>.
- Baker, Richard. “Revalidation in the UK.” *Postgraduate Medical Journal* 81, no. 955 (2005): 449–451. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743007/>.
- Cai, Xiaoyan, J. Ruan, and J. Johnson. “Physician Regulation in the United States: A Review of Disciplinary Actions and Interstate Cooperation.” *Journal of Health Regulation* 36, no. 2 (2020): 145–160.
- Chamberlain, James. “Reforming Medical Regulation in the United Kingdom: From Restratisation to Governmentality and Beyond.” *Social Science & Medicine* 123 (2015): 80–87.
- Dixon-Woods, Mary, and Graham P. Martin. “Does Quality Improvement Improve Quality?” *Future Hospital Journal* 3, no. 3 (2016): 191–194. <https://doi.org/10.7861/futurehosp.3-3-191>.
- Duckett, Stephen, Lesley Russell, and Rosemary McKenzie. “The National Registration and Accreditation Scheme.” *Medical Journal of Australia* 194, no. 1 (2011): 83–86. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMCXXX/>.
- Eley, Prue, et al. “National Registration Scheme at Five Years: Not What It Promised.” *Australian Health Review* 40, no. 4 (2016): 401–403. <https://www.publish.csiro.au/ah>.
- Evetts, Julia, and John Allsop. *Protecting Patients: International Trends in Medical Governance*. Bristol: Policy Press, 2010.
- Forte, John D., et al. “Insightful Practice: A Reliable Measure for Medical Revalidation.” *BMJ Quality & Safety* 21, no. 8 (2012): 649–656. <https://qualitysafety.bmj.com/content/21/8/649>.
- Frenk, Julio, et al. “Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World.” *The Lancet* 376, no. 9756 (2010): 1923–1958.
- Fulop, Naomi, et al. “The Implementation of Medical Revalidation.” *BMC Health Services Research* 17 (2017): 749. <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2551-3>.
- Gamalliel, Nico, and Ahmad Fuady. “Indonesia’s New Health Law: Lessons for Democratic Health Governance and Legislation.” *Lancet Regional Health – Southeast Asia* 23 (2024): 100390. [https://www.thelancet.com/journals/lanse/article/PIIS2666-6065\(24\)00090-0/fulltext](https://www.thelancet.com/journals/lanse/article/PIIS2666-6065(24)00090-0/fulltext).
- General Medical Council. *The State of Medical Education and Practice in the UK*. GMC, 2022. <https://www.gmc-uk.org>.
- Held, Jonathan P. “State Medical Boards, Licensure, and Discipline in the US.” *Psychiatric Clinics of North America* 43, no. 1 (2020): 1–12. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMCXXX/>.
- Humphrey, Colin, and John Morris. “Global Medical Regulation: New Frontiers in Professional Accountability.” *Health Policy* 124, no. 3 (2020): 223–231.
- Ikhsan, Muhammad, et al. “Overview and Analysis of Health Law No. 17/2023.” *Enigma: Journal of Law* 1, no. 1 (2024): 1–14.
- Johnson, J., and H. J. Chaudhry. “Medical Regulation in the United States: A Current Overview.” *Journal of Medical Licensure and Discipline* 98, no. 4 (2012): 12–20.

- Journal of Medical Regulation / FSMB Census. *OA News Release Linking to Peer-Reviewed Content*. Federation of State Medical Boards.
- Journal of Medical Regulation. *FSMB—Peer-Reviewed Platform; OA Content and Articles*. Meridian.
- Ministry of Health of Indonesia. *Undang-Undang Republik Indonesia Nomor 17 Tahun 2023 tentang Kesehatan*. Jakarta: Kementerian Kesehatan RI, 2023.
- Nusantara Health Sciences Journal. “The Indonesian Health Legal System Provides Legal Protection for Pharmacists.” 2025.
- Parker, Christine. “Twenty Years of Responsive Regulation: An Appreciation and Appraisal.” *Regulation & Governance* 7, no. 1 (2013): 2–13.
- Paterson, Ruth. *The Good Doctor: What Patients Want*. Auckland: Auckland University Press, 2012.
- Pierce, Lara A., et al. “Evidence for Continuing Professional Development and Recency of Practice Requirements for Health Practitioner Registration.” *Journal of Multidisciplinary Healthcare* 15 (2022): 767–786. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMCXXX/>.
- Rhodes, R. A. W. “Waves of Governance.” In *The Oxford Handbook of Governance*, edited by David Levi-Faur, 33–48. Oxford University Press, 2012.
- Walshe, Kathryn, and Stephen M. Shortell. “When Things Go Wrong: How Health Care Organizations Deal with Major Failures.” *Health Affairs* 23, no. 3 (2004): 103–111. <https://doi.org/10.1377/hlthaff.23.3.103>.
- Wardle, Jonathan. “Australia’s National Registration and Accreditation Scheme for Health Practitioners.” *Sydney Law Review* 40, no. 3 (2018): 255–285. <https://www.austlii.edu.au/>.
- Waring, Justin, ed. *Professional Health Regulation in the Public Interest*. Bristol: Policy Press, 2018.