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COMPARATIVE LEGAL PERSPECTIVES ON MEDICAL EMERGENCY SERVICES AND HUMAN RIGHTS IN INDONESIA AND BRAZIL

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Abstract
This study examines the comparative legal frameworks governing medical emergency services in Indonesia and Brazil, emphasizing the implementation of the right to life and the right to health as fundamental human rights. These two countries were chosen due to their distinct legal systems and institutional capacities in providing emergency healthcare. Using a normative juridical method with legislative and comparative approaches, this research analyzes how both nations ensure access to emergency medical services as part of their human rights obligations. The findings indicate that Brazil offers comprehensive emergency care coverage through the *Sistema Único de Saúde* (SUS), a national integrated health system that guarantees universal and non-discriminatory access. Conversely, Indonesia still encounters significant challenges in operationalizing similar protections despite the formal acknowledgment of these rights. The study highlights the urgent need for Indonesia to reform its health and legal policies to better align with international human rights standards, particularly concerning emergency medical care, which directly affects citizens' lives and safety.

Keywords: human rights, right to life, right to health, comparative law, medical emergency services

1. Introduction

Emergency medical services are a crucial component of the healthcare system directly linked to the protection of human rights, particularly the right to life and the right to health [1]. According to international legal instruments such as the *International Covenant on Civil and Political Rights (ICCPR)* and the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*, these rights are recognized as fundamental and must be protected by states without discrimination [2].

The failure of a state to provide prompt, fair, and high-quality medical services, especially during emergencies, can constitute a serious violation of human rights [3]. Such failures may result in preventable deaths, undermining the inherent right to life possessed by every individual. In practice, however, various countries demonstrate differing degrees of commitment and effectiveness in ensuring these rights, depending on their legal frameworks, institutional capacities, and health policy orientations. Two representative cases are Indonesia and Brazil.

Indonesia and Brazil share similarities as developing nations with significant regional influence [4]. Both countries are undergoing reform in various sectors and thus share a mutual understanding of the challenges in equalizing access to healthcare, distributing medical personnel, and improving service quality [5,6]. Despite these similarities, substantial differences exist in their legal and policy approaches toward health governance.

, through its *Sistema Único de Saúde (SUS)*, has established a universal health coverage system that enshrines the right to health as a constitutional obligation of the state, guaranteeing non-discriminatory access for all citizens [7]. This system is reinforced by federal policies emphasizing the principles of universality, comprehensiveness, and social participation [8]. Under Brazilian law, all hospitals—public or private—are mandated to treat patients in emergency conditions regardless of administrative or financial status [9]. This obligation is outlined in Law No. 8.080/1990 on the National Health System and has been upheld by the Constitutional Court of Brazil, which considers the refusal to treat emergency patients a constitutional violation of the right to life [10].

In contrast, Indonesia, although legally recognizing the right to health under Article 28H(1) and the right to life under Article 28A of the 1945 Constitution, continues to face structural and normative challenges in implementing emergency medical services [11]. The Health Law (No. 36/2009) and the Hospital Law (No. 44/2009) mandate hospitals to provide emergency care for patients [12]; however, weak enforcement, ambiguous administrative provisions, and lack of sanctions often undermine these guarantees [13]. Bureaucratic obstacles within the *Jaminan Kesehatan Nasional (JKN)* system further exacerbate inequities, as hospitals occasionally reject emergency patients due to inactive or unregistered insurance status [14].

Reports of patient rejection during medical emergencies frequently appear in national media and citizen complaints [15]. For instance, in June 2025, a patient named DA (44) from Padang allegedly died after being denied emergency treatment at RSUD Dr. Rasidin despite holding an *Indonesia Health Card (KIS)*. Similarly, in Tarakan, North Kalimantan, the Ombudsman reported cases of patients being denied emergency care due to BPJS insurance verification issues [16].

These discrepancies highlight three central aspects of the legal gap between Indonesia and Brazil: (1) the strength and clarity of legal norms guaranteeing the right to emergency medical services; (2) mechanisms for oversight and law enforcement against rights violations; and (3) the judiciary's role in expanding the protection of these rights. Therefore, this study undertakes a comparative legal analysis to assess how Indonesia and Brazil implement medical emergency regulations concerning the right to life and the right to health. It aims to contribute to strengthening legal protection for emergency healthcare services in Indonesia, where significant reforms are still required.

2. Methods

This study employed a **normative legal research design**, which examines law as a system of norms or rules that govern human behavior in social and institutional contexts [17]. The normative method was chosen because this research does not analyze empirical data from society, but rather focuses on the analysis, interpretation, and evaluation of written legal norms related to emergency medical services in both Indonesia and Brazil. The normative framework allows for a comprehensive understanding of how the law should function ideally (das sollen) compared to its actual implementation (das sein), which is crucial for assessing compliance with human rights standards.

As a normative study, this research utilized two complementary analytical approaches: the **statutory approach** and the **comparative approach** [18]. The statutory approach was applied to examine medical emergency regulations and their derivative provisions, including constitutional guarantees, legislative acts, and ministerial regulations in both countries. This approach enabled the identification of normative foundations that regulate the right to health and the right to life within the context of emergency medical care. Meanwhile, the comparative approach was used to systematically compare how Indonesia and Brazil implement and enforce their legal frameworks in fulfilling these rights. Through comparison, the research identified similarities, contrasts, and contextual factors that influence each country's policy orientation and legal enforcement regarding emergency medical services.

In normative legal research, three categories of legal materials were utilized: **primary**, **secondary**, and **tertiary legal sources** [19].

- **Primary legal materials** include binding legal instruments such as constitutional provisions, statutes, government regulations, and other formal documents applicable in both Indonesia and Brazil [20]. These sources form the backbone of legal argumentation and are treated as authoritative texts that define the scope and substance of legal obligations.
- **Secondary legal materials** consist of scientific articles, academic journals, policy papers, and textbooks that provide scholarly interpretation, critique, and contextual analysis of the primary legal materials [21]. These sources are essential for explaining the theoretical rationale, legislative intent, and practical implications of legal norms.

- **Tertiary legal materials** comprise supporting references such as legal dictionaries, encyclopedias, and electronic databases [22]. These materials facilitate conceptual clarification, cross-referencing of terminologies, and identification of related doctrines across different legal systems.

Data collection was carried out through an extensive **literature review** encompassing both printed and electronic sources. Legal documents from official government databases, court decisions, and academic publications were systematically gathered and organized based on their relevance to the study's objectives. This process ensured that the research maintained both **depth and validity**, providing a solid basis for doctrinal interpretation.

analysis was conducted using **qualitative legal interpretation**, involving a careful and critical examination of texts, doctrines, and judicial decisions to uncover underlying legal principles and policy directions [23]. The qualitative approach enabled the integration of diverse legal perspectives and the construction of a coherent analytical framework for comparison between the two legal systems.

analytical process employed a **hermeneutic analysis of legal norms**, which involves interpreting statutory texts in light of broader principles of justice, human rights, and state responsibility. This interpretive process sought to explore how each country conceptualizes and implements the protection of the right to life and the right to health, particularly in the context of emergency medical services. The analysis also examined the correlation between legal recognition and practical realization, identifying structural gaps and normative inconsistencies that may hinder the effective fulfillment of these rights.

, the qualitative synthesis stage focused on identifying the strengths and weaknesses of Indonesia's and Brazil's legal systems, assessing their degree of alignment with international human rights instruments, and formulating recommendations for improving Indonesia's normative framework. The expected outcome of this analytical process is a clearer understanding of how legal reform can enhance accessibility, fairness, and responsiveness in emergency medical services as a reflection of the state's commitment to human rights protection.

3. Results and Discussion

3.1 The Relationship Between the Right to Life and the Right to Health within the Framework of Human Rights Protection

1. The right to life and the right to health are two fundamental and inseparable pillars in the framework of human rights protection [24]. Both rights are universally recognized under international and national legal instruments as essential for ensuring human dignity and well-being. From a human rights perspective, the right to life is considered the most basic and inherent to human existence, as it forms the foundation for the enjoyment and realization of all other rights [25]. Without the effective protection of the right to life, the recognition of other human rights becomes merely declarative and lacks substantive meaning. Conversely, the right to health serves as an indispensable prerequisite for maintaining life itself, as the capacity to live depends on one's access to appropriate healthcare, prevention of disease, and protection from conditions that threaten survival. Therefore, when individuals are denied access to adequate healthcare—especially in emergency situations where timely intervention determines life or death—their right to life is placed in direct jeopardy.

2. The **Universal Declaration of Human Rights (UDHR)** of 1948 explicitly affirms these two rights as part of the universal moral and legal framework that binds all nations. Article 3 states that "everyone has the right to life, liberty and security of person," emphasizing the inviolability of human existence as the supreme value in international law. Article 25 further articulates the state's responsibility to guarantee a standard of living adequate for health and well-being, encompassing food, clothing, housing, and crucially, medical care. The later adoption of the **International Covenant on Economic, Social, and Cultural Rights (ICESCR)** in 1966 reinforced this recognition by translating the moral aspirations of the UDHR into legally binding obligations for state parties.

Article 12 of the ICESCR specifically obliges governments to ensure "the highest attainable standard of physical and mental health," including the prevention, treatment, and control of diseases, and the creation of conditions assuring medical service and attention in the event of sickness [26]. Together, these instruments establish a holistic understanding that health is not merely a social service but an inseparable dimension of the right to life.

3. The interdependence between the right to life and the right to health implies that the absence of access to essential healthcare—particularly in life-threatening circumstances—can amount to a direct violation of the right to life itself. This relationship illustrates that both rights are **mutually reinforcing**: the preservation of life requires access to adequate healthcare, while the protection of health sustains the quality and continuity of life. When emergency health systems fail to provide prompt, equitable, and non-discriminatory care, they effectively endanger human survival and undermine the credibility of the state's human rights commitments. States, therefore, bear a **positive obligation** not only to abstain from violating these rights but also to actively implement measures ensuring that healthcare services are **accessible, available, acceptable, and of high quality**, particularly in critical emergencies. The absence of ambulances, shortages of medical personnel, lack of essential medicines, or inadequate hospital facilities leading to preventable deaths can constitute a breach of both national and international human rights standards [27].

4. In fulfilling these obligations, the responsibilities of the state are generally classified into three complementary dimensions: **to respect, to protect, and to fulfill** human rights [28].

5. **The obligation to respect** requires the state and its agents to refrain from actions or policies that directly interfere with or infringe upon the rights to life and health. For example, denying emergency medical treatment due to administrative or financial barriers, or delaying access based on bureaucratic considerations, violates this duty. The state must ensure that its regulations, institutional practices, and budgetary decisions do not restrict emergency medical access.

6. **The obligation to protect** mandates that the state safeguard individuals from human rights violations perpetrated by third parties, such as private healthcare institutions or insurance providers. This includes enacting effective regulations that prohibit hospitals from refusing treatment to emergency patients, enforcing strict penalties for violations, and establishing monitoring mechanisms to ensure compliance with ethical and legal standards in healthcare delivery.

7. **The obligation to fulfill** requires the state to take proactive measures—legislative, administrative, and budgetary—to ensure that all individuals enjoy their rights to life and health in practice. This involves building and maintaining adequate health infrastructure, ensuring equitable distribution of medical professionals, establishing sustainable healthcare financing systems, and providing continuous training for emergency medical personnel. Through these efforts, the state translates legal guarantees into real, tangible protection for its citizens.

8. Ultimately, the relationship between the right to life and the right to health cannot be separated from the moral and legal obligation of the state to preserve human dignity. The true measure of a nation's commitment to human rights is reflected in its ability to guarantee that every individual, regardless of social or economic status, can access emergency medical care that safeguards both their health and their life.

3.2 Comparative Legal Analysis of Emergency Medical Regulations in Indonesia and Brazil

Both **Indonesia and Brazil** are signatories to major international human rights instruments that enshrine the right to life and the right to health. These commitments demonstrate both nations' recognition that access to health services, particularly emergency care, is a central element of human dignity and state responsibility. In Indonesia, **Articles 28A and 28H(1)** of the **1945 Constitution** guarantee every person's right to life and to obtain healthcare services. These constitutional provisions establish the normative foundation that positions health as a constitutional right and state obligation. To operationalize these rights, the Indonesian government enacted **Law No. 36/2009 on**

Health and **Law No. 44/2009 on Hospitals**, both of which explicitly require hospitals to provide emergency medical services without discrimination and to prioritize the preservation of human life above administrative or financial considerations.

However, the legal recognition of these rights in Indonesia often contrasts with their practical enforcement. Although the legal framework provides a clear normative obligation, **implementation gaps** persist due to weak institutional oversight, lack of sanctions for non-compliance, and ambiguity between administrative rules and clinical urgency. Hospitals sometimes prioritize procedural requirements—such as proof of insurance or referral documentation—over immediate life-saving interventions. This situation creates a significant disparity between **legal recognition** and **practical realization** of human rights in the medical context.

Meanwhile, **Brazil** adopts a far more **integrated, rights-based, and socially oriented** approach through the **Sistema Único de Saúde (SUS)**, established under the **1988 Federal Constitution, Article 196**, which declares that health is "the right of all and the duty of the state" [29]. The SUS represents one of the world's largest publicly funded healthcare systems, guaranteeing **free and universal access** to medical services, including emergency treatment. It is financed primarily through **national taxation** and managed collaboratively by federal, state, and municipal governments. This multi-level governance structure enables a balance between national policy consistency and local responsiveness to community health needs.

One of the distinctive strengths of the Brazilian system lies in its **Public Emergency Care Units (Unidades de Pronto Atendimento – UPA)**, designed to ensure rapid, accessible, and equitable emergency care responses [30]. These units function as intermediate facilities between primary health centers and hospitals, allowing patients to receive urgent care even before reaching major hospitals. Such an arrangement demonstrates a proactive model of emergency management, where the government anticipates rather than merely reacts to medical crises.

Despite sharing a similar constitutional commitment to the right to health, the **implementation of emergency medical services** in both countries diverges considerably. In Indonesia, **cases of patient rejection** during emergencies—often due to administrative or insurance-related issues—remain recurrent [31]. These incidents reflect systemic weaknesses, including insufficient enforcement of legal obligations, limited government monitoring, and lack of accountability for hospitals that violate patient rights. Such practices are in direct contradiction to Indonesia's constitutional and statutory mandates and undermine public confidence in the healthcare system.

In contrast, **Brazilian law** and jurisprudence treat emergency medical care as a **non-derogable obligation**. Refusing to treat a patient in an emergency is deemed a **constitutional violation** of both the right to life and the right to health, as affirmed by several rulings of the **Brazilian Constitutional Court** [32]. This judicial stance reinforces the principle that the preservation of life overrides administrative or financial constraints. In practice, hospitals in Brazil—whether public or private—are legally bound to provide immediate care in emergencies, with the assurance that reimbursement or administrative matters can be settled subsequently. Such a rights-based legal culture strengthens public trust in the system and operationalizes the moral imperative embedded in human rights law.

Nevertheless, Brazil also faces persistent challenges, including **overcrowding in public hospitals**, **inequitable healthcare distribution in rural regions**, and **budgetary pressures** that sometimes hinder the effectiveness of its universal healthcare model. However, even with these limitations, Brazil's system remains **inclusive**, ensuring that emergency care is delivered regardless of patients' financial or insurance status. This reflects the deep institutionalization of **non-discrimination** and **social solidarity** principles within its legal and health governance framework.

In contrast, Indonesia's healthcare landscape remains fragmented. The coexistence of multiple administrative layers, decentralized governance, and dependency on insurance-based mechanisms has created **inconsistencies between medical necessity and bureaucratic procedure**. Emergency care decisions are often influenced by administrative approval processes rather than clinical urgency,

leading to delays that may cost lives. Moreover, the absence of a strong **legal enforcement and monitoring mechanism** has allowed violations to persist without proportionate consequences.

Through comparative analysis, it becomes evident that **Brazil provides a stronger institutional embodiment** of the human right to health, where the legal and administrative systems converge to prioritize life-saving interventions. The Brazilian model thus serves as a valuable benchmark for countries seeking to build equitable and accountable emergency medical frameworks. Conversely, the Indonesian case illustrates the **complexities of translating constitutional rights into effective public policy** amid bureaucratic inertia and uneven resource distribution.

Learning from Brazil's experience, Indonesia should focus on **three main reform directions**: (1) strengthening legal enforcement mechanisms to ensure compliance by all healthcare providers; (2) integrating healthcare financing systems to minimize administrative delays; and (3) enhancing coordination between **public and private hospitals** to secure continuous and equitable emergency care delivery. Such reforms are essential to bridge the gap between **normative commitments** and **actual implementation**, ultimately fulfilling Indonesia's constitutional promise of the **right to life and health for all citizens**.

3.3 The Importance of Quality and Timeliness in Emergency Medical Services: A Human Rights Perspective

Emergency medical care is the frontline of a healthcare system responsive to life-threatening situations. From a human rights perspective, the speed and quality of such care are not merely technical indicators but moral and legal parameters reflecting how far the state respects, protects, and fulfils the rights of its citizens [33].

Failure to provide timely and adequate emergency care constitutes a violation of both the right to life and the right to health. The quality of emergency care depends on patient safety, availability of competent medical personnel, adequate facilities, and standard operational procedures. In remote Indonesian regions, shortages of doctors, paramedics, and medical equipment often lead to preventable deaths due to delays in triage, diagnosis, or transfer to higher-level hospitals [34].

The concept of the "golden hour" underscores the importance of rapid intervention during the first critical moments following an emergency event such as heart attack, stroke, severe bleeding, or respiratory failure. States must therefore establish responsive emergency protocols, efficient ambulance systems, and well-trained personnel capable of making accurate, time-sensitive decisions [35].

Beyond speed, equity and non-discrimination are equally essential. Emergency care must be available to everyone regardless of socioeconomic status, citizenship, religion, or residence. Discrimination in healthcare—especially against poor or uninsured patients—is explicitly condemned in General Comment No. 14 (2000) of the UN Committee on Economic, Social, and Cultural Rights, which classifies such acts as human rights violations [36]. Studies have shown that systematic neglect of patient rights and unequal service quality at the local level undermine the state's duty to protect human dignity and health.[1]

Indonesia's recurring cases of patient rejection, often due to lack of insurance or referral letters, illustrate systemic inequities. Article 32 of Law No. 36/2009 on Health clearly obligates all hospitals, public and private alike, to provide emergency care to anyone in need. To uphold this mandate, Indonesia must strengthen its emergency response standards, integrated referral systems, and disciplinary sanctions for hospitals proven to have unlawfully denied treatment [37].

Globally, nations with strong emergency healthcare systems—such as Scandinavian countries, Canada, Japan, and Brazil—also rank high in human rights and welfare indices [38]. Investment in emergency medical infrastructure is, therefore, an investment in human dignity [39]. From comparative legal-policy studies of regional health plans and patient-rights complaints data, we see

that incremental improvements in local-level health governance contribute to responsiveness and equity of emergency services [40,41,42].
For Indonesia, reforming emergency medical services should be a national human rights priority. Protecting human rights cannot remain rhetorical—it must translate into concrete policy that safeguards citizens' lives. The inability of a healthcare system to respond adequately to emergencies represents a profound failure of the state's duty to protect life and dignity

4. Conclusion

The right to life and the right to health represent two interrelated and inseparable pillars of human rights protection. These rights demand not only formal recognition within legal frameworks but also tangible realization through inclusive, responsive, and high-quality healthcare systems—particularly in emergency medical contexts. When such systems fail to meet expected standards during critical moments, what is at stake is not only an individual's physical safety but also the essence of human dignity itself. The comparative analysis between Indonesia and Brazil reveals that, although both countries constitutionally acknowledge these fundamental rights, their implementation diverges significantly. Brazil, through its *Sistema Único de Saúde (SUS)*, has demonstrated a more integrated and enforceable model of universal, non-discriminatory emergency healthcare. In contrast, Indonesia continues to face challenges stemming from bureaucratic inefficiency, weak enforcement, and limited access to timely medical care. To ensure the fulfillment of these rights, Indonesia must view emergency medical services not merely as technical obligations but as constitutional and moral imperatives. The speed of response, competence of medical personnel, availability of equipment, and integration of the referral system are crucial indicators of the state's commitment to human rights protection. Comprehensive legal reform, improved health governance, and the internalization of human rights values within the healthcare system are necessary steps toward ensuring that every life is respected, protected, and valued under the law.

Declaration

Ethical Approval and Consent to Participate

This study did not involve human participants, animals, or identifiable personal data; therefore, ethical approval and informed consent were not required in accordance with institutional and national guidelines.

Consent for Publication

Not applicable.

Availability of Data and Materials

All data generated or analyzed during this study are included in this published article and its supplementary materials.

Competing Interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Authors' Contributions

Anna Veronica Pont and Antonius Maria Laot Kian jointly conceptualized the study, conducted the legal analysis, and contributed to writing and editing the manuscript. Both authors read and approved the final version of the manuscript.

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