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Is State Licensure Enough? Evaluating The Gaps And Proposing A Specialized Credentialing Model For Aesthetic Medical Practice In Indonesia

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Abstract: This study examines the weaknesses of the regulatory framework for aesthetic medical practice in Indonesia, which have led to a public health crisis due to malpractice by incompetent practitioners. The objective of this research is to design a specialized credentialing model to ensure patient safety and legal certainty. Using a normative legal research methodology through statutory, comparative, and conceptual approaches, this study analyzes the regulatory systems in Indonesia, Malaysia, and Singapore. The results show that Indonesia, relying solely on general medical licenses (STR and SIP), operates in a regulatory vacuum. In contrast, Malaysia, with its Letter of Credentialing and Privileging (LCP) system, and Singapore, with its Certificate of Competence (COC), have successfully implemented frameworks focused on procedural competency. As a solution, a hybrid model is proposed for Indonesia, the "Aesthetic Competency Certificate", which combines evidence-based risk stratification from Singapore and the renewable privileging mechanism from Malaysia. This model would be managed by a national committee, mandate standardized training, and be supported by a public registry to ensure accountability and protect the public.

Keyword: Credentialing Model, Aesthetic Medicine, Medical License, Aesthetic Medical Practice

INTRODUCTION

Medical aesthetic services are experiencing significant growth, particularly through the rise of aesthetic clinics, which have become essential for individuals seeking such treatments. These clinics are rapidly expanding as providers of cosmetic services. Increasing public awareness among both men and women about the importance of healthy, well-maintained, and problem-free skin has led to aesthetic clinics bringing about not only positive outcomes but also various legal challenges (Lenno Idjianto et al., 2025). Thanks to advancements in modern medicine, beauty treatments are now more widely available. Aesthetic medical procedures, in particular, are seeing rapid development and a surge in popularity (Nikson & Cojocaru, 2025). The rapid pace of innovation and rising consumer demand for aesthetic procedures have placed

considerable pressure on the industry. The significant financial incentives at play are a major factor. Social media's influence has been mixed, as some clinics and doctors have adopted a style more focused on entertainment than on professional medical conduct. This behavior necessitates a careful review of key ethical obligations, such as ensuring patient benefit, avoiding harm, and still upholding patient rights (Qureshi et al., 2025). These trends highlight the complex interplay of medical innovation, market forces, and ethical considerations, underscoring the need for robust regulatory frameworks and a continued emphasis on patient safety and professional integrity within the rapid growing aesthetic industry.

Aesthetic medicine, a highly commercialized and often controversial field, encounters many conflicts, especially in developing nations. The global industry needs stronger legal and oversight frameworks, as well as improved risk management (Deng et al., 2024). Regulations for aesthetic medicine in India, Malaysia, Singapore, South Korea, and Thailand are currently integrated into broader legal frameworks, rather than being governed by specific, dedicated laws (Gopalan, 2024). In Indonesia, there are currently no established laws or regulations that specifically address medical aesthetic services (Yeo, 2023). The practice of aesthetic medicine in Indonesia also currently operates within a general regulatory framework established for all medical services, a system that is proving increasingly inadequate for the unique challenges of this rapidly expanding, consumer-driven field.

Officially, the legal landscape of licensing is defined by a broader law such as Law Number 17 of 2023 Concerning Health, series of ministerial regulations and decisions from the Indonesian Medical Council (Konsil Kedokteran Indonesia - KKI). The Ministry of Health (Kementerian Kesehatan - Kemenkes) governs the operational licensing of healthcare facilities, including clinic that is practicing aesthetic medicine, through risk-based business licensing standards outlined in Regulation of the Minister of Health of the Republic of Indonesia Number 14 of 2021 and its subsequent amendments, such as Regulation of the Minister of Health of the Republic Indonesia Number 17 of 2024. These regulations are there to ensure that clinics meet foundational requirements for infrastructure and operations but do not specify competencies for the aesthetic procedures performed within them. Concurrently, the KKI is responsible for setting the educational and professional standards for all physicians (Prihatiningsih, 2016), as outlined in its general mandate and through the establishment of the Professional Education Standars for Indonesian Doctor, most recently updated via KKI Decree No. 193/KKI/KEP/VIII/2024. While the KKI does approve rigorous, multi year educational standards for relevant specializations like Dermatology and Venereology (KKI Decree No. 147/KKI/KEP/VI/2023) and Plastic, Reconstructive, and Aesthetic Surgery (KKI Regulation No. 75/2020), this creates a clear pathway only for complex surgical procedures, leaving a vast and poorly defined domain of non-surgical and minimally invasive procedures open to general practitioners (Yeo, 2023). This structure, reinforced by Minister of Health's general affirmation that medical acts in clinics must be performed by licensed doctors, establishes a system of implicit permission where a basic state license, Registration Certificate (Surat Tanda Registrasi - STR) and Medical License (Surat Izin Praktik – SIP) in order to provide a medical services in Indonesia (Dirkareshza et al., 2022). Both are the credentials that validates a physician's general qualification but not their specific skill in aesthetic techniques.

The gap in Indonesia's regulatory oversight lies not in a complete absence of law, but in the profound disconnect between the de jure framework of general licensure and the de facto realities of a multidiscipline and high-risk medical field. This is best described as the lack of a procedure-specific competency and credentialing framework, an "unknown" in the current system that this article seeks to address. The consequences of this regulatory vacuum are not theoretical but are manifesting as a severe public health crisis, evidenced by several cases of unsatisfied result and adverse events of aesthetic practices such as blindness caused by filler injection by a general practitioner in Makassar (Khaidir, 2020), death of a patient after

liposuction by general practitioner (Dwi & Muhtarom, 2024) and another case of death after liposuction treatment (Marvela, 2023) which all are a direct result of a mismatch between practitioner qualifications and procedural complexity. The rapid pace of technological innovation in aesthetics, with new lasers, injectables, and energy-based devices entering the market, continuously outpaces the static, generalist nature of the current laws, perpetuating a cycle where patient safety is perpetually at risk.

The rationale for fundamentally reforming Indonesia's approach to aesthetic medicine regulation is rooted in the urgent need to halt the demonstrable and often fatal harm caused by the current system's failures. The purpose of this article is to move beyond identifying the problem and to propose a concrete, evidence-based solution by designing a specialized credentialing model. The "why" is clear from a consistent stream of documented incidents we have previously described. These are not isolated tragedies but predictable outcomes of a system that lacks the tools to differentiate a competent practitioner from an incompetent or illegal one. The "how" is illuminated by the successful regulatory precedents set by Indonesia's neighbors, Malaysia and Singapore, which have developed robust, procedure-focused frameworks, including Malaysia's "Letter of Credentialing and Privileging (LCP)" system and Singapore's "Certificate of Competence (COC)" requirement. Therefore, the central hypothesis of this analysis is that the implementation of a specialized, multi-tiered credentialing system for aesthetic medicine in Indonesia, one that clearly defines the scope of practice, mandates procedure-specific training and competency validation, and creates a transparent national registry of qualified practitioners will significantly reduce the incidence of malpractice, marginalize illegal operators, and elevate patient safety to align with international best practices.

METHOD

This study employs a normative legal research methodology (Negara, 2023). This approach is fundamentally doctrinal, focusing on the law as a system of norms, rules, and principles, or law in books. As defined by legal scholars, normative legal research is a process of discovering and analyzing legal rules, principles, and doctrines to provide a prescriptive answer to a specific legal issue, making it the ideal methodology for evaluating the adequacy of an existing legal framework and proposing a new one. The research utilizes several established approaches within this methodology, including a statute approach, which involves a meticulous examination of all relevant laws, ministerial regulations, and council decisions in Indonesia, Malaysia, and Singapore; a comparative approach, which systematically contrasts the regulatory systems of the three nations to identify strengths, weaknesses, and transferable models; and a conceptual approach to analyze the application of core legal concepts such as "licensure," "competence," and "credentialing" across these jurisdictions.

RESULTS AND DISCUSSION

Indonesia: A System of Ambiguity and Consequence

The Indonesian regulatory framework for aesthetic medicine is not a cohesive system but a patchwork of general health laws that fail to address the specific risks of the field. Regulations such as Regulation of the Minister of Health of the Republic of Indonesia Number 14 of 2021 and its 2024 amendment govern the licensing of clinics based on a general risk assessment but contain no specific provisions for credentialing the aesthetic procedures performed within them. The Indonesian Medical Council (KKI) defines the educational pathways for formal specializations like dermatology and plastic surgery, but this leaves a vast, unregulated gray area for the multitude of non-invasive and minimally invasive procedures that are increasingly performed by general practitioners. This legal ambiguity creates a dangerous environment

where a basic medical license is perceived as a blanket authorization to perform any aesthetic procedure, regardless of specific training or competence.

This systemic failure in regulatory design is the direct cause of a public health crisis. The legal vacuum has enabled a shadow economy of unqualified and illegal practitioners to flourish, leading to a horrifying series of preventable injuries and deaths. News reports and police investigations document a recurring pattern of fatal filler injections performed by non-doctors in makeshift settings like salons and hotel rooms (Fika & Trianita, 2024). This crisis is compounded by the widespread circulation of illegal and dangerous cosmetic products, with the Food and Drug Supervisory Agency (BPOM) conducting frequent raids on illegal manufacturing facilities and clinics, seizing millions of dollars worth of unregistered goods that often contain banned substances. These incidents are not mere anecdotes but the predictable and tragic outcomes of a regulatory model that is fundamentally unfit for its purpose.

Malaysia: A Model of Centralized Credentialing and Privileging

In contrast, Malaysia has moved decisively beyond general licensure by implementing a specific and robust regulatory system. The foundation of this system is the "Guidelines on Aesthetic Medical Practice," a comprehensive document developed by the Ministry of Health in collaboration with professional bodies. These guidelines explicitly recognize aesthetic medicine as a distinct "area of interest" rather than a formal specialty, creating a clear and regulated pathway for qualified practitioners, including general practitioners, to engage in the field.

The cornerstone of the Malaysian model is the Letter of Credentialing and Privileging (LCP). The LCP is a mandatory secondary credential that a physician must obtain for specific aesthetic procedures they wish to perform. This process is not a mere formality; it is managed by a Main Credentialing and Privileging Committee, which assesses each applicant's training, experience, and competence, ensuring a standardized, national-level evaluation. This creates an unambiguous distinction between holding a basic medical license and being privileged to perform a specific aesthetic act. To ensure public transparency and accountability, the government maintains a National Registry of all LCP holders and the procedures they are credentialed to perform. Furthermore, the guidelines clearly classify procedures into non-invasive, minimally invasive, and invasive categories, defining which levels of practitioners are eligible to perform them, contingent upon obtaining the relevant LCP, thereby establishing a clear and enforceable scope of practice for all.

Singapore: A Model of Risk Stratification and Competency Certification

Singapore has adopted an equally sophisticated, albeit structurally different, approach centered on risk stratification and verifiable competency. The system is governed by the Singapore Medical Council's (SMC) "Guidelines on Aesthetic Practices for Doctors," which are enforced by a dedicated Aesthetic Practice Oversight Committee. Like Malaysia, Singapore defines aesthetics as an "area of practice," not a formal specialty, and explicitly prohibits the use of potentially misleading titles such as "aesthetic physician" to prevent public confusion.

The Singaporean model is built on a foundation of risk stratification. Approved procedures are administratively classified into Table 1, which lists procedures that may be performed by general practitioners and other non-core specialists, and Table 2, which lists more complex procedures reserved for designated specialists like dermatologists and plastic surgeons. To perform any procedure listed in Table 1, a doctor must either provide evidence of prior experience or, crucially, obtain a Certificate of Competence (COC). The COC is awarded only after the successful completion of a standardized, SMC-accredited training course that includes both theoretical and practical components, ensuring a baseline, verifiable level of skill

for each procedure. Reinforcing its commitment to patient safety and evidence-based medicine, the SMC further classifies procedures into List A (well-established, scientifically proven treatments) and List B (procedures with low or unproven evidence that may only be performed within a formal research framework). This prevents the premature commercialization of experimental or unproven treatments and protects patients from potential harm.

The juxtaposition of Indonesia's regulatory framework against those of Malaysia and Singapore reveals a fundamental philosophical divide with life-or-death consequences. While Indonesia clings to an outdated, binary model of qualification (specialist versus general practitioner), its neighbors have embraced a modern, procedure-centric philosophy that prioritizes demonstrated competency.

The Contrast: A Comparative Analysis

The profound differences in regulatory approach and maturity among the three nations are most clearly illustrated through a direct comparison of their key systemic components. The following table distills the complex findings into a clear, comparative summary, highlighting the structural deficiencies in Indonesia's framework.

This comparison makes the central issue irrefutably clear: Indonesia lacks the specialized regulatory architecture necessary to manage the risks of aesthetic medicine. While Malaysia and Singapore have built dedicated systems with specific guidelines, credentialing mechanisms, and oversight bodies, Indonesia relies on a generalist framework that leaves both practitioners and the public in a state of dangerous ambiguity.

Table 1. Comparison of the regulatory parameters in aesthetic medicine (Indonesia, Malaysia, Singapore)

Regulatory Parameter	Indonesia	Malaysia	Singapore
Governing Authority	Ministry of Health (Kemenkes), Indonesian Medical Council (KKI)	Ministry of Health, Malaysian Medical Council (MMC)	Singapore Medical Council (SMC), Ministry of Health (MOH)
Primary Regulatory Document	General regulations (e.g., Permenkes No. 17/2024); No specific aesthetic guideline	"Guidelines on Aesthetic Medical Practice"	"Guidelines on Aesthetic Practices for Doctors"
Legal Status of Aesthetics	Undefined; implicitly covered under general medical practice	"Area of Interest" (not a specialty)	"Area of Practice" (not a specialty)
Practitioner Credentialing Mechanism	Basic state licensure (STR/SIP) only; no procedure-specific credentialing	Letter of Credentialing & Privileging (LCP): Mandatory, renewable, procedure-specific credential	Certificate of Competence (COC): Mandatory, procedure-specific certification via accredited courses
Procedure Classification	None; no official classification of aesthetic procedures	Classified as Non-Invasive, Minimally Invasive, and Invasive	Classified by practitioner type (Table 1/2) and evidence level (List A/B)
Oversight Body	No dedicated body for aesthetic medicine	Main Credentialing and Privileging Committee	Aesthetic Practice Oversight Committee
Public Transparency	No public registry of competent practitioners	National Registry of LCP Holders	Publicly available guidelines and lists of accredited COC courses

The Core Philosophical Divide and Its Consequences

The fundamental failure of the Indonesian system stems from its reliance on a qualification-based paradigm (a doctor is either a general practitioner or a specialist) to regulate

a field that is inherently procedure-based and multidisciplinary. Aesthetic medicine involves a discrete set of technical skills such as injecting fillers, operating a laser, performing a chemical peel that are not exclusive to any single traditional specialty and are not covered in basic medical training. Malaysia and Singapore have recognized this reality and have shifted their regulatory philosophy accordingly. Their systems are not primarily concerned with a doctor's title but with a more critical question: have you been specifically trained, assessed, and deemed competent to perform this particular procedure?

This philosophical shift has profound practical consequences. By creating a legitimate, regulated, and achievable pathway for general practitioners to gain competency and credentials through Malaysia's LCP and Singapore's COC, these countries strengthen the formal medical sector. Competent doctors are empowered to offer these services safely and ethically, providing patients with reliable and accountable options. This, in turn, systematically marginalizes the black market. In Indonesia, the absence of such a pathway creates a vacuum that illegal operators are only too eager to fill. With no clear standard of care and no easy way for the public to verify a practitioner's specific skills, unqualified individuals can mimic the services of real doctors, leading directly to the tragic outcomes documented in the news and court records. The crisis in Indonesia is therefore not simply a problem of enforcement but a problem of design; the system itself inadvertently fosters the conditions for the black market to thrive.

Designing the Indonesian Solution: A Hybrid Model

Indonesia does not need to reinvent the wheel, nor does it need to copy one model wholesale. It is in the advantageous position of being able to learn from its neighbors to create a superior, contextually appropriate hybrid system that combines the strongest elements of both the Malaysian and Singaporean approaches.

First, Indonesia should adopt Singapore's framework of risk and evidence-based stratification. The classification of procedures into lists based on their evidence base (List A for established treatments, List B for experimental ones) is a critical patient safety measure that would prevent the proliferation of unproven and potentially dangerous treatments in the Indonesian market. This scientific rigor provides a strong foundation for any regulatory system.

Second, upon this foundation, Indonesia should implement a credentialing mechanism inspired by Malaysia's Letter of Credentialing and Privileging (LCP). While Singapore's COC is effective, it is largely a one-time certification obtained after a course. Given the documented history of widespread malpractice and the challenges of regulatory enforcement in Indonesia, the Malaysian concept of a renewable "privilege" to practice is arguably more robust and suitable. A renewable credential, contingent upon ongoing professional development and a clean disciplinary record, establishes a system of continuous oversight. It reframes aesthetic practice not as a right conferred by a one-time certificate, but as a privilege that must be continuously earned and can be revoked, providing a much stronger tool for discipline and quality control. This hybrid model—using Singapore's risk classification as the base and Malaysia's privileging system as the mechanism—would provide Indonesia with a comprehensive, defensible, and powerful framework for ensuring aesthetic safety.

State licensure alone is a demonstrably insufficient and dangerous paradigm for regulating the high-stakes field of aesthetic medicine in Indonesia. The current fragmented legal framework has created a regulatory vacuum, which has been filled by a increasing black market of illegal operators and unregistered products, resulting in a public health crisis characterized by widespread malpractice, severe patient injury, and preventable deaths. In contrast, the purpose-built, procedure-focused credentialing systems established in Malaysia and Singapore provide proven, effective models for ensuring patient safety and professional accountability. This article concludes by formally proposing the creation of a specialized

credentialing system for Indonesia, the "Sertifikat Kompetensi Estetika" (SKE), which synthesizes the best practices from these regional precedents into a robust framework tailored to the Indonesian context.

The proposed SKE, or Aesthetic Competency Certificate, would be a mandatory prerequisite for any doctor whether its general practitioner or specialist wishing to perform designated aesthetic procedures. It would not replace the existing STR and SIP but would serve as an essential secondary credential verifying procedure-specific competence. The SKE system would be built upon the following key features:

a. Centralized Oversight: The system would be administered by a newly established National Committee for Aesthetic Medicine Safety (Komite Nasional Keselamatan Kedokteran Estetika - KNKEA). This would be a joint body operating under the authority of the Indonesian Medical Council (KKI) and the Ministry of Health, ensuring collaboration between the body that sets professional standards and the body that regulates health services.
b. Tiered and Procedure-Specific Credentialing: Adopting Singapore's risk-based approach, the SKE would be granted for specific tiers of procedures (e.g., Tier 1: Non-invasive procedures like superficial chemical peels; Tier 2: Minimally Invasive Injectables like botulinum toxin and dermal fillers; Tier 3: Minimally Invasive Energy-Based Devices like lasers and radiofrequency). A doctor would need to obtain a separate SKE for each tier or specific high-risk procedure they wish to perform.
c. Mandatory Standardized Training: To obtain an SKE, a physician would be required to complete a standardized, KNKEA-accredited training program for that specific tier. This training must include comprehensive theoretical knowledge, a logbook of a required number of supervised hands-on procedures, and successful completion of both written and practical competency examinations.
d. Renewable Privilege: Reflecting the robust "privileging" philosophy of the Malaysian LCP model, the SKE would be a renewable credential, valid for a period of three to five years. Renewal would be contingent upon the practitioner demonstrating completion of required continuing professional development (CPD) in aesthetic medicine and maintaining a clean disciplinary record with the KKI. This ensures that competence is not a one-time event but an ongoing commitment.
e. Public National Registry: The KKI would develop, host, and maintain a public, searchable online national registry of all SKE holders. This registry would clearly list each doctor's name, their primary qualification, and the specific aesthetic procedures or tiers of procedures they are currently credentialed to perform, along with the SKE's expiry date. This transparency empowers patients to make informed choices and verify the credentials of their provider.

CONCLUSION

Based on the analysis of Indonesia's regulatory failures and the successful models in Malaysia and Singapore, it is concluded that reliance on a general medical license is no longer adequate for regulating the complex and high-risk field of aesthetic medicine. To address the problem of the lack of a procedure-specific competency and credentialing framework, this study recommends the establishment of an "Aesthetic Competency Certificate" (SKE) system. This system directly answers the research objective by creating a mandatory secondary credentialing mechanism for any doctor wishing to perform aesthetic procedures. The implementation of the SKE would be a significant advancement for medical science and health systems engineering in Indonesia by introducing a competency-centered regulatory paradigm. This system establishes clear training standards, an objective evaluation process, and continuous oversight through renewal requirements, effectively separating competent practitioners from incompetent ones. Furthermore, by creating a publicly accessible national

registry, the system empowers patients to make informed decisions, thereby fundamentally enhancing patient safety and reducing incidents of malpractice and illegal practice.

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