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Drug Price Transparency after Minister of Health Regulation No. 5 of 2026: Reconstructing Information Duties in Indonesian Health Law

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Abstract: Drug price transparency links the right to health, consumer protection, and pharmaceutical governance in Indonesia. Earlier studies mainly examined affordability, procurement, and compliance under the former maximum retail price regime, leaving the legal consequences of Minister of Health Regulation No. 5 of 2026 underexplored. This study analyzes the current legal construction and develops an implementable information-duty model. Normative legal research is conducted through statutory and conceptual approaches, legal synchronization, and grammatical, systematic, and teleological interpretation. The 2026 regulation strengthens transparency through broader obligated parties, integrated digital reporting, monitoring, complaints, and administrative sanctions. Regulatory reporting, however, must be distinguished from public disclosure and reconciled with trade-secret and personal-data protection. The study's novelty is a layered model separating mandatory public information, regulator-accessible information, and legally protected information within the limits of delegated regulatory authority.

Keywords: Drug Price Transparency, Health Law, Consumer Protection, Trade Secrets, Personal Data Protection

Abstrak: *Transparansi harga obat menghubungkan hak atas kesehatan, perlindungan konsumen, dan tata kelola kefarmasian. Kajian terdahulu berfokus pada keterjangkauan, pengadaan, dan kepatuhan rezim Harga Eceran Tertinggi sehingga konsekuensi hukum Peraturan Menteri Kesehatan Nomor 5 Tahun 2026 belum banyak dikaji. Penelitian ini menganalisis konstruksi hukum dan merumuskan model kewajiban informasi melalui penelitian hukum normatif, pendekatan peraturan perundang-undangan dan konseptual, sinkronisasi hukum, serta interpretasi gramatikal, sistematis, dan teleologis. Hasil menunjukkan bahwa regulasi tahun 2026 memperkuat transparansi melalui perluasan subjek wajib, pelaporan digital, pengawasan, pengaduan, dan sanksi administratif. Pelaporan kepada regulator harus dibedakan dari keterbukaan publik serta diselaraskan dengan rahasia dagang dan data pribadi. Kebaruannya adalah model transparansi berlapis yang memisahkan informasi publik, informasi regulator, dan informasi yang dilindungi hukum dalam batas delegasi kewenangan.*

Kata Kunci: *Transparansi Harga Obat, Hukum Kesehatan, Perlindungan Konsumen, Rahasia Dagang, Pelindungan Data Pribadi*

INTRODUCTION

The right to health in Indonesian law extends beyond access to medical treatment. It also requires a legal environment in which health services and essential health supplies are accessible, safe, of adequate quality, and reasonably affordable. Article 28H paragraph (1) of the 1945 Constitution of the Republic of Indonesia recognizes the right to obtain health services, while Article 28F protects the right to communicate and obtain information. Read together, these constitutional guarantees support the proposition that information materially affecting a person's ability to obtain health services cannot be treated solely as a private commercial matter. In the pharmaceutical context, price is material information because it influences whether patients can purchase prescribed medicines, compare lawful alternatives, anticipate out-of-pocket expenditure, and make informed decisions before a transaction occurs. This connection between information and access is also consistent with the broader understanding of health law as a field that structures rights, obligations, professional responsibilities, and state intervention in order to protect patients and public health (Mannas & Elvandari, 2023).

Law No. 17 of 2023 on Health strengthens this relationship between access to information, affordability, and government responsibility. Article 4 paragraph (1) recognizes the right to balanced and responsible health information and to safe, quality, and affordable health services. At the governance level, Article 314 places responsibility on the Central Government and Regional Governments for the availability, equitable distribution, and affordability of Health Supplies, while Article 318 authorizes the Central Government to regulate and control prices, particularly for medicines and medical devices. Government Regulation No. 28 of 2024 further operationalizes this statutory mandate. The resulting legal structure makes drug-price transparency more than a consumer-choice mechanism: it is also an instrument through which public authorities can supervise pricing, identify unreasonable price formation, and support the statutory objective of affordability.

Empirical evidence illustrates why this legal issue is consequential. Pisani et al. (2023) documented wide price variation among cardiovascular and diabetes medicines in East Java, even where products served similar therapeutic indications. A larger Indonesian survey by Maria et al. (2025) also found substantial variation in medicine prices and showed that higher prices were not consistently associated with better quality. More recently, Rahmawati et al. (2025) examined compliance with official medicine-pricing policies in Indonesia and demonstrated that the existence of a formal pricing rule does not automatically produce equivalent compliance in practice. These findings are legally significant because price regulation can only protect patients if regulated information is visible, current, comparable, and sufficiently reliable to be used at the point at which purchasing decisions are made.

Public procurement illustrates both the effect and the limits of regulatory intervention. Anggriani et al. (2020) found that pharmaceutical policy reforms and the national e-catalogue were associated with lower procurement prices for many medicines under Indonesia's social health insurance system. Yet a public procurement price is not necessarily the acquisition price of a health facility or the final price paid by a patient. Procurement transparency strengthens accountability but does not by itself eliminate information asymmetry at pharmacies, hospitals, clinics, or other points of service.

Before 2026, the regulation most directly associated with medicine-price information was Minister of Health Regulation No. 98 of 2015 on the Provision of Information on the Maximum Retail Price of Medicines. Its regulatory design centered on the Maximum Retail

Price and its presentation on medicine labeling. The model was important because it supplied a visible price reference, but it largely operated through static labeling and did not create a broad, integrated data architecture connecting producers, distributors, health-care facilities, government authorities, and patients. The legal landscape changed when Minister of Health Regulation No. 5 of 2026 on Health Supplies entered into force on 4 May 2026 and expressly revoked the 2015 regulation. The new regulation situates transparency within a wider price-control framework and combines it with digital reporting, price formulas, monitoring, complaints, and administrative enforcement.

Article 108 of Minister of Health Regulation No. 5 of 2026 is central to that transition. It states that price transparency is intended to provide the public with correct, clear, and honest information on Health Supply prices. Producers, distributors, health-care facilities, and other facilities are required to submit price information transparently. Significantly, the regulated information includes discounts or other incentives provided to medical personnel, health workers, health-care facilities, other facilities, professional organizations, and institutions. The information is submitted through a Health Information System integrated with the National Health Information System, or through another health information system or medium where integration is not yet available. This changes the regulatory logic from a predominantly label-based disclosure mechanism toward an information-flow regime that can support continuous supervision and price governance.

The change, however, creates a new doctrinal problem. A duty to submit information to a government information system is not necessarily identical to a duty to publish every submitted data element to the public. Article 108 simultaneously expresses a public-facing purpose and a regulatory-reporting mechanism. Without further classification, the system may produce two opposite risks. First, compliance may be reduced to reporting data to a regulator without providing information that patients can actually use. Second, an overly broad interpretation of public transparency may expose commercial or personal information that is not necessary for patients to understand medicine prices. The legal question is therefore not whether transparency is desirable, but how the scope, audience, timing, and form of disclosure should be constructed within the existing hierarchy of laws.

This problem is reinforced by consumer-protection law. Article 4 letter c of Law No. 8 of 1999 on Consumer Protection gives consumers the right to correct, clear, and honest information regarding goods and services, while Article 7 letter b imposes a corresponding obligation on business actors. Research on consumer information similarly indicates that transparency must be usable rather than merely formal. Ahmad et al. (2021), examining medicine-price transparency in a private health-care setting, found that consumer knowledge and practices affect the ability to benefit from price information. Director (2023) argues that price can be material to meaningful health-care decision-making, while Popovich and Frias (2023) show that price-transparency legislation should be assessed not only by disclosure mandates but also by its effects on consumer welfare. In the digital context, Indonesian legal scholarship has likewise emphasized that accuracy and accountability remain central when information is delivered through technological systems (Putra et al., 2023) and that electronic consumer transactions require a clear allocation of legal responsibility (Shidarta, 2023).

International evidence cautions against treating disclosure as self-executing. Joosse et al. (2023) found that transparency policies depend on institutional design, data quality, and market responses. Russo et al. (2021) identified continuing tension between public transparency and confidential pharmaceutical agreements. Araich et al. (2023) and Wang et al. (2025) likewise report differences in scope, compliance, comparability, and usability across health-price transparency regimes. Feng (2025) shows that disclosure can alter bargaining incentives and patient behavior. These findings support the World Health Assembly's

transparency agenda while confirming that national law must define what is disclosed, to whom, and for what purpose.

Indonesian legal scholarship supplies related but still fragmented elements. Amiati et al. (2024) identify ambiguities arising from Indonesia's health-law restructuring. Shahrullah et al. (2024), Triyanti et al. (2025), and Priliasari (2023) emphasize coherent personal-data governance and privacy protection. Shalmont et al. (2023) shows that responsibility in health-product circulation should follow the functions of actors along the transaction chain, while Lubis (2026) argues that consumer complaints should operate as early corrective mechanisms. These studies do not yet integrate those concerns into the post-2026 medicine-price transparency regime.

The state of the art therefore reveals a specific gap. Pharmaceutical studies address affordability, price variation, procurement, quality, and compliance; international literature evaluates transparency policy; and Indonesian legal studies treat health-law reform, consumer information, complaints, digital transactions, and personal-data protection largely as separate issues. Insufficient attention has been given to the legal construction created by Minister of Health Regulation No. 5 of 2026 when these fields are read together, including the limits of ministerial technical guidance.

The novelty of this study lies in reconstructing that relationship through a layered transparency model. The study first distinguishes the law currently in force, or *de lege lata*, from the implementation architecture proposed as *de lege ferenda*. It then separates three categories of information: information that should be publicly accessible because it is necessary for patients to understand the applicable price; information that must be available to regulators for auditing, calculation, supervision, or enforcement but need not be fully public; and information that remains legally protected because it constitutes a trade secret or personal data unrelated to the public transparency objective. Based on this gap and novelty, the study addresses two questions: (1) how is drug-price transparency legally constructed in Indonesia after the enactment of Minister of Health Regulation No. 5 of 2026; and (2) what implementation design is required so that transparency provides legal certainty, patient protection, accountability, and proportionate protection of legitimate commercial and personal interests?

METHODS

This study uses normative legal research, which treats legislation, legal principles, legal concepts, and legal doctrine as the primary objects of analysis. Normative legal research is appropriate when the research problem concerns the meaning, coherence, hierarchy, and implementation of legal norms rather than the statistical behavior of a sampled population (Marzuki, 2021; Irwansyah, 2021). The study therefore does not use respondents or a quantitative sample. Its research object is the legal framework governing drug-price transparency in Indonesia as in force through September 2026.

The study combines a statutory approach and a conceptual approach. The statutory approach examines the 1945 Constitution, Law No. 8 of 1999 on Consumer Protection, Law No. 30 of 2000 on Trade Secrets, Law No. 14 of 2008 on Public Information Disclosure, Law No. 12 of 2011 on Law-Making as amended by Law No. 13 of 2022 and further adjusted through Article V of Law No. 1 of 2026 on Criminal Adjustment, Law No. 27 of 2022 on Personal Data Protection, Law No. 17 of 2023 on Health, Government Regulation No. 28 of 2024, Minister of Health Regulation No. 98 of 2015, and Minister of Health Regulation No. 5 of 2026. The conceptual approach examines the concepts of information rights, regulatory transparency, legal certainty, proportionality, consumer protection, trade secrets, personal-data protection, and delegated administrative authority.

Primary legal materials were read through vertical and horizontal synchronization. Vertical synchronization assesses consistency between constitutional norms, statutes, government regulations, and ministerial regulations. Horizontal synchronization examines the interaction of health law with consumer-protection law, public-information law, trade-secret law, and personal-data protection. Secondary materials consist of recent national and international peer-reviewed journal articles, legal-research books, health-law literature, and World Health Organization materials concerning pharmaceutical-price transparency. The secondary materials were selected for their relevance to the legal issues, methodological quality, and contribution to contemporary debates on price transparency, consumer information, and data governance.

The legal analysis is prescriptive and employs grammatical, systematic, and teleological interpretation. Grammatical interpretation is used particularly to examine the relationship between the requirement to submit information and the stated purpose of providing correct, clear, and honest information to the public in Article 108. Systematic interpretation connects those obligations with consumer information rights, price-control authority, public-information rules, trade-secret protection, personal-data protection, complaints, and administrative sanctions. Teleological interpretation assesses whether the implementation design advances affordability, reasonable pricing, accountability, and patient protection without exceeding the scope of delegated authority. The results are then formulated as a normative implementation model that distinguishes existing positive law from recommendations for technical guidance under Article 112 of Minister of Health Regulation No. 5 of 2026.

RESULTS AND DISCUSSION

The Legal Shift in Drug Price Transparency After Minister of Health Regulation No. 5 of 2026

The first research question concerns the legal construction of drug-price transparency after the 2026 regulatory change. The starting point is the hierarchy of norms. At the constitutional level, Article 28H paragraph (1) gives normative direction to the fulfillment of health rights, while Article 28F protects access to information. These provisions do not themselves specify the categories of price data, reporting formats, or obligated private actors. Their function is constitutional orientation. More specific duties must therefore be traced through statutes and valid implementing regulations. This distinction is important because direct obligations imposed on businesses require a legal basis that is sufficiently clear and within the competence of the rule-maker.

Law No. 17 of 2023 provides the sector-specific foundation. Article 314 assigns responsibility for the availability, distribution, and affordability of Health Supplies, and Article 318 expressly authorizes the Central Government to regulate and control Health Supply prices, especially medicines and medical devices. Government Regulation No. 28 of 2024 develops this mandate. Article 913 directs price-control policy toward obtaining reasonable prices for the public, industry, and government, while Article 915 provides a basis for further ministerial regulation concerning the management of Health Supplies. Within this structure, Minister of Health Regulation No. 5 of 2026 is an implementing regulation. It must be interpreted consistently with the purpose, scope, and substantive limits of the superior legal instruments.

Consumer-protection law supplies a second normative layer. The expression “correct, clear, and honest” used in Article 108 paragraph (1) of the 2026 regulation closely corresponds to the consumer-information standard in Law No. 8 of 1999. This similarity is legally meaningful. It indicates that medicine-price information is not solely a data input for administrative supervision. At the patient-facing level, the information is part of the quality of the consumer relationship. Shidarta (2023) explains that electronic consumer transactions

require legal certainty as to when obligations and rights arise, while Putra et al. (2023) demonstrate the continuing relevance of information accuracy and legal protection in technology-mediated services. In a digital price-transparency system, those considerations support a design in which data accuracy, update history, and responsibility for correction are legally attributable rather than technically anonymous.

Public-information law has a more limited but still important role. Law No. 14 of 2008 concerns information produced, stored, managed, sent, or received by public bodies and defines public bodies according to public functions and funding. It cannot therefore be treated as a blanket legal basis requiring every private pharmaceutical company to publish its entire cost structure or commercial arrangements. Its relevance is strongest for information held by public authorities, public procurement using state funds, policy decisions, public contracts to the extent they fall within the statutory disclosure regime, and other records legally controlled by public bodies. For private producers and distributors, the direct obligation to submit price information arises from the sectoral regulation and consumer-protection law, not from a generalized extension of the Public Information Disclosure Law.

The shift from Minister of Health Regulation No. 98 of 2015 to Minister of Health Regulation No. 5 of 2026 appears in regulatory orientation, obligated actors, information objects, and enforcement. The former regime centered on Maximum Retail Price information and labeling. The new regime retains an upper price boundary but embeds it in wider price regulation and control. Article 106 combines consolidation, transparency, and the highest selling-price formula, expanding static labeling into reporting, digital integration, monitoring, and administrative enforcement.

Table 1. Main Differences between the 2015 and 2026 Drug-Price Transparency Regimes

Aspect	Minister of Health Regulation No. 98 of 2015	Minister of Health Regulation No. 5 of 2026
Regulatory orientation	Provision of Maximum Retail Price information, primarily through medicine labeling.	Price regulation and control through consolidation, transparency, and a highest selling-price formula.
Obligated actors	Obligations were structured around the former maximum retail price and labeling chain.	Producers, distributors, health-care facilities, and other facilities are expressly required to submit price information.
Information object	Maximum Retail Price.	Price information, including discounts or incentives; highest selling-price limits and relevant price changes.
Information channel	Labeling and other mechanisms for communicating the Maximum Retail Price.	Integrated Health Information System, other media when integration is unavailable, and medicine labeling for specified information.
Monitoring and complaints	Did not establish an integrated digital price-governance architecture comparable to the 2026 regime.	Monitoring and evaluation, public reports, complaints, central/regional supervision, and an ad hoc panel process.
Administrative enforcement	The former regulation did not construct the same range of explicit administrative enforcement for the new transparency duties.	Specified failures to submit price information or display the highest selling-price limit may trigger administrative sanctions under Article 117.

Source: Authors' analysis of Minister of Health Regulation No. 98 of 2015 and Minister of Health Regulation No. 5 of 2026.

Article 108 paragraph (2) clarifies responsibility by identifying producers, distributors, health-care facilities, and other facilities as obligated actors. The rule follows the product from production to the point of service, reducing fragmentation when prices change along the supply chain. This is consistent with Shalmont et al. (2023), who emphasize functional responsibility

in health-product circulation. The category of "other facilities," however, still requires operational clarification to avoid inconsistent application.

Article 108 paragraph (3) broadens the information object to include specified discounts and incentives. This matters because a list price may not reveal the facility's actual acquisition basis. Article 109 makes such discounts legally relevant to the highest selling-price calculation. Yet the fact that transaction details are relevant to regulatory calculation does not mean that every detail must automatically be made public.

Article 110 connects the pricing regime with an integrated digital architecture. Pharmaceutical industries and production facilities that manufacture medicines are required to submit the highest selling-price limit through the Health Information System integrated with the National Health Information System and to place specified information on labeling. Changes must also be reported through the system. This mechanism preserves the visibility function of labeling while enabling faster updating and regulatory analysis. It is particularly relevant in light of empirical findings that formal rules can coexist with gaps in actual compliance. Rahmawati et al. (2025) demonstrate that official pricing policies require verification of implementation rather than reliance on the mere existence of the rule. A digital reporting trail can therefore support auditability if it records the submitting actor, time of submission, effective date, and change history.

The distinction between reporting and public accessibility follows directly from this architecture. An information system can operate as a regulator-only data repository, a public database, or a layered combination of both. Article 108 paragraph (1) establishes the public purpose of correct, clear, and honest information, while the subsequent provisions identify reporting channels and data elements. Technical guidance must connect those two levels. If all reported data remain inaccessible to patients, compliance may become an administrative exercise that does not reduce information asymmetry. Conversely, if every data element is automatically published, the system may disclose information beyond what is necessary for the public purpose. The legal solution is therefore classification rather than an all-or-nothing approach.

The enforcement architecture is also stronger. Article 111 authorizes monitoring and evaluation and allows public reporting of non-conforming price information. Article 117 treats specified failures, including non-submission of required price information and failure to state the highest selling-price limit on labeling, as administrative violations. Articles 119 to 121 provide a complaint route for individuals, groups, and institutions, protect complainant identity, and provide follow-up through an ad hoc panel. Transparency would be ineffective if inaccurate information could be identified but not corrected through an accessible procedure.

The transitional provision must also shape legal assessment. Article 122 allows up to one year from promulgation for existing arrangements concerning Health Supplies to adjust. Because the regulation was promulgated on 4 May 2026, the adjustment period runs no later than 4 May 2027. In September 2026, the regulatory system is therefore still in an implementation phase. This timing is important methodologically and legally. It would be premature to evaluate the regime solely through final compliance outcomes. A more appropriate assessment concerns whether technical standards, information systems, role allocation, public interfaces, verification mechanisms, complaint channels, and enforcement procedures are sufficiently developed to make the new duties operational by the end of the transition.

The first research question can thus be answered as follows: Indonesia now has a positive-law basis for drug-price transparency that is substantially broader than the former Maximum Retail Price regime. The legal chain begins with constitutional rights and statutory price-control authority, is operationalized through Government Regulation No. 28 of 2024, and is specified in Minister of Health Regulation No. 5 of 2026. The regime expressly identifies

obligated actors, integrates discounts and incentives into price governance, uses a digital reporting system, preserves labeling, establishes monitoring and complaint mechanisms, and links non-compliance to administrative sanctions. The remaining legal issue is no longer whether transparency has a normative basis, but how the content and audiences of disclosure should be structured so that the regime functions consistently with other branches of Indonesian law.

Reconstructing Information Duties: Public Access, Trade Secrets, and Personal Data

The second research question concerns the implementation design required to convert the new transparency duty into an effective and legally proportionate information architecture. The first requirement is to distinguish a reporting duty from a public-access right. A regulator may legitimately require detailed transaction data to calculate acquisition prices, audit discounts, verify incentives, or detect non-compliance. Patients, however, usually require a narrower set of information to understand the price they may lawfully be charged. The legal design should therefore identify a public minimum rather than equate transparency with unrestricted publication of the entire regulatory database.

A public minimum should contain information that is directly useful before a medicine is purchased: the medicine's identity, dosage form and strength, producer, applicable highest selling-price limit, the facility price where such publication is required, the effective or last-updated date, and an accessible complaint channel. Where reliable and legally appropriate, contextual information such as coverage under the National Health Insurance system or the availability of generic alternatives may also be linked. The central principle is usability. Ahmad et al. (2021) demonstrate that consumers' knowledge and practices shape whether they can benefit from medicine-price transparency. Director (2023) similarly argues that cost information can be material to informed health-care decision-making. These findings support public disclosure before, not merely after, the transaction.

The second requirement is a layered classification of information. This study proposes three layers. The first is mandatory public information: data needed by patients to understand the applicable price and to challenge an apparent discrepancy. The second is mandatory regulatory information: detailed acquisition prices, discounts, incentives, transaction data, and supporting records required for calculation, audit, conflict-of-interest assessment, supervision, or enforcement. These data must be available to competent authorities but may be restricted, aggregated, or redacted when full public disclosure is unnecessary. The third is legally protected information: commercial or personal data that fall within another statutory protection regime and are not necessary to achieve the public-facing transparency purpose.

Trade-secret law illustrates why such differentiation is necessary. Law No. 30 of 2000 protects information in technology or business that is not generally known, has economic value because of its secrecy, and is subject to reasonable efforts to maintain secrecy. Article 15 letter a provides an exception where disclosure or use is based on defense, security, health, or public-safety interests. The exception prevents a trade-secret claim from being used as an absolute shield against a valid regulatory reporting requirement for public-health purposes. It does not, however, mean that every confidential commercial detail must be published on a public portal. Proportionality remains essential. The regulator may need itemized transaction data to verify the acquisition-price formula, while the patient may only need the resulting lawful price boundary and sufficient information to understand whether the facility's price is compliant.

This interpretation also addresses the international tension between negotiated confidentiality and transparency. Russo et al. (2021) show that European medicine markets continue to use confidential managed-entry arrangements even while governments seek greater price transparency. The World Health Assembly (2019) called on member states to improve transparency of markets for medicines, vaccines, and other health products, while the World

Health Organization Regional Office for Europe (2022) notes that the degree of disclosure varies by legal system and by the type of price information involved. These materials support a legal architecture that distinguishes list prices, net prices, procurement prices, and other cost components instead of assuming that all price concepts are interchangeable.

The third requirement is personal-data protection. A medicine name, producer, public price limit, or facility price is not inherently personal data. The issue arises when the system contains patient or complainant identities, transaction records, health-service information, or other data identifying a person. Law No. 27 of 2022 treats health data and information as specific personal data and requires lawful, secure processing.

Indonesian legal scholarship reinforces the need for this distinction. Shahrullah et al. (2024) emphasize the relationship between personal-data legislation and the fulfillment of privacy rights, while Triyanti et al. (2025) identify continuing legal gaps that require institutional and regulatory coherence. Priliasari (2023) shows that personal-data protection is particularly important in consumer transactions where digital systems collect information beyond what consumers may anticipate. In a medicine-price complaint system, a patient may submit a receipt, prescription, health-facility identity, and personal details. The system can use those materials for verification without displaying them publicly. A layered access model therefore reduces the false choice between transparency and privacy: the public interface can remain open while complaint evidence is held in a controlled-access regulatory layer.

The fourth requirement is auditability. The phrase "correct, clear, and honest" in Article 108 paragraph (1) should be operationalized through technical parameters. "Correct" should require correspondence between the displayed information and the applicable price or transaction source. "Clear" should require consistent units, product identifiers, dosage information, price categories, and explanatory labels. "Honest" should prohibit the omission or presentation of a material component in a way that creates a misleading impression, particularly where discounts or incentives are legally relevant to the price calculation. These standards require metadata identifying the data supplier, a time stamp, an effective date, version history, and a correction mechanism. Digital systems should make it possible to determine not only the current value but also when and why it changed.

The fifth requirement is timely updating. Article 110 already requires the submission of changes to the highest selling-price limit. Technical guidance should distinguish between information that requires immediate updating and information that may be updated periodically. For any price that directly affects what a patient can be charged, the system should ensure that a new value is reflected no later than the point at which it becomes effective. A portal that is publicly available but contains obsolete values can create a more serious consumer problem than no portal at all because it produces a false appearance of regulatory reliability. The need for accurate digital information is consistent with Putra et al. (2023), who emphasize accountability for accuracy in technology-mediated information services.

The sixth requirement is interoperability. Price data interact with health-information, procurement, insurance, formulary, licensing, and facility systems. Different product identifiers or meanings of "price" can make integrated data impossible to compare. Technical standards should therefore use consistent medicine and facility identifiers, source metadata, price-type labels, and exchange rules so that every displayed value remains traceable to its origin and legal meaning.

International research shows why data architecture matters. Joosse et al. (2023), Araich et al. (2023), and Wang et al. (2025) identify heterogeneous effects, comparability problems, data-quality issues, and compliance gaps. Feng (2025) shows that disclosure can also change bargaining and purchasing behavior. Transparency should therefore be designed as regulated data governance: the law must define which data are disclosed, to whom, in what form, with what validation, and with what consequences for inaccuracy.

The seventh requirement concerns complaints. Articles 119 to 121 should be implemented as an early-correction mechanism. A public price entry can provide a reporting function for the facility, medicine, displayed and charged prices, date, and supporting evidence, while personal data remain protected. Lubis (2026) argues that consumer complaints should prevent disputes and enable early correction. In medicine pricing, this is particularly important because inaccurate information can affect treatment decisions.

The eighth requirement is proportionate administrative enforcement. Article 117 provides a spectrum of measures, but implementation should distinguish a promptly corrected clerical error from repeated non-compliance, deliberate manipulation, concealment of legally relevant information, or conduct causing actual harm. Technical guidance may establish verification, correction, evidence, and risk procedures but may not create new sanctions. Regulated parties should be able to respond and receive reasons for decisions, while deliberate or repeated violations should produce effective consequences.

These requirements can be summarized in a normative model that connects public access, regulatory supervision, confidentiality, data quality, and enforcement. The model is not a statement that every proposed component is already expressly mandated in identical terms by positive law. Instead, it translates the objectives of Article 108 and the technical-guidance authority of Article 112 into an implementation architecture that remains within the existing statutory framework.

Table 2. Proposed Layered Model for Implementing Drug-Price Transparency

Component	Proposed Standard	Legal Purpose
Public minimum information	Medicine identity, applicable highest selling-price limit, facility price where required, effective/update date, and complaint channel.	Consumer information rights and the public purpose of Article 108 paragraph (1).
Regulator-accessible information	Acquisition price, discounts, incentives, and transaction data required for calculation, audit, supervision, or enforcement.	Articles 108 paragraph (3) and 109; effective price control.
Protected commercial information	Production formulas, technology, business strategy, and other information meeting trade-secret requirements where disclosure is unnecessary for public price transparency.	Law No. 30 of 2000 and proportionality.
Protected personal information	Patient, complainant, health-worker, and health-related data that identify individuals and are unnecessary for the public display.	Law No. 27 of 2022; privacy and data security.
Data quality	Standard product/facility identifiers, source metadata, time stamps, version history, validation, and correction mechanisms.	Operational meaning of correct, clear, and honest information; legal certainty.
Interoperability	Connection with the National Health Information System and relevant procurement/insurance data without conflating different price categories.	Traceability, comparability, and accountability.
Complaints	Digital reporting linked to each price entry, registration number, response status, protected identity, and evidence handling.	Articles 111 and 119–121; early correction and enforcement.
Administrative enforcement	Risk-based verification, opportunity to correct or respond, written reasons, and application of sanctions only within the existing legal basis.	Article 117; proportionality and administrative due process.
Evaluation	Post-transition audit of reporting compliance, public usability, accuracy, correction time, data security, and reduction of information asymmetry.	Article 122 and regulatory effectiveness.

Source: Authors' normative construction based on the applicable Indonesian legal framework.

Juridical Implications for Technical Guidelines and Administrative Enforcement

The layered model has direct implications for the legal status and permissible content of the technical guidelines contemplated by Article 112. Ministerial technical guidance can legitimately regulate operational matters that are necessary to implement duties already created by the regulation. These matters include data fields, data formats, reporting procedures, submission frequency, update protocols, validation methods, interoperability standards, access controls, complaint workflows, and correction procedures. Such rules give practical effect to existing obligations and can be adjusted as technology and administrative systems develop.

The legal boundary is reached when a technical instrument attempts to create a new substantive obligation or sanction. Adding an entirely new category of obligated actor, creating a new type of administrative violation, introducing a sanction not supported by the regulation, or restricting a statutory right beyond the delegated legal basis would raise questions of authority and hierarchy. The principle of correspondence between the type, hierarchy, and substantive content of legislation is part of Indonesia's law-making framework. Law No. 12 of 2011 on Law-Making was amended by Law No. 13 of 2022 and was further adjusted through Article V of Law No. 1 of 2026 on Criminal Adjustment. The 2026 adjustment concerns Article 15 and does not alter the general hierarchical principle relevant to this analysis, but the current status of the statute must nevertheless be identified accurately when assessing delegated rule-making.

Institutional functions must be translated into an operational sequence. Article 111 places monitoring and evaluation within ministerial authority, while central and regional governments retain guidance and supervisory roles. Articles 119 to 121 provide complaint and follow-up routes. The system should identify who receives and validates price data, which data become public, who corrects inaccurate entries, how complaints are escalated, and which authority may impose sanctions. This prevents fragmentation between system administrators, health regulators, licensing authorities, and regional supervisors.

Personal-data governance should be built into the same sequence. Data should not be collected merely because the system can collect them. Where identity is necessary for verification or enforcement, access and retention should be limited to the lawful purpose. Shahrullah et al. (2024) and Triyanti et al. (2025) show that privacy rights require institutional mechanisms. Here, *privacy by design* means structurally separating public price information from personal evidence and regulatory case files.

Evaluation during the transition should use multidimensional indicators, not merely the number of submissions. Regulators should examine validation rates, update timeliness, consistency between labeling and system data, public accessibility, correction time, complaint performance, data security, and enforcement consistency. The results can show whether a problem is procedural and suitable for technical guidance or reflects a substantive gap requiring higher-level regulatory amendment.

The novelty emerging from the results and discussion is therefore a legal architecture of layered transparency rather than a simple argument for greater disclosure. The model links three distinct access levels to their legal purposes: public information for patient decision-making, regulator-accessible information for calculation and enforcement, and protected information for trade secrets and personal data. It further integrates auditability, interoperability, complaint correction, proportionate sanctions, and limits on delegated authority. This construction contributes to Indonesian health-law scholarship by showing that effective transparency requires classification and governance of information, not merely publication, and by locating that governance within the hierarchy of health, consumer, commercial, information, privacy, and administrative law.

CONCLUSIONS AND RECOMMENDATIONS

Conclusion

The study concludes that Indonesian drug-price transparency has entered a substantially different legal phase after Minister of Health Regulation No. 5 of 2026. The positive-law framework no longer relies primarily on Maximum Retail Price labeling. It is grounded in the price-control authority of Law No. 17 of 2023 and Government Regulation No. 28 of 2024 and is operationalized through a regime that identifies multiple obligated actors, requires integrated digital reporting, treats discounts and incentives as legally relevant price information, retains labeling for specified price limits, and connects transparency with monitoring, complaints, and administrative sanctions. The first research question is therefore answered by identifying a coherent but still developing regulatory chain from constitutional and statutory rights to sector-specific administrative duties.

The second research question is answered through the proposed layered transparency model. Effective implementation requires a legal distinction between information that patients must be able to access before a transaction, detailed information that regulators need for calculation, audit, and enforcement, and information that remains legally protected because it constitutes a trade secret or personal data unrelated to the public disclosure objective. The model also requires data verification, timely updating, interoperability, protected complaint evidence, and proportionate administrative enforcement. These elements are proposed as *de lege ferenda* guidance for the implementation of Articles 108 and 112 rather than as claims that every technical detail is already expressly mandated by positive law. The contribution of the study lies in reconstructing transparency as a governed information architecture that can simultaneously advance affordability, consumer protection, regulatory accountability, lawful commercial confidentiality, privacy, and the limits of delegated authority.

Limitations

This doctrinal study analyzes the applicable Indonesian legal framework as of September 2026 and does not empirically assess facility-level compliance, patient understanding, system usability, or the effects of the regulation on medicine prices. The study was conducted while the implementation of Minister of Health Regulation No. 5 of 2026 was still within the regulatory adjustment period provided under Article 122, which extends until no later than 4 May 2027. Accordingly, technical and institutional implementation practices may continue to develop. The proposed layered transparency model is therefore a normative framework that requires subsequent empirical evaluation and should not be interpreted as evidence that its components have already been implemented uniformly across Indonesia.

Recommendations

The Ministry of Health should issue technical guidance under Article 112 of Minister of Health Regulation No. 5 of 2026 to regulate information classification, minimum public data, data verification and updating, interoperability, complaint mechanisms, and access controls. Publicly accessible information should prioritize data that patients need before purchasing medicines, while detailed commercial and personal information should be restricted where public disclosure is not legally required. After the adjustment period under Article 122, implementation should be evaluated in terms of accuracy, usability, data security, complaint handling, and enforcement consistency. Future research should empirically test the proposed layered transparency model across relevant health-care and regulatory actors.

Author Contributions

Both authors contributed to the study conception, legal-material collection, legal analysis, interpretation, manuscript preparation, scholarly revision, and final approval. Both authors have read and approved the final manuscript.

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