

Mediation and Arbitration Reform in Healthcare Business Disputes for Human Rights: Indonesian and the United Arab Emirates Perspectives

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Abstract

The commercialization of healthcare services has increased the use of mediation and arbitration to resolve medical business disputes, raising concerns regarding the protection of the right to health within private dispute resolution mechanisms. This study examines the regulation and implementation of mediation and arbitration in Indonesia and the United Arab Emirates through the framework of the UNGPs and formulates an ideal legal reform model. Employing normative legal research with comparative and conceptual approaches, the study analyzes legislation, international instruments, and relevant legal doctrines. The findings reveal that both jurisdictions prioritize procedural efficiency over human rights protection. The study proposes a Rights-Based ADR Model integrating UNGPs, institutional independence, human rights due diligence, limited transparency, and culturally responsive dispute resolution to strengthen effective access to remedies and balance patients' rights with commercial interests

Keywords: *Mediation; Arbitration; Healthcare Business Dispute Reform; Human Rights*

A. INTRODUCTION

The right to health is recognized as a fundamental human right in Article 25 of the Universal Declaration of Human Rights, which states that everyone has the right to a standard of living adequate for their health and well-being. This recognition was subsequently reinforced in a binding manner through Article 12 of the International

Covenant on Economic, Social and Cultural Rights (ICESCR), which recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In practice, however, current global health governance policies have shifted from the pure provision of public services by the state toward a commercialized ecosystem, driven by demographic pressures and the dominance of the private sector (Sekalala et al., 2026). This phenomenon directly contributes to the soaring global health expenditure, which has reached USD 9.8 trillion according to data from the World Health Organization (WHO) (Organization, 2023).

This shift creates a conflict of interest between commercial market efficiency and the state's obligation to protect patient rights, particularly when health dispute resolutions are diverted from public courts to private alternative dispute resolution forums that emphasize absolute confidentiality and the finality of awards (Dimitrov & Miteva-Katrandzhieva, 2024). The concept of Public Interest in Private Dispute Resolution asserts that disputes impacting public safety cannot be viewed solely as private contractual relationships, as their outcomes carry consequences for the broader public interest (Okudan & Çevikbaş, 2022). Therefore, the implementation of mediation and arbitration in healthcare services disputes must be examined for its alignment with the United Nations Guiding Principles on Business and Human Rights (UNGPs), particularly Pillar III: Access to Remedy. This pillar affirms that victims of human rights abuses must have access to effective remedy mechanisms through processes that are fair, accessible, transparent, and accountable, ensuring that the efficiency of dispute resolution does not undermine the protection of patient rights.

In Indonesia, the post-pandemic legal policy direction integrates out-of-court

medical dispute resolution through Law Number 17 of 2023 concerning Health (Health Law), which applies the principles of restorative justice. Article 310 of the Health Law positions non-litigation resolution as the primary option in healthcare service disputes; however, this dispute diversion policy faces jurisprudential challenges. The Constitutional Court Decision Number 161/PUU-XXIII/2025 declared that the judicial review petition regarding the medical disciplinary board was inadmissible due to the petitioner's lack of legal standing. This decision implies a deadlock in formal constitutional justice for patients, meaning that the effective protection of patients' human rights depends entirely on the integrity of non-litigation alternative dispute resolution processes. Meanwhile, the United Arab Emirates implements a policy of legal dualism through Federal Decree-Law No. 40 of 2023 on Mediation and Conciliation in Civil and Commercial Disputes, which expands the jurisdiction of formal mediation centers to expedite the finalization of commercial disputes. On the other hand, cross-border healthcare business disputes in the UAE also intersect with offshore jurisdictions in the Dubai International Financial Centre (DIFC) and Abu Dhabi Global Market (ADGM), both of which adopt independent arbitration regimes (AL-Mustafa, 2025) based on DIFC Law No. 1 of 2008 on Arbitration, which is modeled after the UNCITRAL Model Law. This legal pluralism creates procedural fragmentation, wherein international medical disputes are resolved under the closed logic of commercial law, while the protection of patient rights remains subject to federal public policy parameters.

Indonesia and the United Arab Emirates share similarities in integrating civil law traditions with Islamic law values, which fundamentally influence how both countries perceive modern alternative dispute resolution institutions. The traditional

values of Sulh as reconciliation and Tahkim as arbitration are no longer viewed merely as moral-religious mechanisms; instead, they have been adopted as instruments of state policy to reduce litigation rates in public courts. Both nations also exhibit temporal alignment in updating their national legislation through the enactment of Indonesia's 2023 Health Law and the UAE's 2023 Federal Decree-Law No. 40, which simultaneously overhauled their health regulatory systems and dispute resolution mechanisms. This comparison brings together two contrasting healthcare economic paradigms, wherein Indonesia represents a massive domestic market with a universal health coverage system (BPJS Kesehatan) that covers 98% of the population (Susilo et al., 2025). Conversely, the UAE relies on a global health-hub economic strategy, driven by international medical tourism clusters such as Dubai Healthcare City (Alshamsi, 2024). A comparison between Indonesia's population-dense social security system and the UAE's foreign capital-oriented medical business model will demonstrate the adaptability of the UNGPs principles in confronting distinct macroeconomic pressures.

The urgency of this research lies in the gap between the legal ideals of patient protection and the operational realities of private dispute resolution forums. This gap is highlighted by World Health Organization data, which estimates that approximately 42.7 million medical adverse events occur in hospitalized patients globally each year, out of a total of 421 million hospitalizations (Organization, 2019). The high rate of these medical incidents stands in stark contrast to dispute resolutions via commercial mediation, which typically culminate in financial compensation agreements accompanied by Non-Disclosure Agreements. These agreements restrict information disclosure, effectively concealing systemic institutional malpractice

tracks from the scrutiny of human rights authorities and the public. This imbalance in bargaining power becomes even more acute within the UAE's cross-border medical tourism industry, where international patients frequently encounter exculpatory clauses in standardized electronic contracts drafted by global insurance corporations. In Indonesia, following the Constitutional Court Decision Number 161/PUU-XXIII/2025 which restricted patients' constitutional review rights, non-litigation institutions hold absolute control over rights enforcement without adequate judicial oversight.

If alternative dispute resolution forums continue to operate purely on the principles of business efficiency, there is a distinct risk of normalizing impunity for violations of the right to health—a direct contradiction to the mandate of the UNGPs Third Pillar. This research is urgently required to provide a blueprint for alternative dispute resolution governance that integrates limited transparency principles to fulfill the right to effective remedy, thereby bridging the gap between commercial efficiency interests and human rights protection obligations within the healthcare sector. Raymond Nadeak et al., in *PENA LAW: International Journal of Law*, elucidate that mediation serves as a dispute resolution mechanism geared toward substantive justice through a human-centered dispute resolution approach. Consequently, dispute resolution is directed not merely toward providing financial compensation, but also toward restoring relationships between the parties, protecting human dignity, and strengthening access to justice within global health law. (Nadeak et al., 2026).

Thimothy Aryadi Perangin-Angin et al., in *JUSTISI*, conclude that mediation serves as a faster, simpler, and more efficient alternative dispute resolution

mechanism compared to litigation, and is capable of preserving the relationship between patients and healthcare professionals through a deliberative approach oriented toward an amicable settlement (Perangin-Angin et al., 2025). Muhammad Fakihi et al., in *Hasanuddin Law Review*, find that the practice of medical arbitration in the United States can serve as a reference for reforming the Indonesian legal system, as it provides legal certainty, efficiency in dispute resolution, and case adjudication by arbitrators who possess specialized competence in the healthcare sector (Fakihi et al., 2025). Ziad Al-Enizi et al., in the *Global Digital Health Knowledge Exchange & Empowerment Conference*, elaborate on the complexities of the United Arab Emirates courts' authority in resolving cross-border digital health disputes, focusing on the interaction between federal law, the legal regimes of special economic zones, and the development of electronic contracts in determining competent jurisdiction (AL-Enizi et al., 2024). Jaime Lindsey et al., in *Clinical Ethics*, assert that mediation plays a vital role in enhancing communication, strengthening patient participation, reducing conflict escalation, and building a more collaborative dispute resolution framework within healthcare services (Lindsey et al., 2024).

Nevertheless, these existing studies continue to examine mediation, arbitration, and jurisdiction in a fragmented manner, and have yet to integrate a comparative analysis concerning the regulation and implementation of mediation and arbitration in healthcare services business disputes between Indonesia and the United Arab Emirates through a human rights perspective. This research aims to address this gap by introducing a novel comparative analysis between the legal systems of Indonesia and the United Arab Emirates regarding the regulation and implementation of

mediation and arbitration in healthcare services business disputes, utilizing the human rights perspective within the United Nations Guiding Principles on Business and Human Rights—specifically Pillar III: Access to Remedy—as a normative evaluative framework. Distinguishing itself from prior literature that merely addresses mediation, arbitration, or jurisdiction in isolation, this study interconnects the protection of the right to health, the commercial interests of healthcare corporations, and the private nature of alternative dispute resolution within a single analytical construct to formulate an ideal concept for legal reform. The objectives of this research are to: (i) analyze the regulation and implementation of mediation and arbitration mechanisms in resolving healthcare services business disputes in Indonesia and the United Arab Emirates based on the principles of protecting the right to health under the UNGPs regime; and (ii) formulate an ideal concept for the reform of mediation and arbitration laws to foster a balance between human rights protection and the commercial interests of healthcare corporations in dispute resolution.

This study constitutes a normative legal research focusing on the legal reform of mediation and arbitration in resolving healthcare services business disputes from a human rights perspective through a comparative study between Indonesia and the United Arab Emirates. This research employs a comparative approach to analyze the similarities and differences in the regulation and implementation of mediation and arbitration in healthcare business dispute resolution across both countries, as well as a conceptual approach to examine the principles, doctrines, and theories relating to the protection of the right to health, alternative dispute resolution, and Access to Remedy under the United Nations Guiding Principles on Business and Human Rights regime. The primary legal materials utilized include Law Number 17 of 2023 concerning Health, Law Number 30 of 1999 concerning

Arbitration and Alternative Dispute Resolution, Federal Decree-Law No. 40 of 2023 on Mediation and Conciliation, DIFC Law No. 1 of 2008 on Arbitration along with its amendments, the United Nations Guiding Principles on Business and Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Universal Declaration of Human Rights, and other legal instruments relevant to dispute resolution and the protection of the right to health.

Secondary legal materials consist of books, scholarly articles, research findings, and expert opinions addressing health law, business law, human rights, mediation, arbitration, and comparative law. Meanwhile, non-legal materials used encompass legal dictionaries, language dictionaries, World Health Organization reports, and publications from international institutions related to healthcare governance and dispute resolution. Both legal and non-legal materials were collected through literature review and processed using inventory, classification, and systematization techniques tailored to the legal issues under investigation. Data analysis was conducted qualitatively using a prescriptive method through legal interpretation, comparative legal system analysis, and legal argumentation to formulate a concept for mediation and arbitration reform capable of balancing the protection of the right to health with the commercial interests of healthcare corporations

B. RESULT AND DISCUSSION

1. The Paradox of Commercial Efficiency and Human Rights Accountability: Medical Mediation and Arbitration Forums in Indonesia and the United Arab Emirates

Studies The right to health as an integral part of human rights positions healthcare service dispute resolution not merely as a matter of private law, but also as an instrument for rights protection that must fulfill international human rights standards. The United Nations Guiding Principles on Business and Human Rights (UNGPs) framework, endorsed by the United Nations Human Rights Council through Human Rights Council Resolution 17/4 of

2011 (Kurniawan et al., 2025), establishes three primary pillars consisting of the State Duty to Protect, Corporate Responsibility to Respect, and Access to Remedy (Ewing, 2023). Principle 31 of the UNGPs specifically formulates eight effectiveness criteria for non-judicial grievance mechanisms, which include legitimacy, accessibility, predictability, equity, transparency, rights-compatibility, a source of continuous learning, and based on engagement and dialogue. Healthcare business disputes cannot be reduced to mere ordinary civil disputes; instead, they are disputes in which the right to health is inherently embedded as a human right. The theory of access to justice developed by Mauro Cappelletti and Bryant Garth through the concept of three waves—namely legal aid, representation of collective interests, and informal mechanisms as the third wave (Garth, 2025), serve as an instrument to assess whether mediation and arbitration in Indonesia and the United Arab Emirates truly expand access to justice for patients.

Healthcare business disputes possess distinct characteristics compared to general civil disputes, as the underlying legal relationship is fundamentally based on a fiduciary relationship between the patient and the healthcare provider (Sormin et al., 2026). This relationship gives rise to an information asymmetry, as medical professionals and hospitals possess a far greater mastery of medical knowledge compared to patients, thereby creating an imbalance in the parties' bargaining power (Decataldo et al., 2025). This imbalance becomes increasingly evident in the application of the informed consent doctrine, which mandates that any medical intervention may only be performed after the patient has received adequate information concerning the diagnosis, benefits, risks, alternative courses of action, and potential consequences arising from it (Putri et al., 2025). The patient's position in subsequent dispute resolution processes, including mediation and arbitration, is likewise shaped by this same imbalance. Consequently, the assessment of these mechanisms cannot rely solely on neutral civil law benchmarks, such as freedom of contract. The nature of this imbalance demands consideration of the patient's position as a structurally weaker party in any dispute resolution forum; hence, the principle of party autonomy cannot be applied

absolute without due regard for the protection of the right to health.

The development of the healthcare services business in Indonesia demonstrates an increasingly complex nexus between public service and commercial activities through private hospitals, the pharmaceutical industry, medical device providers, telemedicine services, as well as healthcare facilities collaborating with the National Health Insurance via BPJS Kesehatan. The complexity of these relationships gives rise to various forms of disputes, including alleged medical negligence, health financing claim disputes, contractual disagreements between healthcare providers, and consumer disputes regarding service quality and information disclosure (Helmawan Trintono Subekti et al., 2024) As regulated under Law Number 8 of 1999 concerning Consumer Protection. The nature of these disputes demonstrates that the patient's position—simultaneously as a healthcare service consumer and a holder of the right to health—is situated at the intersection of two legal regimes: business and consumer law, and health law. These two legal regimes feature distinct and not fully integrated dispute resolution forums, thereby creating confusion for patients in determining the appropriate pathway to remedy. This structural complexity reinforces the urgency of evaluating the mediation and arbitration mechanisms available to patients within the Indonesian legal system.

Law Number 17 of 2023 concerning Health (the Health Law) integrates the resolution of medical disputes, with particular emphasis on Article 322 paragraph (4), which mandates law enforcement agencies to prioritize restorative justice before judicial proceedings commence. In parallel, healthcare service consumer disputes can also be submitted to the Consumer Dispute Resolution Board (Badan Penyelesaian Sengketa Konsumen – BPSK) pursuant to the Consumer Protection Law (Hidayati & Aripin, 2024), Meanwhile, within the realm of professional disciplinary assessment, the Professional Disciplinary Tribunal operates under the Indonesian Health Council (Konsil Kesehatan Indonesia – KKI) to examine alleged violations of professional discipline (Khalif Ardi et al., 2023). The existence of these various institutions demonstrates a plurality of dispute resolution mechanisms that

offers alternatives to the parties involved; however, it simultaneously risks triggering a fragmentation of authority, preventing the full realization of a simple, certain, and easily comprehensible resolution pathway for patients. This institutional complexity is further exacerbated by the Constitutional Court Decision Number 161/PUU-XXIII/2025, which declared the judicial review against the disciplinary recommendation mechanism in the Health Law inadmissible due to issues regarding the applicant's legal standing. Consequently, this decision effectively closes the door to formal constitutional justice for patients, shifting the entire burden of conflict resolution into a multi-layered bureaucratic labyrinth between criminal and civil law enforcement pathways, the State Disciplinary Tribunal, and Professional Ethics Boards (Disantara et al., 2026).

Normatively, commercial non-litigation resolution within the Indonesian healthcare sector relies on the framework of Law Number 30 of 1999 concerning Arbitration and Alternative Dispute Resolution. Meanwhile, as an implementation of the mandate under Article 310 of the 2023 Health Law, the legal and medical communities established the Indonesian Medical and Health Mediation and Arbitration Institution (Lembaga Mediasi dan Arbitrase Medis dan Kesehatan Indonesia – LMA-MKI) as a specialized non-litigation adjudication forum for the healthcare sector (Sriwidodo et al., 2025). In its operationalization, however, LMA-MKI faces sharp criticism regarding its neutrality, as the available panels of mediators and arbitrators are heavily dominated by legal and medical figures closely affiliated with professional organizations (Sriwidodo et al., 2025). This problem of structural independence becomes critical when dealing with patients as the weaker party, as the dominance of professional affiliations potentially creates conflicts of interest in the adjudication process. The closed nature of the proceedings and the widespread use of confidentiality clauses in amicable dispute settlements violate the criteria of equity, transparency, and the function of public evaluation (Fitria Mukhtar Siregar et al., 2026) As formulated in Principle 31 of the UNGPs. This condition indicates that the mediation and

arbitration mechanisms in Indonesia do not yet fully satisfy the standards for effective non-judicial grievance mechanisms as formulated by the UN.

Under the first pillar of the UNGPs, which governs the state duty to protect, Indonesia has demonstrated a regulatory commitment through the enactment of the 2023 Health Law and the establishment of the LMA-MKI institution as a non-litigation adjudication forum. Nonetheless, this commitment has not been followed by an independent state oversight mechanism over the conduct of medical mediation and arbitration. This deficiency arises because the majority of alternative dispute resolution governance is delegated to a self-regulatory model managed by a consortium of professional organizations. Under the second pillar, which governs corporate responsibility to respect human rights, Indonesian regulations have not explicitly mandated hospital corporations to conduct human rights due diligence; thus, the fulfillment of patient rights still relies on the internal ethical compliance of the institutions. Consequently, the standards of patient rights protection in Indonesia are not yet on par with the international human rights standards expected within the UNGPs framework. Under the third pillar, which governs access to remedy, the legal consequences of the Constitutional Court Decision Number 161/PUU-XXIII/2025 demonstrate barriers for patients in accessing constitutional justice, such that the multi-layered bureaucratic procedures preceding civil judicial processes or alternative dispute resolution precisely undermine the accessibility and predictability criteria of the rights remedy mechanism.

The healthcare services sector in the United Arab Emirates is dominated by private providers regulated hierarchically by centralized administrative authorities, ranging from the Ministry of Health and Prevention (MOHAP) at the federal level (Al Hazarmerdi, 2026) to the Dubai Health Authority (DHA) and the Department of Health-Abu Dhabi at the emirate level (Hussein et al., 2026). The UAE's economic strategy, which is strongly oriented toward attracting foreign direct investment and developing the international medical tourism industry—as seen in the Dubai Healthcare City special economic zone (Kim & Hyun, 2022), triggers dispute characteristics distinct from those in Indonesia. Potential disputes in the UAE

are dominated by a cross-border dimension, encompassing alleged medical malpractice between foreign patients and transnational healthcare facilities, as well as high-value commercial investment disputes among global private hospital operators (Bulatovic & Iankova, 2021). The power relation imbalance is highly pronounced in the position of foreign medical tourism patients, who possess limited understanding of the local legal system when facing multinational healthcare corporations (Cynthia, 2025). This socio-legal reality reinforces the urgency of implementing a rights-holder-oriented remedy mechanism, as underscored within the UNGPs regime concerning transnational business disputes.

Federal Decree-Law No. 4 of 2016 Concerning Medical Liability mandates that any medical negligence claim in the UAE must first be submitted hierarchically to the local Medical Liability Committee before it can be accessed by civil or criminal courts. Recent jurisprudential dynamics through the UAE Federal Supreme Court Decision in Administrative Appeal No. 696 of 2024 bring a significant structural shift, wherein reports from the Higher Committee for Medical Liability are now established as administrative decisions subject to judicial review by the courts. This development opens an additional pathway to remedy for both patients and medical professionals against committee determinations that were previously final, thereby reinforcing judicial oversight mechanisms over administrative processes. Within the realm of internal regulation, the oversight of the healthcare business in the UAE is highly centralized under state control (ALameeri et al., 2026) Through Federal Law No. 4 of 2015 on Private Health Facilities, which regulates the operational standardization and licensing of private facilities. This strict model of administrative oversight distinguishes the UAE from the professional organization-based self-regulatory approach dominant in Indonesia, thereby placing the state in a more active position to oversee the delivery of healthcare services.

Normatively, mediation institutions in the UAE are regulated through Federal Decree-Law No. 40 of 2023 on Mediation and Conciliation in Civil and Commercial Disputes, while commercial arbitration frameworks are subject to Federal Law No. 6 of 2018 on Arbitration.

In institutional practice, health business disputes involving large-scale investments and international pharmaceutical partnerships are generally directed to general secular commercial arbitration institutions, such as the Dubai International Arbitration Centre (AL-Mustafa, 2025) or offshore common law judicial forums within the jurisdictions of the DIFC and ADGM. Conversely, small-scale medical cases are resolved through reconciliation centers attached to the federal courts of first instance (AL-Mustafa, 2025), thereby resulting in a stratification of forums based on the scale and complexity of the dispute. The fundamental structural distinction between the UAE and Indonesia lies in the absence of a specialized alternative dispute resolution forum focusing on the healthcare sector in the UAE, unlike the LMA-MKI in Indonesia. Medical-commercial disputes in the UAE are resolved through general commercial arbitration forums that are not designed to respond to the information asymmetry between patients and medical corporations; consequently, the adjudication process within these private forums tends to be dominated by pure business logic.

When evaluated through the first pillar of the UNGPs, the state's regulatory intervention in the UAE is relatively more stringent than in Indonesia, implemented via the mandatory referral of cases to the formal Medical Liability Committee and the availability of judicial review pathways over the committee's reports. This rigorous administrative oversight minimizes the risk of professional immunity, which frequently poses an obstacle in medical disputes across various jurisdictions. However, under the second pillar governing corporate responsibility, the UAE's orientation as a global medical tourism hub drives private healthcare facilities to focus predominantly on compliance with international clinical standardization for market reputation, rather than explicitly adopting human rights due diligence mechanisms. Under the third pillar governing access to remedy, the absence of a specialized healthcare alternative dispute resolution forum that considers the

vulnerability of the patient's position, compounded by the high operational costs of international commercial arbitration such as the DIAC or DIFC in the UAE, creates significant financial barriers for individual patients. This closed forum structure, which is oriented toward international business actors, potentially disregards the equity and accessibility criteria mandated under Principle 31 of the UNGPs.

Table 1

The Healthcare Alternative Dispute Resolution System Based on the UNGPs in Indonesia and the United Arab Emirates

Dimensi	Indonesia	Uni Emirat Arab
Legal Basis (Lex Specialis)	Articles 304–310 of the Health Law, which institutionalize the ADR forum for the medical sector.	Lacks a <i>lex specialis</i> for healthcare ADR; medical disputes are subject to general commercial law (Federal Decree-Law No. 40/2023).
Institutional and Operational Mechanisms	Features a specialized ADR forum for the healthcare sector via the Indonesian Medical and Health Mediation and Arbitration Institution (LMA-MKI).	No specialized forum; transnational medical/medical tourism disputes are routed to general commercial arbitration (DIAC/DIFC).
State Oversight and Professional Autonomy (Pillar I UNGPs)	Partial-Weak The state provides the regulations, but oversight is delegated to a professional self-regulation model that is susceptible to conflict-of-interest biases.	Partial-Strong State intervention is highly dominant through stringent administrative control (MOHAP/DHA) and open access to judicial review pathways.
Corporate Responsibility to	Regulatory Void There is no regulatory obligation yet for private	Regulatory Void Private hospitals are only required to meet

Respect Human Rights (Pillar II UNGPs)	hospital corporations to conduct human rights due diligence (HRDD).	international clinical standardization for market reputation, rather than adopting human rights compliance instruments.
Access to Effective Remedy and Transparency (Pillar III UNGPs)	Procedural Obstacles The impact of the Constitutional Court Decision No. 161/PUU-XXIII/2025 and the abuse of absolute non-disclosure agreements (NDAs) that close off public evaluation.	Financial Barriers The dominance of high-cost international commercial arbitration that marginalizes the financial bargaining position of individual patients.

Sources: Author, 2026

Indonesia and the UAE possess contrasting strengths and weaknesses in integrating the UNGPs principles into healthcare business disputes. Indonesia excels in institutional design through the establishment of a specialized alternative dispute resolution (ADR) forum for the healthcare sector, namely LMA-MKI. However, it falls short in the dimensions of independence and procedural transparency due to the dominance of professional self-regulation. Conversely, the UAE is superior in fulfilling state protection obligations through strict administrative oversight by medical committees and open access to judicial appeals. Yet, it remains weak due to the absence of an inclusive private ADR forum design for individual patients facing multinational corporations. The positive laws of both Indonesia and the UAE have not consciously adopted the eight criteria of Principle 31 of the UNGPs as the foundation for designing their ADR legal policies. The alignment achieved thus far tends to be partial and incidental for the sake of case resolution efficiency, rather than the result of a regulatory design oriented toward the comprehensive protection of the right to health as a human right.

The procedural efficiency offered by mediation and arbitration mechanisms in healthcare service business disputes in both countries has not been proportional to the fulfillment of the principle of protecting the right to health within the UNGPs regime. Diverting dispute resolution to private forums tends to obscure public transparency in order to protect the commercial reputation of corporations, thereby depriving the public of access to critical information regarding the patterns and resolutions of medical disputes. In Indonesia, the dominance of professional self-regulation within LMA-MKI raises doubts about the forum's independence, while in the UAE, the high cost of international commercial arbitration creates structural barriers for patients (Alhashemi, 2023). Both models fail to meet the criteria of equity and accessibility, which are absolute requirements for an effective remedy mechanism under Principle 31 of the UNGPs. Therefore, legal reform must be directed toward strengthening institutional independence, implementing limited transparency, and explicitly integrating the eight effectiveness criteria of Principle 31 of the UNGPs into the design of alternative dispute resolution forums in the healthcare sector across both jurisdictions.

2. The HR-ADR Model in Healthcare Service Business Disputes: Formulation of Responsive Legal Reform in Indonesia and the United Arab Emirates

The legal reform of mediation and arbitration In healthcare service business disputes must begin with a paradigm shift from a procedure-oriented certainty approach to a human rights protection-oriented approach. This shift aligns with the theory of responsive law proposed by Philippe Nonet and Philip Selznick in *Law and Society in Transition*, which explains that responsive law is a form of law that prioritizes the fulfillment of societal needs and social objectives over mere compliance with formal procedures (Sukmana, 2023). The current legal framework for mediation and arbitration in Indonesia and the United Arab Emirates tends to reflect the character of autonomous law, where alternative dispute

resolution forums operate independently of external intervention with a primary focus on swift and confidential resolution (Prasetio et al., 2025). Legislative reform in both jurisdictions must steer alternative dispute resolution institutions toward a responsive character, wherein the primary function of non-litigation forums is no longer merely to resolve disputes quickly and privately, but also to guarantee the enforcement of patients' human rights. This paradigmatic transformation is a fundamental prerequisite for achieving substantive justice in the resolution of healthcare disputes in both countries.

Reforms in the form of institutional restructuring in both nations represent the initial step toward strengthening the legitimacy of mediation and arbitration in the healthcare sector. Governance, which has thus far been dominated by professional self-regulation or pure commercial logic, must be transformed into a tripartite institutional model that mandates equal involvement among state representatives, professional organizations, and representatives of patient interests or non-governmental organizations within decision-making structures and the composition of mediator and arbitrator panels. The procedural law principle of *audi et alteram partem* must be interpreted broadly so that equality of position is applied not only during individual case examinations but also from the stage of representing patient group interests in forming the structures of the alternative dispute resolution institutions themselves (Dicky Eko Prasetio, Muh. Ali Masnun, Arinto Nugroho, Denial Ikram, 2024). This policy aligns with the First Pillar of the UNGPs, which obligates the state to ensure that non-judicial remedy mechanisms are not dominated by the unilateral interests of business enterprises (Kumar et al., 2025). For Indonesia, this strengthening must be realized through the revision of the implementing regulations of Article 310 of Law Number 17 of 2023 concerning Health (Health Law) by mandating a tripartite composition for LMA-MKI, whereas for the United Arab Emirates, reform is achieved through expanding the scope of Federal Decree-Law No. 40 of 2023 on Mediation and Conciliation by inserting a specific clause for healthcare service disputes.

The second reform mandates the adoption of the eight effectiveness criteria of Principle 31 of the UNGPs as mandatory standards in healthcare mediation and arbitration procedural law. Principle 31 of the UNGPs formulates the criteria of legitimacy, accessibility, predictability, equity, transparency, rights-compatibility, a source of continuous learning, and based on engagement and dialogue as benchmarks for the effectiveness of non-judicial remedy mechanisms. This process represents a form of soft law hardening, namely the transformation of non-binding international norms into legally binding national law through domestic implementing regulations or jurisprudence (Joseph & Kyriakakis, 2023). The implementation of the accessibility and predictability criteria demands the simplification of the multi-layered bureaucratic procedures currently in force in both countries, given that procedural complexity acts as a structural barrier to patients' access to remedy. In Indonesia, following the Constitutional Court Decision Number 161/PUU-XXIII/2025 which restricted direct constitutional adjudication pathways for patients, simplifying the mandatory requirement of professional disciplinary board recommendations prior to court or alternative dispute resolution became an absolute obligation for policymakers. A similar measure must be applied in the United Arab Emirates by revising the mandatory referral provisions to the Medical Liability Committee under Article 18 of Federal Law No. 4 of 2016 Concerning Medical Liability, ensuring that pre-alternative dispute resolution procedures do not turn into structural barriers that obstruct victims' access to effective rights remedy.

The third reform establishes the obligation to conduct human rights due diligence for healthcare corporations as a legal prerequisite before such business entities can exercise the right to conceal disputes within mediation or arbitration forums. Based on the Second Pillar of the UNGPs regarding the corporate responsibility to respect human rights, business enterprises are obligated to continuously identify, prevent, and mitigate the impacts of consumer rights violations, rather than merely complying with standard clinical quality metrics or conventional commercial accreditations (Kumar et al., 2025). The integration of

this policy can be implemented as one of the administrative requirements for health facility operational licensing, thereby transforming human rights due diligence into an integral part of good corporate governance in the healthcare sector. In Indonesia, this mechanism can be inserted through the implementing regulations of the Health Law, whereas in the United Arab Emirates, it can be accommodated through the renewal of Federal Law No. 4 of 2015 on Private Health Facilities, which regulates operational standardization and private facility licensing. Through this approach, the obligation of human rights due diligence is no longer reactive after a violation occurs, but becomes a preventive instrument embedded within the sustainable governance of healthcare corporations.

The fourth reform prioritizes the revitalization of traditional Sulh and Tahkim values as the living philosophical-cultural basis in the Islamic legal traditions of both countries. Sulh is a legal institution in the form of a contract to end a dispute peacefully (Binti Che Adnan, 2024) yang which is rooted in the mandate of the Qur'an, Surah Al-Hujurat verse 9, regarding the obligation to reconcile disputing parties, whereas Tahkim constitutes the appointment of a third party to resolve a dispute based on the agreement of the parties (Noor et al., 2023). From an Islamic law perspective, Sulh is not merely a transactional instrument to financially terminate a dispute, but rather a restorative justice process that prioritizes the remedy of the wronged party's rights and the moral reformation of the wrongdoer (Fahmi, 2025). The essential value offered by Sulh lies in its philosophical orientation that emphasizes the restoration of relationships as the primary objective, thereby aligning with the concept of restorative justice developed by Howard Zehr regarding dispute resolution oriented toward the fulfillment of victim needs and social relations (Malazoniia, 2025). By transplanting the essence of substantive justice from Sulh and Tahkim into the operationalization of LMA-MKI in Indonesia and the mediation and arbitration centers in the United Arab Emirates, both jurisdictions can construct a healthcare alternative dispute resolution system that not only meets the universal standards of the UNGPs but also possesses robust cultural legitimacy.

Based on the theory of living law propounded by Eugen Ehrlich, the effectiveness of law is determined by its ability to stem from the social norms active within society, rather than merely from formal written law (Maliska, 2023). Combined with Alan Watson's legal transplant theory, which states that the success of transferring legal norms across systems is heavily influenced by their compatibility with deep-rooted local values (Trikoz & Gulyaeva, 2023), The integration of Sulh and Tahkim into healthcare alternative dispute resolution reforms in Indonesia and the United Arab Emirates provides robust sociological legitimacy for both Muslim-majority jurisdictions. Tahkim offers legitimacy for modern medical arbitration through the mandatory selection of arbitrators whose moral integrity is mutually agreed upon by the parties (Karadağ, 2025). Consequently, if these moral qualifications are formalized into professional rules, public trust in arbitration awards—which has thus far been vulnerable to perceived bias toward corporate interests—can be restored. The orientation of Sulh, which emphasizes the restoration of relationships, strengthens the patient's position without destructively sacrificing the reputational interests of the healthcare corporation, as reconciliation-based resolution enables both parties to achieve a mutually beneficial agreement. Thus, these traditional values serve as a bridge between the orientation of relationship restoration and the commercial interests that frequently clash in healthcare disputes.

The proposed institutional reform concept is the establishment of a formal-cultural hybrid model that marries the formal structure of modern alternative dispute resolution with the substantive values of Sulh and Tahkim as the philosophical foundation of the proceedings. This hybrid model encompasses the creation of specialized healthcare forums, tripartite panels, and the fulfillment of the Principle 31 UNGPs criteria as formal elements, while simultaneously integrating the values of Sulh and Tahkim as the animating spirit of the dispute resolution process. Through this approach, healthcare alternative dispute resolution forums will avoid becoming mere replicas of general commercial arbitration; instead, they will possess a responsive character sensitive to the unique nature of the

relationship between patients and healthcare providers. Based on the theory of procedural justice developed by Tom R. Tyler, public compliance with and acceptance of a legal decision are heavily determined by the perceived fairness of the process they undergo (Tyler, 2025), including a sense of being respected and heard throughout the proceedings. Consequently, institutional designs that adopt cultural values close to the community are proven effective in enhancing the legitimacy of healthcare alternative dispute resolution processes in the eyes of patients, who structurally occupy the weaker position.

The next reform is directed toward establishing a structural transparency mechanism in the healthcare alternative dispute resolution forums of both countries, which mandates a legal obligation for medical mediation and arbitration institutions to periodically publish aggregated data on dispute patterns to the public. This mechanism is designed without disclosing the identities, medical records, or individual case details of the parties, thereby preserving the principle of confidentiality—the primary appeal of alternative dispute resolution for healthcare corporations—while still fulfilling public accountability for the forums' performance. This policy embodies the continuous learning criterion within Principle 31 of the UNGPs, which demands that non-judicial remedy mechanisms be capable of identifying recurring clinical violation patterns to drive service quality improvements. This evaluative function is currently absent in both the practices of LMA-MKI in Indonesia and commercial arbitration forums in the United Arab Emirates, as medical disputes are resolved behind closed doors without any aggregated data reporting to public health authorities. This structural transparency enables health authorities to identify systemic flaws in healthcare delivery and take preventive corrective measures.

The character of the healthcare service business in the United Arab Emirates, which heavily relies on the cross-border medical tourism industry—a similar trend now being developed in Indonesia—necessitates legal reforms that encompass the harmonization of the recognition and enforcement of transnational healthcare mediation and arbitration awards. Cross-border disputes frequently trigger jurisdictional conflicts due to disparate patient rights

protection standards between nations, thus requiring a legal framework that accommodates the international dimension without sacrificing the protection of patients' human rights. The principle of *pacta sunt servanda* in international law, alongside the framework of the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (New York Convention 1958)—ratified by both Indonesia and the United Arab Emirates—must be optimized; however, the utilization of said convention must not be confined to the technical-procedural aspects of executing ordinary commercial awards. Both nations need to initiate specific bilateral agreements in the healthcare sector containing minimum standards for protecting cross-border patient rights, ensuring that the legal harmonization process continually integrates human rights protection substance as a parameter for the validity of executed awards. This step is critical to prevent multinational healthcare corporations from evading liability through forum shopping that favors business enterprises.

The ideal reform model for healthcare service business dispute mediation and arbitration is a Rights-Based Alternative Dispute Resolution Model that systemically encompasses five fundamental pillars (Kurniawan et al., 2024). Institutionally, this model is independent, featuring a tripartite structure involving the state, professional organizations, and patient representatives. Procedurally, it adopts the eight effectiveness criteria of Principle 31 of the UNGPs as mandatory design standards in every dispute resolution process. Substantively, it mandates the execution of human rights due diligence by healthcare corporations as a prerequisite prior to utilizing mediation or arbitration forums. Culturally, it is rooted in the traditional values of *Sulh* and *Tahkim* as a source of living sociological legitimacy within society, and structurally open through the application of aggregated data transparency and cross-jurisdictional harmonization. This model asserts that the balance between guaranteeing the protection of patients' human rights and the commercial interests of healthcare service corporations is not a mutually destructive relationship to be pitted against each other, but can rather be reconciled through a legal institutional design that establishes substantive justice as the primary prerequisite for efficiency and legal certainty.

C. CONCLUSION

The regulation and application of mediation and arbitration in resolving healthcare service business disputes in Indonesia and the United Arab Emirates have acknowledged the importance of alternative dispute resolution mechanisms; however, they have not fully integrated the principle of protecting the right to health as stipulated in the United Nations Guiding Principles on Business and Human Rights (UNGPs). Indonesia has strengthened its normative foundation through the Health Law, which promotes out-of-court dispute resolution, yet it still faces challenges in the form of institutional fragmentation, the dominance of self-regulation mechanisms, and the absence of human rights due diligence obligations for healthcare corporations. Conversely, the United Arab Emirates possesses a stronger state oversight system regarding healthcare delivery and medical liability, but its mediation and arbitration mechanisms remain oriented toward general commercial dispute resolution, thereby failing to fully accommodate the distinct characteristics of medical disputes and the protection of patients as holders of the right to health.

This research formulates a legal reform concept through the Rights-Based ADR Model, which focuses on strengthening institutional independence, adopting the eight effectiveness criteria of Principle 31 of the UNGPs, mandating human rights due diligence, integrating the values of Sulh and Tahkim as a foundation for cultural legitimacy, implementing limited transparency, and harmonizing cross-jurisdictional dispute resolution. This model is expected to be capable of establishing a balance between the protection of human rights and the commercial interests of healthcare service corporations, ensuring that mediation and arbitration serve not merely as

instruments for efficient dispute resolution, but also as a means to fulfill the right to an effective remedy.

The governments of Indonesia and the United Arab Emirates need to refine their regulations by explicitly integrating UNGPs principles into the legal frameworks of mediation and arbitration within the healthcare sector. This includes establishing independent oversight mechanisms, strengthening patient participation in institutional governance, and mandating the application of human rights due diligence for healthcare corporations. Furthermore, dispute resolution institutions need to develop limited transparency mechanisms by publishing aggregated data without compromising the confidentiality of the parties' identities, as an effort to enhance public accountability and continuous institutional learning. Future research is recommended to conduct empirical studies on the effectiveness of implementing mediation and arbitration in the healthcare sector through case studies at dispute resolution institutions in both Indonesia and the United Arab Emirates. Future studies may also expand the scope of research by comparing other countries with different legal system characteristics, thereby yielding a more comprehensive and applicable rights-based alternative dispute resolution model for transnational healthcare service business disputes.

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