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A Juridical Analysis of the Welfare of Civil Servant Medical Personnel in Remote Areas of Indonesia

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Abstract: This study examines the welfare of medical personnel serving as Civil Servants (PNS) under the Indonesian civil service system, particularly those assigned to remote areas. Employing a normative juridical method with both a statute approach and a conceptual approach, this research explores the government's responsibility to guarantee fair welfare and evaluates the adequacy of the existing legal framework. Legal materials were collected through literature study and analyzed using prescriptive legal analysis. Statistical data indicate an uneven distribution of health workers, with more than 60% concentrated in Java–Bali, whereas remote, border, and island regions continue to face critical shortages. Relevant legal instruments, including Law Number 20 of 2023 on the State Civil Apparatus and Law Number 17 of 2023 on Health, establish the legal basis for civil servant welfare. Nevertheless, normative gaps remain, particularly regarding technical arrangements such as incentive amounts, distribution mechanisms, and employment security guarantees. The findings reveal that current welfare protections for medical civil servants in remote areas are not yet fully effective, underscoring the need for more detailed derivative regulations to ensure legal certainty, distributive justice, and equitable deployment. The research contributes to legal scholarship by identifying shortcomings in the existing framework, offering policy recommendations for more comprehensive and enforceable welfare protections, and highlighting the importance of aligning normative guarantees with operational realities to strengthen the welfare state in Indonesia. However, this study is limited to normative legal analysis and does not include empirical data on implementation or the lived experiences of medical staff.

Keywords: Welfare, Medical Personnel, Civil Servants, Remote Areas, Health Law

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1. Introduction

The Indonesian government administration system is significantly influenced by the State Civil Apparatus (ASN). ASN are not only a state instrument in the provision of public services, including in the health sector, but they also complement the bureaucratic structure (Ilyasi, 2024; Oslita et al., 2025). Government employees with work agreements (PPPK) and civil servants (PNS) are the two categories into which the ASN personnel system classifies government workers. The term "medical personnel" according to Article 1 number 6 of Law No. 17 of 2023 concerning Health explicitly refers to doctors and dentists. This means that, legally, medical personnel are distinct from other health workers such as nurses, midwives, pharmacists, nutritionists, sanitarians, etc. Meanwhile, "health personnel" is a broader term and encompasses both

medical and non-medical health workers. However, in the context of civil servants (PNS), the 2023 ASN Law and Government Regulation No. 28 of 2024 do not limit them to specific professions. Any qualified citizen, whether a doctor, nurse, midwife, or other health worker, can hold ASN/PNS status if appointed permanently by a civil service development official. This means that PNS medical personnel, in the narrow sense, are PNS doctors/dentists.

Meanwhile Government employees with employment agreements, known as PPPK are appointed through work agreements, while Civil Servants are Indonesian citizens who meet specific requirements and are perpetually appointed to government positions, as defined by Law Number 20 of 2023 concerning the State Civil Apparatus. This underscores the fact that all civil servants are civil servants, despite the fact that not all civil servants possess PNS status. The law also ensures the welfare of civil servants, which includes legal protection, social security, allowances, and salaries. In practice, civil servants are granted more robust employment protections, such as pension rights and family allowances, than PPPK (Permanent Personnel). Compared to the contract system for PPPK, which is susceptible to termination based on the organization's requirements, permanent employment status offers a relatively more secure job security (Almalik & Handayani, 2024; Azani, 2025).

Access to welfare facilities is also affected by this disparity in status. In general, civil servants are granted more comprehensive healthcare facilities, official accommodation, and annual leave than PPPK. This is particularly pertinent when it pertains to civil servant medical personnel who are stationed in outlying regions. The welfare of medical personnel in these regions is a significant concern due to the challenging geographic conditions, limited facilities, and challenges in providing healthcare services (Dussault & Franceschini, 2006a; Filip et al., 2022; Organization, 2010). In an effort to entice medical personnel to serve in regions with restricted access, the government has implemented regulations that offer incentives, special allowances, and supplementary facilities.

The distribution of medical personnel is an essential concern. The island of Java is home to over half of Indonesia's specialist physicians, according to data. Conversely, the eastern provinces, which are characterised by numerous remote areas, are experiencing a shortage of medical personnel. For instance, research conducted by Tri Rini Puji Lestari at community health centres in Mamuju City, West Sulawesi, confirms that there is still a shortage of medical personnel. The majority of medical personnel on duty are not civil servants; rather, they are contract workers or non-permanent employees who have been employed for years but have not yet been appointed as civil servants. This phenomenon illustrates the medical personnel distribution system's vulnerability in remote regions.

The calibre of healthcare services in urban and rural areas is unbalanced as a result of this uneven distribution. On the one hand, there is an abundance of medical personnel in large communities, while there is a shortage in remote areas. Java and Bali are the locations where approximately 60.8% of the national medical personnel are stationed, as per the 2023 Health Profile. Provinces with the lowest number of medical personnel are typically located in the eastern region, including Highlands Papua and

South Papua. The Central Statistics Agency (BPS) has observed that the majority of healthcare services are still concentrated in urban areas, which further exacerbates this situation due to the limited healthcare facilities in rural areas.

This disparity is legally enforceable. The right to healthcare services is guaranteed to all Indonesian citizens by the 1945 Constitution, specifically Article 28H paragraph (1). Consequently, the state is obligated to ensure that medical personnel are available in a fair and equitable manner, rather than merely as a technical distribution issue. The doctor-to-physician ratio in provinces such as East Nusa Tenggara (NTT) is significantly lower than the national standard, as evidenced by the facts on the ground. Conversely, Jakarta maintains a significantly higher ratio. This illustrates the disparity in the provision of public health rights across different regions.

Law Number 17 of 2023 concerning Health, which affirms the shared responsibility between the Central and Regional Governments for the equitable distribution of medical personnel, is the government's attempt to address this issue. A selection mechanism is employed to determine placement, which may involve special assignments or appointment as civil servants (ASN). Nevertheless, this law does not explicitly define remote areas, necessitating the use of technical regulations, such as Minister of Health Regulation Number 90 of 2015, to ensure that health facilities in remote and very remote areas meet the necessary criteria. These regulations are based on the availability of basic infrastructure, geographic conditions, and transportation access.

The Health Law and the Civil Servant Law have both confirmed the protection of the rights of medical personnel in relation to their welfare (Heymann et al., 2013; Kalalo & Kalalo, 2018; Wing & Gilbert, 2006). Additionally, the mechanisms for the appointment, provision of incentives, and distribution of medical personnel in remote, underdeveloped, and border areas are regulated by Government Regulation Number 28 of 2024, a derivative regulation. Nevertheless, there is a deficiency in technical regulations, particularly in the areas of incentive amounts, allowance forms, job security guarantees, and other supportive facilities. The right to special incentives for medical personnel in remote areas is referenced in Article 218 of the Health Law; however, the implementation mechanism and the responsibilities of the relevant institutions are not specified.

The welfare of civil servant medical personnel in remote areas is subject to legal uncertainty as a result of this divide. The compensation that medical personnel receive is disproportionate to the high workloads, minimal facilities, and increased security risks that they encounter in comparison to their counterparts in urban areas (Dussault & Franceschini, 2006b). This raises significant concerns regarding the regulations' implementation of distributive justice. Additionally, the government has implemented numerous incentive programs for medical professionals in far-flung regions. These programs include special allowances that can equal one month's base salary, performance allowances that are contingent upon workload, and regional-specific incentives, such as transportation or housing allowances. The implementation on the ground, however, is still far from equitable. Medical personnel are left feeling

under-rewarded in numerous regions due to the fact that they are unable to afford additional allowances due to severe budget constraints.

This situation underscores the necessity of policies that are more consistent and transparent, and that prioritise medical personnel who operate in remote regions. In order to guarantee the welfare of medical personnel and ensure legal certainty, the state must establish regulations that are not only normative but also feasible. Consequently, this investigation is essential for the legal examination of government obligations and regulations concerning the welfare of civil servant medical personnel employed in remote regions, as well as for the development of future policy recommendations.

The research conducted by Nursari et al. (2018) revealed a persistent deficit of civil servant medical personnel. The majority of those employed are contract workers or non-permanent employees. The distribution of medical personnel was the primary focus of this study, which did not investigate the legal rights and welfare of civil servant medical personnel. In the meantime, Utami & Mustofa (2025) conducted an analysis of incentive policies for healthcare workers in remote regions and discovered that the implementation of incentives is still unequal as a result of variations in regional fiscal capacity. The administrative and budgetary obstacles that were emphasised in this study were not associated with state legal obligations or regulatory deficits. The distribution and welfare of civil servant physicians in Eastern Indonesia were analysed by Nugroho et al. (2022). The study revealed that medical personnel were hesitant to work in remote areas due to the lack of facilities and insufficient welfare guarantees, despite the special allowances. This investigation prioritised motivation and socio-economic factors over legal analysis.

These three studies demonstrate that numerous studies have been conducted on the distribution and incentives for medical personnel in remote areas, but most have focused solely on distribution, policy, and motivational aspects. No research has specifically addressed the welfare of civil servant medical personnel in remote areas from a legal perspective, including the state's responsibilities under the 1945 Constitution, the Civil Servant Law, and the Health Law, as well as regulatory gaps. Therefore, this study is novel because it examines this issue through a more comprehensive legal analysis.

Based on this background, this study seeks to address two main questions. First, how is the government responsible for the welfare of civil servant medical personnel serving in remote areas? Second, how should regulations for the welfare of civil servant medical personnel be designed within the desired legal framework? The purpose of this study is to deeply analyze the form of state responsibility, review existing regulations, and provide a legal perspective on an ideal regulatory model that can guarantee the welfare of civil servant medical personnel in remote areas.

2. Materials and Methods

This research uses a normative juridical method with a statute approach and a conceptual approach. Normative legal research focuses on law as a rule or norm, with the primary source being secondary data consisting of primary, secondary, and tertiary legal materials (Marzuki, 2021; Negara, 2023). This research uses a normative approach

because the object of study is entirely related to positive legal norms, specifically provisions in the Health Law, the Criminal Code, and national and international human rights instruments that regulate abortion. This method was chosen because the research does not require empirical data, but rather examines the consistency, synchronization, and adequacy of legal norms in answering problems, by exploring the legal meaning of developing regulations, principles, and doctrines. In the analysis, the weight of legal materials is determined based on their hierarchy and level of authority: primary legal materials (the 1945 Constitution, laws, government regulations, the Criminal Code) are the main sources because they are binding, secondary materials (books, journals, doctrines, jurisprudence) are used to enrich interpretations, while tertiary materials (dictionaries, encyclopedias) only serve as supporting materials. Regulations are considered to have normative gaps if there is ambiguity or multiple interpretations, conflicts between regulations, the absence of regulations on important issues, or inconsistencies with international human rights standards, so that they are unable to provide certainty, justice, and protection of human rights. The process of collecting legal materials is carried out through inventory, identification, classification, and systematization of relevant regulations and literature, then analyzed prescriptively to assess the suitability of legal provisions to the problem and formulate ideal legal norms and rules that should be applied.

3. Discussions

3.1. *Legal Regulations Concerning Procedures for the Placement of Civil Servant Medical Personnel in Remote Areas*

Law Number 20 of 2023 concerning the State Civil Apparatus (ASN Law) stipulates that ASN consists of Civil Servants (PNS) and Government Employees with Work Agreements (PPPK). As human resources within the state apparatus, ASN play a crucial role in the equitable distribution of public services, including placement in remote areas. Article 20 of the ASN Law stipulates that ASN placement must take into account organizational needs, competencies, and individual potential, with the principle of merit as the primary foundation.

The rights of civil servants, as stipulated in Article 21 of the ASN Law, include income, allowances, social security, legal assistance, work environment, and personal development. Furthermore, the ASN Law mandates the development of derivative regulations in the form of Government Regulations to detail procedures for placement, promotion, transfer, and special incentives for employees assigned to underdeveloped, frontier, and outermost (3T) areas. Coordination between the central and regional governments is necessary to ensure that ASN distribution aligns with the needs of each region (Kurniawan et al., 2020; Paratama et al., 2025).

Government Regulation Number 11 of 2017 concerning Civil Servant Management complements the Civil Servant Law by emphasizing a meritocratic system in employee selection, promotion, and transfer. Each appointment is conducted through a strict and objective mechanism based on qualifications, competencies, and performance track records. The transfer process is also regulated to maintain a balance between organizational needs and civil servant career development, resulting in a more proportional distribution of employees across regions.

The civil servant mobility policy is also aimed at addressing the gap in talent distribution, which has historically been concentrated on Java. With an

"Indonesia-centric" orientation, the government is encouraging the placement of civil servants, including medical personnel, in the 3T (frontier and remote) regions as a measure to achieve equitable national development. This is emphasized in Health Law Number 17 of 2023, which emphasizes the goal of health reform: increasing access to and equity in health services regardless of social, economic, or geographic background.

However, the implementation of the policy on the placement of civil servant medical personnel in remote areas still faces serious obstacles. The number of medical personnel nationally in 2023 was recorded at 183,694 (8.8% of the total health workforce), with doctors making up the largest group. However, distribution is uneven, and many remote areas experience a shortage of medical personnel. This phenomenon highlights the gap between ideal regulations and the reality on the ground, particularly regarding medical personnel retention. Thus, although the legal framework for the placement of civil servants and medical personnel is quite comprehensive, the distribution and welfare of medical personnel in remote areas still require special attention. Harmonizing regulations, increasing regional fiscal capacity, and strict oversight are key to achieving the goal of equitable healthcare services.

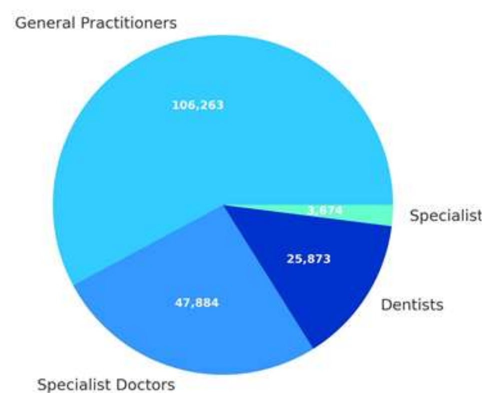

Figure 1. Proportion of Medical Personnel in Idonesia

Sources: Ministry of Health, 2024

The distribution of medical personnel in Indonesia still shows significant disparities between the Java-Bali region and areas outside Java-Bali. Data shows that approximately 60.8% of the total national medical personnel are concentrated in the Java-Bali region. The provinces with the largest number of medical personnel include West Java with 27,091 medical personnel, followed by East Java with 23,047, and Jakarta with 22,724 medical personnel. Conversely, the regions with the fewest medical personnel are in eastern Indonesia, such as Highlands Papua with only 235 medical personnel, South Papua with 308, and Southwest Papua with 385.

The most common type of healthcare worker found in underdeveloped areas is nursing, with 24,242, followed by midwifery with 16,911, and community health workers with 4,271. On the other hand, the types of health workers with the fewest numbers include clinical psychologists, with only 17, traditional health workers with 63, and physical therapy with 140. The distribution of health human resources in underdeveloped areas reflects the number of underdeveloped districts designated by

the government. East Nusa Tenggara and Maluku provinces have the highest number of underdeveloped districts compared to other provinces.

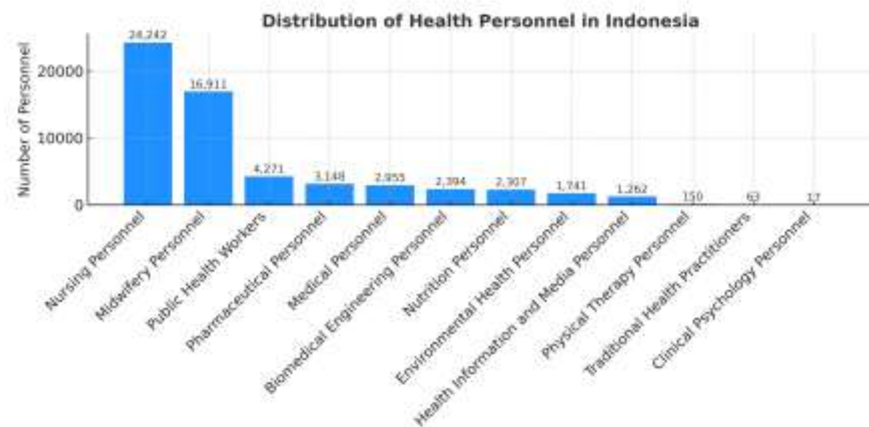

Figure 2. Distribution of Health Human Resources in Remote Areas in 2023

Sources: Ministry of Health, 2024

To address the challenge of disparities in health services, the Indonesian government enacted Law Number 17 of 2023 concerning Health as a step towards reforming the national health system to ensure more equitable and quality services. Based on Article 13 of the law, one of the responsibilities of the central government is to ensure the availability of fair and equitable health resources for all citizens. Furthermore, Article 10 Paragraph (1) emphasizes that this responsibility also rests with regional governments, including those in underdeveloped, frontier, and outermost (3T) regions. Efforts to meet the need for medical personnel are carried out through strategic planning, including special placement schemes, employment contracts, civil service bonds, and mandatory service periods in specific regions.

The limited number of civil servants in remote areas is a crucial issue because it can hamper governance and development at the local level. This shortage has implications for the low quality of public services and the slow implementation of various government programs. The central and regional governments need to strategically design policies that attract civil servants to work in remote areas, including through the provision of special incentives, improvements to supporting infrastructure, and improvements in welfare and career paths. Implementing affirmative action programs in the form of additional allowances or compensation for civil servants willing to work in underdeveloped areas could be a strategic step in addressing the unequal distribution of civil servants.

Utilization of healthcare workers includes equitable distribution, resource optimization, and career development. To ensure sustainable services, a retention strategy in the form of incentives and career paths is necessary, as emphasized in the WHO's Global Strategy on Human Resources for Health: Workforce 2030. This strategy also aligns with the National Health System which emphasizes the need for regulatory support as a foundation for developing and empowering health human resources(Mokoena & Naidoo, 2025; Rahman & Qattan, 2021) .

Health Law Number 17 of 2023 comprehensively regulates the placement of medical personnel through Articles 231–237. Article 231 emphasizes the responsibility of the central and regional governments in the distribution of medical personnel, including through civil servant mechanisms, special assignments, and military/police channels. Article 232 emphasizes the importance of retention, including through assignment extensions, incentives, career paths, and remuneration systems. Article 234 opens the door for healthcare graduates to participate in placement selection, while Article 235 grants special rights to medical personnel in remote areas in the form of incentives, legal protection, special promotions, and guaranteed infrastructure. Article 237 even authorizes the government and the private sector to establish civil service contracts to support the availability of medical personnel in priority areas.

Government Regulation Number 28 of 2024 enhances technical regulations. Article 543 stipulates that healthcare services in poor regions, border territories, islands, forests, and distant indigenous populations must be provided by qualified medical professionals. Article 544 requires central and regional governments to address medical personnel vacancies via reassignment, supplementary training, or delegation of responsibility. The integration of civil service contract regulations, personnel retention, and adaptable mobilization of medical staff is a crucial component of the plan for equitable service allocation.

Current regulations partially align with the principles of distributive justice by granting entitlements such as salary, allowances, incentives, social security, and career development to medical civil servants; however, gaps remain in ensuring fairness, particularly regarding incentive amounts, infrastructure standards, promotion schemes, and sanctions for non-compliance, which perpetuate inequality between urban and remote regions. This discussion contributes to long-term solutions by identifying these normative shortcomings and recommending more detailed derivative regulations to address technical aspects such as incentive distribution, facility standards, and retention mechanisms. Bridging the gap between legal guarantees and operational realities not only enhances the welfare of medical personnel but also supports equitable healthcare access across regions, thereby advancing distributive justice and strengthening the sustainability of the welfare state in Indonesia.

3.2. Legal Protection for the Welfare of Medical Personnel in Indonesia

In essence, legal protection is a tool that the state provides to ensure that citizens' rights are fulfilled and to prevent or resolve any violations that may occur. Definitions of this concept have been provided by certain experts. Rahardjo (2010) underscored that legal protection is an endeavor to safeguard human rights that have been violated by others, thereby enabling society to capitalize on the rights that are legally granted. Mertokusumo (2009)regards legal protection as a guarantee of human rights and obligations, which are applicable in both personal interests and interpersonal relationships. In the meantime, Heintze (2004) defines legal protection as a form of protection that is exclusively provided by law, and is closely associated with human rights and obligations as legal subjects in social interaction. In this regard, legal

protection not only confirms the existence of rights but also guarantees the existence of mechanisms to enforce them in the event of violations.

In practice, legal protection serves two primary objectives. Initially, guaranteeing the fulfillment of citizens' rights to enable them to live and work in a manner that is consistent with the relevant standards. Secondly, the prevention of actions that violate the rights of citizens through the use of regulatory instruments, supervision, and objection mechanisms. Citizens are also granted the ability to prevent violations, seek compensation, or seek redress for their rights that have been violated through legal protection. Consequently, legal protection is not only declarative but also operational through the use of law enforcement instruments.

In relation to the protection of the rights of the citizen, Philipus M. Hadjon (2001) distinguished between two types of protection, namely (a), Insurance Preventive Services. In this preventive legal protection, the court is granted the opportunity to issue a ruling or decision before a definitive decision is made by the government. The objective is to prevent it from occurring, (b). Representative Currency Security. The objective of judicial independence is to ensure justice. This category pertains to the legalization of marijuana by the Supreme and Administrative Courts of Indonesia. The second principle that is based on the protection of the law against the government is the Islamic law of the nation. In relation to the protection and safeguarding of HAM, the protection and safeguarding of HAM are of paramount importance and can be associated with the objectives of the legal state.

This second form of protection is a critical foundation in the legal concept of a nation, in which the protection and respect of human rights are considered the primary principle. In the context of persistent non-communicable diseases (PNS) that are prevalent in rural areas, comprehensive legal protection has been established in various regulations, including the ASN and Health Laws. The basic obligations of a physician as an ASN include the provision of care, training, social support, legal protection, personal development, a safe work environment, and retirement and holiday benefits. The regulations also emphasize the obligation of personnel development officers to implement a merit system consistently, so that placement, promotion and provision of incentives are carried out objectively based on employees, competence and performance. In this regard, the Health Law and PP No. 28 of 2024 provides specific guidance to medical personnel stationed in remote, mountainous, and island regions (DTPK) through the provision of information, assistance, security, emergency response, and disaster preparedness. This safeguard is a specific commitment to the high-risk and work-related risks that they face.

In addition to financial aspects, regulation also encourages the development of medical expertise as a component of long-term security. Article 21 paragraph (8) and Article 49 of the ASN Law argue that an ASN will continue to improve competence via an integrated learning system. This principle is crucial because disasters are not solely associated with material compensation, but also with professional development that enables medical professionals to enhance their quality of life and maximize their career opportunities. Furthermore, the Health Ministry provides doctors with legal protection

and job security, thereby ensuring that they have legal protection when confronted with risks that are specific to their profession.

The mechanism of enforcement is more susceptible to corruption when there is a threat of war. The ASN Law can provide a basis for implementing disciplinary sanctions against officials or ASN who violate their obligations, namely ignoring the rights of medical personnel. This principle is further elaborated in PP No. 94 of 2021 regarding the PNS discipline, which permits the submission of a complaint in a timely, polite, and respectful manner, including the rejection of unfounded complaints. Medical practitioners who wish to terminate their licenses are also granted access to administrative procedures and mechanisms as defined in Article 64 of the ASN. If delivery fails to meet internal standards, it may be transferred to a higher-level institution, such as BKN or KASN.

The ASN professional organization also plays a critical role in representative security by providing legal advice and recommendations regarding ethical codes and merit systems. In addition, the involvement of non-ASN personnel in the construction of ASNs is also a structural security measure. The stakes associated with this issue have the potential to disrupt organizational structure and alter the level of stakes for PNS, including medical personnel, thereby threatening their survival. As a result, the individuals who are involved in this case may be subject to administrative sanctions or prosecution if there is a corruption scandal.

Despite the existence of a comprehensive regulatory framework, the effectiveness of legal protection for medical personnel in rural areas is currently facing numerous challenges. Initially, regulatory inefficiency frequently results in conformity or conformity to the norm, particularly in the context of the implementation of insensitive areas. Second, the insufficient implementation of ideal regulations in the region results in the deterioration of the environment. Third, the primary mechanism of supervision and the inconsistency of the merit system result in discrimination and inequality in the distribution of medical resources. As a result, despite the fact that the medical PNS staff stationed in remote areas have a legal obligation to ensure the safety of the population, these obligations have not been strictly enforced. In order to ensure that legal protection is consistently effective, efficient, and beneficial, it is necessary to harmonize regulations, increase the physical capacity of the region, and establish a strong oversight mechanism by the central government. In this way, medical professionals can work more efficiently, have high motivation, and provide optimal healthcare services to the local population in accordance with the legal framework of the country that prioritizes the welfare of the people.

4. Conclusions

The disparities in medical staff practices between urban and remote regions in Indonesia are stark, particularly in terms of facilities, benefits, workload, and career development, leaving civil servant medical staff in distant areas exposed to greater risk and undermining the public's right to health. Although existing regulations such as the 1945 Constitution, the 2023 Civil Servant Law, the 2023 Health Law, Government Regulation No. 28 of 2024, and Minister of Finance Regulation No. 90 of 2015 provide entitlements to salary, allowances, incentives, social security, safety, and career pathways, they remain

inadequate as they lack clear provisions on incentive amounts, promotion schemes, infrastructure standards, and sanctions for neglectful authorities. To address these gaps, the government must strengthen affirmative action policies through more comprehensive regulations and derivative laws that detail technical matters such as incentive standards, facility upgrades, safety guarantees, and retention measures, ensuring both normative and practical legal protection. However, this study is limited to a normative legal analysis and does not include empirical data on the actual implementation or lived experiences of medical staff in remote regions.

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