Poltekita: Jurnal Ilmu Kesehatan
e-ISSN: 2527-7170 | p-ISSN: 1907-459X
Volume 19 Issue 3, 2025, page 400-406
DOI: 10.33860/jik.v19i3.4297
Website:https://ojs.polkespalupress.id/index.php/JIK
Publisher: Poltekkes Kemenkes Palu

Original Article

Health Ministry's Scholarship Policy: Fulfilling Staffing Needs for Doctors and Dentists

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ARTICLE INFO

Article History:
Received: 2025-08-12
Published: 2025-12-01

Keywords:
health policy; medical workforce fulfillment; educational funding assistance; physician retention; maldistribution; policy analysis.

ABSTRACT

Indonesia faces a critical shortage and maldistribution of medical professionals, particularly in Disadvantaged, Border, and Outermost (DTPK) regions. This study analyzes the effectiveness of the Ministry of Health's Educational Funding Assistance Program (*Bandikdok*) within the new regulatory framework of Law No. 17 of 2023. A qualitative Document and Policy Analysis was conducted. Data were collected from statutory regulations, Ministry of Health workforce reports (2022–2025), and a comparative review of successful retention models from Japan (Jichi Medical University) and Thailand (CPIRD). The analysis reveals that the program is supported by a robust legal foundation and has successfully lowered entry barriers, attracting over 2,278 participants through a centralized digital platform. However, the study identifies a critical structural weakness: the reliance on temporary Non-Civil Servant (Non-ASN) contracts and administrative sanctions creates a transactional "financial bond." This stands in contrast to the "social bond" models utilized in Japan and Thailand, which achieve higher retention through local recruitment and community integration. While the current policy effectively accelerates workforce production, long-term retention remains fragile due to the lack of career security. To ensure sustainability, the policy paradigm must shift from a punitive financial approach to a supportive ecosystem. Recommendations include decentralizing recruitment to create a "rural pipeline" and offering conditional Civil Service (ASN) tracks for graduates committed to long-term service in underserved areas.

INTRODUCTION

Health is a fundamental human right, wherein the World Health Organization (WHO) has set an ideal ratio of one doctor per 1,000 population as an indicator of an adequate health system.[1] Globally, the challenge of fulfilling the health workforce is increasingly evident. Although the global health workforce stock reached 65.1 million in 2020, including 12.7 million medical doctors, the WHO estimates a shortage of 10 million health workers by 2030.[2]

At the national level, Indonesia faces even more pressing challenges. With a projected population of 284 million by 2025, Indonesia requires 284,000 doctors (Ministry of Health, 2025).[3] However, data from the Indonesian Medical Council (KKI) indicates that only around 179,000 doctors are available, resulting in a shortage of over 105,000 personnel. A 2023 supply and demand modeling analysis highlighted specific shortages of 44,478 general practitioners (22.6%) and 13,269 dentists (25.23%).[4] Without intervention, given the current supply of graduates and a 1.5% annual attrition rate, this deficit is projected to persist beyond 2032.[4]

The core problem lies not only in quantity but also in the chronic maldistribution of medical personnel. This inequality is stark in Disadvantaged, Border, and Outermost Regions (known locally as DTPK) and Health Problem Areas (DBK). Ministry of Health data notes that 3,989 Community Health Centers (*Puskesmas*) (39%) lack complete staffing, with 475 having no doctor at all.[5] Previous attempts to resolve this disparity have yielded suboptimal results. Past initiatives often failed due to weak retention mechanisms, uncompetitive incentives compared to private urban practice, and a lack of binding regulatory support to enforce service commitments in remote areas. Consequently, efforts to address maldistribution have historically been temporary and unsustainable.

However, the policy landscape has recently shifted, creating a new "policy window." The enactment of Law Number 17 of 2023 on Health (the Omnibus Health Law) provides a stronger legal foundation for workforce transformation. Within this new framework, the Ministry of Health has revitalized strategies through the Educational Funding Assistance Program for doctors and dentists, regulated under Minister of Health Regulation Number 37 of 2022. Unlike previous scholarship schemes, this program is designed to accelerate production while enforcing stricter placement prioritization in DTPK and DBK areas.

Despite the significance of this regulatory shift, there is limited literature analyzing how this specific funding assistance program aligns with the new Health Law to overcome historic failures in workforce distribution. Therefore, this publication aims to analyze the policy of fulfilling the medical and dental workforce through the Ministry of Health's educational funding assistance program. Specifically, this study evaluates the regulation's potential to address the root causes of maldistribution and provides evidence-based recommendations for its implementation under the new national health strategy.

METHODS

This study employed a qualitative research design using a Document and Policy Analysis approach. This method was chosen to critically evaluate the regulatory framework and implementation strategies of the Ministry of Health's Educational Funding Assistance Program. Unlike a traditional systematic literature review, this approach focuses on statutory regulations and official government reports as the primary data, supported by a targeted review of relevant scientific literature.

Data collection was conducted online from September to October 2025. To ensure a comprehensive analysis, the search strategy was broadened beyond specific program names to include related concepts. Search terms included *"Human Resources for Health Indonesia," "Medical bonding schemes," "Rural retention of doctors," "Medical education funding,"* and *"Health workforce maldistribution."*

Data Sources and Selection Criteria The data sources were categorized into primary regulatory documents and supporting literature.

1. Primary Data: Included Law No. 17 of 2023 (Health Law), Minister of Health Regulation No. 37 of 2022, Indonesian Medical Council (KKI) registration data, and Ministry of Health workforce planning reports (2020–2025).
2. Secondary Data: Included peer-reviewed articles and international case studies relevant to health workforce retention strategies.

Selection criteria were defined as: (a) Direct relevance to medical workforce planning and distribution policy; (b) Published within the last 10 years (to ensure currency), with exceptions for fundamental regulations; and (c) Availability of full-text access.

Data were analyzed using descriptive content analysis. This involved reading the documents to identify key themes, classifying policy mechanisms (recruitment, placement, retention), and synthesizing the information to evaluate alignment between the regulations and the identified problems. The validity of the findings was ensured through data triangulation, cross-referencing official government data with academic findings to minimize bias.

RESULTS

The Legal Mandate for Workforce Fulfillment and Funding The analysis of statutory regulations reveals a strong legal hierarchy mandating the state to fulfill medical workforce needs through educational funding. As summarized in Table 1, the mandate originates from the 1945 Constitution (Article 28H and 34), which guarantees health rights and state responsibility. This constitutional order is operationalized through Law Number 17 of 2023 (Omnibus Health Law).

The new Health Law introduces a paradigm shift in workforce procurement. Article 202 places the obligation on Central and Regional Governments to ensure the quantity and equitable distribution of personnel.[6] Crucially, Article 224 explicitly links educational funding assistance with mandatory service (*ikatan dinas*). Unlike previous regulations, the Omnibus Law provides a stronger enforcement mechanism: beneficiaries who fail to fulfill their service obligations face administrative sanctions, including the revocation of their Registration Certificate (STR).

Table 1. Key Regulatory Framework for the Educational Funding Assistance Program

Regulatory Level	Key Provisions Related to Workforce & Funding
Constitution	Guarantees health as a human right; establishes state responsibility for health facilities.[7]
Law No. 17 of 2023 (Health Law)	Art. 202: Mandates government to fulfill workforce needs. Art. 224: Links funding assistance to mandatory service; imposes sanctions (STR revocation) for non-compliance. [8] Art. 237: Legalizes the *Ikatan Dinas* (service bond) scheme.
Gov. Regulation No. 28 of 2024	Establishes funding as a shared responsibility between Central Govt, Regional Govt, and the community.[9]
Permenkes No. 37 of 2022	The technical regulation for the "Bandikdok" program, detailing recruitment, funding components, and placement prioritization in DTPK areas.[10]

Program Implementation and Participant Data

Public interest in the funding assistance program has been substantial, driven by an open registration system accessible via the Ministry of Health's digital platform. Implementation data from 2022 to 2024 records a total of 2,278 affirmation participants, comprising 1,580 medical students and 698 dental students. This initiative involves a broad collaboration with 34 Faculties of Medicine and 11 Faculties of Dentistry across 34 state universities in Indonesia.[11]

Geographically, the program has successfully reached targeted priority areas. The highest participation was recorded from East Nusa Tenggara (NTT) Province with 255 participants, the majority of whom (240 participants) are pursuing general medical education at Nusa Cendana University, Kupang.[11]

Regarding program output, as of the 2023–2024 period, 77 participants have successfully graduated. Of these, 11 participants have already commenced their mandatory service (*pengabdian*). These early deployments were possible because some participants entered the program mid-clerkship in 2022, allowing for immediate utilization according to their service contracts. Additionally, 66 graduates are currently undergoing the internship program (2023–2024) or awaiting the Batch IV Internship schedule. Looking ahead, the program is projected to significantly boost the workforce supply, with an estimated 536 graduates expected in the 2024–2025 period (205 in 2024 and 331 in 2025).[12]

DISCUSSION

The Regulatory Paradigm Shift: From Voluntary to Mandatory Distribution

The analysis of Law Number 17 of 2023 and Permenkes Number 37 of 2022 indicates a fundamental paradigm shift in Indonesia's health workforce policy: a transition from *voluntary* placement mechanisms to *state-mandated* distribution. While the 1945 Constitution establishes health as a fundamental human right,[13] the previous legal framework lacked the coercive power to ensure doctors served in Disadvantaged, Border, and Outermost (DTPK) regions.[14] The new Omnibus Health Law closes this gap by explicitly linking educational funding to a strict "Return of Service" (RoS) obligation.[15] This aligns with global trends where governments are increasingly asserting regulatory control over the health workforce to correct market failures in distribution.[16]

However, as the analysis below demonstrates, reliance on regulatory mandates alone poses significant challenges regarding long-term retention and the quality of service commitment.[17]

Comparative Analysis: Financial Bonds vs. Social Bonds

A critical evaluation of the "Bandikdok" program reveals that Indonesia currently relies on what international literature terms a "Financial Bond"—a transactional relationship where the government "purchases" service years in exchange for tuition fees. This stands in contrast to successful retention models in Japan and Thailand, which emphasize "Social Bonds." As highlighted in the results, Indonesia's recruitment is centralized (web-based) and open to all, with placement locations determined *after* acceptance. In contrast, Japan's Jichi Medical University (JMU) and Thailand's CPIRD program utilize a "rural pipeline" strategy.[18,19,20]

1. Recruitment Strategy: Japan and Thailand prioritize students from rural backgrounds (*local recruitment*), operating on the evidence that rural origin is the strongest predictor of rural practice.[18,19,20] Indonesia's Permenkes No. 37 of 2022, while offering affirmative quotas, still functions largely as a centralized scholarship rather than a community-tied recruitment program[21].
2. Nature of Obligation: The Indonesian model relies on a contractual debt. If a participant pays off the debt or accepts the sanction, the bond is technically broken. In contrast, the Jichi model builds a moral and social obligation to the sponsoring prefecture, resulting in a 70% retention rate even after the mandatory period ends.[22] Therefore, this study argues that while the Ministry of Health's current program effectively removes financial barriers to entry, it lacks the "social embedding" mechanisms that ensure graduates remain in DTPK areas voluntarily after their contracts expire.

The Challenge of Retention: Employment Status and Sanctions

A major structural weakness identified in this policy is the employment status of graduates. Unlike the Thai CPIRD graduates who enter the civil service with clear career tracks, graduates of the Indonesian "Bandikdok" program are classified as Non-ASN (Non-Civil Servants). This status creates job insecurity and limits long-term career progression. Without the guarantee of permanent employment or a clear pathway to becoming a specialist, the "return on investment" (ROI) for the state diminishes, as doctors are likely to migrate to the private sector in urban areas immediately after their mandatory service concludes. As evidenced by the Australian Bonded Medical Program (BMP), without strong professional support and integration into the rural health system,[23] RoS schemes often function as temporary staffing solutions rather than permanent fixes.[15,23]

Furthermore, the effectiveness of the "stick" approach—specifically the revocation of the Registration Certificate (STR) under Article 224 of the Health Law—remains a subject of debate.[8] While strict sanctions ensure compliance, argue that "coerced" retention often leads to low job satisfaction and high turnover once the coercion ends.[24] The reliance on administrative penalties (STR revocation) suggests a lack of positive incentives powerful enough to retain doctors naturally.[8]

Implications for Policy Improvement

To transition from a short-term staffing solution to a sustainable workforce strategy, Indonesia must look beyond financial incentives. The current "policy window" created by the Omnibus Law offers an opportunity to integrate "rural pipeline" elements into the funding program. This implies that future amendments should consider: (1) Decentralizing recruitment to give greater weight to candidates nominated by local governments in DTPK areas[25,26]; and (2) Converting the post-education status from temporary contracts to permanent Civil Servant (ASN/PPPK) positions, conditional on long-term rural service.

CONCLUSION

This study concludes that while Law Number 17 of 2023 provides a robust legal framework for mandatory distribution, the current implementation of the Educational Funding Assistance Program ("Bandikdok") relies too heavily on centralized financial bonding. Although

the program has successfully removed financial barriers to entry—evidenced by the high recruitment of over 2,200 participants—the reliance on temporary "Non-ASN" contracts and administrative sanctions creates a transactional relationship that is insufficient for long-term retention.

The analysis suggests that without structural changes, the program risks becoming a temporary staffing solution rather than a sustainable fix for maldistribution. Therefore, this study recommends a strategic shift from a purely "Financial Bond" model to a "Social Bond" model. Specifically, the Ministry of Health should: (1) Decentralize recruitment to allow DTPK regional governments to nominate local candidates (creating a "rural pipeline"); and (2) Restructure the employment status from temporary contracts to conditional Civil Service (ASN/PPPK) tracks, ensuring that retention is driven by career security rather than coercion

Author's Contribution Statement: **Farid Kharisma**: contributed to the conceptualization, methodology, formal analysis, investigation, data curation, and writing of the original draft. **Ede Surya Darmawan**: contributed to the supervision, validation of the study design, and critical review and editing of the manuscript. Both authors have read and agreed to the published version of the manuscript.

Conflicts of Interest: The authors declare that the research was conducted without any commercial or financial relationships that could be construed as a potential conflict of interest.

Source of Funding: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Acknowledgments: The authors would like to acknowledge the Faculty of Public Health, Universitas Indonesia, for the institutional support provided during the preparation of this manuscript.

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