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Analyzing the Implementation of Medical Workers' Rights Policy in a Public Hospital: Evidence from Tanjungpinang City through the Edwards III Theory

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ABSTRACT
Medical personnel are strategic actors in the healthcare system who face heavy workloads, legal risks, and complex professional demands, making the protection of their rights essential. This study analyzes the implementation of policies on the fulfillment of medical personnel's rights under Article 721 of Government Regulation Number 28 of 2024 at RSUD Kota Tanjungpinang. Using a descriptive qualitative approach within a constructivist paradigm, data were collected through in-depth interviews, document analysis, and internal hospital regulations. The data were analyzed using the Miles, Huberman, and Saldaña interactive model and interpreted through the Edwards III policy implementation framework. The findings show that the fulfillment of medical personnel's rights has been carried out normatively and administratively, but remains not fully optimal in practice. Basic rights, such as social security and occupational safety, are relatively well fulfilled, while strategic rights particularly legal protection, fair compensation, professional recognition, and career development opportunities still face challenges. Key obstacles include limited policy communication, budget and human resource constraints, varying commitment among implementers, and bureaucratic structures that have not fully supported institutional protection. This study concludes that effective fulfillment of medical personnel's rights requires not only adequate regulations but also stronger institutional capacity and policy implementation at the hospital level.

Keywords: Medical Personnel, Medical Personnel Rights, Policy Implementation, Edwards III.

I. Introduction

Medical personnel represent a strategic profession as the frontline of the healthcare system, encompassing responsibilities in disease prevention, diagnosis, treatment, and patient recovery. This profession demands a high level of clinical competence, precision in medical decision-making, adherence to ethical standards, and continuous readiness to respond to emergency situations. Beyond the complexity of clinical practice, medical personnel are also exposed to heavy workloads, extended working hours, risks of infectious disease exposure, psychological strain, and persistent legal pressures, all of which cumulatively increase vulnerability to stress and burnout (Ying et al., 2022). Night-shift work has been empirically associated

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with disruptions in circadian rhythms, physical fatigue, and reduced cognitive performance, potentially compromising the quality of healthcare services (Peng et al., 2023; Silva-Costa et al., 2011). In many contexts, medical professionals are required to make rapid decisions under conditions of limited time and constrained resources, further intensifying psychological burdens. Accordingly, medical personnel should not be viewed merely as technical service providers, but rather as strategic human resources who require adequate legal protection, welfare guarantee and sustained institutional support.

Evidence from both national and international contexts indicates that the fulfillment of medical personnel's rights continues to face significant challenges. The Ombudsman of the Republic of Indonesia reported thousands of cases involving delayed incentive payments to healthcare workers in Semarang during the 2021–2022 period (Ombudsman RI, 2025). Comparable circumstances have been observed in India, where ESIC hospital staff organized strikes following three consecutive months of unpaid salaries (Deshpande, 2025). From a legal perspective, Indonesia's Ministry of Health documented dozens of malpractice complaints between 2023 and 2025 (Desideria, 2025). In the United States, malpractice claims reached several thousand cases in 2024, with the highest risk concentrated among surgeons, obstetricians–gynecologists, and otolaryngologists (Driscoll, 2024; Miller & Zois, 2025). Substantial disparities are also evident in legal protection and professional liability insurance coverage. In Indonesia, malpractice insurance remains largely confined to certain private hospitals, while most regional public hospitals have yet to allocate funding for such premiums. By contrast, in the United States, medical liability insurance premiums account for nearly half of total healthcare operational expenditures (Henry, 2025). Moreover, the World Health Organization reports that healthcare workers in low-income countries face elevated risks of infectious disease exposure and workplace violence (WHO, 2022). Gaps in rights protection and advocacy support have likewise been identified in Australia, where a majority of junior doctors report inadequate legal and professional backing (Maloney et al., 2022).

These patterns underscore that the protection of medical personnel constitutes a global policy issue with direct implications for workforce well-being and healthcare quality. Similar dynamics are observable at the local level, particularly at RSUD Kota Tanjungpinang, where tensions have emerged between medical staff and hospital management following the suspension of night-shift incentive payments, leading to refusals to undertake night-duty assignments. Given that night work is associated with increased fatigue, additional financial incentives are often perceived as a matter of fairness and a key motivator for performance (Peng et al., 2023; Silva-Costa et al., 2011). Divergent perceptions regarding incentive schemes may contribute to dissatisfaction and internal organizational conflict (Rodriguez et al., 2009; Rudasingwa & Uwizeye, 2017; Sang et al., 2022; Zhou et al., 2022). Beyond compensation-related concerns, dozens of malpractice allegations involving medical personnel at RSUD Kota Tanjungpinang were reported in 2024, with many cases requiring individual legal handling. Sustained legal pressure may undermine professional motivation and adversely affect the quality of healthcare delivery (Malesza, 2021; Ying et al., 2022).

In response to these multifaceted challenges, the Indonesian government has strengthened the legal framework for protecting medical personnel through Law Number 17 of 2023 on Health, further operationalized under Article 721 of Government Regulation Number 28 of 2024. This regulation comprehensively delineates the rights of medical and health workers, including legal protection, occupational safety and health, fair remuneration, social security, competency development, professional recognition, and the right to refuse requests that conflict with professional standards or legal provisions (Mangku et al., 2022). From a public policy perspective, however, the success of regulatory frameworks depends not only on their normative robustness but also on the effectiveness of their implementation at the institutional level. Previous studies have largely focused on the impact of fulfilling medical personnel's rights on job satisfaction, retention, motivation, and healthcare quality (Defar et al., 2021; Duwel et al., 2022; Gupta et al., 2021; Kuhlmann et al., 2021; Mkoka et al., 2015). Nevertheless, empirical investigations into how policies on medical personnel's rights are operationalized within regional public hospitals remain limited. Therefore, this study examines the implementation of policies concerning the fulfillment of medical personnel's rights under Article 721 of Government Regulation Number 28 of 2024 at RSUD Kota Tanjungpinang. It aims to assess the extent to which

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these rights have been integrated into internal hospital policies and to identify factors that facilitate or constrain effective implementation. The findings are expected to contribute to the academic discourse on healthcare policy implementation and to provide practical recommendations for local governments and hospital management in improving healthcare service quality through equitable and sustainable fulfillment of medical personnel's rights.

II. Literature Review and Hypothesis Development

This study performed a systematic literature review utilizing the Scopus database with keywords pertaining to the rights, protection, compensation, and welfare of healthcare professionals. The collected publications were then examined with VOSviewer to delineate thematic connections and research trends in the domain. The bibliometric analysis revealed four primary subject groupings. The initial cluster emphasizes remuneration and work motivation, underscoring the significance of both monetary and non-monetary incentives in improving job performance, job happiness, and employee retention within the medical profession. The second cluster focuses on workload and burnout, highlighting the detrimental impacts of excessive workload, occupational stress, and legal pressures on mental health, professional well-being, and service quality. The third cluster analyzes legal protection and health policy, highlighting ongoing discrepancies between regulatory frameworks and the actual enforcement of protections for medical personnel. The fourth cluster focuses on occupational safety and health security, highlighting the significance of workplace safety protocols, psychosocial support systems, and sustainable institutional policies to protect the welfare of healthcare professionals.

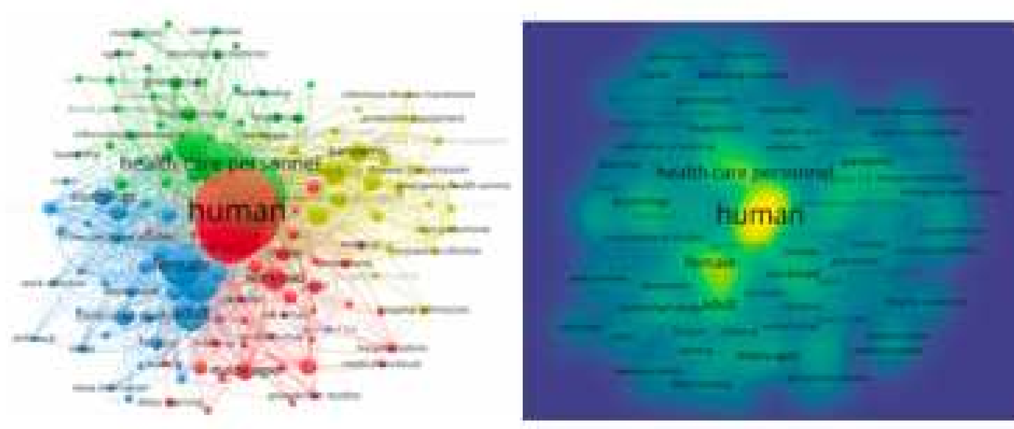

Figure 1. Visualization of Previous Literature Network Mapping from Scopus Database

The literature synthesis indicates that most existing studies examine issues affecting medical personnel in a fragmented manner, focusing separately on themes such as compensation, burnout, occupational safety, or legal protection. To date, there has been limited research that integrates these dimensions within a comprehensive framework of medical personnel rights as formally stipulated in Government Regulation Number 28 of 2024. Consequently, this study seeks to address this scholarly gap by providing a holistic analysis of the implementation of policies governing the fulfillment of ten statutory rights of medical personnel at the regional hospital level, with a particular focus on RSUD Kota Tanjungpinang.

2.1. Theory of Public Policy

Public policy is typically defined as governmental acts or decisions made to tackle public concerns, encompassing intentional choices to either intervene or abstain from intervention (Dye, 2013). Policies function as strategic tools aimed at attaining particular objectives that significantly impact society and

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governance (Anderson, 2003). Dunn (2004) further defines public policy as a framework for governmental action and a strategic orientation that influences the quality of public services and social welfare. In the healthcare sector, health policy is a multifaceted aspect of public policy that includes healthcare institutions, financing mechanisms, legal safeguards for health professionals, and the sustainability of national health systems (Birkland, 2019; Buse et al., 2005). In Indonesia, the enhancement of health policy is presently evidenced by Government rule Number 28 of 2024, which acts as the implementing rule for Law Number 17 of 2023 on Health. This regulatory framework designates medical workers as pivotal participants in the national healthcare system and strengthens their legal, professional, and welfare safeguards (Republic of Indonesia, 2024).

2.2. Public Policy Implementation Models

Since the 1970s, research on public policy implementation has progressed, focusing mostly on the disparity between policy development and actual execution (Kurhayadi, 2023). Van Meter and Van Horn (1975) contend that effective policy implementation is significantly affected by the precision of policy objectives, the accessibility of resources, and the existence of quantifiable performance indicators. Consequently, well articulated policy frameworks and operational procedures enhance the probability of successful implementation. Mazmanian and Sabatier (1983) assert that the efficacy of implementation is influenced by the characteristics of the policy problem, the institutional capacity of the policy, and external environmental factors that affect execution processes. Grindle (1980) underscores the significance of policy content and implementation context, accentuating the role of political, social, and institutional dynamics as important factors influencing policy results. Edwards III (1980) presents a top-down policy implementation model that delineates four critical drivers of successful implementation: communication, resources, implementer disposition, and bureaucratic organization. Communication pertains to the lucidity and uniformity of policy dissemination to implementers; resources include personnel, information, authority, and auxiliary facilities; implementer disposition pertains to the attitudes, commitment, and degree of support among those tasked with execution; and bureaucratic structure involves procedural clarity, authority distribution, and inter-organizational coordination. This study utilizes the Edwards III model for its pertinence in examining internal institutional elements that affect policy implementation at RSUD Kota Tanjungpinang, specifically regarding the fulfillment of medical personnel's rights.

2.3. Policy on the Fulfillment of Medical Personnel’s Rights

In Indonesia, the entitlements of medical workers are clearly enshrined in Article 721 of Government Regulation Number 28 of 2024, serving as a formal system for guaranteeing legal, professional, and welfare protection (Republic of Indonesia, 2024). This legislation specifies eleven essential rights of medical staff, encompassing legal protection in professional activity, the right to receive comprehensive and accurate patient information, and entitlement to equitable salaries, service fees, and benefits. Moreover, medical workers are entitled to occupational safety and health safeguards, social and employment security, protection against demeaning or unethical treatment, and acknowledgment for professional performance and commitment. The rule ensures the right to competency and career advancement, the ability to decline demands that contravene professional norms or legal stipulations, and supplementary rights in compliance with existing laws and regulations (Republic of Indonesia, 2024). This policy framework constitutes the principal normative basis for evaluating the fulfillment of medical personnel's rights at RSUD Kota Tanjungpinang. It offers an analytical framework for assessing the efficacy of policy implementation in regional healthcare facilities.

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III. Research Method

This study adopts a descriptive qualitative research design grounded in a constructivist paradigm, which conceptualizes social reality as being shaped through individual experiences and social interactions (Creswell & Creswell, 2018; Sandelowski, 2000). This approach enables an in-depth exploration of how medical personnel and hospital management interpret and experience the implementation of policies on the fulfillment of medical personnel's rights, particularly in relation to the discontinuation of night-shift incentives at RSUD Kota Tanjungpinang, Indonesia. The unit of analysis focuses on the ten statutory rights of medical personnel as stipulated in Article 721 of Government Regulation Number 28 of 2024. Research participants were selected using purposive sampling, targeting key stakeholders directly involved in policy implementation. These included the Hospital Director, medical personnel, the Chair of the Medical Committee, and the Chair of the Supervisory Board. Informant selection was based on their level of involvement, institutional authority, and depth of understanding of policy implementation processes. Data were collected through in-depth interviews to capture participants' experiences, perceptions, and insights into policy dynamics at the implementation level (Maxwell et al., 2016). In addition, document analysis was conducted on relevant regulations, service standards, standard operating procedures (SOPs), budget documents, institutional reports, and internal hospital policies (Bowen, 2009). To enhance the credibility of the findings, methodological triangulation was applied by cross-validating interview data with documentary evidence.

Data analysis followed the interactive model proposed by Miles, Huberman, and Saldaña (2014), which consists of three interrelated stages: data reduction, data display, and conclusion drawing and verification. The first stage focused on analyzing policy-related documents concerning the ten rights of medical personnel under Article 721 of Government Regulation Number 28 of 2024 to obtain an objective assessment of the normative and administrative fulfillment of these rights. The second stage aimed to identify factors influencing policy implementation using the Edwards III Policy Implementation Model (1980), which examines four key dimensions: communication, resources, implementer disposition, and bureaucratic structure. Empirical data at this stage were primarily derived from in-depth interviews to understand internal dynamics, implementation challenges, and institutional strategies at RSUD Kota Tanjungpinang. Subsequently, findings from document analysis and interviews were integrated through data triangulation to strengthen the validity and trustworthiness of the results (Creswell, 2014). The synthesized findings were then organized into a mapping matrix of medical personnel's rights, which served to identify gaps between normative policy provisions and actual implementation practices, as well as to highlight key factors that facilitate or hinder the fulfillment of medical personnel's rights at RSUD Kota Tanjungpinang.

IV. Result and Discussion

This section presents findings from in-depth interviews with key informants directly involved in healthcare delivery at RSUD Kota Tanjungpinang. Interview data were analyzed and organized according to stakeholder perspectives and systematically linked to the ten rights of medical personnel as stipulated in Article 721 of Government Regulation Number 28 of 2024. This approach ensures coherence between empirical evidence and the normative policy framework.

4.1. Management Perspective: Hospital Director

The Hospital Director underscored that the realization of medical personnel's rights is influenced by internal hospital regulations, financial limitations, and reliance on the national health insurance reimbursement system (BPJS Kesehatan). Concerning service fee payments, management has implemented formal distribution systems; yet, compensation continues to be a cause of internal discord due to the necessity for revenue adjustments to maintain hospital operations. Despite initiatives for financial transparency via

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simulations and open communication forums, misunderstandings and resistance among medical personnel continue to exist.

The hospital has established standard operating procedures (SOPs) and supplied personal protective equipment (PPE) regarding workplace safety and health. However, deficiencies in medical staff, especially within the emergency department, have led to occupational tiredness and increased susceptibility to burnout. The Director also recognized that legal protection procedures for medical personnel in conflict scenarios are inadequately institutionalized, resulting in deficiencies in formal organizational assistance. Simultaneously, social security coverage via BPJS has been administratively satisfied, and competency development programs exist, but they are restricted by civil service laws and financial constraints. The Director emphasized that the welfare of medical professionals is intricately linked to the hospital's financial stability and the promptness of BPJS claim payouts.

4.2. Service Delivery Perspective: Specialist Physicians

From the viewpoint of frontline medical staff, legal protection was identified as the most poorly realized right. Informants recounted experiences of conflicts with patients without the support of organized institutional legal aid, resulting in feelings of vulnerability and a decrease in job motivation. While medical facilities and personal protective equipment were typically deemed sufficient, hospital readiness to address non-clinical conflict threats was regarded as inadequate. Dissatisfaction was articulated over the openness and apparent equity of service charge allocation, which was regarded as ambiguous and a possible catalyst for professional discord. Moreover, possibilities for skill enhancement and career progression were reported to be limited by work laws, especially for civil servant physicians, for whom seeking higher education may lead to wage cutbacks or administrative repercussions. This condition was regarded as an impediment to professional development and motivation.

4.3. Clinical Governance Perspective: Chair of the Medical Committee

The Chair of the Medical Committee noted that, despite the presence of a compensation mechanism, general satisfaction among medical staff remains comparatively low. Legal protection has been recognized once again as a vital domain necessitating enhancement, since medical personnel frequently find themselves obligated to handle legal issues autonomously. The informant emphasized the necessity of implementing organized institutional legal support to protect professional integrity and reputation. Although formal communication channels between management and medical staff are established via committee structures, the efficacy of policy implementation was deemed inadequate. The clinical infrastructure was deemed generally sufficient; however, the lack of transparency in the allocation of service fees remained a significant unresolved issue.

4.4. Oversight Perspective: Chair of the Supervisory Board

The Chair of the Supervisory Board indicated that the allocation of medical personnel's rights has been included into the hospital's annual budgetary framework. Nevertheless, ongoing grievances—especially from emergency department personnel—concerning workload, remuneration, and perceived equity continue to exist. The informant emphasized the imperative for enhanced transparency in service charge computations and more candid financial communication. An analogy was presented, indicating that opaque payment schemes could cultivate perceptions of inequity despite adherence to formal administrative protocols.

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4.5. Synthesis of Interview Findings

The interview findings reveal that the realization of medical personnel's rights at RSUD Kota Tanjungpinang is incomplete and inconsistent. Rights pertaining to social security, occupational safety regulations, and fundamental service protocols have predominantly been managed at an administrative level. Nevertheless, legal safeguards, fair remuneration, professional acknowledgment, and avenues for skill enhancement and career advancement have not yet been completely established. The results further illustrate that the presence of formal policy frameworks does not inherently lead to good implementation. Ongoing disparities arise from financial constraints, inadequate legal protection frameworks, lack of communication transparency, and the partial incorporation of national regulations into internal hospital standard operating procedures. The interviews indicate a distinct disparity between the normative assurances established in national health policy and the actual experiences of medical workers. This gap establishes a crucial basis for further study with the Edwards III policy implementation practice.

4.6. Implementation of Medical Personnel Rights Based on the Edwards III Model

The results demonstrate that the execution of policies on the fulfillment of medical personnel's rights is still inadequate. This situation can be methodically analyzed using the four principal determinants of the Edwards III policy implementation model: communication, resources, implementer disposition, and bureaucratic structure. Despite Government Regulation Number 28 of 2024 establishing a clear normative framework for safeguarding the rights of medical professionals, a significant disparity remains between official policy stipulations and their actual implementation within hospitals. The analysis indicates that information about compensation structures, night-shift incentives, and the rights of medical personnel has not been communicated transparently, consistently, or comprehensively. The communication deficiency has fostered feelings of inequity and discontent among medical personnel, notwithstanding the presence of official policy norms. Restricted access to efficient communication platforms and delays in information distribution have exacerbated staff comprehension of the policy reason. These findings emphasize that the efficacy of policy relies not solely on regulatory clarity but also on the quality, consistency, and transparency of policy communication to implementers and beneficiaries. The study cites budgetary constraints and the hospital's dependence on BPJS Kesehatan payment as key variables impacting the fulfillment of medical personnel's rights, especially regarding salary and incentives. Moreover, the scarcity of medical personnel in high-intensity service units has intensified workloads and heightened the danger of occupational weariness and burnout. Despite the implementation of crucial occupational safety measures, including standardized K3 procedures and personal protective equipment, constraints in financial resources and human capital persistently hinder the institution's capacity to fully fulfill all statutory rights.

The views and dedication of implementers, or policy actors, significantly influence implementation outcomes. Interview results indicate that although several hospital executives and administrators exhibit a sincere dedication to protecting the rights of medical workers, their reaction to staff concerns and grievances is inconsistent. Simultaneously, healthcare professionals display doubt regarding compensation and legal protection measures, primarily due to past experiences that contradict official policy guarantees. This dynamic demonstrates that effective policy implementation depends not solely on written legislation but also on trust, institutional dedication, and the readiness of stakeholders to enforce policies equitably and sustainably. The study reveals that despite hospital implementation of SOPs, a medical committee, and formal oversight mechanisms, the current organizational structure has not sufficiently guaranteed legal protection or certainty in upholding the rights of medical personnel. Dispersed power, inadequately defined procedural rules, and the lack of a specialized unit for the legal protection of medical personnel are substantial institutional obstacles. Moreover, insufficient interdepartmental coordination and inadequate monitoring and evaluation procedures hinder the successful implementation of policy directives into operational practice. The Edwards III-based analysis indicates that the principal barriers to realizing medical personnel's rights arise

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not from an absence of policy, but from deficiencies in policy communication, limited resources, inconsistent commitment from implementers, and bureaucratic frameworks that inadequately facilitate effective implementation. Enhancing these four dimensions is crucial for improving policy implementation to better correspond with national regulatory mandates and the professional requirements of medical workers in frontline healthcare environments.

V. Conclusion

The results demonstrate that the rights of medical workers have been established at both normative and administrative levels; yet, their effectiveness in daily healthcare practice remains incomplete. Numerous fundamental rights such as social security coverage, occupational safety and health protection, and clinical service protocols have been adequately addressed by standard operating procedures and internal hospital rules. Nonetheless, more strategic rights necessitating the operational translation of national regulations specifically legal protection, equitable compensation, night-shift incentives, professional recognition, and opportunities for skill enhancement and career advancement persistently encounter substantial implementation challenges. This circumstance has resulted in a disparity between the normative assurances established in national rules and the actual experiences of medical workers at the institutional level. The Edwards III Policy Implementation Model identifies four critical characteristics that influence the success of upholding medical personnel's rights: communication, resources, implementer disposition, and bureaucratic structure. The primary obstacles are inadequate transparency in policy communication, financial and human resource limitations, disparities in implementers' commitment, and the lack of sufficiently comprehensive and actionable standard operating procedures and related policies. These findings emphasize that the efficacy of policies regarding medical personnel's rights relies not only on the quality of legislative frameworks but also on institutional capacity and the effectiveness of implementation at the hospital level. Enhancing policy communication, optimizing resource distribution, and refining bureaucratic frameworks are crucial for guaranteeing a more equal, sustainable, and quality-oriented realization of medical personnel's rights.

To improve the efficacy of upholding medical personnel's rights, efforts must focus on reinforcing the four principal factors outlined in the Edwards III model: bureaucratic structure, communication, resources, and implementer disposition. The hospital must establish and clarify specific SOPs on legal protection for medical staff, delineate explicit parameters for the right to decline requests that contravene professional standards, and implement structured programs for professional acknowledgment and incentives. Transparency in compensation and service charge structures should be enhanced by consistent, well-documented communication methods to reduce perceptions of inequality. Furthermore, strategic workforce planning, workload management especially in high-demand service units and institutional support for competency and career advancement should be enhanced. Enhancing a participatory organizational culture, coupled with augmented fiscal and regulatory support from local government, is essential for ensuring the sustainable, equitable fulfillment of medical personnel's rights, thereby improving the overall quality of healthcare services.

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