International Journal of Innovation, Creativity and Change. www.ijicc.net
Volume 13, Issue 4, 2020

# The Obstacles of Taluk Kuantan Regional Hospital in Serving the Participants of a Social Security Organising Agency (BPJS) in Kuantan Singingi

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Based on the results of this study, this case clearly violated the provisions of Article 25, Paragraph (1), letter d of the Regulation of the Health Social Security Organising Agency Number 1 of 2014 concerning health insurance providers. In this article it was said that each participant was entitled to obtain health insurance benefits. The intended health insurance is what is stated in Article 25, Paragraph (2) of the Regulations of the Health Social Security Organising Agency Number 1 of 2014 concerning Health Insurance Providers. The obstacles faced by the management of the regional hospital of Teluk Kuantan in providing services to patients participating in the Health BPJS are due to several factors: a. The doctor on duty was not in their place; b. claim issues from BPJS; c. arrears card payments by patients participating in BPJS; d. trauma to the patient due to injury (outside of a traffic accident); e. constraints when referring patients who need ICU space.

**Key words:** *Obstacles, Social Security, Serving.*

## Introduction

Health development is one part of national development that aims to optimally improve the health status of the community (Sundoyo, 2009). Article 28 H of the 1945 Constitution states "Every person lives in prosperity physically and mentally, lives and has a good and healthy environment and has the right to receive health services". The role of the government in health development was realised by placing health insurance under social protection in the

amendment to the 1945 Constitution, Article 34, paragraph (2), which states, "The State is responsible for providing health care facilities and proper public service facilities".

Health is an important indicator of prosperity in communities. Therefore, health services must be universally accessible to all people. This has also become a main pillar in the concept of a welfare state. This is because a healthy life is a basic condition for a community to be able to live a prosperous life, so getting optimal health services is a basic need and right for all citizens (Budi Setiyono, 2018).

In efforts to improve quality of life and optimal health services for the community, the government and the private sector provide institutions for health services called hospitals. Hospitals play a very important role in providing individual health services in a complete manner and provide emergency, outpatient and inpatient services.

Article 4 of Law Number 23 of 1992 concerning health states, "Everyone has the same right to obtain optimal health status". Therefore, in providing health services, there is no justification for discrimination by hospitals. Article 5 also states, "Everyone has an obligation to participate in maintaining and improving the health status of their person, family and environment". Article 65 states, "The implementation of this health effort shall be funded by the government and or the community".

In carrying out public interests and providing legal protection for the community, the government organises the National Health Insurance Program (JKN). As mentioned in the section considering letter a of Law Number 24 of 2011 concerning the Social Security Organising Body, "The national social security system is a program of the state that aims to provide certainty of social protection and welfare for all people".

The National Social Security System was formed as an embodiment and the seriousness of the government is contained in an amendment to the 1945 Constitution. This was then followed up by Law Number 40 of 2004 concerning the National Social Security System (SJSN), hereinafter referred to as the SJSN Law. This law is evidence from the government and other stakeholders who have a great commitment to realise social welfare for all Indonesian people (Sundoyo, 2009).

The SJSN Law mandates the formation of a health insurance agency. Thus, PT. Askes (Persero) is formed as an organising agency for health insurance for civil servants (PNS) once a year as the executor of the community health insurance program (Jamkesmas). This is stated in the provisions of Article 5, paragraph (1), Jo Article 52 of the SJSN Law.

On January 1, 2014, a change was made. PT. Askes (Persero) became the Social Security Organising Agency (BPJS) for Health as the executor of the Jamkesmas program. This is according to the provisions of Law Number 24 of 2011 concerning the Social Security Guarantee Agency (Asih Eka Putri, 2012).

BPJS is a legal entity that can carry out social security programs. BPJS is divided into 2 categories, namely BPJS Health and BPJS Employment. BPJS Health is demanded to be able to guarantee health that is in the form of health protection so that participants get the benefits of health care in health needs. This health insurance must be given to everyone who has paid, whether the payment is paid by the government or not.

The main task of BPJS Health is to provide national health insurance (JKN) for all Indonesian citizens. BPJS guarantees health services in the form of promotional, preventive, curative and rehabilitative services. In addition, there are also medical services and medical materials used for medical needs (Shoraya Yudithia, et. al. 2018; Hamzah, M. L, et. al. 2019).

BPJS Health cooperates with health service providers as a leader in fisheries as well as BPJS Health. This includes government hospitals, the government, private hospitals, clinics, health practitioners, doctors, pharmacies, optics, etc. Partnership between health BPJS and the provision of health services, such as driving in the national agreement, is in the form of a Memorandum of Understanding (MoU), which contains the rights and obligations of each party.

The government program, in helping the community to get health services, has not yet run in five ways. Health services, as the main activity of hospitals, involve doctors and nurses as health workers. They are most closely related to patients in handling illnesses. Relationships in the provision of health services are the relationships between hospitals and doctors, nurses and patients, and the relationships among doctors and nurses and patients. All communities of various groups have the right to benefit from proper health care. All the people serviced by BPJS Health have the right to get good medical action without criminal crimes in accordance with their respective provisions.

BPJS Health needs to pay attention to several things in health services in order to achieve success. Participants of the Health BPJS often complain about the lack of health services they receive. They say that the health services they obtain are different from other participants, being both hidden and only for treatment. Complaints that are often heard by BPJS Health participants involve inhospitable services, bitchiness, examinations not being done maximally, low responsiveness to complaints of patient illnesses and also low responsiveness when giving medication (Soekidjo Notoatmadjo, 2007).

BPJS Health, in carrying out its programs, is still not as optimal as it is expected to be by the Indonesian government. There are still services that are not appropriate to be given to BPJS card owners if compared with other patients.

On Monday, March 21st 2016, the Management of Teluk Kuantan Regional Hospital, Kuantan Singingi Regency, Riau Province, temporarily stopped health care services for BPJS Health patients. This happened because of the provision of problematic drugs for BPJS patients (https://www.goriau.com/, 2018). The hospital could not tend to patients because it did not have a medical doctor. Problematically, the RSUD was in arrears of Rp 2.6 billion. The absence of treatment at the Kuantan Regional Hospital has an impact on the rejection of BPJS patients.

Based on the background description above, the formulation of this research problem regards the inhibiting factors faced by the management of the Teluk Kuantan Regional Hospital in providing fisheries to the participants in the organising agency and the social security guarantee at Teluk Kuantan Regional Hospital.

There are several theories that will be used in this thesis research. First is the theory of role. The role is the implementation of rights and obligations according to position. The role and positions are dependence on each other. Collecting determines what a person must do for the community and what opportunities the community gives them. Roles are also governed by applicable norms (Soerjono Soekanto, 2005; Hamzah, et. al, 2018).

Second is the theory about BPJS, which is an institution organising social security programs in Indonesia according to the provisions of Law Number 40 of 2004 concerning SJSN and Law Number 24 of 2011 concerning BPJS. In Law Number 40 of 2004 concerning SJSN, BPJS is a non-profit legal entity. Health services (using recipient aid cards from the government) can only be served by government-owned hospitals. Meanwhile, private hospitals throughout Indonesia number around 2,000 according to the Ministry of Health's records.

Third, theories about health services are services by health institutions or health workers to their patients (Asih Eka Putri, 2012). The quality of health services refers to the ability of hospitals to perform services according to professional health standards so that they can later be accepted by patients (Fandy Tjiptono, 2007).

This research is analytical descriptive research with a descriptive explanation.

The location of this research is the Regional Hospital of Teluk Kuantan, the Regency of Kuantan Singingi, Riau Province.

The informants in this study were the Director of Regional Hospitals in Teluk Kuantan, the Head of the Media Centre Team of the Riau Provincial Health Service and the Head of Medical Services and Support at the Teluk Kuantan Regional Hospital.

## Method

The type of research used was normative-empirical legal research, namely legal research on the enforcement or implementation of normative provisions (codification, laws, and contracts) on certain legal events in society.

Meanwhile, when viewed according to its nature, the writing of this research is descriptive in nature. This exposure aims to express a complete description of the state of the law in force at a particular place and at a particular time, or regarding existing juridical symptoms, or certain legal events that are happening in society. This research is expected to be able to provide complete and clear information about the rights of BPJS Health participants as consumers according to consumer protection laws.

To solve legal issues and at the same time prescribe what should be, legal sources are needed. Sources of legal materials can be divided into primary legal sources and secondary legal sources. In accordance with the matter to be studied and the problem approach used, in principle this research uses primary and secondary data sources.

Data analysis is the process of compiling data so that the data can be interpreted. Data that has been collected through data collection activities has not given any meaning for the purpose of research. The research cannot be concluded because the data is still raw material, so an effort is needed to process it. The data is processed by studying the case and then presented in the form of a series of clear and detailed sentences. These are compared with the concepts that exist in the secondary materials in the form of books and other literature.

## Results and Discussion

The establishment of the legal basis for health services for BPJS Health participants is inseparable from Article 28 H of the 1945 Constitution, which in paragraph (1) states: "Every person has the right to live in physical and spiritual prosperity, to live and obtain a good and healthy environment and has the right to receive health services. " Paragraph (2) of this article also explains: "Everyone has the right to get special facilities and treatment to obtain equal opportunities and benefits in order to achieve equality and justice". Paragraph (3) states: "Every person has the right to social security, which enables his or her full development as a useful human being".

Pursuant to Article 52, paragraph (1) of the Health Law, general health services shall be composed of two forms of health services:

a. Individual Health Services (medical services)
These health services are organised as individual health care (self-care), and family (family care) or a group of community members in the institution of health services, such as hospitals, in order to cure diseases and restore health to individuals and families.

b. Community Health Services (public health services)
Public health services are organised by groups and communities at certain health centres, such as community health centres, with the aim of maintaining and improving health that refers to promotional and preventive actions.

Health service activities carried out in health centres, clinics and hospitals are generally regulated by Law Number 36 of 2009 concerning health in Article 54, paragraph (1), which states, "the implementation of health services is carried out responsibly, safely, with quality, equitably and non-discriminatorily".

Health services are legal acts that consequently create a penalty relationship between the health service provider (in this case the hospital) and the recipient of the health service (patient). The parties associated with each health service activity in hospitals, health centres, clinics, and private practices, are as follows:

a. Doctors
Doctors are people who have the authority and permission to perform health services, specifically examining and treating diseases based on law and services in the field of health. Article 1, paragraph (1) of Law Number 29 of 2004 concerning medical practices defines the work of a doctor as "work carried out based on a scientific basis. Competencies are obtained through tiered education and codes that are serving the community". A doctor must understand the provisions of the applicable law in the implementation of their professional practice, including their rights and obligations in carrying out their profession as a doctor (Anny Isfandyarie, 2006).

b. Nurses
Nurses always work in situations involving human relations. There is a process of interaction and influence and they can have an impact on each individual concerned (Mimin Emi, 2004). Minister of Health Regulation No. HK. 02. 02/MENKES/148/I/2010 concerning licensing and organisation of nurse practices, in Article 1, paragraph (1), explains the definition of a nurse as a person who has passed nurse education in accordance with statutory regulations.

c. Midwife

Midwives are recognised nationally and internationally by a number of practitioners throughout the world. The definition of a midwife, according to the International Confederation of Midwives (ICM) in 1972, is someone who has completed a midwifery education program that is recognised by the state and is qualified and given permission to carry out midwifery practices in their country. Midwives must be able to provide supervision, care, and provide advice that women need during pregnancy, childbirth, and the postpartum period, leading the delivery of their own responsibilities and care for babies born and children (Atik Purwandi, 2008). Care here includes preventive measures, detection of abnormal conditions in mothers and infants, and seeking medical assistance and emergency action when there are no other medical personnel.

d. Pharmacist

According to Government Regulation No. 51 of 2009 concerning pharmaceutical work, pharmacists are pharmacy graduates who have graduated as pharmacists and have taken the oath of the pharmacist position.

The process of health care begins with the decision of patients and their families to visit doctors and hospitals. The arrival of patients is interpreted as a form of submission of offers from patients to doctors to ask for help in overcoming the health problems they suffer. If a patient and their family have agreed to undergo health services at the hospital, the hospital will provide the medical services that the patient needs. At this stage, the rights and obligations of the patient and the hospital will arise since an agreement between the two occurs.

Activities in health services must be carried out based on the provisions of Article 29, paragraph (1), letter (b) of Law Number 44 of 2009 concerning hospitals, which states, "Hospitals are obliged to provide safe, quality, anti-discrimination and effective health services by prioritising the interests of patients in accordance with hospital service standards".

The implementation of health services has also been regulated in BPJS Health Regulation No. 1 of 2014 concerning the implementation of health insurance, Article 47, which reads,

(1) Every participant has the right to obtain health services that include promotional, preventive, curative, and rehabilitation services including medical services and medical materials after the use of medical needs.
(2) Health services, as referred to in paragraph (1), cover all first-level health facilities and sustainability health facilities. Other health facilities are stipulated by the minister in cooperation with BPJS Health, including the following health supporting facilities:

a. Laboratories;
b. Hospital pharmaceutical installations;
c. Pharmacies;
d. Blood Transfusion Units/Indonesian Red Cross;
e. Optics;
f. Providers of Consumable Ambulatory Peritoneal Dialysis (CAPD) services; and
g. Equal midwife/nurse practices.

Supporting factors are important to know so that the services provided can continue to be improved to provide satisfying services. Inhibiting factors in the service process are also very important in improving quality. It is necessary to know inhibiting factors in the service process so that the services provided can continue to be improved.

According to Muninjaya, inhibiting factors can be classified into three parts: obstacles that are based on organisational capability (organisational weaknesses), obstacles that occur in the environment, and obstacles to the high cost of health services (Novita Ayu, 2016).

The following results are based on an interview with Dr. Diny Ayu Lestari as The Head of Services & Medical Support at Teluk Kuantan Regional Hospital. The constraints faced by the Teluk Kuantan Hospital in providing health services to BPJS Health participants are as follows (Dr. Diny Ayu Lestari, 2018):

1. Constraints come from the doctor in charge: Obstacles to services at Teluk Kuantan Hospital occur if the doctor concerned is not available for a reason. This will be an obstacle to the service of patients participating in BPJS Health.
2. Problems come from claims involving the BPJSL: From 2018 to January 2019, claims were only be in September 2018.

Delays in claims are due to failures regarding target achievements of verification and file collection. The process of claim verification at BPJS is divided into 3 categories: claim verification based on INA-CBGs, verification of non-capitation claims, and other claim verification. In general, BPJS claims start from Health Facilities that prepare various documents and claim requirements that will be submitted to BPJS. Then, BPJS verifiers carry out various verifications, starting from verification of administrative participation, verification of service administration, verification of service, and verification using software. Finally, BPJS will make decisions regarding the payment of claims, whether they will be accepted, rejected or suspended.

The claim verification process is in health care is often hampered because the verification system in BPJS Health takes a long time. Article 25 of BPJS Health Regulation Number 3 of 2017 concerning management of health facilities and claim administration in the

implementation of national health insurance states that BPJS Health must pay health facilities for services provided to participants no later than 15 (fifteen) working days after the claim document is received (to be completes at the BPJS Health Office/Regency/District Office).

In reality, the process of verification of claims requires a long time compared to the provisions of BPJS Health Regulation Number 3 of 2017 concerning management of claims and administration of health facilities in the implementation of national health insurance. It only provides 15 days of work to process claims. This is certainly not beneficial for the hospital because this hospital is a regional referral centre, so services are demanded to be given as much as possible without any obstacles in terms of financing. There is an arrear in card payments by BPJS Health participant patients.

There are still so many patients participating in the health BPJS who are in arrears in payment for reasons of forgetfulness. Not only that, some BPJS Health participants even said they did not know that card payments had to be made every month. BPJS Health participants felt as if they were paying for their cards only when they were paid enough at the BPJS office.

In BPJS Health Regulation Number 1 of 2014 concerning the implementation of health insurance, in Article 33, Paragraph (1), the contribution of the health insurance guarantee, as referred to in Article 2, letter b, must be paid by every participant of the health insurance program. Paragraph (2) states contributions, as referred to in paragraph (1), must be paid no later than 10 months to the Bank that has cooperated with BPJS Health.

2. The existence of trauma to patients due to injury (excluding traffic accidents) usually involves trauma due to falls. Hospital management finds it difficult to sort out this data into the BPJS Employment category or BPJS Health.

Constraints in this case occur if a traumatised patient, when asked by the hospital, finds it difficult to explain the case as belonging to the BPJS Health category or BPJS Employment. A lack of knowledge of a patient about BPJS also becomes its own obstacle when patients have to explain the case they experienced to relevant parties. This eventually hampers the process of health services for BPJS participants, where hospital workers find it difficult to sort out cases experienced by patients, hospital parties, and then determine the cases that are included in the BPJS Health category.

Regarding obstacles when referring patients, patients who are referred are often constrained by the place or mechanism in their referral, especially if a patient participating in BPJS Health who will be referred requires an ICU room. The lack of communication between the hospital and the referral hospital becomes a major factor in the occurrence of resistance in the health services regarding participants in BPJS Health.

Often, when a patient needs an ICU room, the patient is referred to another hospital because the ICU room in the first hospital is full. When the patient arrives at the referral hospital, the same thing happens as at the first hospital; the referral hospital has the pretext that the availability of ICU rooms is insufficient and the ICU rooms are full, so the emergency centres are rejected. Such problems often occur. To this day, no solution has been found. BPJS Health is not able to intervene in the hospital related to the policy and also the availability of the guarantee due to limited authority.

Interviews with BPJS Health participants in Teluk Kuantan could inhibit the treatment process involving the BPJS Health Card. An interview with one of the BPJS participants who underwent treatment in the Teluk Kuantan Regional Hospital using the BPJS Health Card revealed the following:

Mrs. Hartati, when performing benign tumour surgery, said, "when I was operating, I had to wait for hours because it seemed to be slowly handled by the doctor concerned. The doctor said that the operation would be carried out at 14.00 WIB, so I had done fasting before the surgery, but in reality, the new operation would be done at 22.00 WIB" (Hartati, 2019).

Mrs. Hartati also mentioned that the woman was never in arrears in payment for the BPJS Health Card. The monthly contribution was Rp. 51,000 for the treatment. At that time, the mother mentioned obtaining the required medication completely from the hospital in accordance with the guarantee of the medication borne by BPJS Health.

Regarding the promotion and preventive services carried out by BPJS Health, as well as the hospital side, Mrs. Hartati mentions rarely ever getting promotion services in terms of health counselling and prevention, such as immunisation. BPJS Health also did not explain in full the information about the use of the BPJS Health Card and health services that are guaranteed by BPJS Health.

This was emphasised again after the interview with patients of BPJS Health. Ms. Hadrayani used to undergo treatment at the Teluk Kuantan Regional Hospital using a BPJS Health card in 2016 when she wanted to undergo a tumour operation. She said, "At that time I was forced to be referred to the Safira Hospital in Pekanbaru because the surgeon was in education and there was no substitute doctor at the Kuantan Bay Regional Hospital. Other than that, the supply of drugs was also problematic" (Hadrayani, 2019).

At that time, the stock of medicine was completely known at the Teluk Kuantan Regional Hospital. This is because of the availability of medication for BPJS Health patients. The Regional Hospital did not have the provision of medication because the Regional Hospital was in arrears for the cost of Rp. 2.6 billion to third parties, namely apotas as partners. Hence,

services for BPJS Health participants had to be stopped. After the incident in 2016, Mrs. BPJS Health also did not explain in full the uses of the BPJS Health Card and health services guaranteed by BPJS Health.

Based on interviews that have been done with hospital management, and also with BPJS Health participants, it is known that these obstacles are not only felt by the hospital staff, but these also come from the BPJS Health participants themselves. There are still many BPJS Health participants in arrears in payment of BPJS card fees for a variety of reasons. The author considers that this is a wrong action. BPJS Health participants hope to get optimal health services but some BPJS Health participants themselves do not follow the provisions of existing regulations to pay monthly fees that should be in accordance with Article 26 BPJS of Health Regulation Number 1 of 2014 concerning the implementation of health insurance, as expressed below.

Each participant is required to:

a. Pay dues;
b. Report changes in membership data;
c. Report changes in membership status;
d. Report damage and/or loss of a participants' health insurance identity card.

Furthermore, Article 33 of BPJS Health Regulation No. 1 of 2014 concerning the implementation of health insurance states,

1. Membership contributions to health insurance, as referred to in Article 2, letter b, must be paid by each participant of the health insurance program.
2. Contributions, as referred to in paragraph (1), must be paid no later than the 10th of each month to the bank that has cooperated with BPJS Health.

It is clear in these laws and regulations that every BPJS Health participant has obligations, one of which is paying membership fees. There should be no more excuses for forgetting or reasons for being far from the reach of the bank, making it difficult to make payments. Participants of BPJS Health should know that if they want to get their benefits, then their obligation must be fulfilled first.

**Conclusion**

The constraints faced by the management of the Regional Hospital of Teluk Kuantan in providing services to the participants of BPJS Health were caused by several factors: a. The doctor on duty was not in their place; b. claim issues from BPJS; c. arrears card payments by

patients participating in BPJS; d. trauma to the patient due to injury (outside of a traffic accident); e. constraints when referring patients who need ICU space.

It is suggested that the BPJS program is truly realised in accordance with the applicable provisions. RSUD must always control logistic stock of medicines and be checked for availability. Additionally, RSUD and BPJS Health should work well in order to be acceptable

**Acknowledgment**

We would like to thank the Directorate of Research and Community Service, Directorate of General Strengthening Research and Development, and Ministry of Research, Technology and Higher Education (KEMENRISTEKDIKTI) for funding this research.

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