REGIONAL REGULATION OF PROBOLINGGO REGENCY TO IMPROVE THE QUALITY OF LOWER-CLASS HEALTH SERVICES

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ABSTRACT

*This research uses the concurrent embedded design approach. The objective of this research is to identify the regional regulation of Probolinggo Regency in the health sector in an effort to improve the quality of lower-class health services and the factors or obstacles in the implementation of health policies as well as to know the quality of the health services delivered to that poor community. The results show that the provision of lower-class health services is in the form of JKN membership (Jaminan Kesehatan Nasional or National Health Insurance) held by BPJS (Badan Penyelenggara Jaminan Sosial or Social Security Agency) in the health sector through PBI (Penerima Bantuan Iuran or Beneficiaries); Jamkesda (Jaminan Kesehatan Daerah or Regional Health Insurance) funds sharing participants; through a statement of incapacity (SKTM or Surat Keterangan Tidak Mampu). In this matter, the policy is in the form of Regent Decree number 12 of 2015 concerning the lower-class health services which are not included in JKN and Jamkesda at RSUD Waluyo Jati Kraksaan Probolinggo (Waluyo Jati Kraksaan Probolinggo Regional Public Hospital). The factor which becomes the obstacle in the policy implementation is the lack of specialist doctors such as a dermatologist and surgeon. The regional budget also becomes a barrier to meet various health facilities and infrastructure. Besides that, the problem from the lower class itself is the reluctance of the family to be referred to a government hospital (East Java Province) due to their incapability to meet the living and transportation expenses while they wait for the patient. Therefore, quantitatively, the policy implementation to improve the lower-class health services is able to make a positive contribution to the quality of health services in a public hospital. It is also known that various variable indicators are in a good category. Nevertheless, cert*ain indicators still not good and need deep improvements in the service.

Keywords: health policy, service quality, lower-class community

INTRODUCTION

The Indonesian government is obliged to pay attention to the health of each citizen as mandated in the Preamble of the 1945 Constitution that is, among others, to protect the entire Indonesian nation and all of the Indonesian people as well as to promote public welfare and social justice. The Government of Indonesia adopted the doctrine of social welfare that is clearly stated in Article 27, 33, and 34 of the 1945 Constitution. The constitution of Indonesia has mandated the nation manager to build the nation and state of Indonesia based on the welfare understanding. By that, the state must have a role in the doctrine of the welfare state. In this context, the state has a very important role to build a system that can realize wealth and prosperity for the people of Indonesia. Therefore, social policy must give adequate priority in increasing social spending especially to improve health services.

In Indonesia, various policies in the health sector experienced a variety of fairly basic changes from time to time. The government's attention in the health sector can be seen from

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the financial support provided by the government. The amendment of Law number 23/1999 on Health mentioned that each region should allocate at least 15% of the Regional Budget for the health sector. In the Law number 36 of 2009 on Health, it is written that the amount of the budget for the central government is regulated in article 171 paragraph 1 saying that the fulfillment of health budget allocation for the central government (State Budget) is 5%. The size of the Regional Budget (provincial/district/city) is regulated in article 171 paragraph 2 saying that 10% of the yearly total budget is outside the employee salaries. Then, article 171 paragraph 3 states that the amount of the health budget is prioritized for the benefit of public services (especially for the poor, elderly, and homeless children) whose size is at least 2/3 (two thirds) of the health budget in the State Budget and Regional Budget.

However, since 2005, it is known that the average health budget is only allocated by 2% of the State Budget expenditure. Even though the Law number 36/2009 on Health mandates a health budget by 5%, the national health budget continues to decline. In 2009 and 2010, the budget in the health sector only happens to be 3.0% of the total State Budget and not to mention the smaller health budget for the poor community. This size is still far from the one recommended by the WHO that is 15%. A budget of 3.0% is used for various needs such as health facilities, health and medicine services, Jamkesmas (*Jaminan Kesehatan Masyarakat* or Community Health Insurance), medical devices, ambulances, and so on. Of the total State Budget, the exact allocation for the lower class has not yet been specified which, of course, will have a small number. The lack of a national health budget also appeared in 2011 (3.3%), 2012 (3.1%), 2013 (3.3%), and 2014 (3.8%). The health budget for lower-class society managed by the Ministry of Health from 2009 to 2014 has a tendency to increase in quantity. However, it decreased in 2016 and 2017.

Table 1. The budget from the Ministry of Health of Indonesia for Lower-class Community

Number	Fiscal Year	Amount (Trillion Rupiahs)
1	2009	11,5
2	2010	14,0
3	2011	17,4
4	2012	19,4
5	2013	22,6
6	2015	26,2
7	2016	24,8
8	2017	25,4

Source: http://www.anggaran.depkeu.go.id and www.depkes.go.id (accessed on 7/6/2018).

Radical changes in national policies (in the health sector) are part of JKN program (*Jaminan Kesehatan Nasional* or National Health Insurance) that is established under the Law number 40 of 2004 concerning the SJSN (*Sistem Jaminan Sosial Nasional* or National Social Security System). In fact, the law regulates the establishment of BPJS with the aim to run the JKN program. As a follow-up, the Law number 24 of 2011 on BPJS was formed. BPJS of Health is a transformation of *PT Asuransi Kesehatan* (Askes) that is a health insurance agency. The member of BPJS of Health is the former Askes participants such as civil servants, retired civil servants, military, police, and veterans. In addition, the membership also comes from the active TNI (Indonesian National Army) and Polri (Indonesian National Police) which were previously covered by Asabri. Not only that, the salaries from companies which were previously covered by Jamsostek (*Jaminan Sosial Ketenagakerjaan* or Indonesian Social Security) also entered the BPJS of Health. Then, the government program in the form of Jamkesmas also becomes the member of the BPJS of Health. The regional government also has a program known as Jamkesda which its membership was transferred to BPJS of Health

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in 2015. Therefore, the participants of BPJS of Health can be divided into two groups namely PBI (beneficiaries) and non-PBI. The members classified as PBI are those who have an incapability in financial terms so that the fee assistance will be paid by the government. Whereas, non-PBI are the people that its fee assistance will be paid either by the employer or the employee itself from its own income.

In the implementation, the BPJS of Health that is established since January 2013 still experiencing various problems such as complicated services, restrictions, lack of medicines supply, referral system that is not good and limited, as well as patient room service. In addition, there is only one medical rehabilitation measure. This means that the health services which are not covered in health care programs such as BPJS become the responsibility of the community without having to look at the background of their abilities. Yet, according to the BPS of East Java, the poverty rate in Probolinggo Regency as the location of the study shows that the area is in a poor category from 2013 until 2017. The poverty rate can be seen in Table 2 below:

Table 2. The Poverty Number in East Java Province and Probolinggo Regency (%)

Number	Year	East Java Province (%)	Probolinggo Regency (%)
1	2012	13.08	22.15
2	2013	12.73	21.21
3	2014	12.28	20.44
4	2015	12.34	20.82
5	2016	12.05	20.98
6	2017	11.20	20.52

Source: BPS of East Java, 2017.

RESEARCH OBJECTIVES

The purpose of this study is to identify the regional regulation of Probolinggo Regency in the field of health in an effort to improve the quality of lower-class health services and the factors that become obstacles in the health policies implementation as well as to know the quality of health services in RSUD Waluyo Jati Probolinggo towards the poor community.

LITERATURE REVIEW

The Government Role in Health Services

The provision of health services is the authority of both central and regional government. Through the authority held by the central and regional governments, various policies in concern with health services can be made by providing various health facilities and infrastructure. Through the role of the government that is various authorities in the form of a policy to make a conducive health service climate, the welfare of the people can be created. The role of the government can be interpreted as the rights, authorities, and obligations of the government to realize a good public service climate in the health sector. Increasing the role of the central and regional government can be done by providing health infrastructures. From the basic functions of government roles in general, various policies can be developed to improve public services in various regions. According to Anderson and Hughes (1994: 104), there are basic functions of the general role of government such as "the provision of various collective goods and services in the form of some high-valuable goods for the community but difficult to be met by individuals including the provision of hospitals, medical and non-medical personnel, as well as various other hospital infrastructure". Therefore, the task of the government is to provide health services to the poor community.

ISSN: 2223-9944, e ISSN: 2223-9553

Policy Implementation

Effendi (2000) and Darwin (1999) suggest that some policy might be easy and difficult to implement. One of the important things in implementation study is how to recognize the degree of difficulty of a policy to be implemented. Welliam Dun (2000: 476-477) maps a procedure to identify limitations and barriers to achieve the policies and programs into 6 categories, namely 1. Physical barriers. Achieving targets is likely to be limited by the state of knowledge of technology. 2. Legal barriers. Public law, ownership rights, and institutional regulations often hinder the efforts to achieve goals. 3. Organizational barriers. The organizational structure and process available to implement the program can limit the efforts to achieve goals. 4. Political barriers. Political opposition can create tremendous obstacles in the program implementation and in the initial program acceptance. This kind of opposition is reflected in the program's inaction (difficulty to change) and in the tendency to avoid problems by making incremental decisions in decision-making. 5. Distributive barriers. Public programs designed to provide effective social services are often limited by the need to ensure that costs and benefits are distributed fairly among different groups. 6. Budget barriers. Because the government budget is limited, the targeting process must consider the limited funds.

Based on the research of Lester and Stewat (in Winarno 2014: 147), "broadly speaking, implementation has the meaning of implementing the law in which various actors, organizations, procedures, and techniques work together to carry out policies in an effort to achieve policy or program objectives". This means that to achieve a specific goal, the law or policy implementation will involve actors and organizations as well as certain procedures and techniques to cooperate. This is what Ripley and Franklin say (in Winarno, 2014: 148) that "implementation is what happens after the law is established, giving an authority to a program, policy, benefits, or tangible output...implementation includes actions (no actions) by various actors, particularly the bureaucrats, which is intended to make the program run well". Van Meter and Van Horn (in Winarno, 2014: 149) also write that "the limitation on policy implementation is the actions carried out by individuals (or groups) either from the government or the private sector directed to achieve the goals set in the previous decision-making". Grindle (1980) sees implementation in general that "the task of an implementation is a form of linkage to realize and facilitate policy objectives as a result of a government activity".

Gross (in Winarno, 2014: 156) identifies several factors that influence objective consensus: "one of the factors is the extent to which subordinate officials (implementers) participate in policy decision-making. First, participation can create high spirit for the employee in which his high spirit is needed for a successful implementation; Second, participation can increase commitment and a high level of commitment is needed to influence a change; Third, participation will make a greater transparency on an update in which it is needed for an implementation; Fourth, by using the basic resistance postulate to a change, it is assumed that participants will reduce the initial resistance and thus will facilitate successful implementation; Fifth, subordinate officials will tend to oppose an update if the initiative on the policy implementation only comes from higher officials (superiors)". Then, Grindle (in Tangkilisan (2003: 20) creates a policy implementation model that the achievements will be influenced by the contents of the policy such as "(1) the interests that are influenced, (2) the types of benefits, (3) the degree of change expected, (4) the location of decision making, (5) the implementation of the program, and (6) the resources involved". On the other hand, George C. Edward (Winarno, 2014) found four factors that could inhibit the policy implementation, namely "communication, sources, trends or steps of behavior, and organizational structures".

ISSN: 2223-9944, e ISSN: 2223-9553

Public Health Services

According to Notoatmodjo (2010: 109-110), there are two categories of services in the health sector based on the objectives and orientation. 1. Public-oriented category. Health services included in the public category consist of environmental sanitation (clean water, waste disposal facilities both solid and liquid, immunization, air quality protection, and etc.). The orientation of this public health service is prevention and improvement. 2. Personal-oriented category. Personal health services are directly delivered to individuals who generally experience health problems or illness. The orientation of this health service is healing and treatment (curative) as well as recovery (rehabilitative) aimed directly to private users (individual consumers). The health-seeking behavior here is more related to an individual who experiences health problems or illness in an effort to use the available health services in the community.

Lovelock (1992) believes that the expectations of the consumers/service users on the service quality are based on 5 dimensions such as (a) reliability which is the ability to provide services accurately and professionally, (b) responsiveness that is the ability to capture consumer desires and provide the services needed in a quick manner, (c) assurance that is the ability to convince consumers to get the right and trustworthy service, (d) empathy which is giving personal and special attention to consumers and always trying to understand complaints and desires, and (e) tangibility that is the appearance and capability of physical facilities and infrastructure. Zeitham l (1990) in the research have more detailed criteria for public services quality which consists of 1. Tangible, the physical condition as the support of services; 2. Reliable, the ability to provide appropriate and trustworthy services; 3. Responsiveness, the responsibility of the service provider for the quality of service; 4. Competence, the ability of the personnel in accordance with knowledge, experience, expertise, and skills. 5. Courtesy, good comprehension and attitude of the apparatus as to meet customer satisfaction; 6. Credibility, honesty, and trustworthiness; 7. Security, a guarantee of a safe sense that is free from risk; 8. Accessibility, the ease to obtain fair and impartial service; 9. Communication, the ability to understand, listen, and deliver messages/information about the services, and lastly; 10. Understanding the customer, trying to always understand the needs of consumers/service users. Ratminto (2006: 21-24) also formulates a service standard which at least includes: Service procedures for providers and recipients of services including the complaint of a) Completion time. What is stipulated from the time of application submission until the completion of the service and complaint; b) Service fees. This includes the details specified in the service delivery process; c) Product service. The results of the services received are in accordance with the stipulated provisions; d) Facilities and infrastructure. The provision of adequate service facilities and infrastructure by the implementation of public services; e) Service providers' competency. The competencies of service providers must be determined precisely based on the knowledge, skills, attitudes, and behaviors needed.

RESEARCH METHODS

This study uses a concurrent embedded design approach which is a mix of qualitative and quantitative research method. However, it is important to note that the weight of the method is different. The method is used together at the same time (Sugiyono, 2013: 537). In this model, there is a primary method and a secondary method. The primary method is used to obtain the main data while the second method is used to obtain the supporting data from the primary method. In this research, the primary method is qualitative while the secondary is the numbers in the quantitative-descriptive form used only to support the qualitative especially for the impact of policy on service quality.

ISSN: 2223-9944, e ISSN: 2223-9553

The research took place in Probolinggo Regency. In this study, the object of research was the Health Department of Probolinggo Regency and RSUD Waluyo Jati Kraksaan Probolinggo. The informants of this research are the policy-making officials in the health sector which are the officials of the Health Department, Hospital Officers, Doctors, and nurses with civil servant status. The data collection techniques were carried out with triangulation, in-depth interviews/FGDs, participant observations, documentation studies, and questionnaires.

Miles and Huberman (2014) described that qualitative data analysis is the condition where the data collection and data analysis are carried out simultaneously interactively such as namely data condensation, data displays, and conclusions: drawing/verification. This research used a single site data analysis method (Miles & Haberman; Bogdan & Biklen, 1998; Yin, 2004). Furthermore, the secondary quantitative-descriptive method is used to see the quality of hospital services to the poor community. This quantitative-descriptive method uses a quota sampling technique in which the sample is determined by 150 patients/families consisting of 50 male and 50 female inpatients and 50 outpatients. This sampling was based on the guidelines from Roscoe (1975) who proposed that in most studies, the sample sizes should be more than 30 and less than 500 to be considered appropriate (in Uma Sekaran, 2006).

The assessment of poor patients on the quality of health services is divided into the aspects of facilities and infrastructure, systems and procedures, and the quality of health service personnel. Meanwhile, the scoring is determined by using a Likert scale to provide four (4) alternative answers, such as a) 1 for "poor"; b) 2 for "fair"; c) 3 for "good"; and d) 4 is "excellent". The qualification value is determined by the number of answers frequency multiplied by the weight of the value and then divided by the number of respondents. The formula to calculate the average value according to Nazir (2005: 380) is as follows:

$$\text{Qualification value} = \frac{\text{Quantity (answer frequency X weight)}}{\text{Number of respondents}}$$

$$= \frac{\text{Total value}}{\text{Number of respondents}}$$

Then, the interval value is determined to get the interpretation qualification. In order to find the size of the interval, range and number of classes are also used (Nazir (2005:380).

$$I = \frac{R}{K}$$

Description: I = interval value; R = distance measurement (highest value-lowest value); K= class.

By that, the interval value is: $I = \frac{4-1}{4} = 0{,}75$

From there, the interpretation of respondents regarding the quality of service hospital can be known as a) qualification value from 3.26 to 4.00 is in the excellent category, b) qualification value from 2.51 to 3.25 is in a good category, c) qualification value from 1.76 to 2.50 is in fair category, and d) qualification value from 1.00 to 1.75 is in the poor category.

RESULTS AND DISCUSSION

Regional Policy to Improve the Quality of Lower-class Health Services

To improve health services for the poor community, the Regional Government of Probolinggo Regency have some regional policies, including 1) Providing health services for BPJS participants through PBI; 2) Providing health services for Jamkesda sharing funds participants, and 3) Providing health services through SKTM. The regional policy from Probolinggo Regency to provide health services is in the form of Regent Decree number 12

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of 2015 in concern with the Health Care for the Poor Community Excluded from the National Health Insurance and the Regional Health Insurance in Waluyo Jati Kraksaan Hospital, Probolinggo.

The commitment of the Regional Government to improve services to the poor is enshrined in the Decree of Probolinggo Regent number 12 of 2015 which contains many things such as:

1. Lower-class patients can get health services at the Emergency Room, Outpatient, Inpatient, Installation of Operating Rooms, Supporting Facilities, as well as transportation (ambulance for hospital referral/corpse delivery).
2. Lower-class patients who require hospitalization must sign a letter of approval for hospitalization by the patient or family representation.
3. Medicines used for outpatients and inpatients are generic drugs within National Formularies and Hospital Formularies.
4. If there is a drug request/prescription from a doctor for certain types of drugs such as chemotherapy drugs, insulin, albumin, and certain other drugs, it must be accompanied by a therapeutic protocol signed by the Service Control Team.
5. Drug prescription and medical devices are taken at the Hospital Pharmacy Installation with a one-door system.
6. The use of medical devices such as IOL, Orthopedic Implants, and other implants are implemented after being approved by the Service Control Team.
7. Diagnostic support is carried out at the hospital.
8. If there is a necessary investigation which cannot be carried out by the hospital, patients/samples/tissues can be sent to other health facilities/laboratories that work with the hospital.
9. The patients who require hospitalization will be treated in Class III (three) according to their illness.
10. If any operative medical action is needed, the patient/family must complete an informed consent form.
11. During the treatment at the hospital, the patient/family must obey the medication/instructions of the treating doctor and the prevailing laws and regulations.
12. The Regional Government bears 100% of outpatient and hospitalization costs for newborn/children from one/both parents of PBI participants.
13. The Regional Government bears 100% of the outpatient costs and 50% of the hospitalization costs: more or less will be in accordance to the Director's recommendations for patients who are not included in JKN and Jamkesda membership.
14. For patients who need further treatment (referral to a higher level of the hospital), the transportation costs for lower-class patients will be guaranteed by the Regional Government.
15. The Regional Government bears the cost of transportation (for hospital referrals and corpse delivery) for non-JKN patients and non-Jamkesda patients in accordance with the prevailing laws and regulations.
16. The Regional Government will bear the referral transportation costs partially for JKN participants, Jamkesda participants, and other poor communities.

ISSN: 2223-9944, e ISSN: 2223-9553

17. The regional government bears the cost of referral transportation for patients with Jamkesda card holders.
18. The amount of the health services cost reduction for non-JKN participants can be determined after the completeness of the requirements is verified by the Hospital Verification Team and approved by the Director.
19. The determination of cost reduction in the health services of more than 50% will be carried out by the Head of Finance at the hospital.
20. The treatment for the corpse from a poor community in class III becomes the responsibility of the Regional Government in accordance with the prevailing laws and regulations.
21. Outpatient services, class III hospitalizations, childbirth, and operational activities for HIV/AIDS patients in the area are guaranteed by the Regional Government.
22. The treatment for HIV / AIDS corpse from the poor community and neglected corpse will be guaranteed by the Regional Government.
23. The Regional Government will bear higher transportation costs for CD4 laboratory examinations to higher health facilities for HIV/AIDS patients.

The targets of the policy for the poor in health services provision contained in Probolinggo Regional Regulation number 12 of 2015 consist of 1. Older people who are the same age or more than 60 years and do not have an insurance card; 2. Orphans registered in the Social Affairs Department of Probolinggo Regency; 3. Newborn/children who are being cared for by one parent/both parents that is a PBI; 4. Patients who acquire a Poverty Statement Letter (*Surat Pernyataan Miskin* or SPM) from relevant authorities who have an authority to issue the SPM; 5. Homeless people, beggars, neglected children and people, and residents of social institutions, by showing a letter of recommendation from the Social Affairs Department of Probolinggo Regency; 6. Participants of Family Hope Program (*Program Keluarga Harapan* or PKH) who do not have a PBI card by showing the PKH card; 7. Disaster victims and post-emergency response determined by the Regional Government; 8. Mass victims caused by natural disasters and human-caused disasters in accordance with the recommendations from the Director of the hospital; 9. The cases of outbreaks such as dengue fever, diarrhea, mass poisoning, suspected bird flu, and suspected swine flu in accordance with the prevailing regulations; 10. Occupants of Prisons and Detention Centers by showing the recommendation from the Head of Prisons/Detention Centers; 11. Prisoners of Police/Attorney by showing the recommendation from the Police/Attorney Office; 12. People with HIV / AIDS and do not have a JKN or Jamkesda card determined by the treating doctor; 13. Patients with special abnormalities include Hydrocephalus, Meningocele, Hypospadias, genetic disorders, and others (Patients in the K3S Program in Probolinggo Regency) who need to be treated at the hospital; 14. Patients with malnutrition/nutrition problems who do not have JKN or Jamkesda card determined by the treating specialist; 15. Leprosy and post-leprosy patients (Leprosy reaction) who need to be treated by the hospital; 16. Thalassemia Major Patients who have been registered in the Thalassemia Major Indonesia Foundation (*Yayasan Thalassaemia Mayor Indonesia* or YTI) or those who have not been registered but have received a letter of recommendation from the Director of the hospital; 17. Patients with Post-Immunization Accident Events (*Penderita Kejadian Ikutan Pasca Imunisasi* or KIPI) who have received a statement of KIPI from a Specialist Doctor; and lastly, 18. People with mental disorders and do not have a JKN or Jamkesda card that is determined by the specialists who treat them. The cost of outpatient treatment services for JKN and Jamkesda patients who are served in the ED and not guaranteed by BPJS will be paid by the Regional Government.

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Regional policies for the types of hospital services that do not have JKN or Jamkesda cards cover several types of services, namely: 1. Emergency Services; 2. Outpatient Services; a. Specialist clinical services, including: Child Health and Growth; Internal disease; Obstetrics and Gynecology including family planning services; General Surgery; ENT; Eye; Dental and Oral Diseases; Orthodontics; Nerve; Orthopedics; Cardiovascular; VCT and CST; TB-DOTS; Medical Rehabilitation and Physiotherapy; Nutrition; Mental Health; Skin and Genitals; b. Medical consultation, physical examination, and health counseling by specialist doctors/general doctors; c. The examination of high-risk pregnancies and complications; d. Family Planning Services, including effective Contraception, Postpartum/Miscarriage Contraception, as well as side effects and complications treatment; e. The provision of medicines based on the indications and rationality of generic drugs or in accordance with the National Formulary and the applicable Hospital Formulary; 3. Inpatient services in class III, consisting of a. Child Care Room; b. OBGYN Treatment Room; c. General Surgery and Orthopedic Surgery Room; d. Non-Surgical Male Treatment Room; e. Non-Surgical Female Treatment Room; f. Perinatology Treatment Room; 4. Operating Room Installation Services including Small operations, medium operations, and major operations both elective and emergency; 5. Intensive services in ICU and NICU room; 6. Medical and non-medical support services, such as a. Radiology Services; b. Clinical Laboratory Services; c. Electro-medical services: ECG and EEG; d. Pharmacy Services; e. Nutrition Installation Services; f. Ambulance/hearse Services; g. Corpse Treatment Services.

The source of funding to implement the program of lower-class health services improvement comes from the Central Government as well as provincial and regional fund sharing. There is also a program of Fee Assistant from Regional Budget. So far, there are some people (lower-class society) who do not have a Jamkesda. In handling this problem, the regional policy takes some steps such as 1. First, all patients who visit Waluyo Jati Kraksaan Hospital will be verified at the BPJS of Health database whether the patient is guaranteed or not. The registered patients will be covered by the BPJS of Health and the unregistered patients will be covered by the Probolinggo Regency through Regional Budget; 2. Secondly, if the patient does not have a BPJS, the patient will be verified through Jamkesda database of the Provincial sharing fund; 3. Lastly, if the patient does not have any health insurance such as BPJS and Jamkesda, it is recommended to get a recommendation letter from the Health Department of Probolinggo with SKM (*Surat Keterangan Miskin* or Poverty Statement Letter) so that it will be guaranteed by the Regional Budget.

Barriers in the Policy Implementation

The regional government in providing health services for the poor community have taken curative policy measures. The curative barrier in this matter is that BPJS cannot guarantee the health services for HIV/AIDS patients (both outpatient and inpatient BPJS participants) unless there is a comorbid disease (Opportunistic Infection). As for HIV/AIDS cases, the BPJS participants who are not covered will be guaranteed by the regional budget in the form of side funds. As a result, the budget for side funds in Waluyo Jati Kraksaan Hospital is allocated for HIV/AIDS cases in which the number of HIV/AIDS patients increased every month.

So far, the regional government in providing health services for the poor community is based on Jamkesmas and Jamkesda program. However, with the enactment of BPJS of Health, there are various obstacles to implement this health service including:

A. Budget constraints. These budgetary constraints are caused by 1). Newborns in which the mother is the participant of BPJS of Health. BPJS of Health cannot automatically guarantee the PBI. Many procedures must be fulfilled by the parents of the baby, most of

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whom are working class with low education and uncertain jobs and as a result: a. The guarantee will be delivered to the SKM users through the side funds from Regional Budget; b. Most of the side funds will largely be absorbed by the patients treated in the NICU (Neonatal Intensive Care Unit). 2). The case of One Day Care services could not be covered by the BPJS of Health so that it had to be included in outpatient services. This is a disadvantage for the hospital because One Day Care services used more costs than outpatient services. 3). The supporting examination for outpatients exceeds the INA CBG's package from outpatient claims. 4). Medical Rehabilitation Services for BPJS of Health patients with the presence of Physical Medicine and Rehabilitation Specialists so that every medical rehabilitation visit must be guaranteed. 5). The service of Female Operation Method or is better known as Tubectomy which was guaranteed by BPJS of Health is not guaranteed by BPJS of Health anymore. 6). Bone Surgery Services by orthopedic specialists in the hospital can be confirmed as a minus from the financial side. 7). The sources of funds for the lower-class health services comes from the provincial sharing fund and the Regional Budget of Probolinggo Regency. The form of sharing fund in between the central government, provincial government, and regional government to finance the health services for the poor community consisted of 1. The central government shares 100% of the budget for BPJS-PBI participants. 2. The provincial government, as well as the Probolinggo Regency, shares 50% of the budget for Jamkesda participants who have a membership card. 3. The Regional Government of Probolinggo shares 100% of the Regional Budget for SKM users (recommendation from the Health Department), elderly, HIV/AIDS patients, and some cases guaranteed by the side funds. Nevertheless, it is considered that the budget provided by the central government and the regional government is still lacking. It is important to pay attention to the budget of living for the lower-class patients especially for patients referred to provincial hospitals.

B. The regulation to determine the poor community. The problem in this matter is that there is no definite indicator; the ministries and central agencies do not have the same indicators. This makes the regions difficult to specify poverty. Therefore, the poverty indicators need to be integrated into the regulation so that there is a certainty of which actors or agencies should play the role. By that, there is no confusion in determining the poverty. The constraints in the problem of data collection occur when they do not give honest answers about poverty especially if they find out about the assistance or programs. As a result, poverty data becomes swollen.

C. The human resources (HR). There are some obstacles to the availability of medical and non-medical personnel such as 1). The number of specialists in Waluyo Jati Hospital that have not been fulfilled. If there is any, they are not permanent doctors so that it becomes an obstacle to go to higher types of hospitals. It is known that there is a lack of dermatology and genital specialist as well as surgeons. 2). The HR for non-medical personnel is sufficient but the issuance of Participant Eligibility Letter (*Surat Eligibilitas Peserta* or SEP) from the BPJS still uses the personnel from the hospital. However, it is a challenge that the development of the number of patients as well as the complexity of the disease status requires an additional qualification for the medical personnel; the regional government has a limited budget to provide good qualifications for medical personnel because many doctors have double occupations outside the official duties in the hospital. In Waluyo Jati Kraksaan Hospital, an ethics committee was established in which it periodically conducts a competency test for the doctors in the hospital. By now, the ethics committee is more focused on the academic issues of the doctors. During this time, the budgetary constraints of the hospital and the Regional Government of Probolinggo Regency occur in the training program implementation for medical and non-medical personnel. The policies to improve the quality of health services for the poor community used to recruit the adequate human resources for

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medical and non-medical personnel are done by: recruiting the medical personnel by assigning several doctors who take specialist study or have an MOU with Dr. Sutomo Surabaya Hospital related to the need of specialist doctors as well as recruiting the specialists with honorary status to be appointed as civil servants. Secondly, recruiting non-medical personnel who have an honorary status from the Probolinggo Regency or the personnel who are paid by the Waluyo Jati Kraksaan Hospital.

The Quality of Lower-class Health Services

The shift from Jamkesmas and Jamkesda to JKN Program have an impact on the quality of health services delivered to the poor community. To find out the quality of health services held by the hospital, it can be seen from a variety of indicator conditions including the quality of health facilities and infrastructure, systems and procedures, as well as the quality of health service personnel. The assessment of poor community patients on the quality of health services at Waluyo Jati Kraksaan Hospital is in the form of:

1) An assessment of hospital facilities and infrastructure. These facilities and infrastructure include A) It is relatively affordable to reach the location of the hospital. Public transportation to the hospital is relatively accessible because it is on the main route which connects public transport from several cities around Probolinggo Regency in which also connects Java-Bali. If the people who are in the countryside do not have a transportation device, they will use *ojek* (taxi bike) or ask the neighbors to take them to hospital. The transportation to the hospital can be categorized as good with an average value of 3.0. B) The hospital environment in terms of building and land area is considered to be spacious and comfortable with lots of trees but the condition of the parking lot is still not wide enough, especially for the car parking area. As a result, the car parking area is not neatly arranged. In general, the hospital environment is good and clean but there are still many conditions that are considered to be less clean or dirty because there are still certain dirty corners. Even worse, there is an inpatient bathroom that is dirty and the roof of the room is leaking. This dirty bathroom shows the inconsistency of the hospital to maintain hygiene. In other words, the hospital does not have a specificity to take action or address the family or visitors who do not maintain the cleanliness of the hospital as a public place. Such environmental conditions are still judged to be fair (2.45). C) Medical equipment is considered quite complete and has many developments. Many of the medical equipment is relatively new. The old medical equipment is well maintained and can be operated. However, there are some item restrictions for laboratory facilities (no longer free). In addition, there is only one (1) medical rehabilitation measure. The completeness of medical and supporting facilities is considered excellent by the patient (3.55). This can be seen from the current development of the hospital which has become a reference in the area around Probolinggo such as Probolinggo and Situbondo. D) The condition of information and communication facilities is considered by the respondents to be quite complete and in a good category (2.85). Near the main entrance, there is an information center and there are also officers to help. In delivering information, the hospital uses loudspeakers and bulletin boards in some rooms.

2) The assessment of the administrative procedures and service information includes several things, namely: a) Patient assessment related to the administration of medical records (patient status). In finding the patient status, especially the outpatients, the speed of administering the medical record is considered to be quite fast and good (2.62); b) The clarity of medication claim guarantees is still perceived complicated by the lower-class patient/family in which the services also have some restrictions. Nevertheless, the medication claims are in a good category (2.95); b) In fact, not all drugs are available and can be claimed so that the lower-class patient may have to incur additional costs. The claim of drugs and treatment items is now more limited. In general, respondents stated that in handling drugs and

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claims, the procedures are not complicated and are served in a quick manner; c) The claim procedure appears to be more difficult because of the limited drug items. There are restrictions and lack of supply in terms of drugs that the referral system is also not good and limited. However, the procedure related to health services is not understood by all lower-class patients as a whole. This medical procedure is considered by the patient to be good (2.60).

Table 2. Patient Assessment of the Health Service Quality

No.	Health Service Aspects	Service Quality	
		Average Value	Qualification Value
A.	**Hospital Infrastructure**	**3.06**	**Good**
1	Access to the hospital	3.20	Good
2	Obstacles because of the access to hospital	3.25	Good
3	Convenience of hospital environment	2.45	Fair
4	Medical facilities/infrastructure availability	3.55	Excellent
5	Information and communication facilities/infrastructure	2.85	Good
B.	**Administration System and Service Procedure**	**2.89**	**Good**
1	The speed of medical record administration (patient status)	2.62	Good
2	Medication claim guarantee explanation	2.95	Good
3	The procedures to obtain and use the medical card	2.25	Fair
4	The ease of treatment procedures	2.60	Good
5	Service complaint procedures explanation	3.47	Excellent
6	Response to service complaints	3.75	Excellent
7	Information service	2.60	Good
C.	**Human Resources of the Officers:**	**3.53**	**Excellent**
1	The certainty of working officers absence	3.87	Excellent
2	Discipline in providing service	3.80	Excellent
3	Responsibility for providing service	3.77	Excellent
4	Capacity in providing service	3.72	Excellent
5	The speed of service	3.55	Excellent
6	Fairness in the service	3.37	Excellent
7	Hospitality and manner of the officers	3,02	Good
8	Clarity in the delivery of information related to the type of patient's disease	3.00	Good
9	Security of service (risk of practice errors)	3.85	Excellent
10	Sincerity in providing service	3.05	Good
11	Empathy in providing service	3.82	Excellent
	Average	**3,16**	**Good**

Source: processed primary data

3) The assessment from the lower-class patients on the hospital apparatus in providing health services is considered to be responsive. Therefore, the responsibility and the capacity of the officers in providing services are considered to be excellent by the patients (3.77 and 3.72 consecutively). However, there are some officers who do not immediately treat the patients because they are waiting for the doctor's order; the doctors often come late to the hospital. In general, the hospitality of the officers to the lower-class patients is quite friendly and polite (3.02). The empathy of the hospital staff can be seen in the willingness to listen and to give advice on patient complaints (3.00). Nevertheless, there are still patients who are waiting for a long time to get treatment. It is also known that sometimes the officers do not understand the needs of the patient. If the officers were not being asked by the patient regarding the health condition of the patient, the officers do not take initiatives to give an explanation. Besides that, there is a different treatment in between the lower-class and higher-

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class patients in terms of service speed although it is still considered as good and caring by the patients (3.37).

4) Based on the assessment from the lower-class patients to the service quality in Waluyo Jati Kraksaan Hospital, it is known that the variables of infrastructure and facilities are in a good category (3.06). Similarly, the administrative system and hospital service procedures are in a good category (2.89). On the other hand, the quality of the health service apparatus (HR) is said to be excellent (3.53). As a result, the overall quality of hospital services according to the lower-class patient is good (3.16).

CONCLUSION

The regional policy in an effort to improve lower-class health services is conducted by Regional Government of Probolinggo Regency in the form of BPJS of Health through PBI (*Penerima Bantuan Iuran* or Beneficiaries); Jamkesda (*Jaminan Kesehatan Daerah* or Regional Health Insurance) funds sharing participants*;* through a statement of incapacity (SKTM or *Surat Keterangan Tidak Mampu*). The consistency to provide health services can be seen from the Regent Decree number 12 of 2015 concerning the lower-class health services which are not included in the National Health Insurance and the Regional Health Insurance in Waluyo Jati Kraksaan Hospital, Probolinggo.

The obstacles to the implementation of the policy mainly occur in the human resources aspect. It is seen that the hospital still does not have enough medical staff such as specialist doctors. If there is any, the doctors are not permanent so that it becomes an obstacle to go to higher types of hospital that is type B. Even though the human resources for non-medical personnel already adequate, the issuance of Participant Eligibility Letter (*Surat Eligibilitas Peserta* or SEP) from the BPJS still uses the personnel from the hospital. In addition, the regional government has difficulties in determining the poverty indicators because the benchmarks/indicators between agencies are different. Besides that, the problem from the lower class itself is the reluctance of the family to be referred to a provincial hospital due to their incapability to meet the living and transportation expenses while they wait for the patient in the hospital.

The policy implementation to improve the health services for the poor community has been able to make a positive contribution to the quality of health services. The overall service quality in Waluyo Jati Kraksaan Hospital, Probolinggo is good even though certain indicators still in a poor category and need more improvements.

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