

Legal Review of Inpatient Services for Five Diagnoses (Typhoid, Dyspepsia, Gastroenteritis, Febricular Observation and Dengue Fever) for National Health Insurance Participants at Primary Level Health Care Facilities

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Abstract. *The national health insurance promulgated in the National Social Security System (SJSN) law in 2014 is an implementation of SJSN. Based on BPJS Health data from 2017 to 2019, Thypus, Dyspepsia, Gastroenteritis, Febrile Observation and Dengue Fever which are 5 (five) non-specialist diagnoses are included in the 10 (ten) diagnoses absorbing the largest costs and the most diagnoses in Advanced Inpatient (RITL) where the results of secondary data analysis of data amounted to 39% during 2017 – 2019 from all reference data with Severity Level light. In the study, the research method used is through the normative juridical method approach. The results of the discussion explained that primary health care in the JKN program is tasked with managing cases from 144 diagnoses. The capacity of inpatient services at FKTP is the main key in completing the diagnosis of Typhoid, Dyspepsia, Gastroenteritis, Febrile Observation and Dengue Fever, and this is formed from the competence of human resources owned, availability of facilities.*

Keywords: *National Health Insurance, Primary Health Care, Non-Specialist Diagnoses*

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INTRODUCTION

The right to health is a constitutional right. In the amendment to the 1945 Constitution, Article 28H paragraph (1) states "Everyone has the right to live in physical and spiritual prosperity, to have a place to live and to have a good and healthy living environment and has the right to obtain health services". Furthermore, in Article 34 paragraph (3) of the 4th amendment, it states "the state is responsible for providing adequate health care facilities and public service facilities". The mandate of the 1945 Constitution has been responded to by the government by establishing Law No. 40 of 2004 concerning the National Social Security System (SJSN) which includes health care insurance.

The national health insurance enacted in the National Social Security System (SJSN) law in 2014 is an implementation of the SJSN (Dewi & Israhadi, 2021; Trisnantoro, 2018; Sadiq et al., 2024; Triyunarti et al., 2022). The SJSN aims to provide social security that includes various forms of protection, such as health insurance, pension insurance, employment insurance, and social assistance. Health insurance is also health protection so that participants receive health care benefits and protection in meeting basic health needs. This is given to everyone who pays contributions or is paid by the government in accordance with the principles of social health insurance (Gusnita, 2017; Sutrisno & Maimory, 2022).

Universal Health Coverage (UHC) is a health system that ensures that every member of society has fair and high-quality access to quality promotive, preventive, curative, and rehabilitative health services at affordable costs (Septiana et al., 2024; Manita & Afrita, 2024). The two main pillars of UHC coverage are (1) ensuring that everyone has fair and high-quality access to health services; and (2) protecting everyone from financial risk as long as they have access to health services.

WHO states that realizing Universal Health Coverage (UHC) is an important issue for developed and developing countries today (Sitorus et al., 2024; Bintoro & Erliyana, 2023). Therefore, in an effort to ensure health for all people, the state must develop a health financing system to ensure that everyone has fair access to affordable preventive, promotive, curative, and rehabilitative health services, and this is also stated in Law No. 17 of 2023 concerning Health. The national health insurance program states that every participant has the right to receive health insurance benefits in the form of individual health services, including promotive, preventive, curative, and rehabilitative services (Alawode & Adewole, 2021; Mulupi et al., 2013; Kipo-Sunyehzi et al., 2019).

The implementation of health efforts involves various activities and steps to maintain and improve public health (Hidayat, 2020; Aminah et al., 2021). Many things are done to maintain and improve public health, including disease prevention, treatment, health promotion, monitoring and evaluation, and health service management, to achieve better public health goals, various parties work together, including the government, health industry, community, and international institutions. The implementation of health efforts is carried out through activities including health services consisting of: a) Individual health services that aim to cure diseases and restore the health of individuals and families; b) Public health services that aim to maintain and improve health and prevent disease in a group and society.

The Ministry of Health of the Republic of Indonesia in the Regulation of the Minister of Health of the Republic of Indonesia Number 75 of 2014 concerning Public Health Centers has also set standardization of facilities and infrastructure in Health Centers including inpatient room requirements (Lutfiana et al., 2023; Virnata & Masayu, 2024). In practice, there are still cases from the 144 diagnoses that are referred to Advanced Referral Health Facilities (FKRTL) perhaps due to the competency standards of medical personnel at the Level of Inpatient Health Facilities (FKTP), the availability of facilities and infrastructure, or because of special patient requests. In the long term, this condition will cause a significant economic burden on the community (Solida et al., 2023; Jati et al., 2021)

According to JKN statistical data from 2014 to 2018, there are several disease diagnoses that should be able to be treated at FKTP which have First Level Inpatient Care (RITP), such as Dengue Hemorrhagic Fever (DHF), Typhoid, Gastroenteritis and

Dyspepsia (DJSN, 2020). These diagnoses are also the top 10 most common diseases and also the largest expenditures at FKRTL (DJSN, 2020). Based on BPJS Kesehatan data from 2017 to 2019, Typhus, Dyspepsia, Gastroenteritis, Febrile Observation and Dengue Fever which are 5 (five) non-specialist diagnoses are included in the 10 (ten) diagnoses that absorb the largest costs and the most diagnoses in Advanced Inpatient Care (RITL) where the results of secondary data analysis data were 39% during 2017 - 2019 from all referral data with mild Severity Level. These diagnoses are included in the 144 (one hundred and forty four) types of basic competency diagnoses of General Practitioners/4A competency standards included in the 2012 Indonesian Medical Council that must be completed at FKTP but are still referred to FKRTL. These cases are part of the 144 diagnoses that are referred to Advanced Referral Health Facilities (FKRTL) possibly due to the competency standards of medical personnel at the Level of Care Health Facilities (FKTP), the availability of infrastructure, or because of special patient requests.

In the long term, this condition will cause a significant economic burden on program financing, because if cases can be resolved at the FKTP level, the Social Security Administering Body (BPJS) Health can streamline the cost of these health services. The health service pyramid of the National Health Insurance-Indonesian Healthy Card (JKN-KIS) program places First Level Health Facilities (FKTP) as the basis for health services FKTP functions as the first contact for individuals and families to obtain medical care (Kustiyanti, 2023). FKTP must be ready to provide comprehensive health services according to their ability to meet the needs of JKN-KIS participants (Rahmah & Basri, 2024; Fahlevi & Alharbi, 2021).

BPJS Kesehatan always monitors and evaluates the quality of FKTP services so that BPJS Kesehatan participants receive health services that are in accordance with the ability/competence of FKTP in handling 155 disease diagnoses where this monitoring is carried out through the P-Care application in each FKTP and it is expected that the number of visits and referrals can be controlled effectively and efficiently. Optimal service at FKTP to JKN participants will have an impact on the quality of service from FKTP. Based on the description that has been presented above, the author is interested in researching health services at RITP with the following title: "Legal Review of Inpatient Services for Five Diagnoses (Typhus, Dyspepsia, Gastroenteritis, Febrile Observation and Dengue Fever) for National Health Insurance Participants at First Level Health Facilities".

METHODS

In the study, the research method used is through a normative legal method approach. This normative legal approach includes research on legal systematics, research on the level of legal synchronization. Normative legal research is also called library legal research, which is research conducted by examining existing library materials, namely primary legal materials, secondary legal materials, and tertiary legal materials, to then arrange these legal materials systematically, study them, and then draw a conclusion in relation to the problem being studied. This approach is carried out by examining all laws and regulations related to the legal issue (das Sein) being faced, an approach used to examine laws and regulations that still have shortcomings in their normativeization, especially regarding health service policies at FKTP and regulations governing JKN services at FKTP in collaboration with BPJS Kesehatan.

RESULT AND DISCUSSION

Health is the most important aspect of human life because a good quality of life and prosperity are obtained from optimal health conditions. According to Indonesian law,

health is a state of well-being of the body, soul, and social that allows everyone to live productively socially and economically. A person's health condition including a healthy body, healthy soul, and good social health allows a person to live productively socially and economically. In the Constitution of the World Health Organization (WHO) in 1948 it is written that "Health is a fundamental human right" which means that it is an obligation to heal the sick and maintain the healthy. This underlies the idea that health is a human right and health is an investment for life.

Health development is part of national development which aims to increase awareness, motivation, and the ability of everyone to live healthily so that the highest level of public health can be achieved. This health development is carried out by referring to the National Health System (SKN). The National Health System is a system that brings together various efforts of the Indonesian nation in an integrated and mutually supportive manner to ensure the highest level of health as a manifestation of public welfare as referred to in the Preamble to the 1945 Constitution. In accordance with the National Health System, the actors involved in health development are the community, central government, provincial government and district/city government, legislative bodies and judicial bodies. Thus, within the government environment, the central government and regional governments must work together synergistically to implement planned, integrated and sustainable health development in this country in our joint efforts to achieve the highest level of health.

The implementation of social security for all people as mandated in Article 28H paragraph (3) and Article 34 paragraph (2) of the 1945 Constitution of the Republic of Indonesia. Article 28H paragraph (3) of the 1945 Constitution regulates the right to social security. The social security has been stated in Law Number 40 of 2004 concerning the SJSN Social Security System, which is basically a state program that aims to provide certainty of protection and social welfare for all Indonesian people. Through this program, every resident is expected to be able to meet the basic needs of a decent life if things happen that can result in loss or reduction of income, due to illness, accident, loss of job, entering old age, or retirement (Academic Manuscript, 2003). The social security system can be realized after the formation of Law Number 24 of 2011 concerning the Social Security Administering Body (BPJS Law). Officially operational since January 1, 2014, in the health sector it is known as the National Health Insurance (JKN) program. The JKN program is managed by the Social Security Administering Agency (BPJS) Health in accordance with the mandate of Law Number 24 of 2011.

According to Presidential Regulation No. 82/2018, it is stated that JKN benefits are individual health services, including promotive, preventive, curative and rehabilitative services, and medical materials including drug services, medical devices and disposable medical materials. Medical benefits are not differentiated based on the amount of contributions. Meanwhile, non-medical benefits are provided based on the amount of participant contributions. Health services for participants are carried out in stages according to medical needs and the competence of health facilities, except in emergencies. BPJS Health together with other stakeholders organizes the JKN Program using the managed care principle which is also used in the health insurance sector in America. Managed Care is a health service financing system that was developed due to the failure of the fee for services financing system.

The managed care principle seeks to control various things such as how health facilities provide services with the ultimate goal of controlling costs without reducing the

quality of service. The gatekeeper concept refers to the role or function played by an entity or individual in controlling or regulating access to a resource or service. In the context of health, the concept of gatekeeper is often used to describe the role of primary health facilities, such as community health centers or family doctors, as the main gateway for access to more specialist health services. As gatekeepers, primary health facilities are responsible for conducting initial triage, providing basic care, and referring patients to more advanced health facilities if needed. The goal of the gatekeeper concept is to optimize the use of limited health resources, ensure patients receive care that is appropriate to their needs, and reduce queues at advanced health facilities.

In the implementation of the Social Security Administration Agency (BPJS), it is a unified system that cannot be separated from primary health facilities. Primary health facilities are known as health centers or equivalent, doctor's practices or dentist's practices, or in the form of primary clinics or equivalent and primary level/class D hospitals or equivalent in accordance with applicable regulations. This classification is carried out due to the limited provision of primary health facilities, especially health center services in the regions (Santoso, 2014). In connection with the existence of BPJS, health centers have an important role in the implementation of the National Health Insurance Program. BPJS Kesehatan as the organizer of the social security program, in carrying out its duties is given guidelines in the form of Presidential Regulation Number 12 concerning Health Insurance in conjunction with Presidential Regulation Number 111 of 2013 concerning National Health Insurance.

In implementing the national health insurance program (JKN), BPJS collaborates with qualified health facilities to meet the medical needs of a number of participants, sending health workers, or providing certain health facilities. However, it is important to remember that the implementation of the gatekeeper concept must pay attention to the availability of adequate primary health facilities, quality of service, and accessibility for the community. In addition, the role of the gatekeeper must also be balanced with the needs of patients to get direct access to more specialist health services if needed. One of the ways that BPJS Kesehatan does in the JKN program at primary health care facilities (FKTP) is by implementing gatekeeper policies and tiered referrals.

Gatekeeper policies and tiered referrals are part of the managed care approach, namely giving roles to FKTP as providers of basic services (first level). In the implementation of the JKN program, basic health services must be provided by FKTP consisting of 144 diagnoses that must be able to be completed at FKTP. (Minister of Health Regulation Number 5 of 2014 and Indonesian Medical Council Regulation Number 11 of 2012). Although the policy for the implementation of managed care at FKTP already exists, in reality there are still referral cases originating from the list of diagnoses that should be able to be completed at FKTP. BPJS Kesehatan reported that: (1) Dengue Hemorrhagic Fever (DHF), (2) Typhoid, (3) Gastroenteritis (GE), (4) Dyspepsia and (5) observation of fever are among the ten most frequent diagnoses in referral health facilities at the national level. Meanwhile, the diagnosis of Typhoid and DHF are also among the ten diagnoses with the highest costs in referral service facilities.

Inpatient Health Center is a health service facility that organizes public health efforts and first-level individual health efforts, with more emphasis on promotive and preventive efforts, to achieve the highest level of public health in its working area which is given additional resources to organize inpatient services, and in accordance with considerations of health service needs.

In the Regulation of the Minister of Health No. 71 of 2013, it is regulated that first-level services for participants are carried out at the FKTP where the participant is registered (however, this is excluded in emergency situations, and the participant is not in the FKTP area where they are registered). In the event that a participant requires advanced health services, the FKTP is required to refer to the FKRTL according to the case and the competence of the health facility and the referral system. The FKRTL is required to refer back to the FKTP where the participant is registered (except for certain cases) which provisions have been regulated in the Minister of Health Regulation related to national health insurance.

We know that the JKN program has had an impact on increasing public access to health services. Looking at the trend in service data which shows that from 2014 to 2018 the cost of health services has increased every month. This condition must certainly be anticipated with the readiness of health facilities to always be ready to meet the medical needs of visiting patients. In line with this condition, the competence and authority of doctors to provide medical care are very necessary to carry out medical service practices. A person's ability is based on knowledge, skills, and professional attitudes during practice; while authority is the legal authority given by the authorized party to the doctor to carry out the practice.

A doctor has a certificate of competence and a registration certificate (STR). A doctor who has an STR is a person who has been officially registered by the state that he has certain qualifications and is legally recognized to carry out his professional actions and carry out practice. A doctor has a certificate of competence and a registration certificate (STR). Thus, it can be said that the granting of authority to a doctor as a medical worker to carry out medical practice is based on the competence he has. If a patient comes to him with a health problem that is beyond his competence or authority, the doctor is required to refer the patient to another doctor.

In medical services, there are basic ethics that must be fulfilled by doctors in serving patients. These basic ethics consist of four Basic Moral Principles (KDM), namely beneficence (beneficial), non-maleficence (no bad consequences), autonomy (freedom to make choices) and justice (fair). Beneficence is the principle that doctors must do the best for patients (do good for patients), non-maleficence is the principle that doctors must not act to harm patients (first do no harms), autonomy is the principle that patients have the right to decide about their treatment according to their belief system, values and culture, while justice is the principle that doctors must treat all their patients fairly.

The ability to act as a professional based on the education and training that has been received is known as competence. Knowledge, skills, and professional attitudes are three components related to competence. A person can be said to be competent in an activity or job, if the person concerned knows enough information based on his activities, has seen and carried out procedures under the supervision of experts, and knows how to act professionally in taking action. Therefore, the professional must obtain appropriate training and education before he/she is allowed to perform professional work.

Doctors obtain their competence through the education and training they undergo. A doctor's competence is formally proven by a competency certificate stating that the person concerned has been recognized for his/her competence in a particular field. A person who completes medical education and is declared to have passed the national competency test for the first time will receive a professional certificate and a competency certificate at the same time.

The minimum competency that must be possessed by a newly graduated doctor can be seen from the Indonesian Doctor Competency Standards (SKDI). The latest SKDI document is stipulated through the Indonesian Medical Council Regulation Number 11 of 2012 concerning the Indonesian Doctor Competency Standards. In the 2012 SKDI document, it is stated that there are 736 types of diseases that must be known by a doctor and may only be treated according to the level of ability they have. Doctors' abilities are divided into 4 levels, namely: (1). Able to recognize and explain the clinical picture of the disease, and know the most appropriate way to obtain further information about the disease; (2). Able to make a clinical diagnosis of the disease; (3). Diagnose, and carry out initial management and refer if beyond their competence. If it is not an emergency, able to make a clinical diagnosis and provide preliminary therapy. If it is an emergency, able to make a clinical diagnosis and provide preliminary therapy to save lives or prevent severity and/or disability; (4). Able to diagnose, carry out management independently and completely. Of the 736 types of diseases that a doctor must know, only 144 types of diseases can be treated completely or around 19.6%. Of the 261 types of diseases, they are at capability level 3, which means that doctors are allowed to provide preliminary therapy and then referred to the relevant specialist doctor.

In the level 2, there are 261 types of diseases that can be diagnosed by doctors and then referred to the appropriate specialist doctor, and for the other 70 types of diseases, doctors do not have the ability to diagnose and must be referred to a specialist doctor. There are still 331 types of diseases that are at capability levels 1 and 2, where doctors are not allowed to provide therapy or any action. The competence of doctors based on the 2012 SKDI is the competence that must be achieved by doctors when they graduate from the medical faculty. This competence can be called core competence. Not only core competence, the medical faculty can also develop its curriculum to equip its graduates with special competence aimed at meeting the needs of specific health services in certain areas. Special competencies are competencies outside of core competencies that are in accordance with the special/excellent mission of the university, including urban medicine, population/community health, and holistic health approaches. Both types of competencies mentioned above can be obtained in the medical education process.

Competence outside of formal education obtained by medical personnel is called additional competence. Additional competence can be obtained by doctors through continuing medical education (PKB) and certain training. Achievement of additional competence is proven through the issuance of an Additional Competence Certificate by the relevant medical college in accordance with the provisions of Article 8 of the Regulation of the Indonesian Medical Council No. 48 of 2010 concerning Additional Authorities of Doctors and Dentists. The Additional Competence Certificate can be the basis for granting additional authority to a doctor under certain conditions.

The competence of specialist doctors and subspecialist doctors (consultants) is much deeper in a specific field compared to general practitioners. Specialist/subspecialist doctor education can be taken after someone completes medical education, as well as specialist consultant doctor education which can only be taken after completing previous specialist education. Unlike doctors who have a level of ability 4 for only around 19.6% of the 736 diseases that they must know, a specialist doctor has a level of ability 4 for most diseases related to their specialty.

Competence and authority are two different concepts, but can be interpreted similarly in relation to skills and both are also closely related to each other. Qualification

is a skill that someone acquires through training in a particular field. Authority or competence means "het Vermogen tot het verbeilten van bepaalde rechtshandelingen", namely the ability to carry out certain legal acts. It is further stated that power includes rights and obligations. The right to do or not to do certain acts or ask other parties to do certain acts; and duties in the sense that certain acts must be done or not done.

The authority of a doctor can thus be considered as the freedom of the doctor to do or not to do certain aspects of his professional actions that contain certain obligations. The doctor's obligations have been regulated in Article 274 of the Health Law No. 17 of 2023, stating that medical personnel (general practitioners or dentists) in carrying out medical practice services have an obligation to provide medical services in accordance with professional standards and standard operating procedures and the patient's medical needs; refer patients to other medical personnel who have better expertise or abilities, if they are unable to carry out an examination or treatment. In line with the principle of legality as one of the pillars of a state based on law, the source of a doctor's authority to practice medicine is statutory regulations.

The statutory regulations that form the basis of the doctor's authority are Article 279 of Law Number 17 of 2023 concerning Medical Practice which grants authority to doctors who already have a STR to: Interview patients; examine the patient physically and mentally; determine supporting examinations; establish a diagnosis; determine the management and treatment of patients; perform medical or dental procedures; write prescriptions for drugs and medical devices; issue medical or dental certificates; store drugs in permitted quantities and types; and dispense and deliver drugs to patients, for those who practice in remote areas where there are no pharmacies.

Based on the Regulation of the Minister of Health Number 5 of 2014 concerning Clinical Practice Guidelines for Doctors in Primary Health Care Facilities and the Regulation of the Indonesian Medical Council Number 11 of 2012 concerning the Competency Standards of Indonesian Doctors, there are 144 disease diagnoses that should be able to be treated to completion in FKTP. In it, medical cases such as typhus, fever observation, diarrhea, dyspepsia and dengue fever are also listed. These diagnoses can be treated in FKTP that have inpatient care capacity, and medical personnel are considered capable of handling until completion of services in primary health care facilities. In the Regulation of the Minister of Health of the Republic of Indonesia Number 75 of 2014 concerning Community Health Centers (Puskesmas), it has regulated first-level health facilities in this case are Puskesmas along with the standardization of facilities and infrastructure in the implementation of health services in Puskesmas.

The regulation regulates the requirements that must be met by Puskesmas related to the facilities and infrastructure in them. In this regulation, there are several important points related to the standardization of facilities and infrastructure in Community Health Centers: Buildings and Service Rooms: This regulation stipulates requirements related to Community Health Center buildings, including the size and number of rooms required for various health service activities. For example, there are provisions regarding waiting rooms, examination rooms, treatment rooms, pharmacy rooms, and administration rooms. This standard aims to ensure comfort, privacy, and safety for patients as well as efficiency in the provision of services. Laboratory Facilities: This regulation stipulates requirements for laboratory facilities in Community Health Centers. Community Health Centers must have adequate basic laboratory facilities to conduct simple laboratory tests, such as blood, urine, and stool tests. This standard is needed to support disease diagnosis

and monitoring, as well as to ensure the quality of the test results obtained. **Basic Medical Equipment:** This regulation requires Community Health Centers to have basic medical equipment needed for primary health care. This equipment includes, but is not limited to, blood pressure monitors, thermometers, simple EKG devices, nebulizers, and sterilization equipment. This standard aims to ensure the availability of medical equipment needed to provide adequate health services. In medical equipment, the number of inpatient beds is also regulated, consisting of 5-8 adult beds and 2 child beds. For health centers in rural, remote, and very remote areas, they can have a maximum of 10 beds; while in urban areas, a maximum of 5 beds. **Availability of Medicines and Medical Materials:** This regulation requires Health Centers to provide medicines and basic health materials needed for public health services in their work areas. Health centers must have adequate stock of medicines to support medical services for patients.

The government has also issued Regulation of the Minister of Health Number 34 of 2022 concerning Accreditation of Public Health Centers, Clinics, Health Laboratories, Blood Transfusion Units, Independent Doctors' Practices, and Independent Dentists' Practices in addition to policies that regulate the obligations, authorities, types of services, and infrastructure at FKTP.

Research conducted by Wenang et al (2021) shows that there is a significant correlation between the level of per capita income of a region, the availability of health workers, and the availability of health infrastructure. In Indonesia, as many as 14.4% of health workers work in 27.8% of areas that are classified as remote. The availability of health human resources and health infrastructure (including beds) is directly proportional to the per capita income of the region. This shows that there are differences in the availability of resources between regions which can cause differences in the services provided between regions, which are very likely to affect the perception of decision-making to refer patients from FKTP to FKTRL. Furthermore, the existence of neat and consistent medical record recording by FKTP including anamnesis to patient management plans can influence the decisions and accuracy of general practitioners to make referrals to specialists (Mehrotra et al, 2011). This needs to be continuously developed in Indonesia, considering that there are still many medical records that have not been standardized and this can affect the quality of patient referrals. One example of a referral service system that has been running in foreign countries is the health service system implemented in Thailand.

The system starts from primary care units of ≤ 8000 PCUs, district hospitals or commonly called secondary and tertiary hospitals of 800 units at the provincial level and teaching hospitals. Meanwhile, promotive and preventive hospitals are PCUs where these PCUs must have minimum service standards that must be set nationally. The development of infrastructure facilities is very much needed in the implementation of the UHC system. In addition, this implementation also requires quality human resources who are willing to work wholeheartedly, where these human resources require motivation and passion in providing maximum service to the community. Thailand has a health center, where these quality human resources are placed in rural areas. These human resources are health and non-health workers who will be trained in providing good services to the community (Indrayathi PA, 2016).

CONCLUSION

FKTP as the backbone and gatekeeper of the health service system plays a very important role in the current health system. One of its functions is to provide health

services (UKP) for the community/JKN participants who will require inpatient care at the first level (RITP). Strengthening this function at FKTP is very necessary considering the limited availability of FKRTL in most districts/cities. FKTP in the JKN program is tasked with managing cases from 144 diagnoses. FKTP with RITP is tasked with managing cases that require hospitalization at the facility. The capacity of inpatient services at FKTP is the main key in completing the diagnosis of Typhus, Dyspepsia, Gastroenteritis, Febris Observation and Dengue Fever, and this is formed from the competence of the human resources owned, the availability of facilities, the availability of drugs and Consumables (BHP), the availability of infrastructure. The success of health insurance is largely determined by the availability of health facilities that meet the required standards. Without health facilities that meet the standards, the health insurance program will not run according to the intent and purpose of the national social security system law. The provision of these health facilities is a form of state responsibility as mandated by Article 34 (3) of the 1945 NRI Constitution. FKTP has an important role in the implementation of the National Health Insurance Program. BPJS Kesehatan as the organizer of the social security program, in carrying out its duties is given guidelines in the form of Presidential Regulation Number 12 concerning Health Insurance in conjunction with Presidential Regulation Number 111 of 2013 concerning National Health Insurance.

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