Development Management Model of Specialist and Sub-specialist Doctor in the Context of UU-JKN at RSUP-HAM Medan

Zulfendri[1], Juanita[1], A. M. Lubis[1]
[1]*Fakultas Kesehatan Masyarakat, Univeritas Sumatera Utara*

Keywords: Specialist and Sub-specialist Doctor Management, National Health Insurance, General Hospital, Medan

Abstract: In Indonesia has not adopted clinical governance system in clinic to improve clinical quality. One important factor is the fact that doctors have a place of practice in private hospitals and private practice areas. The purpose of this study is to develop a model of management of specialist doctors and sub-specialists in the context of the National Health Insurance Law (UU-JKN) in every SMF Haji Adam Malik General Hospital Medan (RSUP -HAM). This research is qualitative research. Data obtained from interviews and FGDs. From the result, the Human Resource Management system of Specialist and Sub-Specialist Doctors has been implemented in accordance with the hospital's internal regulations based on the regulation of Hospital Bylaws and Staff of Medical Bylaws owned by RSUP HAM. Therefore, it is necessary to improve the system that has been built through regulation Bylaws Hospital and Medical Staff Bylaws develop according to the development of science and technology of health services in hospitals.

1 INTRODUCTION

Since January 1, 2014, Indonesia has undergone a transformation of the health financing system by the enactment of the National Health Insurance (JKN) held by the Social Security Insurance Provider (BPJS) which is mandated by Law no. 40 of 2004 (UU RI) on the National Social Security System. The benefits of JKN can provide comprehensive benefits with affordable premiums and apply the principles of cost and quality control. That means participants can get adequate quality service at a reasonable cost and under control, not "up to the doctor" or up to "hospital". In addition, it also ensures sustainability (certainty of sustainable health financing) and has portability, so it can be used in all parts of Indonesia. In the 2019 JKN target it is expected that at least 85% of participants will be satisfied, either in service at BPJS or in service at health facilities contracted by BPJS.

Clinical Governance and Tradition management system of specialists and sub-specialists in government hospitals. One of the key factors in the development of hospital services is how to improve the quality of clinical services. Hospitals are institutions that provide clinical services so that clinical quality is an important indicator for the good of the hospital. Good and bad clinical service process is influenced by the appearance of specialist doctors work at the hospital. As with the governance system in hospital management, a current governance system is developed at the clinic. This development was pioneered by the British in the decade of the 90s by using the term clinical governance

The basic principle in the development of clinical governance management is how to develop systems to improve clinical quality. The quality improvement is done by combining management, organizational and clinical approaches together (Trisnantoro, 2017). Clinical governance is in charge of ensuring that there is a system for monitoring the quality of well-functioning clinical practice; clinical practice is always evaluated and the results of its evaluation are used to make improvements; and clinical practice is in accordance with the standards, as issued by the national professional regulatory body.

In detail, systems implemented in clinical governance include activities such as clinical audit, effective management of poorly performing

Zulfendri, ., Juanita, . and Lubis, A.
Development Management Model of Specialist and Sub-specialist Doctor in the Context of UU-JKN at RSUP-HAM Medan.
DOI: 10.5220/0010078405610567
In *Proceedings of the International Conference of Science, Technology, Engineering, Environmental and Ramification Researches (ICOSTEERR 2018) - Research in Industry 4.0*, pages 561-567
ISBN: 978-989-758-449-7

clinical colleagues, risk management, evidence-based clinical practice, clinical effectiveness evidence implementation, leadership skills development for clinicians, education sustainable for all clinical staff, until consumer feedback audits

Knowledge and leadership skills among clinical staff. In this case there must be a clinician who becomes the leader of the clinician Clinical governance framework is composed of four things: evidence based medicine, good information, clinical work assessment, and the relationship between clinicians and management. Large implications arise with this framework. First, the organization conducts evidence-based practice.

Implementation of evidence based is severe. Second, the improvement of clinical information infrastructure. Third, a mechanism is developed to assess the performance of clinics integrated with management performance. Fourth, development needs to be done.

Traditionally, clinical management systems in Indonesia have not adopted these activities. One important factor is the fact that physicians have a place of practice in private hospitals and private practice areas. Due to the difficulty of doctors dividing time in government hospitals, clinical management is still not applicable. This will lead to conflict. The Medical Practice Law about the practice of doctors is a rule that has the meaning of changing the culture of doctors. It is conceivable that there is a possibility of conflict between the traditions and work culture of a specialist with the intent of the Medical Practice Law.

2 THE PROBLEM RESEARCH

How does the human resources management system of specialist physicians and sub-physicians include recruitment, training, working time, compensation, and retirement in the in-patient wards of Haji Adam Malik General Hospital (RSUP-HAM) Medan?

How the specialist physician's management system and the sub-specialist doctors in the implementation of clinical governance include activities such as clinical audit, effective management of poorly performing clinical colleagues, risk management, evidence-based clinical practice, evidence of clinical effectiveness in inpatient wards Haji Adam Malik General Hospital (RSUP-HAM) Medan?

2.1 Research Objectives

Describes the human resources management system of specialist physicians and subclinical doctors including recruitment, training, working time, compensation, and retirement at the Adam Malik Hospital General Hospital (RSUP-HAM) Medan.

Describe the implementation of specialist doctors and sub-specialist management systems in the implementation of clinical governance covering various activities such as clinical audit, effective management for clinical colleagues, risk management, evidence-based clinical practice, clinical effectiveness evidence implementation in inpatient wards of the General Hospital Haji Adam Malik Center (RSUP-HAM) Medan.

Develop a model of management of specialist doctors and sub-specialists in the context of the National Health Insurance Law (UU-JKN) in every SMF Haji Adam Malik General Hospital Medan.

2.2 The Benefits of Research

This research is useful as a source of information about: Human resources management system of specialist physicians and physicians sub spesilis in the context of National Health Insurance Act (UU-JKN) in every SMF in Medan-Medan General Hospital. Implementation of specialist doctors management system and sub specialist in the implementation of clinical governance in RSUP-HAM Medan

2.3 Study of Literature Clinical Governance

Clinical governance is a term applied to collect all activities that promote, review, measure and monitor the quality of patient care into a coherent whole. In Western Australia, it has been defined as a systematic and integrated approach to guarantees and reviews of clinical responsibility and accountability that improve quality and safety so patients optimize outcomes (Department of health, 2001).

Clinical governance as "the framework within which the organization's NHS is responsible for continuously improving the quality of their services and maintaining high standards of care by creating an environment where clinical care excellence will flourish" (Kane, 2005). It further mentioned that

from the results of literature study and expert opinion there are 6 elements of clinical governance namely clinical effectiveness, quality assurance, providing development and education, clinical audit, risk management, development and research.

Clinical governance is the main framework used by hospitals and should be responsible for protecting the highest standards of health care (including dealing with poor professional performance), to continuously improve the quality of their services, and to create and maintain an environment where clinical excellence can develop (Department of Health, 2001). The introduction of clinical governance is therefore aimed at improving the quality of clinical care at all levels of the organization by consolidating, codifying, and standardizing.

2.4 Hospital Bylaws

One of the obligations of the hospital is to prepare and implement internal hospital regulations or Hospital By Law (Article 29 of Hospital Law Number 44 of 2009 on Hospital). Hospital By Laws (HBL) is an internal regulation of hospitals designated by the owner of a hospital or a representative of which governs the organization of the owner or who represents, the roles, duties and authorities of the owner or who represent, the roles, duties and authorities of the director of the hospital, organization of medical staff, as well as the roles, duties, and authorities of medical staff (KMKRI, 2002).

A rule or management discipline poured into HBL must be adhered to, so HBL can also serve as a guide in running the wheels of hospital management well and orderly. All of this depends on the willingness and compliance of the whole range and related parties in the hospital, from the highest to the lowest. HBL rules must be obeyed and if violated there will be sanctions

Designing a "Basic Hospital Rules (PDRS)", must be created something new that is in accordance with the social culture of the Indonesian nation. Looking at the different hospitals in Indonesia today that have different history of establishment, religion, vision, and mission, purpose and purpose, PDRS can not be made uniformly for PDRS for all hospitals (Guwandi, 2004).

2.5 UU BPJS with Explanation

According to the Law of the Republic of Indonesia Number 24 Year 2011 on the Social Security Administration Agency in Article 1 mention the Social Security Implementing Agency hereinafter abbreviated as BPJS is a Legal Entity formed to organize the social security program. This law forms two BPJS namely BPJS Health and BPJS Employment. BPJS Health organizes a health insurance program and BPJS Employment program provides work accident insurance, pension, pension and death insurance. The formation of two BPJS is expected to gradually expand the coverage of social security programs.

2.6 The Perception of the Specialist Doctor and Sub-specialist Doctor UU BPJS

Perception is an observation that is a combination of sight, smell, hearing and past experience. Perception is expressed as a process of interpreting sensations and giving meaning to stimuli. Perception is the interpretation of reality and each person views reality from a different perspective angle (Notoadmodjo, 2003). The factors that affect the perception that is, the level of knowledge and education of a person, factors on perception / party perception, the object or target is perceived, the situation where the perception is done

After the enactment of Law No. 24 of 2011 on BPJS ynag is a direct command of law number 40 About SJSN, has brought good news for all levels of Indonesian society, including those who crave health services with social justice. According to both laws, from January 2014, all Indonesian citizens (not to mention doctors) are obliged to become participants of national social security (health). As a result, they are required to pay health insurance contributions to BPJS. With ketetntua, capable residents will pay for themselves, while for those who can not afford, the fee paid by the state therefore the payment of health services / honorarium doctor has been done by BPJS health. Health providers are not arbitrary because he must work with BPJS through a contract accompanied by certain requirements that must be fulfilled.

Facing the two great powers above, maybe doctors and health professionals, are in a very weak position. Doctors and health professionals who have been reported to be very strong because they can

determine various things in the provision of health services will certainly change. Hospitals controlled by business principles would always hope to make a big profit by taking advantage of doctors and health professionals as their money seekers

The critical review is whether the primary care physician included in Law no. 20 of 2013 is a solution of national health problems, especially the financial deficit BPJS. According to this Law the Primary Services Doctor (DLP) is a general practitioner who must undertake specialist equivalent education in order to provide first-rate health facilities such as puskesmas, outpatient clinics and others. Doctors who do not participate in primary care physicians should not serve BPJS patients even though they have been declared graduated as a doctor through a national competency exam. It is naïve that the struggle of medical students of 6 years of study plus national and internship competence exams in remote areas has not convinced the government of their competence. On the one hand the government is behaving for the business of competence and quality of the government to expect high-standard doctors equivalent to foreign doctors but at the same time the government's appreciation of doctors is still minimal compared to responsibilities and lawsuits when carrying out his profession

That greatness hegemony BPJS not only can monopolize health insurance but can change the system of health education services radically. All will be submissive and forced to obey the rules of BPJS although the system is not necessarily good and benefit the community. The first health services in the community should be improved, but the way of improvement is not by imposing DLP but creating a holistic and sustainable integrated system, by collaborating a well-established system, listening to all aspirations of field practitioners rather than partial ways like the DLP.

Law No. 20 of 2013 which passed was too fast and without adequate academic studies and only imitate a health system of other countries. As a result DLP was rejected by doctors all over Indonesia who are members of the Indonesian Doctors Association and have done legal efforts with material tests to the Court has been done even though defeated.

2.7 National Health Insurance

Many new parties realize that JKN has triggered various reforms in health services. With the Single Payer design for the entire population, BPJS and the government have strong controls to improve service quality and service efficiency. Doctors are particularly most directly affected by the prospective change of retrospective to prospective payment. The head of the hospital changes its business strategy and services to ensure sufficient funds are received. In the long term, JKN is designed to balance the public interest and private interests (employers and private healthcare facilities) (Thabrany, 2015).

The National Health Insurance (JKN) developed in Indonesia is part of the National Social Security System (SJSN). The National Social Security System is organized through a mandatory Social Insurance mechanism based on Law No.40 of 2004 on the National Social Security System. The aim is that all Indonesians are protected in the insurance system, so that they can meet basic public health needs.

2.8 The Principle of National Health Insurance

The National Health Insurance refers to the following principles of the National Social Security System (SJSN):

1. Principle of mutual cooperation

In SJSN, the principle of gotong royong means participants who are able to help disadvantaged participants, healthy participants help the sick or at high risk, and healthy participants help the sick. This is realized because SJSN membership is mandatory for the entire population, indiscriminately. Thus, through the principle of mutual social assistance mutual aid can foster social justice for all Indonesian people.

2. Nonprofit principle

Fund management is mandated by BPJS is a non-profit not for profit (profit-oriented). Instead, the main objective is to meet the maximum interest of the participants. Funds collected from the public are trust funds, so that the results of development, will be utilized as much as possible for the benefit of participants

3. Principles of openness, prudence, accountability, efficiency, and effectiveness

These management principles underlie all fund management activities derived from participant contributions and development outcomes.

4. The principle of portability

The principle of social security portability is intended to provide continuous guarantee to the participants even if they move jobs or residence within the territory of NKRI.

5. The principle of participation is mandatory

Membership shall be intended for all citizens to be participants so as to be protected. Although membership is mandatory for all people its application is still adjusted to the economic capacity of the people and government and the feasibility of program implementation.

6. The principle of trust fund

Funds collected from participant contributions are deposited funds to the organizing bodies to be managed as well as possible in order to optimize the funds for the welfare of the participants.

7. Principles of management of the Social Security Fund

Utilized entirely for program development and for the greatest interest of the participants

3 RESEARCH METHODS

The type of this research is qualitative research to develop the management model of specialist doctors and sub-specialist of Adam Malik Center General Hospital (RSUP-HAM) Medan. The study was conducted at Adam Malik Center General Hospital (RSUP-HAM) Medan and the study was take 6 (six) months (June - November 2017).

The study population is all of SMF is 16 SMF, all specialist and sub-specialist, Director, Human Resources Director of General Hospital of Adam Malik Haji Center (RSUP-HAM) Medan. Samples for SMF were taken throughout the existing SMF, as did the hospital director and director of the hospital tbsp. While the samples for specialists and sub-specialists, determined according to the needs, purposive, ie 3 specialist doctors / sub specialists from SMF surgery and 3 specialist doctors / sub specialists from non-surgical SMF

3.1 Methods of Data Collection

The method used to collect research data is done by in-depth interview. The in-depth interview method was done to the informants of the SMF chairman, the Director of the Hospital, the Director of Human Resources, and the surgeon and non-surgical physicians, respectively, 3 guides to instruments with unstructured answers (open answers) that have been prepared in advance. To complete the interview result data, the researcher also collects the secondary data that is the data that already exist and according to the research needs

3.2 Data Analysis

Based on the type of data that has been collected, the data analysis is done using interactive model analysis (Miles, 2005). The interactive model analysis consists of three paths, namely data reduction, data presentation and conclusion / verification. These three paths are a type of analysis activity and the data collection activities themselves are cyclical and interactive processes

4 RESEARCH RESULTS

From the interview result, Human Resource Management system of Specialist Doctor and Sub-Specialist staff has been implemented in accordance with the hospital's internal regulation which is guided by regulation of Hospital Bylaws and Staff of Medical Bylaws owned by RSUP HAM.

a. Recruitment and selection: After going through a recruitment process and obtaining a clinical assignment letter (SPK) and having a SIP at the HAM Hospital, doctors work at the SMF in accordance with the clinical authority they have.
b. Training: doctors always take part in educational and training activities both conducted internally and external by SMF to improve competencies in order to be able to work professionally. The education and training activities are generally funded by the doctor concerned or in collaboration with pharmacy.
c. Working time: 7.45-16.15 WIB (Monday-Friday)
d. Compensation: payment of medical services (remuneration) based on individual performance indicators (IKI), the better the doctor's performance, the more medical services he receives. Payment of medical services directly deposited by the finance department to the account of each doctor. Most doctors' payment system medical services respond well because it is in accordance with the results of the performance.
e. Retirement: There is no retirement process in SMF. If anyone wants to resign, the specialist and sub-specialist must provide a letter of

resignation to the Director of Medan Hospital or in accordance with ASN rules.

f. Permission to practice: Every 5 years the doctor is obliged to extend his SIP and attendance has been using finger print which is connected to doctor's data on the central computer network, so that he cannot receive remuneration because he is considered not working if he not to extend his SIP.
g. Quality Assurance: Evaluation of performance every 6 months, and time of service to maintain the quality of service provided to patients. To improve the quality of services, specialist doctors and sub-specialists must also improve their education.

Implementation of specialist doctors and sub-specialist management systems in the implementation of clinical governance is in accordance with the regulation of Medic Bylaws staff covering various activities.

a. Clinical audit: RSUP HAM has carried out a medical audit, but its implementation still tends to be incidental when a medical case occurs.
b. Effective management of clinical colleagues: communication between specialist doctors and sub-sepsis to the clinical section is considered important in the SMF clinical pathology, anatomical, radiological, skin and genital pathology, and teeth.
c. Risk management: all SMFs have implemented clinical risk management in a planned and systematic manner in an effort to anticipate unexpected possibilities in clinical services.
d. Evidence-based clinical practice: all SMFs have carried out evidence-based clinical practices such as the use of medicines, if there is a need for drugs outside the national formulary; evidence based on them is required.
e. Evidence of clinical effectiveness: all SMFs have applied clinical effectiveness evidence that every doctor who carries out medical care to patients always uses evidence-based standard operating procedures (SPO) and clinical practice.
f. Leadership development for clinicians: RSUP HAM has implemented clinical leadership through the appointment of a Doctor of Patient Responsibility (DPJP) by the SMF in every medical service for patients participating in the medical service managerial process

Development of the Specialist Doctor and Doctor Sub-Specialist management model by developing clinical leadership for each specialist and Sub-Specialist Doctor through 4 stages of leadership development process that is the personal / team internal stage, the stages of the whole service / cross team, the cross-stages of the service / organization broader and broader stages of the organization / healthcare system.

5 CONCLUSIONS

The Human Resource Management system of Specialist and Sub-Specialist Doctors has been implemented in accordance with the hospital's internal regulation which is guided by the regulation of Hospital Bylaws and Medical Staff Bylaws owned by RSUP HAM

It is necessary to maintain and improve the Human Resource Management system of Specialist Doctors and Sub-Specialists by referring to the system that has been built through the regulation of Hospital Bylaws and Medical Staff Bylaws to develop in accordance with the development of science and technology of health services in the hospital.

ACKNOWLEDGEMENT

Thanks to the University of Sumatera Utara Research Institute which has funded this Applied research through Non-PNBP funds for the fiscal year 2017.

REFERENCES

Undang-Undang Republik Indonesia Nomor 40 Tahun 2004 Tentang Sistem Jaminan Sosial Nasional

Trisnantoro, L 2017 *Aspek Strategis Manajemen Rumah Sakit : antara Misi Sosial dan Tekanan Pasar* (Yogyakarta: Penerbit Andi)

Department of Health Government of Western Australia 2014 Clinical governance, A Framework of Assurance, Department of Health 2001.

Kane, David 2005 *Clinical Governance: A Guide for Primary Health Organisations* (Dunedin: BPAC)

Undang-Undang Republik Indonesia Nomor 44 tahun 2009 Tentang Rumah Sakit

Keputusan Menteri Kesehatan Republik Indonesia Nomor 772 Tahun 2002 Tentang Pedoman Peraturan Internal Rumah Sakit (*Hospital By Laws*)

Guwandi, J 2004 *Merangkai Hospital By Laws*. (Jakarta: Fakultas Kedokteran Universitas Indonesia)

Undang-Undang Republik Indonesia Nomor 24 Tahun 2011 Tentang Badan Penyelenggaraan Jaminan Sosial

Notoatmodjo, Soekidjo 2003 Pendidikan dan Perilaku Kesehatan. (Jakarta, Rineka Cipta)

Undang-Undang Republik Indonesia Nomor 20 Tahun 2013 Tentang Pendidikan Kedokteran

Thabrany, Hasbullah 2015 *Jaminan Kesehatan Nasional Edisi Kedua* (Jakarta: Rajawali Pers)

Miles, Matthew B. and A. Michael Huberman 2005 *Qualitative Data Analysis* (terjemahan) (Jakarta: UI Press)