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Liberalization of the Health Sector and Fulfillment of the Right to Health: How does international law respond to this condition?

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Abstract

The liberalization of the health sector has become a contentious issue, raising questions about its impact on the fulfillment of the right to health. This paper explores the dynamics between health sector liberalization and the realization of the right to health within the framework of international law. It examines the principles and obligations enshrined in international human rights instruments, trade agreements, and other relevant legal frameworks concerning health and trade. Through a comprehensive review of case studies and legal analyses, the paper evaluates how international law addresses the challenges posed by health sector liberalization and seeks to safeguard the right to health. Additionally, it considers the role of international organizations, such as the World Health Organization (WHO) and the World Trade Organization (WTO), in

balancing trade liberalization objectives with public health imperatives. The analysis highlights the tensions and synergies between economic interests and health rights, offering insights into potential strategies for reconciling these competing priorities. By elucidating the evolving landscape of international legal responses, this paper contributes to the ongoing discourse on achieving equitable access to healthcare while promoting global economic integration.

KEYWORDS *Liberalization, Health Services, Human Rights, International Law Discourse*

Introduction

The liberalization of the health sector has emerged as a significant issue in the context of global trade and human rights. While economic liberalization has led to increased access to goods and services across borders, it has also raised concerns about its impact on essential services like healthcare.[1] The intersection of health sector liberalization and the fulfillment of the right to health presents complex challenges that demand careful examination within the framework of international law.

The right to health, as articulated in various international human rights instruments, including the Universal Declaration of Human Rights and the International Covenant on Economic, Social, and Cultural Rights, embodies the fundamental principle that everyone has the right to enjoy the highest attainable standard of physical and mental health. However, the realization of this right is often hindered by factors such as inadequate healthcare infrastructure, unequal distribution of resources, and disparities in access to essential medicines and treatment.[2]

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[1] Missoni, Eduardo. "Understanding the impact of global trade liberalization on health systems pursuing universal health coverage." *Value in Health* 16.1 (2013): S14-S18; McNamara, Courtney. "Trade liberalization, social policies and health: an empirical case study." *Globalization and Health* 11 (2015): 1-19.

[2] Backman, Gunilla, et al. "Health systems and the right to health: an assessment of 194 countries." *The Lancet* 372.9655 (2008): 2047-2085; Leary, Virginia A. "The right to health in international human rights law." *Health and Human*

In recent decades, efforts to liberalize trade and investment have increasingly intersected with the provision of healthcare services. Governments around the world have pursued policies aimed at opening up the health sector to foreign investment, deregulating markets, and promoting competition. While proponents argue that liberalization can lead to improved efficiency, innovation, and quality of care, critics raise concerns about its potential adverse effects on public health, particularly for marginalized and vulnerable populations.[3]

In addition, international law plays a crucial role in shaping the parameters of health sector liberalization and safeguarding the right to health. Various legal instruments and mechanisms establish principles and obligations that govern the relationship between trade and health. These include human rights instruments, such as the right to health, as well as trade agreements, bilateral investment treaties, and agreements within the World Trade Organization (WTO) framework.[4]

This paper seeks to explore how international law responds to the complex interplay between health sector liberalization and the right to health, especially in Southeast Asian and Indonesia practices. By examining the relevant legal frameworks, case studies, and jurisprudence, it aims to analyze the tensions and synergies between economic liberalization objectives and public health imperatives. Additionally, it will consider the roles and responsibilities of international organizations, such as the World Health Organization (WHO) and the WTO, in reconciling competing priorities and advancing global health equity.

Rights (1994): 24-56; Toebes, Brigit. "The right to health as a human right in international law." *Refugee Survey Quarterly* 20.3 (2001).

[3] Irwin, Alec, and Elena Scali. "Action on the social determinants of health: a historical perspective." *Global Public Health* 2.3 (2007): 235-256; Bettcher, Douglas W., Derek Yach, and G. Emmanuel Guindon. "Global trade and health: key linkages and future challenges." *Bulletin of the World Health Organization* 78.4 (2000): 521.

[4] Woodward, David. "The GATS and trade in health services: implications for health care in developing countries." *Review of International Political Economy* 12.3 (2005): 511-534; Timmermans, Karin. "Developing countries and trade in health services: which way is forward?." *International Journal of Health Services* 34.3 (2004): 453-466; Bloche, M. Gregg, and Elizabeth R. Jungman. "Health Policy and the WTO." *Journal of Law, Medicine & Ethics* 31.4 (2003): 529-545.

Through this examination, the paper seeks to contribute to a deeper understanding of the challenges and opportunities inherent in balancing economic interests with the imperative to ensure universal access to healthcare. It underscores the importance of a rights-based approach to health policy and governance that places the well-being of individuals and communities at the forefront of decision-making processes.

Human rights, understood as universal entitlements inherent to all individuals regardless of their social status, have been a focal point of discourse and advocacy throughout history. Rooted in the principle of human dignity, the pursuit of human rights has evolved alongside the progress of civilization, serving as a cornerstone of societal development and the enhancement of human life. Central to this discourse is the endeavor to ensure that all individuals are afforded equal protection and opportunities, irrespective of their affiliations or positions within society.

The quest for human rights has spurred collective action and organized movements across various epochs, reflecting humanity's enduring commitment to upholding the inherent worth and freedoms of every person. It is within this context that the formation of states has emerged as a means to consolidate efforts in safeguarding human rights and fostering communal well-being. By coming together in organized structures, individuals seek to establish frameworks that promote justice, security, and the realization of fundamental rights for all members of society.

Moreover, the intersection of human rights with the liberalization of the health sector underscores the intricate relationship between individual well-being and broader socio-economic dynamics. As nations navigate the complexities of trade liberalization and market-oriented reforms in healthcare, ensuring the protection and fulfillment of the right to health remains paramount. International law serves as a crucial instrument in addressing these challenges, providing a framework for balancing economic interests with the imperative of upholding human rights standards.[5]

[5] Ramadhani, Fauziah. "Liberalization of Health Services in Indonesia in The Context of Justice." *Semarang State University Undergraduate Law and Society Review* 2.1 (2022): 87-104; Chapman, Audrey R. "Globalization, human rights,

This paper examines the nexus between Human Rights and the provision of healthcare facilities in Indonesia, evaluating whether the current state of healthcare provision adequately meets the needs of all segments of society. The study seeks to explore the extent to which Indonesians have access to sufficient and equitable healthcare facilities. It delves into the formulation of the problem by analyzing the landscape of healthcare access across different societal groups, aiming to highlight any disparities or inadequacies in the fulfillment of health rights.

Additionally, the paper presents a case study illustrating instances where Indonesian citizens have not received healthcare facilities in accordance with government policies. Liberalism, characterized by the belief in freedom and equal rights as core political values, is discussed in the context of healthcare rights fulfillment.[6] The paper explores how liberalism intersects with efforts to ensure universal access to healthcare, identifying obstacles that hinder the realization of these rights. By critically analyzing the challenges inherent in the intersection of liberalism and health rights, the paper contributes to a deeper understanding of the complexities surrounding healthcare provision in Indonesia.

In light of these considerations, this paper aims to examine how international law responds to the condition of health sector liberalization and its implications for the fulfillment of the right to health. Through a nuanced analysis of legal frameworks, case studies, and global trends, it seeks to elucidate the ways in which international law navigates the tensions between economic objectives and the promotion of human rights in healthcare. By delving into this multifaceted discourse, the paper aims to contribute to a deeper understanding of the complexities inherent in reconciling competing interests while advancing the collective goal of ensuring universal access to healthcare and upholding human dignity.

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and the social determinants of health." *Bioethics* 23.2 (2009): 97-111; Chapman, Audrey R., and Salil D. Benegal. "Globalization and the Right to Health." *The State of Economic and Social Human Rights: A Global Overview* (2013): 61.

6 Galston, William A. "Two concepts of liberalism." *Ethics* 105.3 (1995): 516-534; Almgren, Gunnar. *Health care politics, policy, and services: a social justice analysis*. Springer publishing company, 2017.

Meaning of Liberalism in the Health Sector

As delineated earlier, liberalism denotes an ideology, philosophical perspective, and political doctrine predicated on the premise that liberty and egalitarian rights constitute paramount political virtues. Central to liberalism is the repudiation of constraints, particularly those imposed by governmental and religious institutions.[7] Within contemporary society, liberalism finds fertile ground for advancement within democratic frameworks, given their shared emphasis on the primacy of majority freedom. Nonetheless, numerous nations diverge from these precepts. The nexus between liberalism and the healthcare domain manifests in the paradigm shift towards community-centric health provisioning, wherein determinations of health service delivery increasingly devolve from centralized governance structures to individual health agencies.[8]

This transformation has attracted scholarly attention, with various experts offering insights into its implications. Renowned sociologist Zygmunt Bauman, for instance, elucidates how the commodification of healthcare reconfigures societal perceptions of hospitals, diminishing their traditional role as bastions of social welfare and transforming them into profit-driven entities.[9] Similarly, political economist Naomi Klein contends that the expansion of profit-oriented healthcare services reflects a broader neoliberal agenda, wherein public goods and services are increasingly subjected to market forces.[10] Moreover, healthcare scholars such as Paul Farmer highlight how the pursuit of profit in healthcare

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[7] Armstrong, Mark, and David E. M. Sappington. "Regulation, competition, and liberalization." *Journal of economic literature* 44.2 (2006): 325-366; Wacziarg, Romain, and Karen Horn Welch. "Trade liberalization and growth: New evidence." *The World Bank Economic Review* 22.2 (2008): 187-231.

[8] Donnelly, Mary. *Healthcare decision-making and the law: autonomy, capacity and the limits of liberalism*. Vol. 12. Cambridge University Press, 2010; Giarelli, Guido. "The changing role of the state in a neo-liberal healthcare policy arena." *National Health Services of Western Europe*. Routledge, 2023. 213-241.

[9] Bauman, Zygmunt. *The individualized society*. John Wiley & Sons, 2013.

[10] Koren, Gideon, and Naomi Klein. "Bias against negative studies in newspaper reports of medical research." *Jama* 266.13 (1991): 1824-1826; Klein, Naomi. *This changes everything: Capitalism vs. the climate*. Simon and Schuster, 2015.

exacerbates existing health disparities, disproportionately impacting marginalized communities.[11]

These perspectives collectively underscore the multifaceted ramifications of the marketization of healthcare, shedding light on its socio-economic, political, and ethical dimensions. By incorporating scholarly insights, we gain a more nuanced understanding of the complex interplay between market dynamics and healthcare provision, thereby informing efforts to address the challenges posed by the commercialization of healthcare.[12]

Consequently, the pervasive influence of commercial imperatives permeates virtually every aspect of patient care, while the fulfillment of healthcare's social obligations lags conspicuously behind. Externally, hospitals increasingly project a commercial visage, seemingly forsaking their inherent societal responsibilities. However, this perception belies the enduring presence of these social functions, as articulated by dr. Adib Abdullah Yahya, Chairman of the Indonesian Hospital Association, who underscores that essential services, particularly in emergency departments, remain steadfastly operational.[13]

He contends that the perceived commercial ethos stems from hospitals' imperative to sustain themselves financially. He explains that hospitals must operate viably, necessitating fee structures aligned with the cost per unit of service. Conversely, dr. Kartono Mohamad, a health expert and former Chairman of the Executive Board of the Indonesian Medical Association, observes a pronounced trend towards liberalization in

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[11] Kim, Jim Yong, Paul Farmer, and Michael E. Porter. "Redefining global health-care delivery." *The Lancet* 382.9897 (2013): 1060-1069; De Maio, Fernando. "Paul Farmer: Structural violence and the embodiment of inequality." *The Palgrave handbook of social theory in health, illness and medicine*. London: Palgrave Macmillan UK, 2015. 675-690.

[12] Mackintosh, Maureen, and Meri Koivusalo, eds. *Commercialization of health care: global and local dynamics and policy responses*. Springer, 2005; Boni, Arthur A. "The business of commercialization and innovation." *Journal of Commercial Biotechnology* 24.1 (2018).

[13] Husada, Richard, and Raymond R. Tjandrawinata. "The healthcare System and the pharmaceutical industry in Indonesia." *The New Political Economy of Pharmaceuticals: Production, Innovation and TRIPS in the Global South* (2013): 134-151.

Indonesia's healthcare sector, wherein market forces exert disproportionate influence. dr. Mohamad laments the absence of clear regulations governing service charges, noting a prevailing orientation towards profit maximization among healthcare financiers.[14]

Indeed, as Kartono observed, even routine procedures such as suture removal following surgery incur separate charges distinct from the initial operation. Furthermore, the oversight of post-procedural care appears to be construed not as an integral component of the healthcare provider's responsibility but rather as an additional service subject to its own tariff. However, the issue extends beyond the mere segregation of tariffs; the opacity surrounding fee structures is equally concerning, as they are arbitrarily determined by individual health service managers.

Kartono contends that this fee-for-service healthcare model, wherein each aspect of care incurs a separate charge, necessitates a transition towards an insurance-based system. He advocates for the immediate enactment of the National Social Security System Law, which has remained dormant for five years. From a market-oriented perspective, the prevailing paradigm prioritizes capital accumulation above all else, effectively quantifying healthcare services solely in terms of financial investment and returns.[15]

Despite government denials, this reality pervades the healthcare system of the country at large. As Radhar contends, the core ethos of service is often distorted by considerations of facilities and pricing, leading to the enforcement of discriminatory practices against patients. Compounding these issues, the absence of a supervisory agency to rectify service errors exacerbates the plight of patients. Moreover, the lack of legislation specifically governing health services in hospitals, including protocols for patient care and oversight, underscores a significant

[14] Suryanto, Tulus, et al. "The influence of liberalization on innovation, performance, and competition level of insurance industry in Indonesia." *Sustainability* 12.24 (2020): 10620.

[15] Sumarto, Mulyadi. "Welfare regime change in developing countries: Evidence from Indonesia." *Social Policy & Administration* 51.6 (2017): 940-959.

regulatory gap. The government, entrusted with the role of regulator and arbiter, is conspicuously absent in addressing these challenges.[16]

Upon scrutinizing the multitude of emerging cases, Hasbullah Thabrany, a distinguished public health expert from the University of Indonesia, has unequivocally urged the government to acknowledge the presence of market failure within the healthcare sector. Thabrany asserts that the application of market mechanisms to hospital and health services inherently fails to benefit consumers. This cautionary sentiment echoes the sentiments expressed by numerous health experts affiliated with the People's Health Care Forum.[17]

Thabrany's admonition is grounded in empirical evidence that underscores the ineffectiveness of market mechanisms in healthcare. Indeed, a wealth of literature attests to this failure, revealing a paradox wherein an increase in the number of doctors and hospitals corresponds with escalating service costs. Furthermore, Thabrany highlights the paradoxical phenomenon of government-owned public hospitals participating in competitive market dynamics.

Exploring the Interplay between Community Health Rights and Human Rights Fulfillment

Drawing from Law No. 39 of 1999, outlined in Chapter III on Human Rights and Basic Human Freedoms within Part One concerning the Right to Life, Article 9, paragraph 3 stipulates the entitlement of all individuals to a wholesome and salubrious living environment. Moreover, Article 62 delineates the entitlement of every child to access adequate health and social security services commensurate with their physical, mental, and spiritual needs. These provisions underscore the intrinsic

[16] Yang, Yilin, et al. "A review of IoT-enabled mobile healthcare: technologies, challenges, and future trends." *IEEE Internet of Things Journal* 9.12 (2022): 9478-9502.

[17] Tangcharoensathien, Viroj, et al. "Health-financing reforms in southeast Asia: challenges in achieving universal coverage." *The Lancet* 377.9768 (2011): 863-873; Thabrany, Hasbullah. *Jaminan kesehatan nasional*. Rajawali Pers, 2014.

connection between the fulfillment of health rights for the community and broader human rights principles.[18]

Essentially, the fulfillment of health rights, encompassing essential services and facilities, represents an imperative duty incumbent upon the government to ensure the well-being of its populace. This commitment to healthcare provision constitutes a pivotal aspect of upholding human rights and aligns with the foundational aspirations of the National Struggle.

From a cultural perspective, it is evident that the endeavor to safeguard human rights is inherently intertwined with the historical and cultural imperatives of societies worldwide, including Indonesia. Consequently, advocating for human rights aligns with the endeavor to nurture and cultivate the nation's cultural ethos, effectively serving as a means to advance the process of civilizing the nation. Presently, amidst escalating global competition, healthcare organizations in Indonesia are strategically prioritizing customer-centric or patient-oriented quality healthcare services to sustain their relevance and viability.

One of the most pertinent strategies to navigate this era of heightened competition involves adopting a comprehensive approach to quality, focusing on service processes and delivering healthcare outcomes that align with the expectations of customers or patients. In this context, service quality represents the consumer's evaluation of the level of service received against their anticipated standards. This emphasis on quality service provision not only underscores organizational responsiveness to consumer needs but also reinforces the cultural imperative of upholding human dignity and rights within the healthcare domain.

The quality of health services rendered is indicative of the degree to which healthcare provisions meet the individual needs and preferences of each patient. Enhanced alignment between service offerings and patient expectations correlates with heightened service quality. Within hospital

[18] Smith, George P. "Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care or Health Protection?." *Vanderbilt Journal of Transnational Law* 38.5 (2005): 1295-1321; Braveman, P. "Social conditions, health equity, and human rights." *Health and Human Rights* 12.2 (2010): 31-48.

settings, the quality of healthcare services is profoundly shaped by the intricacies of service delivery processes.[19]

Therefore, in improving the quality of quality factors of physical facilities, available personnel, drugs and medical devices including human resources and professionalism are needed so that quality health services and equitable distribution of health services can be enjoyed by the entire community. The quality of services produced by hospitals will affect customers, improving service quality has an impact on customer loyalty. In addition, *customers* will provide information to the public about the servants in the hospital so that the number of new patient visits will increase. The increasing number of patients will affect hospital revenue. Patient satisfaction is an integral part of health service quality assurance activities. That is, measuring the level of patient satisfaction must be an activity that cannot be separated from measuring the quality of health services.[20]

The dimension of patient satisfaction is one of the most important dimensions of health service quality. Good service quality will cause satisfaction to customers or service users (patients). Customer satisfaction is the main indicator of the standard of a health facility. Measures of service quality, low customer satisfaction will have an impact on the number of visits which will affect the provitability of the health facility. Employee attitudes towards customers will also have an impact on customer satisfaction where customer needs from time to time will increase. Customer satisfaction measurement is one way to measure the appearance of hospitals in providing services to the community. Supervision of services provided to patients must always be carried out with the aim of improving the quality of service.

In fact, services to poor patients provided differently are still common. This distribution aims to obtain information about health services provided by hospitals to poor people in several regions of

[19] Sofaer, Shoshanna, and Kirsten Firminger. "Patient perceptions of the quality of health services." *Annu. Rev. Public Health* 26 (2005): 513-559; Mohammad Mosadeghrad, Ali. "Healthcare service quality: towards a broad definition." *International Journal of Health Care Quality Assurance* 26.3 (2013): 203-219.

[20] Campbell, Stephen M., Martin O. Roland, and Stephen A. Buetow. "Defining quality of care." *Social Science & Medicine* 51.11 (2000): 1611-1625.

Indonesia. The subjects of the study were poor people who were and/or had received health services in hospitals in several parts of Indonesia. The results of the study showed that poor patients in government hospitals and private hospitals generally have an inadequate level of satisfaction, including administrative services that are considered complicated, complicated, uninformed, unfriendly officers, not prescribed generic drugs, and services that take a long time.

In addition, having to pay a down payment is also a barrier for poor people to get health services in hospitals. In addition to health facility services in hospitals, people in the global era also need life insurance facility services. This is provided by life insurance companies offering protection for human life which aims to provide a sense of security and comfort and provide the right solution to overcome risks.[21] Things about the details of the problem of receiving health facilities experienced by the lower class will then be discussed in the third problem formulation later. The parties involved in health services according to Law 36 of 2009 concerning Health, namely in article 1 point 6 states that health workers are everyone who devotes themselves to the health sector and has knowledge and / or skills through education in the health sector which for certain types that require authority to do health.[22]

However, in ancient times before the health law 36 of 2009 had not been enacted, there were two kinds of health workers, namely medical personnel and medical personnel, namely medical personnel are medical experts whose main function is to provide medical services to patients with the best quality by using procedures and techniques based on medical science and ethics that apply and can be accounted for, but along with the development of the regulatory era and the definition and understanding

[21] Imadasari, Rheza. "Penyelesaian Klaim Asuransi Jiwa Menurut Klaim Ex-Gratia." *Unnes Law Journal* 2.2 (2013): 73-78; Afrita, Indra, and Wilda Arifalina. "Tanggung Jawab Hukum Perusahaan Asuransi Jiwa terhadap Tertanggung dalam Pembayaran Klaim Asuransi." *Jurnal Hukum Respublica* 20.2 (2021): 123-134.

[22] Barthos, Megawati, and Agustinus Luturmas. "Positive Legal Aspects of Indonesia in Health Services Based on the Perspective of Law Number 17 of 2023 Concerning Health." *Proceedings of the 3rd Multidisciplinary International Conference, MIC 2023, 28 October 2023, Jakarta, Indonesia*. 2023.

of it has shifted.[23] The quality of service in hospitals is one of the important factors in fulfilling people's right to health.

On the other hand, the quality of service in hospitals comes with a unique phenomenon, due to the different dimensions and indicators between the people involved in the service. To overcome these differences, basic guidelines for the implementation of health services that meet the needs and demands of health service users should be used. The quality of service is directed at perfect health services in meeting the needs and demands of each patient. Thus, the quality of health services is everything that shows the level of perfection of health services that cause satisfaction in each patient.

However, until now the problem of abuse of consumer rights of health services in hospitals is growing without being felt by the hospital, especially if consumers do not express complaints formally. Although not at issue, the abuse of this right is essentially a problem. Deviations that occur continuously will damage various good efforts that have been pursued and affect the positive outlook of society. Abuse of patients' rights in hospitals can occur due to ignorance, dominant attitude, excessive workload and economic factors.[24] For the poor, dissatisfaction with poor health services in hospitals, is often accepted with resignation.

The poor are often victims of unfair and discriminatory health systems. As for the rich, dissatisfaction with such services is enough to give reason to see a doctor or a much more expensive foreign hospital. As a result, the growth of "international" hospitals is mushrooming in Indonesia. In the discussion of the third problem formulation, it will be described about the constraints or problems that exist in a region in Indonesia related to the fulfillment of health rights.

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[23] Mustajab, Mustajab. *Analisis Yuridis Hubungan Hukum Antara Dokter Dan Pasien Dalam Peyanan Kesehatan*. Diss. Tadulako University, 2013.

[24] Lestari, Tri Rini Puji. "Upaya Peningkatan Mutu Pelayanan Di Puskesmas Melalui Pendekatan Manajemen Sumberdaya Manusia Kesehatan." *Kajian* 23.3 (2020): 157-174; Lestari, Tri Rini Puji. "Pelayanan Rumah Sakit bagi Masyarakat Miskin (Studi Kasus di Enam Wilayah Indonesia)." *Kesmas: Jurnal Kesehatan Masyarakat Nasional (National Public Health Journal)* 5.1 (2010): 9-16.

Identifying Challenges in Fulfilling Community Health Rights Across Diverse Contexts

In the present discussion on problem formulation, the author draws insights from a journal article titled "Quality of Service at Regional General Hospitals (Study on Inpatient Satisfaction of JAMKESMAS Participants at Indramayu Regency General Hospital)." Regional General Hospitals (RSUD), serving as primary providers of public healthcare services within localities, often find themselves under scrutiny due to perceived deficiencies in service quality, particularly among impoverished demographics. This scrutiny is understandable, given RSUD's status as a government entity entrusted with a pivotal role in enhancing public health standards within their respective regions. In fulfilling their mandate, RSUDs are expected to prioritize social welfare over profit-seeking endeavors, emphasizing their role as purveyors of non-commercial services aimed at benefitting the wider community.[25]

In the health sector public services, the poor receive extra attention not only because of the high number of poor people from government data, but because their social and psychological conditions tend to make them vulnerable to discriminatory treatment in accessing services aforementioned.[26] We must admit that the government's attention is

[25] Rohman, Taufik, Dewi Laelatul Badriah, and Mamlukah Mamlukah. "Hubungan Antara Mutu Pelayanan Kesehatan Dengan Kepuasan Pasien Bpjs Rawat Jalan Di Puskesmas Haurgeulis Kabupaten Indramayu 2022." *Journal of Nursing Practice and Education* 3.01 (2022): 69-78; Mesran, Mesran, et al. "Sistem Pendukung Keputusan Pemilihan Peserta Jaminan Kesehatan Masyarakat (Jamkesmas) Menerapkan Metode MOORA." *Jurnal Media Informatika Budidarma* 2.2 (2018); Jacobis, Rolando. "Faktor-Faktor Kualitas Pelayanan Pengaruhnya Terhadap Kepuasan Pasien Rawat Inap Peserta Jamkesmas Di BLU RSUP Prof. Dr. RD Kandou Manado." *Jurnal EMBA: Jurnal Riset Ekonomi, Manajemen, Bisnis dan Akuntansi* 1.4 (2013).

[26] Alawiyah, Putri, and Dian Safriantini. "Importance Performance Analysis Kualitas Pelayanan Kesehatan Klien Rawat Jalan Peserta Jaminan Kesehatan Nasional." *Jurnal Kesehatan* 11.1 (2020): 51-60; Mulyawan, Budi. "Kualitas Pelayanan Rumah Sakit Umum Daerah (Studi Tentang Kepuasan Pasien Rawat Inap Peserta Jamkesmas Pada Rumah Sakit Umum Daerah Kabupaten Indramayu)." *Jurnal Aspirasi* 5.2 (2015): 1-14.

increasing with the presence of a number of health insurance programs for the community, but the program still leaves various problems, especially around the attitude and service ethics of service providers. Service providers generally have a stereotypical view of this group as those who utilize service bureaucratic resources without contributing income to the bureaucratic resources themselves.

On the other hand, poor people, low education and access to knowledge are minimal, causing them to be less aware of their rights as citizens (*civil right*) in obtaining health services. This is the cause of the low social control of the poor over service providers, so that service providers do not try to improve service quality which has implications for poor service quality. The Regional General Hospital (RSUD) of Indramayu Regency is one of the SKPD in Indramayu Regency which has the status of a type B Hospital by organizing 13 service units. The number of patients visiting this hospital from year to year shows an increasing trend, both outpatient and inpatient visits. In terms of inpatient visits, data from 2011 to 2013 showed fluctuations.

However, during this three-year period, visits among poor families who use JAMKESMAS and Certificate of Disability (SKTM) facilities are always above 50% of the total inpatient visits. Moving on from the background, the focus of this study is the satisfaction of inpatients participating in JAMKESMAS RSUD Indramayu Regency, considering in today's paradigm of public service delivery which is a parameter of quality or not service provider organizations is customer satisfaction (*customer satisfaction*). Furthermore, the formulation of the problem in this study is: How is the satisfaction of inpatients participating in JAMKESMAS at Indramayu District Hospital? The goal is to understand concepts and theories in solving actual problems in the field, especially in the implementation of public services. To ensure poor people's access to health services as mandated in the 1945 Constitution, since 2005 efforts have been made to overcome these obstacles and constraints through the implementation of the Poor People's Health Care Insurance Program policy. This program is organized by the Ministry of Health through assignment to PT Askes (Persero) based on Decree Number 1241 /

Menkes / SK / XI / 2004, concerning the Assignment of PT Askes (Persero) in managing health maintenance programs for the poor.[27]

To avoid misunderstandings in the guarantee of the poor which include the very poor, poor, and close to poor, this program was renamed Public Health Insurance hereinafter referred to as JAMKESMAS with no change in the number of targets. The general objective of JAMKESMAS is to increase access and quality of health services to all poor and underprivileged people in order to achieve optimal public health status effectively and efficiently. Aspects Inpatient Satisfaction of JAMKESMAS Participants at RSUD Kabupaten Indramayu. All informants who were subjects in this study had the hope of getting help and good service when undergoing treatment, both in terms of comfort, facilities, friendliness of nurses and hospital officers, the thoroughness of doctors and nurses in handling them.[28]

This hope was expressed by an informant who had been hospitalized for typhoid for three days: "... What I expect is definitely in terms of comfort and then adequate facilities, then the friendliness of nurses, the alacrity and thoroughness of doctors and nurses in treating me." Furthermore, when the informant was asked for his response regarding the compatibility between his expectations and the reality experienced after several days of treatment, the informant answered not completely, even

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[27] Utomo, Budi, Purwa K. Sucahya, and Fita R. Utami. "Priorities and realities: addressing the rich-poor gaps in health status and service access in Indonesia." *International Journal for Equity in Health* 10 (2011): 1-14; Shrestha, Ranjan. "Health Insurance for the poor, healthcare use and health outcomes in Indonesia." *Bulletin of Indonesian Economic Studies* 57.1 (2021): 85-110; Kaye, Katherine, and Michael K. Novell. "Health practices and indices of a poor urban population in Indonesia part I: Patterns of health service utilization." *Asia Pacific Journal of Public Health* 7.3 (1994): 178-182.

[28] Wenang, Supriyatiningsih, et al. "Availability and accessibility of primary care for the Remote, Rural, and Poor Population of Indonesia." *Frontiers in Public Health* 9 (2021): 721886; Rosser, Andrew. "Realising free health care for the poor in Indonesia: The politics of illegal fees." *Journal of Contemporary Asia* 42.2 (2012): 255-275; Heriyono, Heriyono. "Pengaruh Pendelegasian Wewenang dan Birokrasi Terhadap Kepuasan Kerja Pegawai RSUD (Survey Pada Rumah Sakit Umum Daerah Kabupaten Cirebon, Kota Cirebon, Kabupaten Indramayu, dan Kabupaten Kuningan)." *Exchall: Economic Challenge* 3.1 (2021): 17-39.

many things were not in accordance with his expectations. "As far as I'm concerned, hospitals are places that should be away from noise and put comfort first." Thus, the reality experienced was different from his expectations. When the same question was addressed to several other informants, six people were found who gave the same essence of the answer, namely that the service of Indramayu Regency Hospital was not in accordance with their expectations because the service was not very good.[29]

The service in question is aimed at aspects of hospitality and courtesy (*courtesy*) as well as speed in responding to medical requests. There are also informants who are dissatisfied with hospital services aimed at dimensions *reliability*, namely the reliability of the services provided by the hospital, such as the following informant statement: "I am not satisfied with the services of this hospital because I have returned home and relapsed." According to the informant, his current hospitalization is the second time. The first hospitalization he underwent for 3 days, just went home for 4 days, the disease recurred and had to undergo hospitalization again.

Incidents like this, according to the hospital, often occur because many patients force to go home even though doctors have not recommended recovery for the patient concerned. Cases like this are confirmed to be one of the causes of ALOS's low achievement *(Average Length of Stay)* or the average length of time the patient was admitted to the hospital. The study informed that most informants had a desire to recover as soon as possible and return home immediately. A desire and hope that certainly exists in everyone who is undergoing treatment in the hospital, even though they are exempt from treatment and medical expenses. Thus, patients who go home forcibly are not solely due to poor quality of care. The quality of good service does not fully guarantee patients to stay in a hospital for a long time, considering that the majority of JAMKESMAS inpatients are poorly educated so they do not understand their health conditions.[30]

[29] Heriyono, "Pengaruh Pendelegasian Wewenang dan Birokrasi Terhadap Kepuasan Kerja Pegawai RSUD (Survey Pada Rumah Sakit Umum Daerah Kabupaten Cirebon, Kota Cirebon, Kabupaten Indramayu, dan Kabupaten Kuningan)."

[30] Heriyono.

In general, they assume that after getting treatment and treatment, they feel they have recovered from the disease suffered. In this context, what patients need is information about their health condition. Thus, the hospital should further increase informative efforts, such as explaining to patients and family members about the progress of their health with the use of easy-to-understand language and through persuasive means. Of course, this requires psychological closeness between medical personnel and patients so that good communication is created between the two. However, the relationship based on affection does not seem to be found in the pattern of relationship between patients and medical workers at Indramayu District Hospital.

This is indicated by the answer of most respondents who say "normal" when the question asked is related to feelings They are in contact with doctors and nurses. The respondents who answered affirmatively the hospital service was in accordance with the expectations of a total of 6 people, including a father who throughout the interview expressed joy, with a smiling face always expressed the following response: "The service of this hospital is in accordance with my expectations and I am satisfied with the service of this hospital. Hopefully hospital services with JAMKESMAS cards will be even better in the future." Meanwhile, there were two informants who were a little hesitant to give a statement when asked for their opinion on the compatibility between expectations and reality they received during hospitalization.[31]

According to them, their expectations were not fully obtained, but when asked if the informant was satisfied with the inpatient services at this hospital. The first respondent replied: "Just satisfied because you have been helped, thank you." From some of the informant's responses above, it can be stated that the category of informants who answered satisfied with the services of Indramayu Regency Hospital were informants who felt their expectations were met. This is related to their positive appreciation of the five dimensions of service quality (*truth, truth, assurance, danem ease*) organized hospitals. Conversely, the categories of informants who felt dissatisfied or dissatisfied, because they felt their expectations were not met. This can be traced from their answers when asked for responses to

[31] Heriyono.

the five dimensions of service quality, the majority have a negative appreciation of one or more dimensions of service quality.

Statements of some of the above respondents – at least – is the answer to the question of why there are still many residents of Indramayu Regency who seek treatment at hospitals outside Indramayu. As once revealed by the Regent of Indramayu, H. Anna Sophanah on one occasion as follows: "To be honest, when the people of Indramayu suffer from illness, there are still many who seek treatment outside Indramayu. This became a matter of introspection for us. Lest the hospital in Indramayu has not met people's expectations." From the study above, it can be stated that based on the classification of types of satisfaction and dissatisfaction of inpatients using JAMKESMAS at Indrmayu District Hospital, two types of patients who tend to be passive in demanding service improvement, namely patients of the type *resigned customer satisfaction* dan stable *customer dissatisfaction*.

But there is something fundamental that distinguishes passive attitudes from the two types. The passive attitude underlying the first type is introspection(*self-fulfilling*) to expect no more than just getting help. People in this category generally consider public services to be the kindness and generosity of the government or state, so they tend to surrender and accept what they are from the government and its bureaucracy. They generally lack concern for the delivery of public services. While the aspect of low awareness of community members of their rights and obligations as citizens and consumers, so they tend to take for granted the services provided by government agencies, especially if the services provided are free.[32] While the second type, *stable customer dissatisfaction*, that is, patients are passive driven by pessimistic feelings that the hospital will make improvements in the future.

The results of interviews with informants stated that complaints were found of inpatient patients participating in JAMKESMAS, but the number was not too much. In general, complaints are directed at aspects of unfriendliness of medical personnel (especially obstetric inpatient

[32] Rahman, Khairul. "Pemberdayaan Partisipasi Masyarakat Dalam Pembangunan Desa." *WEDANA: Jurnal Kajian Pemerintahan, Politik dan Birokrasi* 2.2 (2016): 189-199.

rooms) and cleaners. While patients who feel dissatisfied have a stable customer dissatisfaction type, where patients are not satisfied, but tend to be passive in demanding improvement. Dissatisfied patients have the potential to cause negative word of mouth that can harm the image of the institution in the eyes of the Indramayu public.

Therefore, the Management of Indramayu Regency Hospital should be more serious about improving service quality, considering that based on the results of this study, most informants still complain about service quality, especially aimed at some of the dimensions of service quality above. In this case the patient is of type *resigned customer satisfaction* It cannot be used as a parameter for service providers to claim that the quality of services provided has been good. They feel satisfied driven by introspection with the socioeconomic conditions of their lives. In addition, the low complaint is constituted because there are many inpatients participating in JAMKESMAS *stable customer dissatisfaction*, that is, patients feel dissatisfied with the service, but tend to be passive in demanding improvement. This last type of patient has potential *word of mouth* negative that can harm the image of the institution in the eyes of the public.[33]

Conclusion

In summary, the discussions pertaining to the problem formulation underscore critical issues within the realm of healthcare provision and the protection of human rights. Firstly, human rights are intrinsically linked

[33] Alfiah, Dian, Rosyidah Rosyidah, and Surahma Asti Mulasari. "Analisis penerapan tarif paket pelayanan esensial (PPE) jamkesmas pada pelayanan operasi Caesarea kelas III di Rumah Sakit PKU Muhammadiyah unit I Yogyakarta tahun 2009." *Kes Mas: Jurnal Fakultas Kesehatan Masyarakat Universitas Ahmad Daulan* 5.2 (2011): 24941; Aris Styadi, Aris, and D. W. Dewie Brima Atika. "Indeks Kepuasan Masyarakat Pada Pelayanan Jamkesmas di Rumah Sakit (Studi Pada Rumah Sakit Umum Abdoel Moeloek Bandar Lampung)." *Administratio: Jurnal Ilmiah Administrasi Publik dan Pembangunan* 5.2 (2014): 168-180; Vinensa, Elga Ria, Ietje Nazarudin, and Triyani Maryati. "Analisis Perhitungan Unit Cost Pada Tindakan Tonsilektomi dengan Metode Activity Based Costing (Studi Kasus di Rumah Sakit PKU Muhammadiyah Yogyakarta)." *JMMR (Jurnal Medicoeticolegal dan Manajemen Rumah Sakit)* 3.2 (2014).

to the inherent dignity of individuals, emphasizing the imperative of upholding basic rights irrespective of socio-economic status or other factors. Secondly, the infiltration of liberal principles into the healthcare sector has become a pressing national concern, with significant implications for the accessibility and affordability of healthcare services. The proliferation of profit-driven approaches, exemplified by the emergence of private hospitals prioritizing financial gain over social welfare, exacerbates disparities in healthcare access and affordability, particularly for vulnerable populations.

The empirical findings reveal a concerning trend of inadequate satisfaction levels among impoverished patients accessing healthcare services, both in government and private hospitals. These dissatisfaction issues span various facets, including complex administrative procedures, lack of information, unfriendly staff demeanor, absence of generic drug prescriptions, and prolonged service delivery times. Notably, government hospitals, entrusted with a mandate to cater to the needs of the underprivileged and during emergencies, are not exempt from these shortcomings, further underscoring the urgency of addressing systemic deficiencies in healthcare provision.

Moving forward, there is a compelling need for robust regulatory frameworks to delineate the respective roles and responsibilities of the state and healthcare service providers. Establishing clear guidelines, such as Minimum Service Standards (SPM) and technical standards ensuring patient safety, is crucial to standardizing healthcare delivery and safeguarding patient rights. Streamlining administrative procedures to eliminate disparities in treatment between different patient demographics, particularly those with non-commercial insurance, is essential for promoting equity in access to healthcare. Additionally, instituting transparent cost calculation standards and implementing independent health service audits will enhance accountability and ensure that patients receive commensurate services relative to the costs incurred. Ultimately, concerted efforts by both governmental and non-governmental stakeholders are imperative to counter the encroachment of profit-oriented practices in healthcare and uphold the fundamental rights of all individuals to accessible, affordable, and quality healthcare services.

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