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ETHICAL AND PROFESSIONAL DILEMMAS ENCOUNTERED BY DOCTORS IN THE NATIONAL HEALTH INSURANCE SYSTEM

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ABSTRACT

Background: The National Health Insurance System has had a major impact on health services in Indonesia. It gives health coverage assurance but also raised numerous dilemmas for physician. **Objective:** This study aims to analyse various ethical and professional dilemmas among physicians in the National Health Insurance System (NHIS). **Methods:** This research is a cross-sectional descriptive study. Online questionnaire was distributed to physicians practicing in Indonesia. **Results:** Of the 87 doctors who participated in this study, 60.92% were general practitioners and 39.08% were specialists. The inability to maintain professional independence (63.41%) is the most common ethical dilemma faced by doctors with 65.38% of them experienced in advanced level health facilities. Meanwhile, the limitation of adequate medical care in an emergency (25.45%) is the most dilemmatic situation experienced in terms of professionalism with 85.71% occurring in advanced level health facilities. **Conclusion:** Physicians in Indonesia were deal with various dilemmas while practicing in the NHIS. The high rate of dissatisfaction and the various ethical problems and professional disciplines require a review of the health system to improve the quality of services and maintain the professionalism of doctors.
Keywords: *dilemma, ethical, professional, National Health Insurance System, Indonesia*

INTRODUCTION

The National Health Insurance System (NHIS; or *Jaminan Kesehatan Nasional*) was established by the Government of Indonesia in 2014 to achieve Sustainable Development Goals (SDGs). This universal health coverage system were managed by the Social Security Agency for Health (SSAH; or *Badan Penyelenggara Jaminan Sosial Kesehatan* [BPJS]).[1–3]

In 1995, Taiwan began the implementation of the national health insurance system (NIH). In its implementation, there were several problems including (1) various quality of care related to poor doctor-patient reports and inability to overcome complex problems in one visit, thus contributes to a higher volume of patients and medical costs; (2) poor gatekeeping of specialist services, in which the absence of gatekeepers means the relatively weak role of family physician gatekeepers; (3) financial problems, that the health insurance system does not take much money out of dues to cover all health services provided by hospitals and other medical personnel. Governments often have to provide additional funding to keep the system running.[4]

Problems in the health insurance system are also found in Ghana (National Insurance Scheme or NHIS), some of the problems include (1) reimbursement delays; (2) distances and lack of health facilities; (3) lack of human resource capacity and capability; (4) spatial distribution and poor infrastructure; (5) fraud, abuse, and sustainability; (6) low rates of insurance contributions, in contrast to the health packages covered by health insurance.[5]

As the number of NHIS member was growing, so were the number of challenges, such as an insufficient number of health care providers, facility, drugs, and medical supplies (notably in the rural and remote areas); inaccurate targeting of the lower-income groups; ethical, professionalism, and legal concerns. These issues contributed to inefficient health care services thus decreasing the quality and increasing the risk of medical misconduct and fraud.[1-3]

Despite being faced with various ethical, professionalism, and legal dilemmas during practice, physicians' concern about these fields is lacking. The lack of knowledge on ethical and professionalism issues can be a paradox as the public awareness of their right is rising. While, inappropriate services according to the medical ethical code and law could cause malpractice and legal suits.[6–8]

To the author's knowledge, there is no previous study regarding these concerns in Indonesia. Hence, a study of ethical and professionalism dilemmas among physicians in the NHIS in Indonesia was conducted.

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METHODS

A cross-sectional descriptive study with a purposive sampling method was conducted. A questionnaire was distributed online between June – December 2019 to physicians practicing in Indonesia. The questionnaire was developed to obtain two main issues, namely ethical and professionalism dilemmas. The questions in the ethical dilemma were based on the Indonesian Code of Medical Ethics 2012 (ICME; *Kode Etik Kedokteran Indonesia*) while the professionalism dilemma were based on Professional Discipline of Physician and Dentist, Indonesian Medical Council Regulation Number 4 Year 2011.[8–10]

Data collected from the questionnaire were processed with Microsoft Excel. Of note, data from the open-ended questions were first categorized by the author according to the similarity of the answers before analysis. Descriptive statistics were used to summarize the participants' responses.

Ethical clearance was acquired from the Health Research Ethics Committee of Faculty of Medicine, Diponegoro University, before the commencement of the study (reference number: 493/EC/KEPK/FK-UNDIP/XI/2019).

RESULTS

A questionnaire was sent online, and 87 physicians give consent to participate in the study. Participants' socio-demographic data can be seen in Table 1. The majorities of participants were general physicians (60.92%), followed by specialists (39.08%).

According to the primary practice site, 30 (34.48%) physicians stated to practice in first level health facility (primary health centre and clinic). As for advanced level health facility,57 (65.52%) physicians practice in type A, B, C and D hospital.

Table 1. Participants' socio-demographic data

	n(%)
Gender	
Man	44 (50.57%)
Woman	43 (49.43%)
Age	
26-35	48 (55.1 7%)
36-45	33 (3 7.93%)
46-55	5 (5.75%)
56-65	1 (1.15%)
Doctor Type	
Specialist	34 (39.08%)
General practitioners	53 (60.92%)
Main Practice Place	
FKTP*	30 (34.48%)
FKRTL**	57 (65.52%)

*FKTP (First Level Health Facility); **FKRTL (Advanced Referral Health Facility/Advanced Level Health Facility)

The ICME 2012 divided ethical duty into four categories: general duty, duty to the patient, duty to colleagues, and duty to himself. Table 2 shows the result of ethical dilemmas faced by physicians in the NHIS era. From 87 participants, 82 physicians stated facing ethical dilemmas. The most common ethical dilemmas while practicing in the NHIS era is the ability to practice free from influence that may result in the loss of freedom and independence of the profession (63.41%). In this case, advanced level health facility 34 (65,38%) was chosen as the most common site in which physician faced ethical dilemma compared to primary level health facility 18 (34,62%). Meanwhile, general practitioner 33 (63,46%) faced more ethical dilemma compared to specialist doctor 19 (36,54%). In the open-ended question section, most physicians wrote substandard care (including substandard supporting examination, choice of treatment, choice of drugs, and inability to refer patient) due to limitations by the NHIS as the most day-to-day dilemmas.

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Table 2. Ethical dilemmas faced by physicians in the NHIS era

Ethical Obligations	Health facility		Qualification		Total
	FKTP (%)	FKRTL (%)	Specialist (%)	GP(%)	n = 82 (%)
General Duty					
Obedience to the doctor's oath	7 (38.89)	11 (61,11)	8 (44,44)	10 (55,56)	18 (21.95)
Ability to make professional decisions independently and to maintain professional conduct in the highest measure	11 (32,25)	23 (67,65)	13 (38,24)	21 (61,76)	34 (41,46)
Ability to practice free from influences that may result in loss of freedom and independence of the profession	18 (34,62)	34 (65,38)	19 (36,54)	33 (63,46)	52 (63,41)
Obligation to respect other in the health sector, other fields, and society	7 (31,82)	15 (68,18)	12 (54,55)	10 (45,45)	22 (26,83)
Duty to the patient					
Obligation to be sincere and use all his knowledge and skills for the benefit of the patient; Obligation to refer the patient to a doctor who has the expertise when unable to perform an examination or treatment, with the consent of the patient/family	10 (35,71)	18 (64,29)	11 (39,29)	17 (60,71)	28 (34,15)
Obligation to keep everything he knows about a patient's secret, even after the patient has died	9 (45.00)	11 (55.00)	8 (40.00)	12 (60.00)	20 (24,39)
Obligation to perform emergency aid as a form of humanitarian duty, unless he is sure that someone else is willing and able to provide it	8 (44,44)	10 (55,56)	7 (38,89)	11 (61,11)	18 (21.95)
Duty to colleagues					
Obligation not to take over a patient from a peer, except with the consent of both or based on ethical procedures	8 (40.00)	12 (60.00)	11 (55.00)	9 (45.00)	20 (24,39)
Duty to himself					
Obligation to maintain health	9 (31.03)	20 (68,97)	11 (37,93)	18 (62.07)	29 (35,37)
Obligation to always keep up with the development of health knowledge and technology	9 (37.50)	15 (62.50)	10 (41,67)	14 (58,33)	24 (29,27)

*FKTP (First Level Health Facility); **FKRTL (Advanced Referral Health Facility/Advanced Level Health Facility); ***GP (general practitioner)

Professionalism dilemmas were analyzed based on Regulation Number 4 Year 2011 about Professional Discipline of Physician and Dentist, Indonesian Medical Council. Of 87 participants, 55 respondents stated to have Professionalism dilemmas in which the most faced in the NHIS era were no adequate medical care in situations that may endanger the patient 14 (25,45%) (Table 3). Advanced level health facility 12 (85,71%) was chosen as the most common site in which physician faced professionalism dilemma compared to primary level health facility 2 (14,29%). In the open-ended question section, most physicians wrote substandard care due to limitations by the NHIS as their most common dilemmas.

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Table 3. Professionalism dilemmas faced by physicians in the NHIS era

Professionalism Duty	Health facility		Qualification		Amount
	FKTP (%)	FKRTL (%)	Specialist (%)	GP (%)	n = 55 (%)
Performing incompetent medical practice	4 (44,44)	5 (55,56)	1 (11,11)	8 (88,89)	9 (16,36)
No referrals to other doctors with appropriate competence	5 (41.67)	7 (58,33)	4 (33,33)	8 (66,67)	12 (21.82)
Delegation of duty to incompetent health workers	4 (44,44)	5 (55,56)	5 (55,56)	4 (44,44)	9 (16,36)
Employing a temporary replacement with no appropriate competence and authority	2 (28,57)	5 (71.43)	4 (57,14)	3 (42.86)	7 (12.73)
Practicing in a condition of physical and mental health in such a way that it is incompetent and may endanger patients	0	9 (100.00)	3 (33,33)	6 (66,67)	9 (16,36)
No adequate medical care in situations that may endanger the patient	2 (14,29)	12 (85,71)	9 (64,29)	5 (35,71)	14 (25,45)
No honest, ethical, and adequate information to patients or patients' families	2 (18,18)	9 (81,82)	5 (45,45)	6 (54,55)	11 (20.00)
Reveal confidential medical information	1 (16,67)	5 (83,33)	2 (33,33)	4 (66,67)	6 (10.91)
Providing a medical letter or opinions not based on a direct and proper results of the examination	1 (14,29)	6 (85,71)	2 (28,57)	5 (71.43)	7 (12.73)
Receiving compensation as a result of referring, requesting examinations, or prescribing drugs/devices	1 (10.00)	9 (90.00)	4 (40.00)	6 (60.00)	10 (18,18)
Dishonesty in determining medical services' payment	1 (12.50)	7(87,50)	5 (62.50)	3 (37.50)	8 (14.55)

FKTP (First Level Health Facility); FKRTL (Advanced Referral Health Facility/Advanced Level Health Facility); GP (general practitioner)

DISCUSSION

4.1 Ethical Dilemmas Among Physicians

In this study, the most frequently encountered ethical dilemma is the inability to practice free from influences that can result in loss of freedom and independence of the profession. This situation was encountered by doctors who served in FKRTL as many as 34 respondents (65.38%) compared to 18 respondents (34.62%) who served in FKTP. This ethical dilemma is faced more by general practitioners 33 (63.46%) than specialist doctors 19 (36.54%).

In Article 3 of the Indonesian Code of Medical Ethics (ICME) stated that, in carrying out his medical work, a doctor may not be influenced by something that results in loss of freedom and independence of the profession, for example giving medicine, medical devices/products, medical recommendations or actions, management systems clinical and/or application of science and technology which is not yet based on scientific evidence or recognized in the field of medicine.[8]

The BPJS (Social Security Administrative Body) tariff system is considered to affect the autonomy of doctors in providing health services to patients. Some procedures cannot be covered by Case-Based Group (INA-CBG; or Indonesia Case-Based Group) rates at hospitals because they do not meet the requirements according to JKN standards or because they exceed existing health package policies. At referral health facilities, the health problems being handled will be increasingly complex, requiring better and more comprehensive management. However, this situation will be even more complicated when several medical

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procedures cannot be carried out completely due to limited medical management and funding. [11,12]

There is also need for further review of the total health expenditure. Currently, most of the health expenditures are still focused on curative and rehabilitative efforts which are very costly. Emphasis on promotion and prevention through the primary level facility can streamline the health expenditure.

Some participants deemed the premium for NHIS membership was too low and also the needs to compliance to premium payment. This suggestion arises because of the high gap between premium costs and maintenance costs. Benefit cooperation with private insurance or with the community (out-of-pocket payments) is needed. This is mainly due to the high number of procedures and medicines that are not covered by the BPJS because not included in the formulary or because the patients do not meet the requirements according to existing standards.

The second highest ethical dilemma is in terms of the ability to make professional decisions independently and to maintain professional conduct in the highest degree. Good medical practice standards are carried out by maintaining professional standards, moral integrity, and intellectual honesty as the basis for professional decision making.[8] As stated in Article 2 of the IMCE, medical professional decision making is aimed at the attitudes, actions and behaviour of doctors who have consistent good intentions, seriousness and completeness of work, scientific and social integrity as a manifestation of moral integrity and intellectual honesty as a deontological and altruistic ethical component of a professional standard, bearing in mind that the facilities and infrastructure of the health service facility where doctors work are not yet/not optimal to carry out competence owned by a doctor. This is in line with the findings in this study that doctors who work in FKRTL (67.65%) have more dilemmas than in FKTP (32.25%).

Through open-ended questions, the majority of respondents stated that substandard care (including examination limitations, treatment options, drug choices, and the inability to refer patients) was the most frequently encountered dilemma. At first-level health facilities, the low capitation per patient has limited the choice of therapy and examination.[11,12] Transparency in deciding drug formularies, conformity with Evidence-Based Medicine guidelines, and socialization of formularies to all health facilities are very important in developing optimal drug formularies.[24] Harmonization between drug formularies in the e-catalogue, national formulary, and hospital formulary is needed. With clear guidelines, the minimal standard of drugs that need to be provided in each health facility could be determined.

Inadequate numbers of health resources and unequal distribution, especially at the primary level, can also result in an inability to practice according to standards.[1,17,19–21] In Indonesia, the low ratio of doctors and patients does not only result in a high workload and high stress levels that have the potential to interfere with physical and mental health but also limited consultation time, so that the information conveyed is insufficient.[17]

WHO and the International Network for the Rational Use of Drugs state that consultation time is one of the indicators to improve safety and efficiency in prescribing drugs. Short consultation times have been found to lead to poor communication, polypharmacy, overuse of antibiotics, higher rates of side effects, and ultimately lower quality of patient care.[14–16]

Other factors that can affect adherence to standard of care are limited knowledge and skills, weak adherence to existing policies, empiricism (experience over theory), the habit of not following evidence-based guidelines, socio-cultural pressures including from the patient's/patient's family, unavailability medical resources and constraints in the management system.[19,23]

In providing health services, doctors must apply their knowledge and act in accordance with standards of care, professional standards, codes of ethics, professional code of conduct, standard operating procedures, applicable provisions and general practice in the medical field.[10]

4.2 Professionalism Dilemmas Among Physicians

The medical profession is a noble profession because it has the main task of meeting basic human needs for health. In carrying out their professional duties, apart from being bound by ethical and legal norms, doctors are also bound by professional disciplinary norms. Professional discipline is adherence to the rules and/or provisions for the application of science in carrying out medical practice. In this study, the professionalism dilemma that most doctors face is the lack of adequate medical

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care in situations that could endanger the patient. Dilemmas occur when the required resources are not available and/or when patients insist even threaten to be referred despite not complying with existing policies or the patient's condition does not allow for a referral. Spatial distribution of health facilities and personnel makes the workload more stressful. Health access problems are exacerbated by poor infrastructure.[5] The insufficiency of infrastructure and health equipment and the lack of health workers are major obstacles in the achievement of universal health coverage (UHC).[22]

While the second highest dilemma is in terms of not referring patients to other doctors who have the appropriate competence. This is further elaborated in an open question in the form of limitations on medical treatment in emergencies due to existing policies. In a situation where the patient's disease or condition is beyond his competence due to limited knowledge, limited skills, or limited available equipment, the doctor is obliged to offer the patient to be referred or consulted with another doctor or other more appropriate health care facilities.

A doctor may refer patients to advanced referral facilities on a gradual basis when no improvement or progression of the clinical condition is observed after standard care. This policy has been successful in preventing the accumulation of patients but it also takes longer, hinders patients from receiving optimal care in the golden period, and causes patients to fall into unsafe conditions. [17,19]

During the JKN period, patients were required to follow referral regulations except in emergencies. The number of non-specialist referral levels is targeted to be below 5% by BPJS.[18] This referral limit aims to maximize services so that the 155 diagnoses assigned can be fully handled at first-level facilities. Referral limits influence physicians to comply with administrative policies rather than prioritizing patient needs for referrals. In the management of medical management, a doctor is not justified in taking an action that should not be taken or conversely not taking an action that should be carried out in accordance with his professional responsibilities, without valid justification or forgiveness so that it can harm the patient.

In the 5-year implementation of NHIS, 57.47% of participants were not entirely satisfied with NHIS performance. A discussion with the policy holders, optimization of existing laws for HCP, and lower tax for medical supplies was amongst the suggestion by the participants for the government. An increase in public health attention and spending is an initial step to address the inequality of healthcare resources in Indonesia.

The high public expectations towards physicians in the NHIS was one of the root causes of ethical and professionalism dilemmas. Wider socialization to the public regarding SSAH regulations and their limitations should be more prioritized. Effective communication will improve patients' satisfaction and avoid various dilemmas.

CONCLUSION

Doctors in Indonesia are deal with various ethical dilemmas and professional disciplines while practicing in the National Health Insurance System. The inability to practice free from influences that may result in loss of freedom and independence of the profession as well as the ability to make professional decisions independently to maintain professional behaviour at the highest standard is a situation of ethical dilemma encountered by doctors. Meanwhile, the absence of adequate medical care in situations that could endanger the patient and the limitations of referring patients to other doctors who have the appropriate competence are the most common dilemmas in the professionalism discipline.

There were respondents who were unsatisfied with the existing policies, and the majority considered that this partly contradicted with medical ethics and professional discipline. The high level of dissatisfaction and problems faced by doctors requires a review of the existing health insurance system either through discussions with policy makers, optimizing regulations or increasing the allocation of public health financing in order to improve the quality of health services and maintain the professionalism of doctors.

ETHICAL APPROVAL

This research has passed the ethical clearance at the Ethics Committee for Health Research, Faculty of Medicine, Diponegoro University, before the start of the study (reference number: 493/EC/KEPK/FK-UNDIP/XI/2019).

CONFLICTS OF INTEREST

The authors declare no conflict of interest.

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AUTHOR CONTRIBUTIONS

TD were responsible for the completeness and accuracy of the manuscript data and drafts, and wrote the main draft of the screenplay. WPA, INR, and SKLB were responsible for study design and contributed to data analysis and interpretation.

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