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RESEARCH/REVIEW ARTICLE

Fulfillment of Legal Rights Protection on Incentives and Allowances for Indonesian Health Professionals during the COVID-19 Pandemic

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ABSTRACT

The problem relies on the suboptimal fulfillment of incentives and allowances for Indonesian health professionals. It becomes urgency that health professionals are the front liner in the treatment and countermeasures of COVID-19, especially with the high work risk burden that is faced, thus, making the government strive to fulfill at its best. The problem always repeats due to an unsynchronized implementation by the central and the local government until now, so it also worsens the unfulfilled rights of health professionals. The method used in this research was the socio-legal method. The data were collected from the existing laws and regulations and the result from sociological observation. The results indicated that there is a study on rights fulfillment for health professionals based on the laws of the rights of health professionals in Indonesia. The study elaborates on the problem that is currently happening with COVID-19 cases in Indonesia and the reality of the rights fulfillment of health professionals. This article also discusses legal reality in the making of laws and regulations das sollen and das sein.

Keywords: *Health Professionals, Incentives, Allowance, COVID-19, Rights Fulfillment*

INTRODUCTION

At the end of 2019, an outbreak of pneumonia known as coronavirus disease (COVID-19) first appeared in Wuhan, China. Investigators found that the patients had previously worked in the Huanan Seafood Wholesale Market, a selling hub of animals. The etiology was confirmed to be a novel beta-genus coronavirus (2019-nCoV). The disease was, hence, termed novel coronavirus-infected pneumonia (Arshad Ali et al., 2020). The World Health Organization (WHO) has declared the COVID-19 outbreak in China as a Public Health Emergency that is plaguing the world (Public Health Emergency of International Concern) indicating COVID-19 is a threat (N.C. Peeri et.al, 2020). The spread of COVID-19 occurs rapidly in other countries, including Indonesia. The first country announced its first two COVID-19 infections in early March 2020. Within one month, the

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number of infected people has reached close to 3,000, with an 8 percent case fatality rate. Under the most recent projection, 1.2 million people in the country will eventually be infected (Suryahadi, 2020). After finding the first case of COVID-19, the number of cases of COVID-19 in Indonesia continually fluctuates. Data from the Indonesian COVID-19 Task Force as of May 2023, showed that there were 6.798.097 confirmed positive patients, 6.619.790 recovered patients, and 161.630 dead patients. Furthermore, the number of additional COVID-19 cases in Indonesia is also very high, with the highest addition occurring on February 17, 2022, with the addition of 63.956 new cases. Although currently, the number of COVID-19 sufferers is not as many as before, the possibility of spread is still high. The region with the highest number of COVID-19 incidents in Indonesia, namely Jakarta as of May 15, 2023, the development of COVID-19 was treated by 7,330 people, confirmed as many as 1,141,024 people, recovered patients as many as 1,121,197 people and the number of deaths as many as 12,497.

The increasing number of COVID-19 cases certainly has a direct effect on the health sector, such as the limited number of health professionals and health facilities that can provide treatment and countermeasures. This can happen due to an imbalance of health professionals and health facilities with the number of patients who are confirmed positive for COVID-19. Usually, this causes health professionals to face a very heavy workload and a high risk of being infected. This can also be seen in the data from the Mitigation Team for the Indonesian Doctors Association (IDI) regarding data on health professionals who died from COVID-19 (i.e., 1,323 cases), with details of the work of doctors (i.e., 545 cases), midwives (i.e., 223 cases), pharmacists (i.e., 42 cases), nurses (i.e., 445 cases), medical laboratory technology experts (i.e., 25 cases), and dentists (i.e., 43 cases) (Kustiani, 2021). It would become an irony if health professionals on the front line in the prevention and countermeasure of COVID-19 became victims due to the spike in cases. The factors behind the infection of health professionals to COVID-19 include limited personal protective equipment and health facilities, dishonesty of patients during treatment or ill consultation, and high working hours and workloads. The limited personal protective equipment and health facilities are the main thing that is most highlighted, where this health instrument becomes a shield for the protection of health professionals. A survey by the Tsunami and TDMRC (Disaster Mitigation Research Center), Unsyiah (Team at Syiah Kuala University) stated that 51% of health professionals felt that their workplace had not provided optimal protection for them to avoid COVID-19 (Setyadi, 2020). It also happened with health facilities, in this case, the referral hospital for COVID-19, the addition of very high daily cases a few weeks ago caused many hospitals to run out of patient rooms so they set up emergency rooms outside the hospital or utilized other buildings for COVID-19 patients. As happened at the regional public hospital in Solo City, Central Java, they set up tents outside the building to accommodate patients. One of the oxygen supply vendors, PT

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Samator Gas Industri Surakarta is overwhelmed to meet the spike in oxygen from some hospitals (BBC News, 2021).

Furthermore, the dishonesty of the patients during treatment and handling of the disease causes health professionals potentially infected. This can be seen from the implementation of informed consent which is used as a means of providing true information regarding the history of the disease and all things needed by health professionals from patients to provide medical treatment and as a means for patients to find out all information regarding medical actions that will do. This dishonesty incident has also been repeated in various areas with the patient's dishonesty in terms of informing on the history of traveling outside the region or abroad which incidentally has the potential to be a red zone. Most of the patients will only be informed about common sicknesses by not including any information on the activities they have done in the previous term. This can be seen from the 17 health professionals who were infected with COVID-19 in 2020 in West Kalimantan (Saputra, 2020).

Another factor that also plays a role in the vulnerability of health professionals to being infected by COVID-19 is the workload and high risk that must be faced by them. This is directly related to the ability of health professionals to handle and control many COVID-19 patients at one time. In general, one doctor can monitor 10 patients with mild symptoms. Meanwhile, for patients with moderate symptoms, one doctor can monitor five patients (CNN Indonesia, 2021a). Also, this workload is related to the obligation of health professionals to provide health services as part of their profession. Having faced with a calling in an emergency that requires health professionals to work by humanitarian principles, health professionals can work outside the working hours as stated in Article 77 of Law No. 13 of 2003. With this workload and risk, truly, protection and guarantee of rights for health professionals must be implemented properly. As stated in Article 8 of Law No. 4 of 1984 concerning infectious epidemics, those who experience property losses caused by efforts to control the epidemic as referred to in Article 5 paragraph (1) can be given compensation. Besides, it is also stated in Article 9 that certain officers who carry out efforts to control the epidemic as referred to in Article 5 paragraph (1) may be given awards for the risks borne in carrying out their duties. It is necessary to provide guarantees for the implementation of the provision of allowances and incentives as part of legal protection for the health professional. With the background above, this article will discuss the legal regulations on the fulfillment of incentives and allowances for health professionals in giving treatment for COVID-19 and the implementation of the fulfillment of incentives and allowances for health professionals who give treatment for COVID-19 in Indonesia.

This article used socio-legal research methods, which was a combination of approaches in the social sciences, including political science, economics, culture, history, anthropology, communication, and several other sciences which were combined with an approach known in legal science, such as learning about principles, doctrines and the

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hierarchy of legislation (Wiratman, 2016). The characteristics of the socio-legal research method could be identified through two things. *First*, socio-legal studies carried out textual studies, articles on laws and regulations, policies and studies on judge decisions could be analyzed critically and explained their meanings and implications for legal subjects (Hammerslev, 2005). *Second*, socio-legal studies developed various "new" methods as the result of mixing legal methods and social sciences, such as socio-legal qualitative research and socio-legal ethnography (Ziegert, 2005). Socio-legal research provided a new perspective on the fulfillment of the law on health professionals in the sociological life of the community related to the fulfillment of the right to receive incentives and allowances.

METHODS

The writing of this article uses socio-legal research methods, where the socio-legal approach is a combination of approaches that are in the social sciences, including political science, economics, culture, history, anthropology, communication, and several other sciences, combined with approaches known in legal science, such as learning about principles, doctrines and legislative hierarchy (Wiratman, 2016). The characteristics of sociolegal research methods can be identified through the following two things. First, sociolegal studies conduct textual studies, articles on laws and regulations, policies, and studies on judges' decisions can be critically analyzed and explained their meaning and implications for legal subjects (Hammerslev, 2005). Second, sociolegal studies develop various "new" methods of marriage between legal methods and social sciences, such as sociolegal qualitative research and sociolegal ethnography (Ziegert, 2005). Socio-legal research provides a new perspective on the legal fulfillment of health workers in the sociological life of the community related to the fulfillment of the right to benefits and incentives.

RESULTS & DISCUSSION

3.1 Legal regulation on the fulfillment of incentives and allowances for health professionals

The development of a number of the COVID-19 pandemic in Indonesia, which fluctuates from day to day, has direct implications for the workload carried out by health professionals. Health professionals are part of the scope of work and certainly have rights and obligations that must be fulfilled first under special conditions, one of which is the COVID-19 pandemic. The COVID-19 pandemic condition certainly has big implications in all aspects of life. Every day, the data in the world reports the increasing scope and impact of COVID-19 (Junaedi, 2020). Doctors as workers who receive wages/salaries and medical

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services need to know their rights and obligations related to services during the COVID-19 pandemic. In direct proportion to the implementation of the obligations of a health professional, the state also must provide protection and guarantees for the rights of a health professional. This is to Rochim Nur Syahbani's statement that humans work to meet their needs, so they expect that by working, they will get a worthwhile reward that will be used to fulfill these needs (Susilo, 2020). The fulfillment of this right is also regulated in Law No. 4 of 1984 concerning outbreaks of infectious diseases. Furthermore, this right is also stated in Article 8 which regulates that parties who experience property losses caused by the outbreak control can be given compensation, and Article 9 that officers who carry out prevention efforts can be rewarded for the risks they bear.

There are several regulations currently regulated relating to the fulfillment of incentives that are currently being implemented and regulated, including:

a. Decree of the Minister of Health of the Republic of Indonesia No. HK.01.07/Menkes/278/2020

   The decree on giving incentives and death compensation for health professionals who handle the coronavirus 2019 (COVID-19) provides an affirmation of giving incentives and death compensation through the giving guidelines. The matters regulated in this decision include giving incentives and death compensation for health professionals who handle COVID-19, which will be given from March 2020 to May 2020 and can be extended by the provision of the legislation. This guideline aims to provide a reference for every head of health service facilities and leaders of health institutions in providing incentives and death compensation for health professionals who handle COVID-19. Furthermore, the source of funding for incentives and compensation for those who have died has been charged to the State and Regional Revenue and Expenditure Budgets for incentives regulated in this decision, including specialist doctors IDR 15,000,000/OB, general practitioners and dentists IDR 10,000,000/OB, midwives and nurses IDR 7,500,000/OB, and other medical personnel IDR 5.000.000/OB. Furthermore, the death compensation that will be given to health professionals due to being infected with COVID-19 while on duty is given in the amount of IDR 300,000,000. The procedure for proposing incentives certainly has differences between health service facilities owned by the central government or owned by the Ministry of Health and local governments or health institutions owned by local governments at the provincial and city/district levels.

b. Decree of the Minister of Health of the Republic of Indonesia No. HK.01.07/Menkes/4239/2021

   The decree on the giving incentives and death compensation for health professionals who handle COVID-19 is a further decision to adjust to the Minister of Health's decree Number HK.01.07/Menkes/278/2020 related to legal needs and

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the development of dynamics in handling COVID-19. In general, the things regulated in this decree have the same essence as the previous decree, which is related to giving incentives and compensation for health professionals and the difference lies in the period. These incentives and compensation have been given since January 2021 and can be reviewed by the conditions for handling the COVID-19 pandemic. The payments for these incentives are sourced from the State and Regional Revenue and Expenditure Budgets (APBN) and Regional Budgets, while incentives that have not been paid in 2020 will be paid through the 2021 State Budget, the remaining 2020 additional health operational assistance funds in the regional treasury and general allocation funds or profit-sharing funds for the region.

The incentives given to health professionals consist of specialist doctors of IDR 15,000,000, participants of the Specialist Doctors Education Program (PPDS) of IDR 12,500,000, general practitioners and dentists of IDR 10,000,000, midwives and nurses IDR 7,500,000, and other health professionals of IDR 5,000,000. Furthermore, the amount of the fee is the highest limit and is paid by paying attention to the principles of accountability, effectiveness, and efficiency by paying attention to fairness and propriety. Meanwhile, the death compensation fund for health professionals exposed to COVID-19 is given in the amount of IDR 300,000,000. This decision provides more rigid technical implementation guidelines, which provide an explanation of the calculation and the ceiling on the incentives that will be received by a health worker. Besides, other things regulated in this decision are the mechanism for paying incentives and death compensation, procedures for proposing and paying incentives, and a monitoring and evaluation system that will be carried out by the Ministry of Health through the Health PPSDM.

c. Circular Letter No. 440/4066/SJ No.HK.01.08/Menkes/930/2021

The circular letter on the acceleration of providing incentives for health professionals in regions dealing with Corona Disease 2019 is one part of the regulation on providing incentives. This letter is a step to accelerate the giving incentives to provinces/districts/cities.

Some of the things that are accommodated in this letter including the budget allocation for regional revenues and expenditures are insufficient for providing incentives, it is recommended to immediately make a budget shift through changes to the regional leader regarding the elaboration of APBD 2021 budget to be further budgeted in regional regulations regarding the 2021 APBD changes or included in the budget realization report. Furthermore, other matters are also regulated (i.e., the period for giving the incentives, the incentive, and the terms of incentive payment). The role of health professionals in using the COVID-19 incentive application is also the main thing that is accommodated in the letter. Also, the increase of coordination among regional apparatus, regional general hospitals, and regional financial and asset management agencies is one of the things needed in the acceleration. This includes

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the local government's internal supervisory apparatus in cooperation with the financial and development supervisory agency in assisting in the acceleration of giving incentives and supervising regional leaders.

The existence of those regulations is certainly a special guideline for the government to provide compliance with what is regulated. The autonomous regulations in the form of regional regulations and regent's regulations in several regencies also provide their regulations regarding health professionals, especially in giving incentives as part of adjusting regional capabilities and accelerating their fulfillment. Synergy over legal regulations, both from attributive authorities and delegates from the stratification section of Indonesian laws and regulations shows that on a *das sollen* basis it has been implemented well, sustainably, and ideally. Moreover, it is supported by several rules outside the legislation that serve as a bridge for the acceleration of the implementation of the fulfillment of incentives in Indonesia.

3.2 Implementation of the fulfillment of incentives for health professionals in Indonesia

The existence of a regulation that guarantees the fulfillment of incentives for health professionals certainly provides its obligations to the state. This obligation should ideally be an integral part of the fulfillment of the rights to the duties of health professionals that have been carried out in terms of treatment and countermeasures for the COVID-19 pandemic. The realization of this obligation is carried out in a coordinated manner with the synergy between the central and regional governments which are in control of the management and process of budget disbursement. This synergy, of course, has also been manifested in the various regulations previously mentioned, but the reality is that until now the problems related to giving these allowances still occur and have not been implemented optimally. This can be seen from the inconsistency of the mechanism for paying incentives, obstacles in the process of changing the regional revenue and expenditure budget, and the absence of offers and proposals from various health facilities which have led to the government and health facilities being not proactive in seeking to accelerate the disbursement of incentives.

Another problem that has also become an obstacle to the disbursement of the incentives and allowances is the complicated and lengthy bureaucratic process indicated by the inconsistency of data between parties which causes health professionals to not be properly recorded. Besides, one of the causes of the problematic bureaucratic systems is asynchronous information obtained by local governments, causing local governments to experience system inconsistencies that must be met and implemented to obtain government incentives that have been given to the regions. This bureaucratic system for distributing incentives has also succeeded in creating a new loophole for fraud, where there are

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problems with the existence of incentive cuts carried out by irresponsible elements in the management process. As for one of the cases, a nurse at one of the *puskesmas* in Kediri City, East Java, Nuraini (not her real name), admitted that she only received an incentive of IDR 300 thousand in January. The amount of money that Nuraini received was also not by the incentives for nurses, where Nuraini should have received IDR 7.5 million/month.(CNN Indonesia, 2021b) This is directly shown by Amnesty International Indonesia's data that from June 2020 to July 2021, it was recorded that 26,717 health professionals from 21 provinces and 36 districts/cities experienced cuts or delays in paying incentives. The top five districts/cities with the highest number of cuts or delays in incentive payments are Bogor with a total of 4,258 health professionals, followed by Palembang (3,987 health professionals), Bekasi (3,502 health professionals), Tanjung Pinang (2,900 health professionals), and Banyuwangi (1,938 health professionals) (LaporCovid19, 2021).

Furthermore, data from the Indonesian healthcare network as of May 10, 2021, also provide supporting data for the delay in providing these incentives, where there are approximately 1500 nurses who have not received incentives from November to December 2020. Furthermore, 400 nurses also have not received incentives in January 2021. Such a situation is almost similar to that of February – April 2021 where about 1500 nurses never received their rights as pandemic volunteers (Amnesty Indonesia, 2021). Also, data on COVID-19 cases from 8 January to 6 May 2021 from the Ministry of Health shows that 868 health professionals in charge of dealing with COVID-19 have received the incentives, 3,484 people have not received the incentives, and 344 people have received the incentives but have some problem with it. In general, it can be known about the percentage of distribution, where 19% of health professionals have received incentives distribution, 6% of health professionals have received but has problems and 75% have not received it. In detail, the health professionals consist of 1,610 medical laboratory technology experts, 518 nurses, 213 doctors, 179 midwives, 68 internship doctors, 42 pharmaceutical technical personnel, 42 health administration, and police personnel, 31 specialist doctors, and other health professionals (i.e., 39 people). It is known that the synergy in the implementation of the provision of incentives in its development in 2019-2022 is also known to be balanced with the implementation of the establishment of guarantee regulations for the provision of incentives to health workers. As is well known, in 2022 there were 241 reports of health workers in several areas who had not received incentives for handling the COVID-19 pandemic. The reports come from at least 18 provinces. Reports were obtained from various health facilities. Most of the reports were from private hospitals (43), municipal government hospitals (12), provincial government hospitals (9), and central government hospitals (8). There are also reports from health centers and field hospitals(Gandhawangi, 2023). It is development that can be seen since the emergence of COVID-19 until 2022 when there is still an inability to fulfill the rights of medical personnel who have participated

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in handling COVID-19 even though regulations and policies have been mandated by the government.

The data above certainly shows that the implementation of the distribution and disbursement of incentives has not been carried out optimally. Furthermore, this has direct implications for the continuity of work and the capability of medical personnel to deal with COVID-19. The Ministry of Finance, which in this case plays an important role in providing budget allocations for the provision of incentives, has provided support to local governments by issuing Minister of Finance Regulation No.17/pm.07/2021 according to the fact that only 5.7% of the total budget of IDR 7.6 trillion (about US$527.5 million) for health professionals has been disbursed as of June 12, 2021. This figure shows that the disbursement and distribution of incentives have not yet reached 20% of the total budget allocated until mid-2021.

Furthermore, the realization of the distribution of incentives to the new district/city governments is only 18.9% of the total budget or IDR 1.31 trillion. Meanwhile, the realization of the distribution of incentives for health professionals to the provincial government has only reached Rp 780.9 billion, or 40.43% of the total budget or Rp 1.93 trillion. In addition to the involvement of the Ministry of Finance in optimizing the implementation of providing incentives for health professionals, the Ministry of home affairs also issued a warning letter to 19 governors and 368 regents/mayors on July 14, 2021, that disbursement of incentives for health professionals was still below 25%. The warning letter has proven to be effective in accelerating the disbursement of incentives for regional health professionals, because, in a matter of days, 9 Governors (*Pemda*) have realized incentives for regional health professionals above 50% (Kesehatan, 2020).

Efforts to optimize and accelerate the distribution of medical personnel incentives are directly related to the protection and fulfillment of the rights of a health professional, where the protection of these rights is certainly a very important matter where health professionals carry a large task load amid the spread of COVID-19 which fluctuates every time and the obligation of health professionals to provide good health services to ensure that all people can get their right to health with the highest standard (Article 12 ICESCR). Furthermore, health professionals who are at the frontline in handling COVID-19 are also not only experiencing problems regarding incentives but also the negative stigma of the community regarding health professionals which has an impact on the rejection of funerals for COVID-19 patients, refusal of medical personnel to live around the community until the existence of a lawsuit related to giving COVID-19 diagnosis which is considered by the public to be intentional. The complexity of the problems faced by health professionals should be the concern of the state to ensure the rights of health professionals and to prevent violations of international covenants such as economic, social, and cultural rights that apply to everyone where this can certainly affect patient care and society. Patients also needed support because they either did not know how to access resources or prior discrimination

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made them mistrustful of formal health and human services within communities (Bedell et al., 2015).

The existence of synergy between the central government and the regions that have been carried out at the time of course must be something that needs to be optimized by existing regulations to accelerate the fulfillment of incentives as part of the legal protection of rights and obligations. This relates to the existence of co-administration tasks held by local governments to implement central government policies. The existence of a target for fulfilling incentives through this budget is one indicator that can show the success of the state in fulfilling the obligation to fulfill incentives for health professionals which can be used as a benchmark for monitoring health facilities to find out whether their rights have been maximally implemented or not.

Furthermore, the implementation of compliance on a *das sein* of course must be sincrone with legal regulations that have been projected to be a means of accelerating the fulfillment of incentives for the health professional. The government's role as a relevant stakeholder who plays an important role in its fulfillment requires that the government increases its active role both internally between the government and the government under it or the government and related state institutions. This synergy will certainly encourage the compatibility of the fulfillment of rights on das sollen and das sein.

CONCLUSION

The fulfillment of rights to incentives for health professionals is essential in the implementation of the treatment and obligations of health professionals during the COVID-19 pandemic where health professionals are at the front line and certainly hold high responsibilities and workloads, especially with the existence of legal mandate on the obligation to fulfill the rights of health professional, both in the constitution and the legislation under it, of course, it is an obligation for the government as a stakeholder to make it real. However, with the problem of suboptimal distribution and fulfillment of incentive rights, it has been shown that the application of law and legal politics as a means of actualizing rights and obligations has not gone well. Moreover, having been provided with the management bureaucracy among governments that have not been synced, this has become a further problem and has been harmful to certain parties. Therefore, the problem still becomes a joint task between the related institutions to fulfill good and appropriate rights. It needs synergy and synchronization among related institutions, such as central and local governments, health facilities, financial institutions, and other parties to perform the fulfillment of incentives for health professionals properly. Therefore, it is a most important thing where this will certainly have an impact on the performance of health professionals which, in general, will result in health services to the people of Indonesia.

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