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Patient-Centered Communication in the Era of National Health Insurance at Surakarta City, Indonesia

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Abstract

This study discusses patient-centered communication in the era of national health insurance. The next study aims to determine the supporting factors, inhibiting factors, and the doctor's communication process that is patient-centered in the JKN system in the city of Surakarta, Indonesia. This study uses a case study method with qualitative analysis that emphasizes certain cases that occur in the object of analysis. This method uses descriptive analysis with an inductive approach in analyzing data. The research subjects were BPJS primary health facilities, located in Surakarta City. The results showed that there was a patient-centered communication process in building good and effective relationships between primary health facility physicians and patients. Patient-centered communication has a very important role, as stated by Debra Roter and Judith Hall who have described a patient-centered communication model that includes four key elements and is supported by a focus on remote communication. High context communication that emphasizes the main focus on implicit, unspoken, and nonverbal messages is not explicit and verbal messages, as written in the Handbook of health communication, that the quality of interaction between patients and providers is very important for health outcomes in patients. The interaction between the service provider in the patient and the outcome of the patient determines the step of selecting the patient in the next primary health facility. At the end of the achievement, it will further determine the success of patient-centered communication, so that the relationships that occur will influence the outcome of the primary goal of primary health care services to the health of patients.

Keywords: *Patient-Centered Communication; National Health Insurance*

Introduction

Entering an era where social insurance is absolutely mandatory for all citizens living in Indonesia, bringing up a social insurance mechanism that is fully regulated by the State. Government implement the National Health Insurance program to meet the health needs of a decent society is given to every person who has paid dues as independently as well as paid right by the Government.

Law Number 40 of 2004, contained in it a mandate on the National Social Security System (SJSN). Clearly stated in Chapter II, Regarding Principles, Objectives and Principles of Implementation.

Article 3, reads 'The National Social Security System aims to provide guarantees for meeting the basic needs of a decent life for each participant and / or family member'.

This rule is also strengthened in Law No. 40 of 2004 in another chapter, namely Chapter V regarding Participation and Contribution, article 13 paragraph (1), reads 'Gradually the employer is obliged to register himself and his workers as participants to the Social Security Organizing Agency, in accordance with the social security program that is followed'. As well as Article 14 paragraph (1), reads; 'The government is gradually registering beneficiaries as participants to the Social Security Organizing Agency'.

Provisions for health insurance for all citizens in Indonesia are managed in a system called JKN (National Health Insurance). The management of national health insurance is submitted to BPJS as the Social Security Organizing Body and in its implementation it is assisted by Health Facilities (Health Facilities) which are spread in each region.

The implementation of health insurance is regulated in Law Number 24 of 2011 concerning the Social Security Organizing Agency (BPJS), CHAPTER I discusses' General Provisions' article 1, reads' The Social Security Organizing Agency, hereinafter abbreviated as BPJS, is a legal entity established to run a guarantee program social'. BPJS Health operations began on January 1, 2014.

BPJS Health as an Implementing Body is a public legal entity formed to organize a health insurance program for all Indonesian people, having a tiered referral mechanism. First-level health facilities are designated as the primary gatekeeper in tiered referral.

Regulations regarding this first level health facility are regulated in Republic of Indonesia Presidential Regulation No. 19 of 2016 concerning National Health Insurance. Article 29 paragraph (1) reads 'For the first time each Participant is registered with the Health BPJS at a first level Health Facility determined by the BPJS after obtaining a recommendation from the local district / city health service '.

Tiered referral is applied in the utilization of this health facility from the first health facility or also called the primary health facility to the next level of referral health facility or also called the advanced health facility.

Regulations regarding this tiered reference are regulated in Presidential Regulation No. 19 of 2016 concerning National Health Insurance. Article 29 paragraph (5) reads 'In the event that a Participant requires an advanced level of health services, the first level Health Facility must refer to the closest advanced level referral Health Facility in accordance with the referral system set out in the provisions of the legislation'.

Services from the first health facility will be referred to further health facilities if specialist medical examinations are required by a specialist. The advanced health facilities will refer to the next health facilities again if a subspecialist health check is needed by the subspecialist doctor. Every JKN participant in general will always pass the first level health facility as an entry point for further health insurance services. So that the role of the first health facilities will be very calculated in the tiered referral mechanism in the JKN system.

The importance of the role of this first health facility creates opportunities for doctors in health facilities to be more self-sufficient so that many residents choose it as their first health facility. General practitioners in first-level health facilities must have the required professional competency standards.

General physician competency standards set out in the Indonesian Medical Council Regulation No. 11 of 2012 concerning 'Indonesian Doctor Competency Standards' namely 'at level 4A competencies (competencies achieved when graduating doctors) at which level doctors are able to diagnose and manage independently and thoroughly’.

A list of physician competencies is also found in the " Gatekeeper Handbook in the Implementation of the National Social Security System", Directorate of Basic Health Efforts, (2012), Ministry of Health of the Republic of Indonesia. It is written in the pocket book that 'the competencies expected by all Gatekeepers are: 1) Family Physician Competency Standards, 2) Advance Trauma Life Support (ATLS), 3) Advance Cardiac Life Support (ACLS), 4) Endocrine Medical Expertise Certificate, 5) Occupational Health Training, and 6) Other Health Training Certificates'.

In the end, competition among first-level health facilities in seizing the interest of citizens is very high. Many programs are rolled out by each of the first-level health facilities to maintain community members at the choice of health facilities and increase the number of people who will vote for them. One program then emerged was how to attract interest in satisfying health services.

Method and Materials

This study uses qualitative methods with a case study research design. Qualitative research is a process of understanding inquiry tradition investigations methodological explore social issues in a manner described as complex and holistic, m enganalisis said, reporting the views in detail about the informant through observation naturally (Ghoni & Almanshur 2012: 29; Moloeng 2014: 6; Creswell, 1997: 15). In addition, (Berg, 2009: 8-9) defining qualitative research is research that explores social order relating to the use of symbols, social structure, and other social rules that are analyzed and discussed in detail with various social contours and processes used by humans to create and maintain their social reality. Qualitative research methods are used in this study, given the main focus of research is to explore deeply the communication patterns of doctors and patients, it needs to be understood naturally about the views of interactions that occur within the health service. In addition, the patient's doctor communication patterns are formed from the views and daily experiences during interacting. It follows the view (Collin, 2008; Manning, 201 2) stating that qualitative research methods are needed to understand how to conceptualize the communication of patient doctors in health care.

Robert K. Yin (2015: 18) defines a case study research design as an empirical inquiry that investigates phenomena in real life contexts when the boundaries between phenomena and contexts do not appear explicitly by utilizing multiple sources of evidence. The case study is a design panel it ‘s which focuses on cases experienced by personal, group or organization related to the social context with the aim of exploring real interaction significant and occurred at a time (Adlier, 2003: 189; Berg, 2009: 318). Case studies are research that explores cases by way of collecting more detailed and in-depth data (Craswell, 2014: 135). The case study research design consisted of a single case study and a multi-case study. Single case study is a relevant research study used if faced with research with a single experimental analog, extreme or unique case, and the disclosure of a case, while a multi-case design is a case study that is faced with many cases that follow a replica (Yin, 2015: 55- 56).

Considering the case raised in the study is multicased, in order to rerun the case, the researcher will analyze the case using a theoretical framework that is more than one theory.

Data collection techniques in qualitative research consists of four strategies namely observation, interviews, documentation studies and audio-visual material (Craswell, 2012: 267). The principle p enelitian qualitative emphasizes data collection through interview me n on the grounds that in-depth interviews (depth interview) researchers can further explore the hidden information even on the subject of research and information that can be extracted from across time, from time lau, future present or future (Ghony & Almanshur 2012: 176). In addition, in-depth interviews involving interviewers with informants will be more intense, so hopefully the data obtained is able to answer more deeply the research problem formulation (Bungin (2012: 111).

Based on the explanation above, this study uses data collection techniques with in-depth interviews (depth interviews) from research informants chosen based on (purposive sampling). Interviews in this study were conducted face-to-face, with an average time of 15 minutes for each individual research informant. The process of interviewing patients registered at the first- level facility and the doctor at the first-level facility is done separately, this is done to see the suitability of the data obtained.

Qualitative research does not emphasize the size of the number of samples generalized from the population. However, qualitative research places more emphasis on contextual research. There is no count in determining the number of samples, but rather the depth of information to be extracted from research sources. Qualitative research is carried out by collecting as much information as possible from various sources (unit of analysis) so that it can build contextual research (Moelong, 2014: 224).

Data collection in this study uses a purposive sampling technique, which is a sample collection technique by determining research samples based on criteria relevant to the research problem to be discussed (Bungin, 2012: 107). The power of purposive sampling lies in selecting cases that are rich in information and can be studied in depth (Patton, 2006: 81). According to Patton (2006: 82) sampling with purposive sampling has some sample viewing logic, one of which is the sampling logic of maximum variation. This logic is done by way of sampling with the intent and purpose to capture and explain some of the central themes surrounding the results of the principle of a lot of participants of all variations of the program. This logic has the advantage of being able to select small samples of very large diversity, data collection will include two points of discovery (1) High quality, detailed description of each case (2) common important patterns that cut cases and reduce their significance from the emergence of heterogeneity (Patton (2006: 84-85).

Based on Patton's opinion, the logic of sampling in this study was carried out with a variety of membership variations at the study site. The criteria and variations of informants used as research samples are as follows:

a. Hypertensive patients in first-level health facilities with BPJS class I card facilities
b. Hypertensive patients in first level health facilities with BPJS class II card facilities
c. Hypertensive patients in first-level health facilities with BPJS class III card facilities
d. Providing doctors in first-level health facilities in the city of Surakarta.

Based on these criteria, the informants of this study consisted of 10 people. Patient informants with specifications of 2 patients with class I bpjs card facility, 2 patients with class II bpjs card facility, 2 patients with class III bpjs card facility, and 4 physicians providing facilities in 4 different locations.

The definition of patient-centered communication is explained in a journal titled How Medical Interaction Shapes and Reflects the Physician-Patient Relationship, Debra L. Roter, Judith A. Hall, recorded in The Routledge Handbook of Health Communication (2011; 55-68). The patient-centered definition of care as "respecting and responsive to the preferences, needs and values of the patient as an individual, and ensuring that the patient is within those values guided by all clinical decisions " is more philosophical than operational. Other definitions are equally broad, including providing as much information as -banyaknya necessary for patients to participate as far as desirable in medical decision making (Laine & Davidoff, 1996) . M arouses much easier for patients to express concerns, involved in the design of their care, and supported in self-management of patients (Bergeson & Dean, 2006); exceeded attention to all especially with the slogan that emerged from an international meeting of multidisciplinary doctors and researchers, " nothing about me without me" (Delbanco et al., 2001).

Statements that explicitly convey emotions include empathy, legitimacy, assurance, or attention. In addition, positive and negative statements also convey emotional content. There are 2 things that can be used to see the effectiveness of patient doctor communication; Verbal Communication and Non Verbal Communication.

Verbal communication includes positive conversations that capture the general positive atmosphere, which is created during a visit through verbal behavior such as agreement, approval, praise, joking, and laughter. Social conversation is defined as the non- medical exchange of most pleasantries and social greetings, usually functioning as a linguistic bridge of social opening or closing a visit to a visit. Social talk is not charged emotionally as a necessity for positive conversation, but friendliness and personal attention determine the next communication. The negative emotions captured in the statement reflect differences of opinion and criticism. Whereas this type of verbal exchange has just been described capturing "what" of patient-centered communication, nonverbal channels provide "how" through which interactions are conveyed.

Narasi disease and reflection on the experience, perspective and interpretation of symptoms and circumstances may have therapeutic value, and consequently, the disclosure of the patient, especially in the area of psychosocial, can be seen as an indicator of the focus centered on patient visits. Partnership communication assists patients in taking a more active role in medical dialogue, whether through registration, active input from patients (eg, asking for patient opinions and expectations, using cues, paraphrasing and interpreting patient statements) to check so that doctors understand, and in a way explicitly asking for patient understanding or passively assuming attitudes that are less dominant in the relationship (eg, becoming less verbally dominant). Patient participatory communication reflects an active registration component that includes facilitating doctor input through requests for opinion, understanding, paraphrasing and interpretation, and verbal attention.

Nonverbal communication is centered on the patient, in defined as behavior by incorporating various communicative behaviors that are not m ake linguistic content in patients (Knapp & Hall, 2010). In short, this includes facial expressiveness, smiling, eye contact, head nods, hand movements, postural positions (open or closed body postures and forward or back bodies).

Results of the study found between non communication v erbal subject in measuring the level of satisfaction (Roter, Hall, & Katz, 1987). Doctors are more informative and mengur ang i visit so unlucky in the interaction, considered to have a vocal quality more interesting and not men anxious right rather than a doctor who more social visit. The research mainly concerns the doctor's voice, found that the emotional tone of voice doctors distinguishes between the two groups of the (Ambady, LaPlante et al., 2002). Verbal and non-verbal communication is certainly one that needs to be observed in the implementation of patient doctor communication in patient-centered communication in the JKN era.

The guest speaker 'Ibu Nurani' who was interviewed by researchers about the patient's trust in her doctor in her health services, said "I will trust the doctor who always gives a clear and straightforward explanation, on all patient questions, rather than the doctor to the point". Although the majority of health problems are guaranteed, in practice, patients have many things that determine the assessment of this service.

The provision of health insurance for all the people of Indonesia are managed in a system called the JKN (National Health Insurance). The management of national health insurance is submitted to BPJS as the Social Security Organizing Body and in its implementation it is assisted by Health Facilities (Health Facilities) which are spread in each region. The implementation of health insurance is regulated in Law Number 24 of 2011 concerning the Social Security Organizing Agency (BPJS), CHAPTER I discusses' General Provisions' article 1, reads' The Social Security Organizing Agency, hereinafter abbreviated as BPJS, is a legal entity established to run a guarantee program social'. BPJS Health operations began on January 1, 2014.

RI Presidential Regulation No. 19 2016 ten pliers National Health Insurance has menga tour of the health facility first rate, mentioned in Article 29 paragraph (1) reads' for the first time every participant registered to BPJS at health facilities first rate set by BPJS after receiving local district / city health service recommendations'.

The tiered term r is regulated in Presidential Decree No. 19 of 2016 concerning National Health Insurance. Article 29 paragraph (5) reads 'In the event that a Participant requires an advanced level of health services, the first level Health Facility must refer to the closest advanced level referral Health Facility in accordance with the referral system set out in the provisions of the legislation'. The importance of the first healthcare facilities create opportunities for doctors in health facilities are to be memantaskan themselves so that later many residents choose it. The physician in first-level health facilities should Air standards of professional competence. Disappointing health facility services, resulting in the transfer of patients.

The guest speaker 'Mrs. Parman' when asked by researchers, "Have you ever moved from a health facility service?" Answered, "2 times, due to incomplete facilities and because of an explanation from a doctor that was less than satisfactory when asked about his illness". Mrs. Parman is not alone, there are some respondents who are almost similar to the answer. The respondent 'Ibu Kurnia' when asked about 'how many times have you moved health facilities?' answered 'Moving twice, looking for facilities and doctors with longer practice hours'.

This transfer is legally permitted by Presidential Regulation number 19 of 2016 article 29 paragraph (2c) which reads 'In the event that participants can request to be transferred from the first-level Health Facility that they want'. The migration of patients between health facilities has raised a big question mark about the reasons for this. How does the theory of patient-centered communication take place in the JKN system?

Butow, Maclean, Dunn, Tattersall, & Boyer (199 7) were among those who developed the Patient –Centered Communication (PCC) theory. The development of the theory is used for p endekatan analysis and defining communication that is patient-centered differently (ie., Bensing, 2000; Epstein et al., 2005; Mead & Bower, 2000; Stewart, 2001), most of the concepts share key components as following: overcoming the patient's perspective; understand patients in their psychosocial context; involve the patient in the treatment as far as he wants; reach a shared understanding of the problem and agreement on the treatment plan; and make decisions based on the best clinical evidence, consistent with the values of the patient, and to worthy her . Although there are already communication measures utilizing the element of centering in patients, most do not assess PCC comprehensively. In the end in medical communication research, it is hoped that there will be a definite framework related to functions and results.

Result and discussion

The term ' communications centered on the patient (PCC) has been has d igunakan to describe a group of communication strategies and behaviors that promote mutuality, mutual understanding and shared decision-making in meeting the service of health. There is evidence to suggest that practicing doctors and patients use this strategy to contribute to producing highly individualized clinical discourse. Although communication behaviors related to PCC have been studied separately, their impact as a determinant of health service choices has not been studied. PCC as a mid-range theory of health care communication that includes other more specific communication concepts is offered. Midlle Range Theory is a series of ideas / ideas that are interconnected and focus on a limited dimension, namely the reality of medical services. This theory explains specific phenomena and has been tested in research and used to guide medical practice. '

'Mid-range theory is agreed upon as a relatively broad field of phenomena, but does not address the whole phenomenon and pays close attention to discipline' (Chinn and Kramer, 1995, p 216). ' Some mid-range theories are based on grand theories. This statement is confirmed by Smith (1994), that the main function of grand theories is as the main source which will then be developed by middle-range theories. ' Middle-range theory itself is a more focused and detailed discussion of a grand theory. This research places PCC as its grand theory.

Application theory

This study, using the six models of the communication function. This model includes (1) gathering information, (2) establishing relationships, (3) recognizing and responding to emotions, (4) responding to uncertainty, (5) enabling illness and behavior related to treatment and patient independence, and (6) taking the decision. Supporting theories used in this study are exchanging information, fostering healing relationships, the recognizing and responding to emotions, managing uncertainty, the enabling patient self-management, the making decisions and the conflict.

1. Information gathering; Exchanging information.

The relevant theory to explain the phenomenon of PCC in JKN is the Exchange Information Theory. The theory explains that patients are often unsure or unable to articulate their knowledge, beliefs, information needs, values, and preferences; thus, the role of the doctor is to help patients define these factors. Information needs and preferences can usually change the flow of medical services (Butow, Maclean, Dunn, Tattersall, & Boyer, 1997; Squiers, Finney Rutten, Treiman, Bright, & Hesse, 2005). The doctor asked for and meet the needs of the patient information and belief of his, ber aim of reaching a common understanding, are the activities that are taking place in this domain.

Sharing information capture reciprocal exchange of information in an effort right to create meaning and shared understanding. Ideally, patients share their experiences and understanding about the disease they are, and doctors share information is consistent with patient preferences. Communication strategies that help patients understand, assimilate, foster memory, and apply information to their ownership are central to the exchange of information. Doctors tend to neglect to prioritize the level of informativeness and understanding of patients, and they often do not adequately assess patient understanding (Chaitchik, Kreitler, Shaked, Schwartz, & Rosin, 1992; Farrell et al., 2009; Gattellari, Butow, Tattersall, Dunn, & MacLeod, 1999; Knox, Butow, Devine, & Tattersall, 2002; Scott, Scott, & Auld, 2005; Silberman, Tentler, Ramgopal, & Epstein, 2008). Patients are often unsure what kind of information will help (Treiman et al., 2009); thus, this domain includes doctors who share information even when patients do not ask, for example, by suggesting resources that might be relevant to patients.

Some patients with hypertension do not actually feel there is a disorder in their health. Feeling high tension is common and does not cause him pain.

2. The fostering healing relationships

Theory Healing R elationships explain h an association of patient-physician who provides support and understanding emotional can help patients adjust better to their disease (Bakker, Fitch, Gray, Reed, & Bennett, 2001; Fogarty, Curbow, Wingard, McDonnell & Somerfield, 1999; McWilliam, Brown, & Stewart, 2000). The discussion about the roles and responsibilities include the expectations and preferences of the roles and responsibilities in relation patient in the clinic (eg., Patient involvement in decision-making that make).

Effective therapeutic relationship requires patients, family members (other caregivers), and doctors have a mutual understanding of each other on the roles and responsibilities of others. When doctors and patients share preferences for control in relationships, patients are more satisfied with their care (Krupat, Bell, Kravitz, Thom, & Azari, 2001; Krupat et al., 2000). In cases where patients and doctors have different expectations, negotiating and clarifying roles will be involved. The discussion and negotiation of the shared goals created are part of this domain. If the relationship has been well established between the patient's doctor, it will be easy to avoid things that get in the way.

Patient's lack of understanding of his illness can be more easily explained by doctors to patients who have good relations and nothing is in the way. Respondents 'doctor wury' when asked about 'how to facilitate the explanation of the disease to patients?' the resource person answered, 'An explanation will be easier to convey when we have known each other quickly and tried to be close to each other like we have known each other'. Practical steps that can make a doctor's job easier.

3. The recognizing and responding to emotions.

Theory The recognizing and responding to emotions explain how clicking identification, mengeksplo constellation, and express emotions, actions that will involve the help of the patient, in identifying and articulating their emotions. Doctors recognize emotions (especially when it is expressed indirectly) and clarify the understanding (ie., "It sounds like it you feel t acute, is that correct?"). At PCC, physicians explore and ask questions to understand the emotions and communication with patients about understanding his was. Referring to depression, anxiety and psychological pressure when checking depression and other psychological disorders in Indonesia systematically, either through interview techniques common or style t screening. depression, anxiety, and psychological as well as other disorders can have significant effects on quality of life patients and can affect treatment, including resulting in low patient compliance (Jacobsen, 2007; Kennard et al., 2004).

Doctors who rarely start conversations about emotions, and cues from emotional distress from patients are often ignored or dismissed (Lang, Floyd, & Beine, 2000; Levinson, Gorawara-Bhat, & Lamb, 2000). As a result, psychological diagnoses of conditions are often overlooked in oncology practice (Fallowfield, Ratcliffe, Jenkins, & Saul, 2001; Newell, Sanson-Fisher, Girgis, & Bonaventure, 1998). One impediment to identify depression among patients is a common symptom that many encountered. Patients may say 'yes' on the doctor's advice, but then don't.

The interviewee interviewed the researcher 'Doctor Zul', when asked about 'how to easily deal with patients with all kinds of emotions of patients how? '. Doctor Zul answered, 'treat patients as their age, whether old, young or children. Think of yourself as a family, as a grandmother / grandfather, parents or children '. This is quite easy to respond to patient emotions.

4. Uncertainty Managing

Previous research has identified three conceptual domains for dealing with cognitive, affective, and behavioral uncertainties (Camerer & Weber, 1992; Han, Moser, & Klein, 2006; Politi et al., 2007). Theory of Uncertainty menjelaskan about response cognitive include recognition, clarification, and to identify the sources of uncertainty. Focus on affective responses to emotional problems. Behavioral responses deal with more direct uncertainties by identifying information needs and finding information resources. Establishing and defining uncertainty involves the patient and the doctor identifying the existence of uncertainty. Uncertainty is related to the effectiveness of treatments prevalent in their management of chronic diseases and can be a source of anxiety. Short-term uncertainty (ie., Is hypertensive disease curable?) May be resolved with the information that is new, but the uncertainty of chronic (ie., Does hypertension will lead to complications of other diseases?) May need to talk about how to solve it, offering support a social, and put a time limit on how long uncertainty is tolerated.

Assess and understand the uncertainty (cognitive) involves penentuan source and reason of uncertainty. Mishel et al. (2005) state that uncertainty occurs when a person understands aspects of the disease including treatment, prognosis, and recovery that are inconsistent, complex, unknown, or unpredictable.

Patient requests for clarification of the reasons for / sources of uncertainty, and the doctor helps determine the reasons / resources, such as the possibility of unknown outcome of his future, a role / responsibility is unclear, conflicting medical evidence or suggestion of providers, information is too complicated, and various personal risk significance (Kasper et al., 2008; Politiet al., 2007). Patients and patients will also confirm each other that they have a shared understanding of why uncertainty exists. So that in the future it can provide a solution. That hypertension is a disease that can be controlled.

A resource person on behalf of 'Mr Topo' when asked about 'Are there any doubts about the explanation for hypertension delivered by the doctor? '. Answered by the informant, 'in a previous health facility there were doubts, but when moving to a new health facility, doubts about the disease disappeared for a long time'. Positive source suggestions were found for doctors in their new health facilities, allowing patients to eliminate their uncertainties.

5. Make decision; Making Decisions

This function domain is based on two underlying frameworks. Conceptual Framework for Joint Care Decision Making (Charles, Fagnis, & Whelan, 1999) The Making Decisions Theory identifies three decision making approaches to the father's approach, sharing, and information stating that the approach (eg, paternalistic, shared, informed) developed during the meeting. The Ottawa Decision Support Framework for Overcoming Decision Conflicts (O'Connor, 2006) confirms that participants' decision needs affect the quality of decisions, which in turn affect behavior, health outcomes, emotions (eg, regret, blame), and use of health services.

Communicate about the need, support and decision-making process starts with the communication between patients and physicians about what each expected from the decision making process and their role not you like in it. Each party seeks and shares information that supports the decision making process, supports the participation of others, and offers or creates opportunities for involvement (Fiscella, Franks, Srinivasan, Kravitz, & Epstein, 2007; Zandbelt, Smets, Oort, Godfried, & de Haes, 2007). Because of this transactional model may already commonplace, the patient and doctor can be more focus on active listening and building partnerships (Siminoff, Rose, Zhang, & Zyzanski, 2006).

The doctor must also consider the patient's culture because some cultures can influence the amount of information shared patiently, who is the decision maker, and what choices are and are not possible (eg, for religious reasons).

The patient's expected decision is regarding the consistency of the patient's treatment, discipline following the instructions for taking the drug and healthy living behavior and the patient's certainty not to turn into the first health facility. Several approaches have been taken by the owners of health facilities including activating the hypertension disease club.

6. Self-Management

Theory of Self-Management, in which there are due framework to inform the development of the function of this domain. First, the "5 S " model of behavior change (Assess / Assess, Advise / Advise, Arrange / Regulate, Agree / Agree, Assist / Assist,) outlines the behavior of evidence -based clinicians who can be applied to cancer treatments with limited modification (Glasgow, Emont, & Miller, 2006). Second, self-determination this theory postulates that maintaining behavior over time requires patients to internalize values and skills for change and that they experience self -determination (Ryan & Deci, 2000).

Self-management communication can focus on a number of problems, including navigating and accessing resources (Epstein & Street, 2007). Patients with hypertension describe a navigation aid as regard fundamental for treatment (Treiman et al., 2009). Wells et al. (2008) identified common elements of patient navigation, such as reducing barriers, promoting timely and ongoing access to care, focusing on prescribed care episodes and a set of service goals, and focusing on one health condition (as opposed to broader case management).

Study and assess focus on understanding where patients stand in their interests and ability to self-regulate. Pasien and doctors need to share their perspectives on the disease and the role of self-care. The doctor must assess the patient's level of motivation and activation and adjust their guidance, patients who are remembering psychosocial problems can hamper self-management. Sharing and giving advice resembles elements of the Exchange Information function where the patient expresses his needs and priorities (eg, "My work involves physical activity, but I need to eat healthier."). The doctor provides guidance to support patient autonomy and maintain internal motivation.

Priority and planning involves tracking and monitoring patient conditions and supporting patients in the supervision of this process. Patients and doctors collaboratively discuss and decide on goals, plans, and priorities for self-management. The discussion can be more in focus right on a patient support system (or lack thereof) in implementing the care plan or survivors (ie., " There is no one who directed me to an appointment.")

7. Conflicts that arise in the implementation of JKN

How the theory developed by Weber (1905) states that society is an arena of conflict and struggle between strong groups (dominant groups) and weak groups (subordinate groups). Max Weber believes that there are many 'status' groups in society.

In this study, we want to find out the interdependent interests in the selection of first-level health facilities in the long term. Open possibility because of communication factors between doctors and patients that lead to migration opportunities in each health facility.

As written in the book 'Towards a governance-based conflict resolution model' page 108 by Sudarmo. Delivered there that;

' Conflict between individuals occurs when two parties who interact have different needs, goals or approaches. Communication failure is often the main source of interpersonal conflicts.

Conclusion and suggestion

Throughout this study, it was found that the health quality of hypertensive patients is determined primarily by the attitude of the doctor. The quality of health care management of the facilities visited, patient doctor interactions, the completeness of patient infrastructure and how communication is developed between doctors and patients.

Penelitian is quite interesting, because the quality of care at health facilities first-rate long-term basis to build loyalty members. This shows that good quality primary care will support patients to form long-term ownership based on mutual trust. In the city of Solo, the expansion of access to health care was preceded by the National Health Insurance (since 2010) and this has contributed a lot to the improvement marked in the final quality of health. The health sector has evolved based on competition between the private sector of each provider. They maximize profits in practice. Not only a doctor working in a clinic or home nursing. In addition, the majority of hospitals and clinics owned priba in and they are responsible for Hamper all inpatient / bed. There is intense competition between first-level health facilities, which run outpatient centers in the community, and doctors' clinics, some of which have inpatient care. The system references tiered in JKN well as the freedom of patients to choose a first-level health facility, be right to fair and that pasien free to consult with your provider anytime without evidence of medical necessity and reimbursement by BPJS.

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