Preface

Non-state Health Service provision is a major component of the Indonesian health system. It has been operating in Indonesia for more than 100 years. Over the last 10 years, the sector has been growing substantially. With the progressive demographic and epidemiological transition occurring in Indonesia, and with economic growth, the demand for more advanced health-care technology and secondary care has increased. The Indonesian government's current deregulation policies that allow the establishment of new non-state health facilities, ranging from clinics to large-scale international hospitals, have increased the role of the non-state sector in the Indonesian health system.

Non-state providers XE "Non-state providers" can be classified into individual; and (2) institutional providers. Individual providers comprise western medicine practitioners and traditional healers. These individual providers can also be government employees with rights of private practice. This book is primarily concerned with the institutional providers. Institutional providers can be classified into primary-, secondary- and tertiary-care providers. Based on profit motives, non-state providers can also be distinguished as not-for-profit and for-profit. Legally, there is a clear distinction between state and non-state institutional providers. However in practice, the distinction is not so clear. Using the definition of primary-, secondary-, and tertiary-care providers, we acknowledge that the non-state sector is diverse. In this aspect we have deliberately chosen to focus on the hospital sector as it is seen to be developing rapidly and filling the gaps in health-care provision that the public sector has been unable to fill. However, with the rise of this sector it is clear that medicine is now a business for many providers and there are clear markets with competition and profit at play.

The reason for focusing on hospitals is that they represent the institutional health services that have grown the fastest and absorb large amounts of health financing. This includes out- of-pocket payments, non-state health insurance, and, just recently, also social health insurance. The epidemiological transition and rise of non-communicable diseases, together

with increasing urbanization and ageing of the population make the "hospital" an ever more important health-care providing institution. Given this the quality of care and distribution of these services can influence inequities and health outcomes, hospitals also represent the focus of increasing use of medical and pharmaceutical technologies that raise the costs of health care.

This book is an attempt to draw the landscape of the non-state hospital sector in Indonesia today and to bring to the attention of policy makers' important challenges that arise from what has become a very dynamic force in current Indonesian society. We use secondary data sources from various reports of the Ministry of Health as well as studies identified in the literature. We also rely on some primary studies, various sources of data and a mix of methodologies to draw a picture for the reader; and then through case studies, we explore the variety of hospital providers that have emerged over the last 10 years.

Section 1. This chapter is concerned with the current context (around the last 10 years) of non-state providers. The current context is classified as: (1) current hospital environment in terms of economy, demography and epidemiology; (2) the influence of decentralization policy; and (3) health sector governance issues; (4) the changing role of the medical profession.

Chapter 1 aims to analysis the Origin of Non-state Hospital in Indonesia. A historical analysis of hospital service will be described back from the colonial period. Hospital development in Indonesia commenced when the Dutch East India Company founded a hospital in Batavia on July 1, 1626. The construction of this first hospital in Indonesia, provided treatment only for certain groups, such as the military. The establishment of religion-affiliated non-state hospitals commenced in the mid-19th century and then flourished in the early 20th century[1]. This development was driven by *zending* groups from Europe, who founded several non-state hospitals as a medium of spreading religion. The emergence of religion-affiliated hospitals,

[1] D. Schoute. 1937. Occidental Therapeutics in the Netherlands East Indies During three Centuries of Netherlands Settlement (1600-1900) (*The Hague: Netherlands Indian Public Health Service*), p. 28

especially *zending* hospitals, was linked to the existing *zending* network in the Netherlands and Germany.

The growth on non-state hospital based on religion and humanity cannot be isolated from the influences of the Ethical groups, whose members included figures such as Van Deventer, De Wolff and van Westerrode Abendanon. These groups called for the repayment of the "debt" to the Dutch Indies population by improving the welfare of their lives with a famous triad of "irrigation, education, and emigration". The Ethical policy began to be implemented in the Dutch Indies in 1901. In the health sector, the policy was implemented by the provision of government subsidy to public and non-state hospitals. It is worth noting that during the colonial period, doctors were permitted to run private practice. With the salary from the government and additional earnings from private practice, doctors in the time of the Dutch administration became relatively rich professionals, and they had an upper class life style. Many medical doctors became political leaders.

With the handover from the Dutch colonial government to the Japanese in Kalijati on March 8, 1942, all *zending* hospitals were taken over by the Japanese. At the onset of the Indonesian independence in 1945, the new government had limited capacity to continue the subsidies to state and non-state hospitals. Practically, hospitals in Indonesia had to operate with limited budget and to search for additional income to support their operation. That resulted in the use of tariff (user-fee) to support hospital operational expenses. It should be noted that in *Orde Lama* (Old Order) Period (up to 1965) the Indonesian government implemented a policy not to rely on foreign aid. Religion-affiliated hospitals lost the government subsidy and aid from their traditional financing sources. These hospitals began relying on user-fees as their main source of income. This situation became complicated with the development of medical technology, which required higher cost. The cost of medical service increased, and the traditional middle- and low-economy class family clients had difficulty in affording these costs. These hospitals in the 1960s and 1970s then opened a new class of VIP and VVIP wards. This class differentiation actually had been practiced by many faith-based hospitals.

Before independence, there were two tier systems: the first was for the Dutch and noblemen while the second was for the common people. This development of tiers systems in Indonesian hospital reflected the social structure in community. The tiers system indirectly changed the management style of the hospitals: from being non-profit oriented to being for-profit oriented, although their status remained as a 'not-for-profit' foundation. By understanding the origin of hospital growth, a better understanding on current situation will hopefully be achieved.

Chapter 2 is concerned with the economic and political environment between 1990 and 2008. In this period, a very important event happened: the Asian financial crisis of the late 1990s, which seriously affected Indonesia. The impact on Indonesia was disastrous in terms of economy. However, from the viewpoint of the welfare system, the after-crisis policy showed that Indonesia moved toward the introduction of more government intervention to financially support poor families. Right after the crisis, Indonesia embarked the social safety-net for health. This is the first national-scale demand-side subsidy in health.

Despite progress in stabilizing the economy, Indonesia continues to struggle with a number of complex issues. Nearly 18% of the population lives below the poverty line, while 49% of the population lives on less than US$ 2 per day (World Bank, 2006(b)). Distribution of resources across provinces remains highly unequal with provinces in the East of the country receiving substantially less than those in the West.

Nationally, key health indicators, such as infant and child mortality, have improved steadily over the past several decades though in some remote areas the key indicators have remained a problem. Despite these positive trends, improvements in some indicators seem to have slowed down in recent years. Two indicators remain a cause for concern: 1) high child mortality, and 2) maternal mortality rates which remain high at 420 deaths per 100,000 live births.

Due to longer life expectancy and fewer childhood deaths from communicable diseases, the demographic and epidemiological profile of Indonesia is in transition. In the decades to come, Indonesia will face a

"double burden of disease" from both communicable and non-communicable diseases. Presently, the number of people with diabetes, heart disease, and cancer is increasing as the population ages, diets change, and lifestyles become more sedentary (World Bank, 2008). These changes have the potential to greatly increase both the demand for and the cost of health care.

Another important political environment is the decentralization policy in health. Rapid decentralization, a key part of democratization efforts which began in 1999, has further complicated an already complex regulatory environment. There are two important issues on decentralization for non-state hospital growth: (1) the influence of decentralization on the economic condition; and (2) the transfer of central government authority for controlling health services. One impact of decentralization was the significant growth in the discrepancy in fiscal capacity among provinces and districts/municipalities. With the payment of Shared Fund to some local governments by the central treasury, some provinces and districts/municipalities have suddenly become rich. The local government fiscal capacity has become one important factor impacting on economic environment, alongside the strength of the community economy. This economic development increased the number of state and non-state hospitals.

Health sector governance issue is the main topic in **Chapter 3**. In the domain of the health system, there have been some important issues for non-state health providers in the last ten years. The rapid development of the government as a financing agency is clearly recorded. After the economic crisis, the government launched a social safety net subsidy for the poor. This included coverage of the cost of hospitalization for the poor, and has increased the role of the government in financing of health services. This is true not only for the central government but also for local governments. However, this policy is becoming more a political than a technical and equity issue. The extent of the benefits and the extension of the scheme to include the near-poor may open new problems in government financing for the health sector. In some places, this policy still discriminates against non-state providers and restricts its use to state hospitals only.

However, the development of the role of local governments as the stewards and controllers of non-state hospitals has been slow. In the last 10 years, there have been some innovative developments to strengthen the role of local governments in supervising non-state hospitals. In this chapter, the fragmented health sector is discussed as an important factor in the hospital environment. There is a contest in influence and power between the Ministry of Health and Provincial/District/City Health Offices, on one hand, and medical professional groups (medical doctors, especially specialists) on the other. As a result, two different cultures have developed in the health sector: (1) medical culture and (2) public-health culture. One factor behind this contest of cultures is that Provincial/District/City Health Offices operate under the coordination of General Directorate of Public Health (*Direktorat Jenderal Pembinaan Kesehatan Masyarakat/Ditjen Binkesmas*) within the Ministry for Health, while hospitals are under the coordination of General Directorate of Medical Services (*Direktorat Jenderal Pelayanan Medik/Ditjen Yanmed*). This has created a bureaucratic separation between the activities of the Provincial/ District/City Health Offices and those of hospitals.

Market influence due to neo-liberalism and cultural globalization has become stronger in the health sector. More fundamentalist market practices are found in the health sector, especially in medical groups, without adequate control and regulation. The rapid development of the non-state sector in general requires a new analysis of regulation which is related to wider issues around regulation for market failures.

Law-makers' perception of the role of non-state health providers is not appropriate. Current regulation around taxation does not clearly distinguish between for-profit and not-for-profit hospitals. This lack of tax exemption is forcing some not-for-profit hospitals to become for-profit ones. This situation now is different from the colonial period, when the government provided subsidy for hospitals. Members of the national parliament do not understand the rationale for the use of tax incentives for not-for-profit hospitals.

Chapter 4 covers the change of medical profession. The cultural ethos of medical doctors has been moving in opposite directions to that of

health financing. The professional culture of medical doctors is characterized by a high value for market principles. Various researches have found that medical doctors (specialists) tend to work in wealthier regions, earn high and "unlimited" income, shift their activities between the public and non-state hospital without clear regulation, and tend not to trust the hospital management and managed care. This culture is close to that of an artist. The life-style of the doctor follows this global trend. Some specialties deliberately practice fundamentalism in the market in terms of monopolizing the supply. In some places, doctors may act as price makers in fee setting. This culture is not easy for non-state hospitals to manage, except those which have strong bargaining power. This culture has limited the growth of managed or standardized health care systems. There are hardly any standards for doctors' earnings or services. Doctors earn their living from for-service fees.

This chapter also presents a case study of a survey of doctors' income in 8 provinces of Indonesia conducted in 2006 with the collaboration of the Indonesian Doctors Association, Health Insurance Limited Corporation (*PT Asuransi Kesehatan/Askes*) and Universitas Gadjah Mada. The survey examined the amount and sources of income for the surveyed doctors, all of whom were officially civil servants in the government health system. The survey found that the main source of the doctor's income comes from the non-state sector, in the form of salary (22.6%) and incentives (35.1%), as well as private practice (14%); while the earnings from government hospitals contributes only 11.2% of their income in the form of salaries plus 4.2% in the form of incentives.

Section 2 describes the Landscape of Non-state Sector Services. This chapter uses mainly the hospital registration data in the Ministry of Health. There are two Chapters in this section, namely Chapters 5 and 6.

Chapter 5 describes the dynamic of Indonesian hospital. In 1998, the number of state hospitals (589) was larger than the number of non-state (491). The difference was 98. Ten years later, the number of non-state hospitals has increased to 653 while the number of state hospitals has increased to 667. The difference is smaller, only 14 hospitals. The growth of non-state hospitals increased by 2.91 % (on average) per year, while that of

state hospitals was 1.25% per year. The number of beds in non-state hospitals also increased sharply from 2000 to 2004, then slowed between 2003 and 2006, before increasing again after 2006.

The distribution of hospitals reveals that hospitals are urban-focused and generally service the rich and the emerging middle classes. The pull of these hospitals on the health workforce may well be leading to horizontal inequities that are not in line with the national values of providing health care for all, with a particular concern for poor rural regions of Indonesia where the poorly equipped public sector is left to struggle.

The definition of for-profit or not for profit is based on the legal status of the hospital. A non-state hospital is regarded as a for-profit organization if the hospital takes a Limited Corporation (*Perseroan Terbatas/PT*) status (Law No.40/2007 on Limited Corporation and No.8/1995 on Open *PTs*). Under this legislation, the owners of a hospital can receive some earning or dividend from the hospital's operation. For-profit non-state health care organizations can be classified into hospital chains (such as Bunda, Hermina, Eye-Centers, and others), ambulatory and out-patient clinic care networks, emergency providers (such as International SOS), and single providers (such as Happyland Hospital in Yogyakarta).

Chapter 6 describes some case studies of non-state hospital development in different regions. One case study aimed to have an in-depth examination on the relationships between the owners, management, and staff of non-state hospitals, with a purpose to understand the governance and management issues. Six hospitals of different ownership types were selected from different regions in Indonesia: Jakarta (three institution-owned hospitals); and four physician-owned hospitals in Jakarta, Indramayu, Boyolali and Denpasar. The case studies identified a number of significant issues effecting the hospital governance and management, which among others were the motivation of the hospital owners and the hospital management factors (such as the organization type and governance), and the resource utilization. The study identified factors which were supportive of hospital development (the market development, the capital availability,

and the human resources availability), and constraining factors (conflicts and governance failure).

Section 3 tries to portrait the current governance, policy and regulation for non-state hospitals. To date, the Ministry of Health has not paid much attention to policy making for the non-state sector, despite its importance in the existing mixed health system. There is a need for the Ministry of Health to play a better stewardship role not only over the public sector but also the non-state sector.

Chapter 7 covers policies related to the market structure, quality of care, and efficiency of the health system in Indonesia. This chapter examined policies in relation to the market entry, distribution (location), and payment mechanisms. Currently, there is no policy in place to regulate the distribution of non-state service providers, specifically to foster development in remote and rural areas. There is also insufficient incentive to promote redistribution of the health workforce to remote and rural areas. The decreasing number of not-for-profit hospitals in less developed areas also means that there is a growing risk of the poor losing their access to health care.

Although there is an endorsement for the non-state sector to exercise a social function and also policy to support the poor to access non-state healthcare through Health Insurance for the Poor (*Asuransi Kesehatan bagi Rakyat Miskin/Askeskin*) and National Health Insurance *(Jaminan Kesehatan Nasional/Jamkesmas*), there is a lack of policy to encourage more variety in the state and non-state mix. This is room for improvement in the provision of protection from the risk of catastrophic payment and further impoverishment. The Ministry of Finance does not differentiate between not-for-profit service-providers and for-profit service- providers, and there is no tax exemption for not for the former. This might explain the trend of stagnant growth of not-for-profit hospital, and that more and more not-for-profit hospitals are expressing their interest in transforming themselves into for-profit service- providers.

Another issue is that the provincial, district and municipality governments have low capacity to establish a quality framework, exercise

power and authority over ensuring quality and enforcing the registration, licensing, and accreditation system. The role of the professional association in ensuring quality of doctors, nurses and midwives is also very limited. Although there is generic regulation on consumer protection, there is lack of specific regulation ensuring patient rights.

In addition, this chapter also argues that weakness in governance of the national health information system and minimum regulation about sharing information and reporting requirements also means that the government has little information on the activities of the non state sector. There is yet little involvement of the non-state sector and professional associations in developing policy initiatives.

Chapter 8 discusses the local government's regulatory powers in relation to physician behavior in Jambi. This case study explores the problems confronted by the provincial hospital in Jambi and the local government in the management of specialist doctors working at the hospital. Most of the specialist doctors, though they were employed at the government hospital, also had additional shifts at some of the six non-state hospitals in the City. Many of the doctors reported working in five to seven practice locations, exceeding the government regulation which limits practice locations to three. Factors associated with this behavior are explored, including practice facilities, practice locations, type of patients and implications for the regulatory control. It appears that the Jambi Municipal Health Office has been unwilling or unable to enforce the MoH's and the local government's regulations due to their concern to retain needed specialist doctors to provide services in Jambi.

Section 4 presents the analysis of the origin and the environment context of non-state hospital in Chapter 2, the landscape in Chapter 3, and the portrait of regulation in Chapter 4. The interpretation on the data will be presented in the three chapters in this section, Chapter 9, 10, and 11.

Chapter 9. This chapter deals with the ownership, governance and management of non-state hospitals. The different types of hospital ownership (foundation, association, corporate) and institutional arrangements (institutional ownership or individual ownership) have a

significant influence on the management and function of non-state hospitals. The studies have noted differences in the values and motivation of the owners (entrepreneurial, social service, charity) and the managers' degree of autonomy, accountability and residual claimant status. Ownership also impacts on a hospital's selection of the target market, and also on access to capital and investment. In the case of not-for-profit hospitals, these studies suggest that there is a fundamental conflict between the charitable mission and values on which they were founded, and the lack of resources to provide funding for these charitable services either from the owner or through subsidies from the government.

Chapter 10 discusses the role of the medical profession in a mixed public-private system. These discussions have documented the multiple roles that the medical profession plays across the public and private sectors in the health system, and also the impacts that the resulting conflicts of interest have created. In particular, the discussion raises concerns about the professional standards and ethical culture of the medical profession since its behavior has been becoming more aligned to business practices. This chapter considers the various factors that influence providers' behavior, including the environment, incentives, motivation, and market forces. Doctors tend to choose working in hospitals which provide opportunities for professional development rather than working in hospitals which give good compensation but do not offer advanced facilities.

Chapter 11 elaborates the government role in regards to non-state hospitals. This section begins with a review of theoretical concepts regarding the role of government in the management of markets applied to the Indonesian health system. A situation analysis of the government's role in relation to financial, regulatory and delivery functions of the health system highlights the impact of the withdrawal of government financial subsidies for the operation of non-state hospitals; the increasing importance of government financing in the health system through social health insurance; and the complexity of regulatory functions in the decentralized Indonesian health system.

The Indonesian government recognizes state hospitals as autonomous bodies with a social function (Public Service Body*/Badan Layanun Umum or BLU*). Non-state hospitals have mixed characteristics of institutions with both social and commercial functions. What is, then, the role of the non-state hospital in the Indonesian health system? This issue is analyzed from the perspective of market segmentation, which is defined by household ability to pay and level of medical technology. Non-state hospitals are engaged mainly in providing services with middle-level and low-level technology to households of all income levels. This chapter highlights the policy benefits of government intervention to support the role of not-for-profit hospitals in providing health-care services through more active regulation, subsidy and tax exemption.

Closing: Recommendation for Future Non-state Hospital Policy