Section 2.
The Landscape of Non-state Hospital

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Institutional providers can be classified into primary care, secondary and tertiary care. Based on the profit motive, non-state providers can be classified as non-for-profit and for-profit. There is a clear separation between state and non-state institutional providers. In 2000s, private providers had developed across Indonesia. In this analysis private providers can be classified into two main groups based on their service level: (1) Promotive, Preventive, and Primary Care; and (2) Secondary and Tertiary Care. This chapter focuses more in secondary and tertiary providers.

Hospital in Indonesia can be differentiated based on the Hospital Law, its management or its typology. According to the Hospital Law, hospitals can be public hospitals which consist of state and non-profit non-state hospitals, or non-state hospitals. Based on their management, hospitals can be categorized into (1) state-owned hospitals and (2) non-state owned hospitals. State-owned hospitals are managed by Ministry of Health, Provincial governments, District/Municipal governments, the Army/Police, or other Ministries/BUMNs (*Badan Umum Milik Negara/*State Owned Corporation). Non-state-owned hospitals are managed by corporations, foundations (*yayasan*) and community associations (*perkumpulan*). Based on their type, hospitals can be categorized into general hospitals, mental hospitals, and special hospitals which consist of leprosaria, lung-disease hospitals, eye hospitals, maternity hospitals, maternity and child care hospitals, children special hospitals, orthopedic hospitals, infectious diseases hospitals, cardiac hospitals, cancer hospital, brain-stroke hospitals, mouth and teeth care hospitals, internal disease special hospitals, surgical special

hospitals, ENT special hospitals and kidney special hospitals. General hospitals owned by Ministry of Health and local governments can be categorized according to its capacity, namely: Class A, Class B, Class C, and Class D. Meanwhile, army/police-owned hospitals can be categorized into Level 1, Level 2, Level 3, and Level 4. Hospital can also be categorized into teaching hospital and non-teaching hospitals.

CHAPTER 5
Hospital Data Based on Ownership

Based on the absolute number, most hospitals are in Java. For state hospitals, 254 out of 667 are in Java, or approximately 45% of state hospitals. For non-state hospitals, 61% (404 out of 653) are in Java. This shows that non-state hospitals follow the rule of market forces. The market attractiveness of Java attracts many non-state hospitals. The map below shows the distribution of hospitals across provinces in Indonesia.

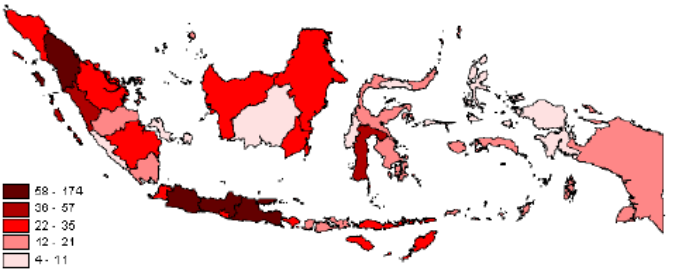

Figure 5. 1 The absolute number of hospitals

Figure 5.1 shows that all Java provinces, except Banten, have more than 58 hospitals. Only North Sumatra Province has the same number of hospitals as Java. West Papua and West Sulawesi have the lowest number of hospitals. Geography-wise, this situation reflects the uneven distribution. However, when comparing the ratio of hospitals to the number of people, a different map is shown in Figure 5.2. Major provinces, such as West Java, have smaller ratios of the number of hospitals to the population.

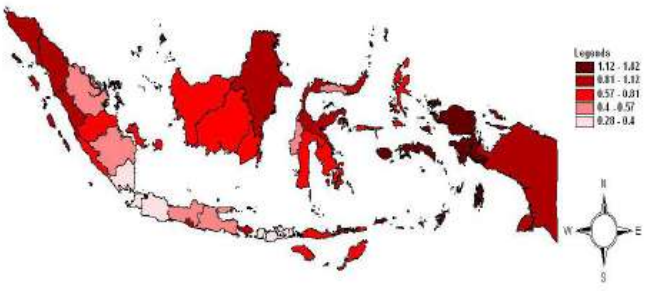

Figure 5. 2 The Ratio of the Number of Hospitals per 100.000 Citizens

The growth of non-state hospitals and that of state hospital are of different pace. In 1998, the number of state hospitals (589) was higher than non-state ones (491). The difference was 98. Ten years later, the non-state hospital number increased to 653 and the state hospital number increased to 667. The difference became smaller: only 14 hospitals. The average growth of non-state hospitals was 2.91% per year, while for state hospitals it was 1.25% per year. These figures indicate that the private sector's investment in hospitals is increasing. Meanwhile, state hospitals have been mostly constructed outside Java.

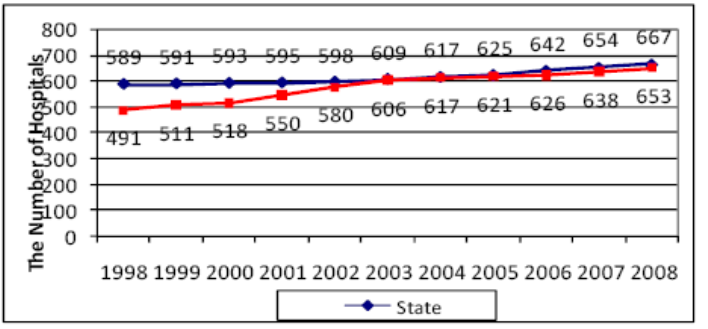

Figure 5. 3 The Growth of Hospitals (1998 – 2008)

The non-state hospitals have smaller number of beds. The graphic shows that nonstate hospitals' bed number is far below the state-hospitals'. It is understandable because state hospitals are

usually big teaching hospitals and provincial hospitals. Big non-state hospitals are faith-based hospitals with a long history since the pre-independence period.

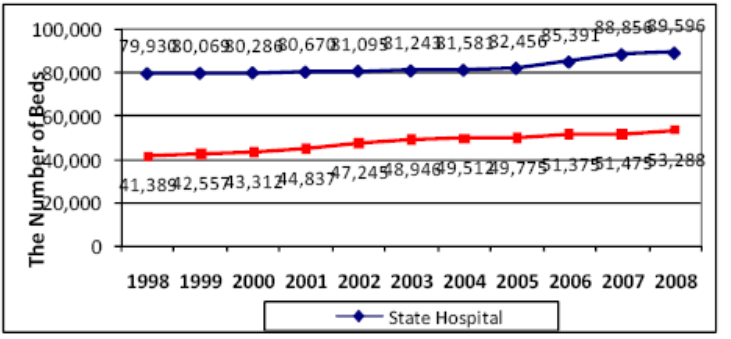

Figure 5. 4 The Growth of Bed Number (1998 – 2008)

The Growth of State Hospitals

As shown in Figure 5.5, the three groups of hospitals based on their bed-capacity had an average growth rate that was only slightly different from 1998 to 2008. Since 2003, the hospital group with the bed capacity of 0 – 50 showed a steady growth rate, the highest of which happened in 2008 with 11 new hospitals. In the hospital group with the bed capacity of 51 – 150, the highest growth rate happened in 2001 with 12 new hospitals. As it looks, however, the group with the bed capacity of >150 indicated a positive growth that happened in the period of 2004 to 20 with the highest growth rate of 16 hospitals in 2007. This might have been influenced by the implementation of the decentralization policy in 2001 and the introduction of *Askeskin,* a health insurance program for the poor, in 2005.

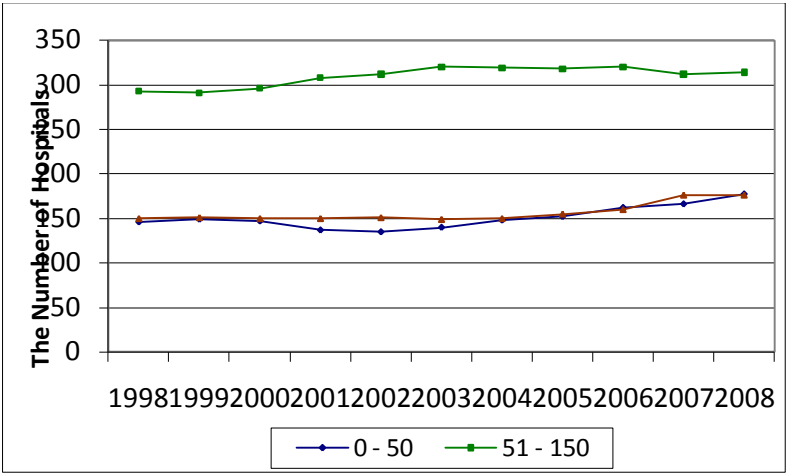

Figure 5. 5 The Growth Rate of State Hospital Based on the Groups of Bed

Table 5. 1 The Number of State Hospital

Bed	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	Average growth (hospital/year)
0-50	146	149	147	137	135	140	148	152	162	166	177	3.1
51-150	293	291	296	308	312	320	319	318	320	312	314	2.1
>150	150	151	150	150	151	149	150	155	160	176	176	2.6
Total	**589**	**591**	**593**	**595**	**598**	**609**	**617**	**625**	**642**	**654**	**667**	**2.6**

The Growth of Non-state Hospitals

Non-state hospitals are run by both for-profit and for-non-profit organizations. The definition of being for-profit or for-non-profit is based on the legal status of a hospital. Non-state hospitals are regarded as for-profit organizations if they have a corporation status (Law No. 40 Year 2007 on Limited Companies and Law No. 8 Year 1995 on Listed Corporations). Under these legislations, hospital owners can receive payments or dividends from the operational profit of their hospitals. For-profit non-state health care

organizations can be classified into hospital chains (such as Bunda, Hermina, Siloam, and Eye-Centers), ambulatory and out-patient health-care clinic networks, emergency providers (such as international SOS), or single providers (such as Prima Medika in Bali).

Non-for-profit hospitals are registered based on the Foundation Law, or *Statblad* for community associations). There is no ownership in the Foundation Law. Faith-based organizations are the common owners of these hospitals, such as Moslem organizations (MUKISI, with many groups, the largest of which is Muhammadiyah), Christian organizations (YAKKUM, the modern successor of the Zending Christian missionary movement), and Catholic organizations (PERDHAKI with its many congregation members). Most hospitals are in the forms of foundations (81.8%), limited corporations (13.8%) and community associations (4.4%) as shown in Table 5.2.

Table 5. 2 Non-state Hospital Ownership

Ownership	**2008**	
	N	%
Companies	90	14%
Foundation	534	82%
Association	29	4%
Total	**653**	**100%**

Using a more detailed table, the distribution of non-state hospitals is shown in Table 5.2. Three provinces have no private hospitals: Central Kalimantan, Gorontalo, and North Moluccas. On the other extreme, Jakarta Special Capital Territory has 90 private hospitals, and Central Java has 114 non-state hospitals. This situation is related to the socio-economic condition of the provinces. Market forces work very strong in the distribution of non-state hospitals.

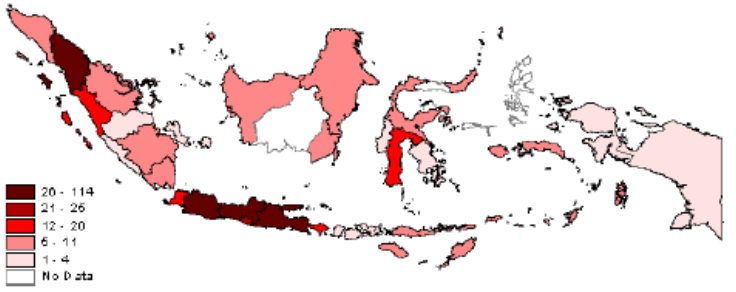

Figure 5. 6 Distribution of Non-state Hospitals

In the last 5 years of the period of 1998 to 2008, the most rapid growth was that of corporation-owned hospitals. In 2003 there were 49 for-profit non-state hospitals. In 2008, the number almost doubled and became 85 hospitals. Most new for-profit hospitals were established in Jakarta and other big cities. In the same period, the number of foundation-owned hospitals increased from 530 to 539. The community-association-owned hospitals grew from 27 to 29. The 1998-2008 growth is described below.

Table 5. 3 Recapitulation per Type of Ownership of Non-state Hospital (1998 – 2008)

Owners	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Companies	20	25	25	26	29	39	42	52	60	71	90
Foundation	448	463	470	501	526	540	548	541	538	539	534
Association	23	23	23	23	25	27	27	28	28	28	29
Total	491	511	518	550	580	606	617	621	626	638	653

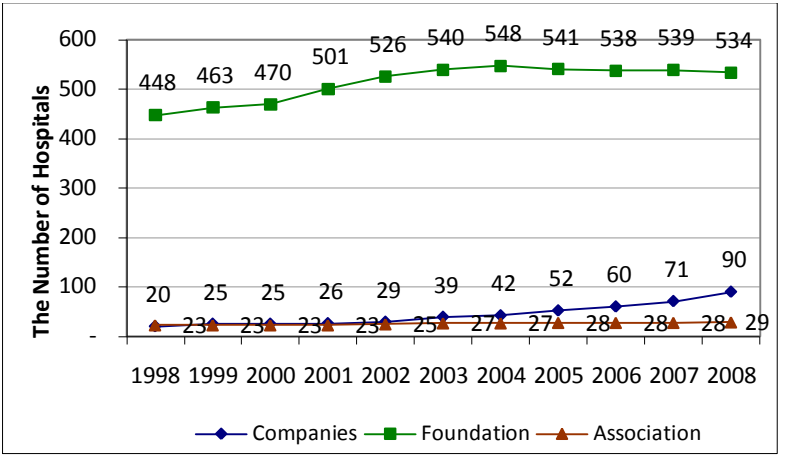

Figure 5. 7 Recapitulation per Type of Ownership of Non-state Hospitals (1998 – 2008)

The growth of non-state hospitals is observed in the small hospitals (with the bed-capacity of below 50) and the medium ones (with the bed-capacity between 50 to 150 hospitals). Since 2000 the number of small hospitals has grown rapidly. Big hospitals have grown grew steadily but not drastically. It is interesting that this rapid growth started at the initial stage of decentralization and also after the monetary crisis in 1998.

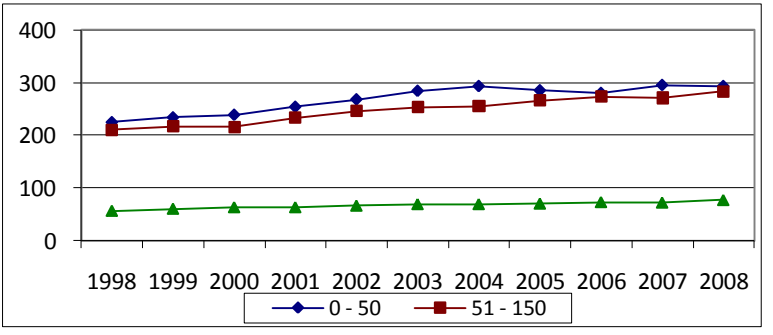

Figure 5. 8 The Growth of Non-state Hospitals based on the Group of Bed Capacity

Table 5. 4 The Number of Non-state Hospitals

Bed	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	Average Growth (Non-state hospital/Year)
0—50	225	234	239	254	268	284	293	285	280	295	293	6.8
51–150	210	217	216	233	246	253	255	266	273	271	283	7.3
> 150	56	60	63	63	66	69	69	70	73	72	77	2.1
Total	491	511	518	550	580	606	617	621	626	638	653	

As shown in the above graph and table, the more detailed description of non-state hospitals presents some interesting features. The group with the bed capacity of 0 – 50 for non-state hospitals achieved a rapid growth from 1998 to 2004. The highest growth rate happened in 2003, with 16 new non-state hospitals. On the average, the growth rate was 6.8 per year. This was smaller than the growth of hospitals with the bed capacity of 51 to 150. This can be explained by the fact that some of the smallest hospitals developed themselves and became the middle-size hospitals.

For non-state hospital, the group with the bed capacity of 51 - 150 had a positive growth rate from 2001 to 2006. The highest growth rate happened in 2001 with the establishment of 17 new non-state hospitals. The average growth rate was 7.3 per year. For non-state hospitals, the group with the bed capacity above 150 experienced a steady growth from 1998 to 2006. The highest growth rate happened in 2008 with 55 new non-state hospitals. The average growth rate was 2.1 per year. The highest average growth of non-state hospitals of the group with the bed capacity of 0 – 50 during the period of 1998-2008) took place in East Java with an average growth rate of two. For non-state hospitals with the capacity of 51 – 150, the highest growth rate was in Central Java (1.2 per year). For non-state hospitals with the bed capacity above 150, the highest growth was in

West Java and Central Java (0.5 per year).Based on the bed capacity, the growth of non-state hospitals showed a similar trend among the three categories, as shown in the following graph. Figure 3.1.8 shows the bed-capacity growth of non-state hospitals.

Non-state hospital owned by corporations

The corporation-owned non-state (for-profit) hospitals grew rapidly in number during the last 10 years. Most hospitals in this group have been established in provinces with a strong economy, such as North Sumatera, Riau, Jakarta, West Java, Central Java, and East Java, and East Kalimantan.

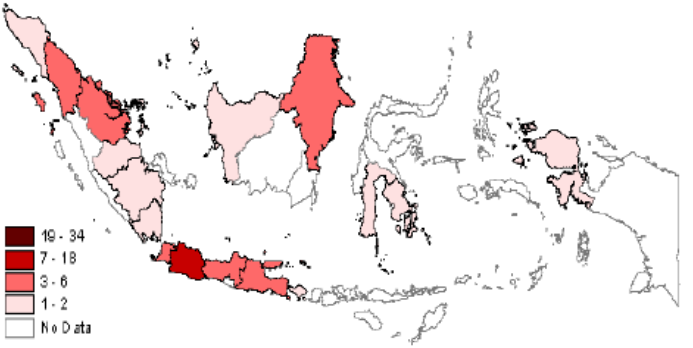

Figure 5. 9 Non-state hospital owned by coporation

The growth of the non-state for-profit hospitals shows a sharp increase in all groups. In the group with the bed capacity of 0 – 50, a rapid growth rate happened from 2000 to 2005, the number decreased in 2006, but it increased again in 2007 and 2008. The highest growth rate was in 2008 with nine new hospitals and the average growth was three hospitals per year. In the group with the bed capacity of 50–150, a positive growth rate of hospitals took place from 2002-2008. The highest growth rate happened in 2008 with seven new hospitals and the average growth was 2.7 hospitals per year. Meanwhile, in the group with the bad capacity >150 a positive

growth rate was observed from 2002-2008. The highest growth rate happened in 2003, 2006 and 2008, each with three new hospitals; and the average growth was of 1.3 hospitals per year.

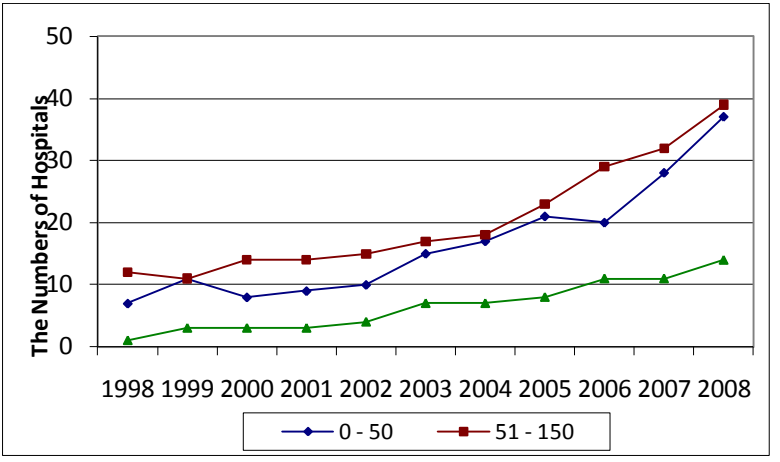

Figure 5. 10 The Growth Rate of Non-state Hospitals Owned by Corporations based on the Bed-Capacity Group

Table 5. 5 The Number of Non-state Hospitals Owned by Corporations

Bed	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	Average Growth (Non-state hospital/Year)
0—50	7	11	8	9	10	15	17	21	20	28	37	3
51–150	12	11	24	14	15	17	18	23	29	32	39	2.7
> 150	1	3	3	3	4	7	7	8	11	11	14	1.3
Total	20	25	25	26	29	42	52	52	60	71	90	

Location-wise, the province that had the highest average growth for hospitals of all bed-capacity categories in the period of 1998-2008) was Jakarta Special Capital Region. The average growth was one hospital per year for hospitals of the group with the bed category of 0 – 50. For the group of the bed capacity of 51 – 150 it was (1.1 hospitals per year), for the group with the bed capacity > 150 was 0.7 hospital per year.

Non-state hospitals owned by foundations

Most hospital owners are faith-based organizations. As described in Chapter 1, the history of faith based hospitals can be tracked back from the colonial period. Many hospitals were established in nearly all areas of Java by the end of the nineteenth century, also in the big cities in such as Palembang and Makassar. For years these hospitals have provided treatment for civilians from all ethnic and religious groups. These hospitals are clustering in big cities and some big foundation hospitals have inherited the legacy of the old Dutch-style hospital buildings. Most foundations hospitals are in Java island as described in the following map.

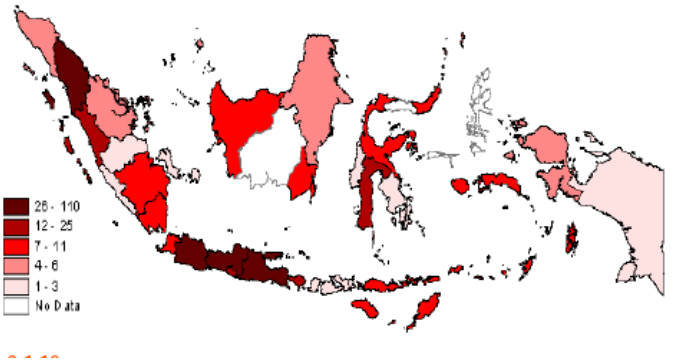

Figure 5. 11 Non-state hospital owned by foundation and association

Most foundation hospitals are small, less than 50 beds, and are developing rapidly. These small hospitals' owners can be medical doctors. The bed-capacity in big foundation hospitals has not grown much. In the group with the bed capacity of 0–50, a growth rate began to increase from 1999 to 2004. The highest growth occurred in 2001 that reached 14 hospitals along with the average growth of 3.6 hospitals per year. In the group of the bed capacity of 50-150, a growth rate began to increase from 2001 to 2006.

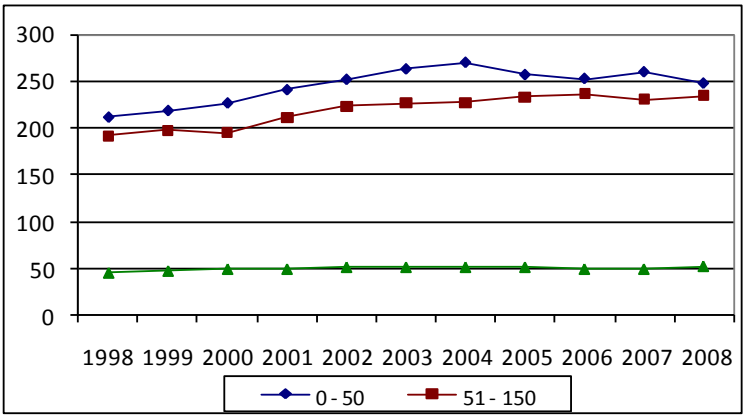

Figure 5. 12 The Growth Rate of Non-state Hospitals Owned by Foundation Based on the Bed-Capacity Group

Table 5. 6 The Number of Non-state Hospitals Owned by Foundation

Bed	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	Average Growth (Hospital/Year)
0—50	212	219	227	241	252	263	270	257	253	260	248	3.6
51–150	191	197	194	211	223	226	227	233	236	230	234	4.3
> 150	45	47	49	49	51	51	51	51	49	49	52	0.7
Total	448	463	470	501	526	540	548	541	538	539	534	

Location-wise, during the period of 1998-2008 the highest average growth of hospitals of the group with the bed capacity of 0 – 50 was observed in East Java with an average growth of 1.7 hospitals per year. For the group with the bed capacity of 51 – 150, the highest growth was observed in Central Java with an average growth of 1.4 hospitals per year. For the group with the bed capacity > 150, the highest was also in Central Java with an average growth of 0.5 hospital per year.

Non-state hospital owned by association

Associations (*perkumpulan*) have been loosely regulated by the old Stadblaad since the colonial period. Examples of associations are Chinese associations, or Moslem associations such as Muhammadiyah. The number of association-owned hospitals is not as high as that of foundation-owned ones. In 2008, there are only 29 hospitals in Indonesia.

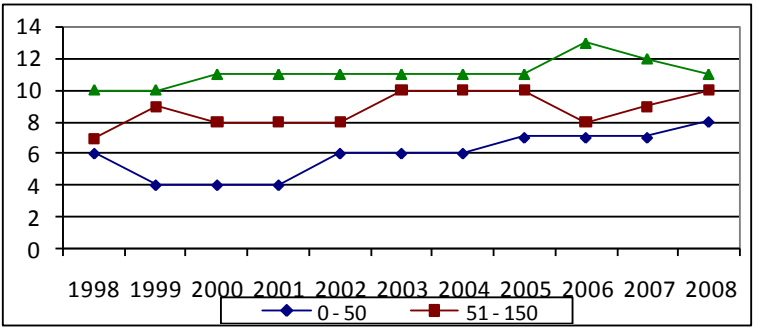

Figure 5. 13 The Growth Rate of Non-state Hospitals Owned by Associations based on the Bed-Capacity Group

Table 5. 7 The Number of Non-state Hospitals Owned by Associations

Bed	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	Average Growth (HospitalYear)
0—50	6	4	4	4	6	6	6	7	7	7	8	0.2
51–150	7	9	8	8	8	10	10	10	8	9	10	0.3
> 150	10	10	11	11	11	11	11	11	13	12	11	0.1
Total	23	23	23	23	25	27	27	28	28	28	29	

In the group with the bed capacity of 0 – 50, the number began to rise from 2001 to 2008. The highest growth rate happened in 2002, which reached two hospitals and the average growth was 0.2 hospital per year. For the group with the bed capacity of 50 – 150, the highest growth occurred in 1999 and 2003, with two new hospitals; and the average growth was 0.3 hospital per year. Meanwhile, for the group with the bed capacity > 150, the highest growth rate happened in 2006, with two new hospitals; and its average growth was 0.1 hospital per year.

Location-wise, during the period of 1998-2008 the highest average growth of hospitals of the group with the bed capacity of 0 – 50 was observed in East Java with an average growth of 0.2 hospital per year. For the group with the bed capacity of 51 – 150, the highest growth was observed in East Java, West Java and Banten, with an average growth of 0.1 hospital per year. For the group with the bed capacity > 150, the highest was in West Java with an average growth of 0.1 hospital per year.

Migration

A dynamic conversion from foundation to for-profit non-state hospitals and vice-versa has been observed. Between 2002 and 2008, 25 foundation hospitals were converted to for-profit hospitals (PT). Conversely, only five for profit (PT) non-state hospitals became foundations. It is clear that the incentives for becoming for-profit hospitals are bigger than those for non-profit ones. Table 3.1.12 shows this migration. In this period of migration, there was an amendment of the Foundation (*Yayasan*) Law, which is deemed not favorable for some foundations. In the Law, it is clearly stated that there is no ownership of in the form of *yayasan*. A “dividend” type of payment from hospitals to *yayasan* officers is a violation of the law. This new *Yayasan* Law is different from the Corporation Law.

Table 5. 8 Corporation-Owned Hospitals

Tahun	New Company	Foundation to Company	Liquidation	Company to Foundation	Growth	Number of Company Hospital
1998						20
1999	5				5	25
2000	1		-1		0	25
2001	1				1	26
2002	2	1			3	29
2003	7	3			10	39
2004	3				3	42
2005	2	8			10	52
2006	4	8		-4	8	60
2007	11				11	71
2008	14	6		-1	19	90

5.1 Utilization

On the common sense ground, the users of non-state hospitals are different from those of state hospitals. Hypothetically, non-state hospitals are used more by the rich. The result of Equitap research on health financing in Indonesia between 2000 and 2005 provides evidence of utilization by socio-economic groups. A secondary data analysis of a socio-economic survey has been implemented to assess the dynamic of utilization in outpatient and in-patient services. After 1998 crises, the government of Indonesia embarked a limited health financing reform. The health financing reform between 2000 and 2005 reduced the socio-economic inequity, by forming a state fund for financing the poor's health service protection (*Jaring Pengaman Sosial Kesehatan*, or Social Safety Net for Health). Before the health financing reform, hospitals (both public and private) were used mostly by richer groups in the community. Most poor people did not use hospitals because there

were limited resources for doing so. The financial protection program reduced poor households' financial barriers to access both hospital and non-hospital services. The parity of utilization decreased but it is still problematic.

Overall, the utilization rates for both public and private hospital services in Indonesia increased across all income groups between 2001 and 2007. Notably, the rate of increase in utilization rates was higher for the poorest quintile than for the richest quintile for all types of public hospital services. In particular, the poorest quintile's utilization of state hospital inpatient services quadrupled during this period, while a more moderate increase of approximately 50% occurred for the richest quintile. Despite these increases, the socioeconomic gradient in use of state hospital services continues to favor the rich, while the gradient for use of outpatient care services favors the poor. Use of private hospital services did not change much, but use of private hospital outpatient care services increased significantly, particularly by the poor. More detailed analysis on the improvement of social-economic equity from 2006 to 2007 will be discussed. There are two utilization analyses. The first analysis is for out-patients in non-state hospitals, private practitioners, state hospitals, and state public health-centers. The second analysis is for in-patients.

Outpatient Care

Non-state Hospital: In 2005 the mean of the utilization rate of outpatient care of non-state hospitals was 0.63% (0.006 from 0-1 probability scale). The richest 20% of the community had a 4.79 times greater utilization of utilizing outpatient care of non-state hospitals than the poorest 20%. This data shows that the rich group use more than the lower socio-economic group. This data support the argument that non-state hospitals are used more by the rich. The tariffs at non-state hospitals are higher than those of the state

hospitals. In 2006 the mean of the utilization rate of outpatient care of non-state hospitals was 0.70% (0.007). The richest 20% of the community had a 6.44 times greater chance of utilizing outpatient care of non-state hospitals than the poorest 20%. In 2007 the mean of the utilization rate of outpatient care of non-state hospitals was 0.82% (0.008). The richest 20% of the community had a 5.21 times greater chance of utilizing outpatient care of non-state hospitals than the poorest 20%. The data from both years show a similar pattern.

Private Practitioners: In Indonesia government-employee medical doctors also practice as private practitioners in the early morning, afternoon until late in the evening. In 2005 the utilization rate of private practitioners was 8.05% (0.08 The richest 20% of the community had a 1.27 times greater chance of utilizing outpatient care of non-state providers than the 20% poorest. It is interesting to compare these data with those of non-state hospital outpatients. The utilization rate difference is not as big as that for non-state hospital outpatients. In 2006 households' chance to utilize outpatient care of non-state providers was 8.0% (0.08). The richest 20% of the community had a 1.12 times greater chance of utilizing outpatient care of non-state providers than the 20% poorest. In 2007 community' chance to utilize outpatient care of non-state providers was 12.88% (0.13). The richest 20% of the community had a 1.03 times greater chance of utilizing outpatient care of non-state providers than the 20% poorest.

State Hospital: In 2005 the mean of the utilization rate of outpatient care of state hospitals was 1.23% (0.012). The richest 20% of the community had a 2.76 times greater chance of utilizing outpatient care of state hospitals than the 20% poorest. This number is still in favor for the rich. This means that outpatient facilities at state hospitals are still used more by the rich. In 2007 the mean of the utilization rate of outpatient care of state hospitals was 1.38% (0.014). The richest 20% of the community had a 2.06 times greater

chance of utilizing outpatient care of state hospitals than the 20% poorest.

State Public Health Centre: In 2005 the mean of the utilization rate of outpatient care of state public health-centers and sub-centers was 5.37% (0.054). The richest 20% of the community had a 0.55 times greater chance of utilizing outpatient care of state public health centers and sub-centers than the poorest 20%. These figures show that state health-centers are used more by the poor than by the rich.

In 2006 the mean of the utilization rate of outpatient care of state public health- centers and sub-centers was 6.44% (0.064). The richest 20% of the community had a 0.536 times greater chance of utilizing outpatient care of state public health centers and sub-centers than the poorest 20%. In 2007 the utilization rate of outpatient care of state public health centers and sub-centers was 7.75% (0.08). The richest 20% of the community had a 0.537 times greater chance of utilizing outpatient care of state public health centers and sub-centers than the poorest 20%.

Inpatient Care

Non-state Hospital: In 2005, the mean of the utilization of the inpatient care of non-state hospitals was 0.26 (scale: 0 to 1) or 2.62%. The estimation of the utilization rate of the inpatient care of non-state hospitals was 2.62%. The utilization of inpatient care of non-state hospitals by the richest 20% of the community was 9.6 times higher than that by the poorest 20%. These figures are almost the same as those for outpatient utilization. Non-state inpatient service was used more by the rich than the poor. In 2006, the mean of the utilization rate of inpatient care of non-state hospitals was 0.027 (2.70%). The utilization the service by the richest 20% of the community was 8.7 times greater than that by the poorest 20%. In 2007, the mean of the utilization in inpatient care of non-state

hospitals was 0.045 (4.46%) The estimation of the utilization rate of inpatient care of non-state hospitals was 4.46 %. The utilization of inpatient care of non-state hospitals by the richest 20% of the community was 6.14 times greater than that by the poorest 20%.

State Hospital: In 2005, the mean of utilization of inpatient care of state hospitals was 0.044 (4.39%). The estimation of the utilization rate of inpatient care of state hospitals was 4.39 %. The utilization of the care by the richest 20% of the community was 3.12 times greater than that by the poorest 20%. In 2006 the mean of the utilization rate of inpatient care of state hospitals was 0.046 (4.58%). The estimation of the utilization rate of inpatient care of state hospitals was 4.58 %. The utilization of this care by the richest 20% of the community was 2.06 times greater than hat by the poorest 20%. These figures show a consistent evidence that the use of inpatient service was higher by the rich than by the poor. In 2007, the mean of the utilization rate of inpatient care of state hospitals was 0.073 (7.33%). The estimation of the utilization rate of inpatient care of state hospitals was 7.33%. The utilization of the service by the richest 20% of the community was 2.19 times greater than that by the poorest 20%.

State Public Health Centre: At some health centers, inpatient service is provided to the community. In 2005, the mean of utilization rate of inpatient care of state public health centers was 0.006 (0.57%). The estimation of the utilization rate of inpatient care of state public health centers and sub-centers was 0.57 %. The utilization of this service by the richest 20% of the community was 0.61 times than that by the poorest 20%. It shows that the inpatient care of state public health-centers was mostly used by the poorest community. In 2006, the mean of the utilization of inpatient care of state public health centers and sub-centers was 0.007 (0.76%). The estimation of the utilization rate of inpatient care of state public health centers and sub-centers was 0.76%. The utilization of the

service by the richest 20% of the community was 0.56 times greater than that by the poorest 20 %. In 2007 the mean of the utilization of inpatient care of state public health centers and sub-centers was 0.01 (1.04%). The estimation of the utilization rate of inpatient care of state public health centers and sub-centers was 1.04 %. The utilization of the service by the richest 20% of the community was 0.56 times greater than that by the poorest 20%. These figures show that health centers are used more often by poor people than the rich. On the other hand, hospitals, especially private ones, are more often used by the rich. By time, the gap of utilization by the rich and the poor is narrowing.

Geographical inequity

Other analyses (based on MoH data on hospital and human resources distribution) show another inequity. Hospitals and medical doctors are not geographically well distributed. In this situation, the National Financial Health Protection Policy (*Jamkesmas = Jaminan Kesehatan Masyarakat*) allows non-state hospitals to treat poor and near-poor patients. The Benefit Package is broad, including high technology and costly medical treatment. This may increase the access of the poor and the near-poor in urban areas and Java for non-state hospital services and high-cost medical care. It is projected that a huge portion of the health budget will be swallowed by these groups. There is a concern from the government regarding the affordability and geographical equity in National Financial Health Protection Policy (*Jaminan Kesehatan Masyarakat)*.

CHAPTER 6
The Case Studies Non-state Hospitals

The more detailed case studies of the landscape will be discussed within socio-economic geographical analysis. As described in Chapter 2 the impacts of decentralization was the significant growth in the discrepancy in fiscal capacity among provinces and districts/municipalities. With the availability of local government shared-funds, some provinces and districts/municipalities suddenly became rich. Most districts remain poor, but there are some districts which are traditionally well off. Using this perspective, the more detailed landscape of non-state hospitals is described in some places.

Table 6. 1 Case Study Based on Classification of Chapter 2

	Low Community Income	**High Community Income**
High Local Government Fiscal Capacity	Jambi	Jakarta; Denpasar
Low Local Government Fiscal Capacity	Bima; Boyolali	Yogyakarta

Case Study Based on Geographic:
Special Capital District of Jakarta Province

Jakarta is situated in the north-west of Java Island. The community economy and government fiscal capacity is high. Jakarta was declared as the Special Capital Province of Great Jakarta and as the capital of Republic of Indonesia (Law No. 10/1964) on 31st August 1964. Since 1966, Jakarta has developed steadily in that it has become a modern metropolitan city. In the administrative context, Jakarta is divided into 6 parts (5 municipalities and 1 regency, namely the administrative region of Seribu Islands). By March 2009, the population was 8.5 million, distributed in the 5 municipalities and one

regency with a composition of 54.6% male residents and 45.4% female residents. The population density was 73.047 residents per square kilometer (km^2). The highest urban population density was in Central Jakarta with 19.656 residents per square kilometer (km2) and the lowest urban population density was in North Jakarta with 10.959 residents per square kilometer (km2).

There were 99 hospitals in Jakarta Special Capital Region in 1998 and the number grew into 121 in 2008. In fact, hospitals owned by companies experienced the highest growth rate: 6 hospitals in 1998 but 34 hospitals in 2008. Hospitals of other ownerships tended to be static (unchanged). The illustration on the hospital growth and its development is presented in the following table:

Table 6. 2 The Number of Hospitals in the Jakarta Special Capital Region

Owner	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Ministry of Health	9	9	9	9	9	9	9	9	9	9	9
Provincial Government	5	5	5	5	5	6	5	5	6	6	6
Local/Municipal Government	0	0	0	0	0	0	1	1	0	0	0
Indonesia National Armed Force/Indonesian Police	9	9	9	9	9	9	9	9	9	9	9
State-owned Corporation/Other Department	5	5	5	5	6	6	6	6	6	6	6
Company	6	9	8	8	14	14	14	16	23	27	34
Foundation	58	58	58	59	59	60	60	60	55	55	50
Association	7	7	7	7	7	7	7	7	7	7	7
Total	99	102	101	102	103	111	111	113	115	119	121

Source: Data Management of Ministry of Health Registration

The comparison of state hospitals and non-state hospitals shows an interesting result. In 2008 there were 28 state hospitals and 71 non-state hospitals. Within 10 years, the number changed respectively into 30 and 91. The number of beds in non-state hospitals was 7.829 units in 1998 and became 9.017 beds in 2008. Therefore, non-state hospitals grew faster that

the state ones. This change indicated an increasing demand for hospital due to the improvement of the community's economic status and the medical needs in the community. In this development, the role of private investor in the hospital sector is significant. In Greater Jakarta the establishment of for-profit corporation-owned hospitals is the reflection of the strong economic demand for medical service in the society.

The ownerships of non-state hospitals in 2008 were in the form of foundation (for 50 hospitals), corporation (34) and association (7). The major foundation hospitals were mostly established at the early history of Indonesian health services, such as RS Cikini and RS St Carolus. Most of these big faith-based (Catholic and Christian) hospitals are locate in Menteng, in the heart of Jakarta. The Moslem hospital, RS Islam Cempaka Putih, was established in early 1970s in Central Jakarta. These big hospitals are clustering in Central Jakarta, so are the national teaching hospital (RS Cipto Mangunkusumo) and the military hospital (RSAD Gatot Soebroto).

The growth of for-profit hospitals was mainly initiated by medical specialists from the national teaching hospitals. The medical doctors' initiatives can be classified into two groups: (1) sole ownership for small and usually special hospitals; and (2) group ownership for quite big non-state hospitals, such RS MMC in Kuningan Jakarta. The medical doctors' initiatives to establish were very pragmatic. Distance from the main hospitals where they practice is an important consideration. Therefore, the location of these medical-doctor-owned hospitals is clustering also in Central Jakarta, close to the big teaching hospitals.

The latest development of non-state hospital ownership in Jakarta is that of the combination of investors and medical specialists or that of pure private investor. The for-profit hospitals owned by private investors' corporations are blossoming with their modern service-organization system. A chain hospital system is adopted by Siloam hospitals. Many corporation-owned hospitals also make an alliance with real estate developers. As the result, the new real suburbs of Jakarta (Tangerang, Cinere, Cibubur, Bekasi) have become the grounds of new hospitals in the last two decades. This development has made the big non-state faith-based hospitals cornered in

Central Jakarta. Some non-profit non-state hospitals have been converted to for-profit institutions. It has also been observed that foundation-owned and faith-based hospitals serve the middle and lower economic classes of the society.

The development of non-state hospitals in Jakarta is the reflection of the increase of community economy. Like shopping malls in Jakarta which compete with overseas competitors, some non-state hospitals such as RS Pondok Indah and RS Siloam declare the upper classes of the society as their market. Consequently, these non-state hospitals face a head-to-head competition with overseas hospitals in Singapore, Bangkok, Malaysia, and developed countries which traditionally lured upper-class Indonesian patients. This competition is not easy for Jakarta's non-state hospitals. Hospitals in Bangkok and Kualalumpur enjoy some industrial protectionist policy by their government. Medical facilities of the non-state hospitals in Jakarta are less modern. Moreover, the regulation of medical specialists in Indonesia cannot match the competitiveness of those in Bangkok hospitals. As a result, there are still many Indonesians who travel abroad for medical care.

In the recent years, the Ministry of Health has realized that non-state hospitals cannot compete with the high technology and human resources provided by overseas health systems. Therefore, a new policy of modernizing teaching hospitals with new technology and new expertise was established around 2008. The tagline is Becoming World Class Hospitals. As the result, RSCM and other teaching hospitals have enjoyed massive subsidy, including the development of VIP wards to compete with overseas hospitals. As the result, big teaching hospitals, such as RSCM in Jakarta, have become the champion of medical technology in Jakarta.

Denpasar City

Denpasar is the capital city of Bali Province. Denpasar City was established on 15th January 1992 supported by Law No.1/1992 on the establishment of Denpasar City. From the economic perspective, this city is prosperous. Tourism industry has improved local government fiscal capacity

and provides jobs to many Balinese. The population in 2008 was 642,358; the average growth was 8.09% though the population census in 2000 showed that the average population growth was 3.01%. The high growth of population has been caused by a predominant migration factor along with a substantive reason of looking for jobs. In part, the population growth rate has been caused by the natural growth, but the main reason was the population relocation from the regencies in Bali or from outside Bali. This has resulted in the high population density.

There were 14 hospitals in Denpasar City in 1998, and this number rose significantly in 2008 (18 hospitals). The hospital ownerships were mostly non-state providers owned by foundations (13 hospitals). The growth and development of non-state providers can be presented as follows:

Table 6. 3 The Number of Hospitals in Denpasar City

Owner	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Ministry of Health	1	1	1	1	1	1	1	1	1	1	1
Provincial Government	1	1	1	1	1	1	1	1	1	1	1
Local/Municipal Government	1	1	1	1	1	1	1	1	1	1	1
Indonesia National Armed Force/Indonesian Police	1	1	1	1	1	1	1	1	1	1	1
State-owned Corporation/Other Department	0	0	0	0	0	0	0	0	0	0	0
Company	0	0	0	0	0	1	1	1	1	1	1
Foundation	10	10	10	11	12	13	13	13	13	13	13
Association	0	0	0	0	0	0	0	0	0	0	0
Total	14	14	14	15	16	18	18	18	18	18	18

Source: Data Management of Ministry of Health Registration

A small number of hospitals are owned by the Ministry of Health, the municipal government, the provincial government and the Indonesian National Armed Force/Indonesian Police. There was no growth of these hospitals during the period of 1998-2008. A company built one hospital in

2003. However, there was no new company-owned hospital from 2003-2008. Hospitals owned by foundations had an average growth rate of 2.7% per year. The highest growth occurred in 2001, amounting to 10%. In general, the highest growth took placed in 2003, which was 12.5%, and the average growth for the period of 1998-2008 was 2.6% per year.

There were 1517 beds in 1998. The last data (2008) indicates an increase of bed capacity into 1577 units. It means that the growth within 10 years was only 69 units. The highest bed capacity within 10 years happened in 2002, which was 1675. Meanwhile, the lowest bed-capacity occurred in 1998, which was 1517.

Similar with Jakarta, the growth of non-state hospitals have been mainly initiated by medical specialists from the national teaching hospitals (RS Sanglah). However, the legal owners are mostly foundations (*Yayasan*). Only one non-state hospital is owned by a company, namely Prima Medika Hospital. Most hospital foundations are owned by senior lecturers from the teaching hospital. Therefore, these medical-doctor-owned hospital are clustered close to Sanglah Hospital, and some of them are even at a walking distance.

Although the business of hospitality industries such as hotels, spas, and restaurants in Bali had started growing many decades ago, the development of hospital industry is very late in Bali. Prior to the establishment RS Prima Medika in Denpasar, most of non-state foundation hospitals in Bali used big houses which were converted to hospital building. This caused serious concerns on the medical care quality, environment issues, and patient satisfaction. Non-state hospitals in Bali before 2002 suffered from chronic problems in capital investment. This is logical because it is difficult for banks to provide loans for foundations. The latest development of non-state hospitals in Bali now is following the path of PT Prima Medika Hospital. Some of the hospital big houses have been demolished and reconstructed with a hospital design. Many hospital foundations have been converted into limited corporations, although they have not been recorded in the Ministry of Health data.

Yogyakarta Special Territory

Yogyakarta Special Territory (*Daerah Istimewa Yogyakarta*) is an autonomous region that has the same level with a provincial region in Indonesia. The population in Yogyakarta Special Territory was ±3.51 million (in2008) with a composition of 51.02% males and women 48.98% females. They are distributed in 4 regencies and one municipality with the biggest population in Sleman Regency (± 908 thousand). There were 27 hospitals in the Special District of Yogyakarta in 1998 and this number became 35 in 2008. The majority of hospital ownership was in the form of foundation (71.43% in 2008). In fact, the foundation hospitals had the highest growth rate, from 18 (1998) to 25 (2008), while for the other ownerships the growth was static. The growth and development of hospitals can be presented in the following table.

Table 6. 4 The Number of Hospital in the Yogyakarta Special Territory

Owner	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Ministry of Health	1	1	1	1	1	1	1	1	1	1	1
Provincial Government	1	1	1	1	1	1	1	1	1	1	1
Local/Municipal Government	5	5	5	5	5	5	5	5	5	5	5
Indonesia National Armed Force/Indonesian Police	2	2	2	2	2	2	2	2	2	2	2
State-owned Corporation/Other Department	0	0	0	0	0	1	1	1	1	1	1
Company	0	0	0	0	0	0	0	0	0	0	0
Foundation	16	19	20	22	23	24	24	24	24	24	25
Association	0	0	0	0	0	0	0	0	0	0	0
Total	27	28	29	31	32	34	34	34	35	34	35

Source: Data Management of Ministry of Health Registration

The ownership composition of the hospitals and nonstate providers is shown in the above graph. In 1998 there were 9 government hospitals and 18 non-state hospitals, and at present this comparison is slightly different since there have been 10 government hospitals and 25 non-state hospitals.

There were 3.134beds in 1998 and, as indicated by the last data, it grew to 3.807 beds in 2008. Thus, this number increased by 673 beds within 10 years. The highest growth of bed capacity took place in foundation-owned hospitals, which was 54.93% in 2008.

The non-state hospitals Yogyakarta are inseparable from the national history of Indonesian health services. Nowadays, people living in Yogyakarta are familiar with prominent hospitals such as Bethesda Hospital, Panti Rapih Hospital, Dr Yap Eye Hospital, and PKU Muhammadiyah Hospital, which were established in the colonial era. Three out of four big Yogyakarta non-state hospitals have religious missions in running their services. Those hospitals are not owned by doctors; however, the doctors serve in the hospital management. Panti Rapih Hospital is the only hospital where nuns' influence is still considered very strong. These nuns are part of the board of directors and actively participate in the daily activities. In contrast, Bethesda and PKU Muhammadiyah Hospitals have no clergymen or Islamic ullemas in their board of directors.

After the declaration of independence, Gadjah Mada University once had several hospitals in some places in Yogyakarta: Pugeran, Mangkuyudan, and Jenggotan. These academic hospitals were actually parts of clinical departments in Faculty of Medical Gadjah Mada University. In the end these hospitals were slowly merged in a single hospital. The new merger was then named Dr. Sardjito Hospital, which started its service in 1973.

The development of non-state hospitals after the Independence has been the emergence of hospitals owned by doctors which has been in line with the development of the Medical Faculty of Gadjah Mada University. The owners of hospital are mostly the senior doctors of Medical Faculty and the hospitals are located in Southern Yogyakarta (near former GMU hospitals). Those hospitals are Sari Asih ENT Specialist Hospital (with 25 beds), Empat Lima Pediatric Hospital (with 43 beds), and Prof R Oepomo ENT Hospital (with 25 beds). This pattern has led to the emergence of some hospitals owned or managed by GMU Medical Faculty's lecturer(s), such as Patmasuri Surgery Hospital (with 50 beds), Dharma Husada Surgery Hospital (with 25 beds), Bhakti Ibu Maternity Hospital (with 25 beds), Soedirman Surgery

Hospital(with 27 beds), and Husada Tama Internal Medicine Hospital (with 27 beds). For mental diseases, there are two hospitals under the same ownership, namely Lokapala Hospital (with 28 beds) and Puri Nirmala Mental Hospital (with 50 beds). Recently, Lokapala Hospital has started to offer general services.

One non-state hospital has an interesting development. Pura Ibunda Maternal and Child Hospital belonged to a non-lecturer medical specialist and it ran well until 1997. After the owner became old, and difficult business environment attacked Indonesia, the management of this hospital collapsed. In 2004, the owner offered this hospital to the public and there were 10 persons who tried to bargain the price but they failed. In 2006, the owner offered it to a prominent urologist in Yogyakarta. On July 19, 2007, the hospital was acquired and renamed as An Nur Hospital, which officially opened on May 3, 2008.

Other specialist hospitals are Permata Bunda Maternal and Child Hospital (with 25 beds), Ummi Khasanah Maternal and Child Hospital (with 25 beds), and Sakinah Idaman Maternal and Child Hospital, which is owned by a midwife.

Besides those specialist hospitals, some general hospitals belonging to religious organizations, such as St Yusup Boro Hospital (with 50 beds) and Panti Baktiningsih General Hospital (with 50 beds), show a remarkable development. JIH Hospital and Ludiro Husada Hospital are new hospitals whose ownership is in the form of *Yayasan* (foundation). A hospital whose ownership is the form of a Limited Corporation (Ltd) is Happy Land Hospital. The phenomenon of hospital in the form of a Limited Corporation has become the new trend since the end of the 2000's in Indonesia. It means that Yogyakarta has become one of the leading cities with big hospitals whose ownership is in a form of a corporation since 1980's.

In the mean time, the development of the public hospital, particularly Dr. Sardjito Hospital, has led it to the use of high technology. Dr. Sardjito Hospital provides many opportunities for the clinicians by

establishing centers for clinical services such as the Cancer Center, Heart Center, and Skin Treatment Center.

Boyolali Regency, Central Java

Boyolali is a low economy district at the slope of Merapi Mountain, Central Java. The population in 2007 was 932.698, distributed in 19 sub-districts, and the composition was 48.88% males and 51.12% females. The population density was 9188 residents per square kilometer (km^2). There were three hospitals in Boyolali Regency in 1998, and the number changed to five in 2008. The majority of ownership was that of a foundation (four hospitals in 2008). The hospital growth and development can be presented in the following table.

Table 5. 9 The Number of Hospitals in Boyolaly Regency

Owner	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Ministry of Health	0	0	0	0	0	0	0	0	0	0	0
Provincial Government	0	0	0	0	0	0	0	0	0	0	0
Local/Municipal Government	1	1	1	1	1	1	1	1	1	1	1
Indonesia National Armed Force/Indonesian Police	0	0	0	0	0	0	0	0	0	0	0
State-owned Corporation/Other Department	0	0	0	0	0	0	0	0	0	0	0
Company	0	0	0	0	0	0	0	0	0	0	0
Foundation	2	2	2	2	3	4	4	4	4	4	4
Association	0	0	0	0	0	0	0	0	0	0	0
Total	3	3	3	3	4	5	5	5	5	5	5

Source: Data Management of Ministry of Health Registration

There were 287 beds in 1998 and the last data showed that the number of beds became 419 in 2008, so it increased by 132 units within 10 years. The highest number of bed capacity in 2008 was that of the local government hospitals (58.23%). There were 2 non-state hospitals in 1998 and then 4 in 2008, each of which belonged to a foundation.

Non-State Hospitals in Boyolali

Umi Barokah General Hospital (UBGH)

UBGH was established in 1993 as a special hospital of maternal and children care; and it was established by a senior ob-gyn in the town of Boyolali. This hospital serves as a working place for general practitioners and midwives living around Boyolali; it is also the public choice to get alternative a service alternative for obstetrics and gynecology cares.

When established, the hospital's bed capacity was less than 30 beds. In 2007, the hospital's status changed into a general hospital. The bed capacity was increased to 50 beds and until today, there has no significance change in terms of its bed capacity. The institution form of UBGH has not changed since its establishment, namely .a foundation.

The medical staffs at UBGH are the founder and some physicians working at the public hospital of Boyolali Regency. Most of physicians working at UGBH also serve patients at other places in the same district.

Al-Amin Hospital (AAH)

AAH was established in 1995; but today it does not operate any longer. When it was established, AAH was a general hospital with a bed capacity of 50. AAH was a hospital belonging to a foundation.

Asyifa Hospital (AH)

Asyifa Hospital was established in 2007 by an obs-gyn working at the public hospital of Boyolali Regency. It is a general hospital which belongs to a foundation.

Since its establishment, the bed capacity has remained the same, namely 50. Its mission is to provide for Boyolali residents general health-care services though its special service is that of obstetric and gynecological cares.

The medical staffs serving at AH are part timers, including the owner, since all of them are civil servants working at the local public hospital.

PKU Hospital (PKUH)

PKUH was established by a general practitioner in 2000 and it is the under-bow of Muhammadiyah's health-care service. PKUH has been a general hospital since its establishment. In terms of the number of patients, PKUH has experienced a significant increase.

The mission of PKUH is to provide alternative health-care service with good quality at an affordable cost. Under the umbrella of Muhammadiyah Group's health-care service, PKUH take the benefits by the presence of the Muhammadiyah community in Boyolali Regency that soon become its "regular customers". However, PKUH also serves non-Muhammadiyah community. The status of PKUH as an institution is foundation.

The health personnel working at PKUH are mostly physicians working at the local public hospital. The permanent personnel owned today are physicians who also serve as managers of PKUH in addition to a functional specialist doctor who has retired from the local public hospital.

Natalia Hospital, Boyolali.

Natalia is a specialist hospital which provides obstetric and gynecological services. This hospital is also located in Boyolali. It is owned by an obstetrician who formerly worked as a civil servant at Boyolali Public Hospital.

Bima City

The administrative town of Bima geographically has a strategic position both for the economic or socio-cultural aspects in Sumbawa Island, Nusa Tenggara Barat. In terms of industry, trade, communication and tourism potentials, Bima has a good prospect in fulfilling the domestic or international market demands. According to the Central Bureau of Statistics (BPS) data, the total population of the town of Bima is 127.4 thousand, consisting of 31.090 households). The composition is 61.770 males and 65.603 females.

There were two hospitals in Bima Regency from 1998 until 2008. The hospital ownership was under the authority of local/municipal government of Bima. The hospital growth and development can be presented in the following table.

Table 5. 10 The Number of Hospitals in the town of Bima

Owner	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Ministry of Health	0	0	0	0	0	0	0	0	0	0	0
Provincial Government	0	0	0	0	0	0	0	0	0	0	0
Local/Municipal Government	2	2	2	2	2	2	2	2	2	2	2
Indonesia National Armed Force/Indonesian Police	0	0	0	0	0	0	0	0	0	0	0
State-owned Corporation/Other Department	0	0	0	0	0	0	0	0	0	0	0
Company	0	0	0	0	0	0	0	0	0	0	0
Foundation	0	0	0	0	0	0	0	0	0	0	0
Association	0	0	0	0	0	0	0	0	0	0	
Owner	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Total	2	2	2	2	2	2	2	2	2	2	2

Source: Data Management of Ministry of Health Registration

There were 91 beds in 1998. The latest data indicated that the number became 120 beds in 2008. Thus, the growth was 29 beds within 10 years. The highest number of beds within 10 years occurred from 2003 to 2005, which was 129 units. According to the data of the Ministry of Health Registration (2008), Bima Regency does not have any non-state hospital, but in fact there is one which is owned by Muhammadiyah, a 60-year-old institution.

Jambi City

The Region Profile

Jambi, as the capital city of Jambi Province, is the only municipality in the province which has nine regencies. It was established based on Sumatra

Governor's Decree No.103/1946 as an Autonomous Region and was supported by the Law No. 9/1956. It was declared as an Autonomous Municipal Region in the territory of Central Sumatra Province. The population in 2005 reached 446.78 thousand people (96.93 thousand households), spread throughout 8 sub-districts with the composition of 50.52% males and 49.48% females. The population increase rate was 2.37% in the same year, while the population density was 2175.8 residents per square kilometers (km^2).

There were 6 hospitals in Jambi City in 1998 and the number increased by 1 in 2008. These hospitals were mostly owned by the Indonesian National Armed Forces/Indonesian Police and foundations. An interesting fact in 2008 was that one hospital belonged to a company. The graphic illustrations of the hospital growth rate and its development are presented in the following table.

Table 5. 11 The Number of Hospitals in Jambi City

Owner	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Ministry of Health	1	1	1	1	0	0	0	0	0	0	0
Provincial Government	1	1	1	1	1	1	1	1	1	1	1
Local/Municipal Government	0	0	0	0	1	1	1	1	1	1	1
Indonesia National Armed Force/Indonesian Police	2	2	2	2	2	2	2	2	2	2	2
State-owned Corporation/Other Department	0	0	0	0	0	0	0	0	0	0	0
Company	0	0	0	0	0	0	0	0	0	0	1
Foundation	2	2	2	2	2	2	2	2	2	2	2
Association	0	0	0	0	0	0	0	0	0	0	0
Total	6	6	6	6	6	6	6	6	6	6	7

Source: Data Management of Ministry of Health Registration

There were 580 beds in 1998, but the latest data indicated that the number grew to 709 in 2008. It means that there was an increase of 129 beds within a ten-year period. The highest growth of bed-capacity in the provincial government hospitals was 38.5%, which took place in 2008.

There were 2 non-state hospitals in 1998 and that number became 3 in 2008. The hospital ownership varies: two belong to foundations and one belongs to a company. The bed capacity in non-state hospitals was 85 in 1998 and that number became 204 in 2008. Thus, it indicates a rising growth rate of 2.4 for the non-state hospitals.

Case Studies Based on Hospital Governance and Management

According to government regulation, there are only 3 forms of non-state hospital organization: a corporation, which is for-profit, a foundation, and an association. The last two are not-for-profit. However, there can be found sub-variation of each form. A corporation, for example, can be a family-owned corporation or a pure corporation. A foundation can be a medical-doctors-owned foundation or a faith-based foundation. This phenomenon is not shown in the document of the Ministry of Health but can be identified in the real practice.

The variation implies to the business concept and technical operations of each hospital. In terms of organizational input, this study explores the legal procedures that have been taken by the management (and owner), the aspect of human resource management (particularly the management of medical doctors, specialist doctors, and nurses), the condition of hospital buildings and facilities, the technology currently offered to the market, the payment systems provided for various customers and the accounting systems, the marketing strategies that have been set up to engage hospitals to particular consumers, the social responsibility of non-state hospitals to their surrounding community, the integration of non-state hospitals in the insurance system (of both social and commercial insurances), and the most prominent or potential conflict that has happened during the operation terms.

The objectives of this case study are to identify the practical definition, function, variation, and dynamic of non-state hospitals, to describe the management and governance of non-state hospitals, and to analyze the driver of non-state hospitals development and its contribution to the strengthening of the health system.

Institution owned non-state hospital in Jakarta.

Association-based hospital: Husada Hospital owned by Chinese society in Jakarta. The vision of the hospital is to be a hospital with international recognition that is capable of providing comprehensive medical service based on 'Love and Care'. The form of the Husada Hospital is as an association due to the history of its establishment 85 years ago as an association. Until 30 years ago, the Management of this hospital was decentralized. Each and every unit of service was managed autonomously, and therefore it can be stated that in the long run there were potential conflicts. In the 90's, the management was then restructured and it adopted a centralized system.

The target consumers that are expected to make visits to the hospital are people of all strata within the community. The consumer responses have been very good. This is proven by the increase in positive reaction from the surrounding community as well as the increase of patient visits. The current medical services are already in accordance to market needs and this is proven by the low level of complaints from the patients concerning the service they receive. It can be stated that there has been almost no complaint whatsoever. Patient data based on income groups are as follows: 20 % are of the high class, 50% are of the middle class, and 30% are of the lower class. The Husada Hospital owns a number of facilities in the form of sophisticated technology such as: CT Scan Multislice 16 and Magnetic Resonance Imaging (MRI) 1.5 Tesla, Olympus PSD-60/Endoplasma Argon Plasma Koagulasi, Echodoppler, EEG Brain Mapping, Digital Subtraction Angiography (DSA).

The Husada Hospital owns a general policlinic for providing complete medical service, starting from child counseling, dentistry, heart, kidney to gynecology and child-birth. The Specialist Policlinic at the Husada Hospital provides first-class medical service for more than 15 types of specialist medication. The hospital is already equipped with a comprehensive license. The social responsibility that has prevailed since the establishment of this hospital is still maintained: the hospital provides for third-class patients a discount of 30%. This is in line to the mission of the hospital since its

establishment which is to provide service to poor community members. No physicians working in this hospital have resigned. Even those who have entered their retirement period still conduct practice at this hospital. The management provides and develops adequate facilities for physicians to perform their practice, which makes the physicians feel comfortable. The facilities that are made available are of sophisticated technology. It can be stated that the patients do not seek physicians but seek a hospital. Therefore satisfaction is from and for the patients, the physicians, and the hospital.

Restructuring and development continues to be undertaken. The number of permanent staff have totaled to around 1400, very much similar to that of government employees in a general public hospital. These staff members have worked for a long time at the hospital. They have adequate competence, but human resources development continues to be improved.

Faith-based hospital: Pondok Kopi Islamic Hospital, Jakarta

This hospital is one of many Muhammadiyah hospitals. The main mission of this hospital has a very strong connection to its establishment history and its initial name of '*Penolong Kesengsaraan Oemat* (PKO or Rescuer for the Suffering of Mankind), which is based on a social mission. Therefore, this mission has become the reference for Muhammadiyah Islamic Hospitals. The total number of beds is 226, of which 12 are of VIP rooms and two are of VIP baby rooms, 114 are in Class I and II rooms (which consist of special isolation rooms, baby rooms, GE rooms), 57 are of Class III rooms (which also service *Gakin, Jamsostek,* and J*amkesmas* card holders).

The sophistication levels of technological equipment made available at the Pondok Kopi Hospital are as follows for the middle level the hospital has CT-Scan equipment, 3-dimensional (3D) USG equipment, and *Laparoscopy* equipment, which is *on loan*; and for the basic level the hospital has the Rontgen and USG equipment.

The proportion of service level currently made available at the hospital is as follows: high level (minimum invasive surgery, 1 hole-

laparoscopy): not available, middle level (laparoscopy): available, and basic level: available.

The missions of the Pondok Kopi Islamic Hospital are:

1. To provide professional medical service for all people from all walks of life within the community in a just and charitable manner.
2. To provide facilities and infrastructure for medical service in accordance with the progress knowledge and technology in order to provide competitive services this globalization era.
3. To conduct sustainable training, research and management development in order to produce human resources with outstanding competence and moral values.

The legal status of RSI Pondok Kopi is a foundation. The two reasons why this type of organization has been selected are:

1. A foundation is a social and charitable entity, whose BPH (*Badan Pengawas Harian/* Daily Management/Operational Board) members can be a religious association or organization.
2. History-wise, when it was first established, the mission of the hospital was to provide medical assistance to disaster areas (was established as BPKOE *Badan Penolong Kesengsaraan Oemat/Human Misery Rescue Agency*)).

The foundation form is already in accordance to the situation and condition of the hospital at the moment, but it is not fully effective because a hospital with this kind of religious mission should conduct a large number of humanitarian and charity works. Currently there are already several humanitarian and charity programs but not so much, and therefore operational funds have come mostly from the patients.

None of the Muhammadiyah leaders become managers at this hospital. The Muhammadiyah Association in this case are represented by Badan Pengawas Harian (BPH or Daily Management or Operational Board). The hospital board of directors are selected and elected by the BPH. There are two types of BPH; the Central BPH (RSI is accountable to the Central

Board) is responsible for: formulating strategic planning and annual budget plan, whereas the Local BPH is responsible for hospital development matters.

The target consumers expected to make visits to the hospital are community members residing in East Jakarta. Response from consumers/the market since the establishment of this hospital has been satisfactory. This is reflected from the high total number of BOR, the high number of patient retention, and the high number of outpatient visits. The data on service efficiency at the RSI Pondok Kopi for year 2008 is as follows: BOR: 76%, LOS: 4 days, NDR : 1.2%, TOI: 1.4 days, BTO: 71 patients, and GDR: 21%.

The form of social responsibility is implemented as follows:

a. Total number of Class III wards fulfills the standard set out by the government, which is 30%.
b. The hospital accepts the five government medical care programs for poor communities, namely the poor-family scheme, *Jamkesmas* card holders, *PT Askes* policy holders, *PT Jamsostek* policy holders, and *SKTM* (Statement Letter Proofing Financially Deprived Status) card holders.
c. Some poor patients or financially deprived patients who cannot pay for medical fees are supported using funds from ZIZ (Zakat, Infak, Zodakoh) donation.

As one of the charity organizations under Muhammadiyah Organization, which has the purpose of implementing the organization's mission and to assist the government in creating a healthy and independent Indonesian community, Jakarta Pondok Kopi Islamic Hospital has implemented the following: Health care programs for the under-privileged families: Since 2005, Pondok Kopi Jakarta Islamic Hospital has provided free medical service for approximately 100 poor families. Costs for the medical service are paid with the management's and the employees' *zakat* fund. Free medical service for under-privileged community is offered routinely. It has assisted victims of natural disasters and provides other humanitarian aids. It has collaborated with the Government, specifically the Health Agency in DKI

Jakarta, in providing medical service to underprivileged families. It has conducted mass circumcision for male children of poor families. It has disseminated medical information to the needy areas. It has conducted and sponsored routine blood donation once in every six months.

Services that are available at the hospital are in accordance to market demand as shown from result of a data survey that states the decision of respondents to always seek medication at the hospital when they are suffering from a severe medical disorder is 63.7 %. This result shows that there is high level of trust from the community in using medical service at the hospital even though there are now several choices of alternative medications that has become a second opinion for the community members.

The hospital is served by full-time and part-time physicians. Full-timers are permanent specialist physicians who have been who have been elected as permanent staff, while part-timers are physicians who have not been elected as staff but are active in the management. The level of satisfaction from specialist physicians working at the Pondok Kopi hospital so far has been satisfactory. And out of the specialist physicians working at this hospital, none of them has resigned.

For the development plan for the upcoming 10 years, it has prioritized the: establishment and development of a trauma center under the consideration that the location of the hospital is surrounded by busy roads and toll roads where accidents frequently occur. Based on the analysis of the total number of visits at the children ward, the hospital also plans to develop the children ward.

Chain-hospital: HERMINA Hospital, Jakarta

The Hermina Daan Mogot hospital is a chain-hospital under the RSIA Hermina Group. This group applies a pattern of management that is similar for all hospitals bearing the name of Hermina. The missions of RSIA Hermina Group are as follows:

1. to organize sustainable effort in improving service quality to all clients

2. to conduct training and education program for all staff to provide professional service, and
3. to manage the hospital in a professional manner in order to achieve high-level efficiency and effectiveness.

The vision is to make the Hermina Hospital as a leading hospital in its service area with the competitive edge in the era of globalization.

The organizational form of Hermina Hospital is a limited company, named PT Medikaloka Hermina. The shareholders hold the highest authority and power over all policies and activities at the Hermina Daan Mogot Hospital. The organizational form of this hospital group was formerly a foundation, but after the issuance of Law of Foundation of 2001 the hospital changed into a limited company because the new Foundation Law limits the development of hospitals. Transforming the hospital into a company will also increase the opportunities for expansion. This limited-company organization is considered as more effective and appropriate. The ownership of shares in PT Medikaloka Hermina is based on the *shariah (Islamic Law)* pattern, where 40% of the shares belong to the physicians (physicians around the Daan Mogot area who already have patients).

The consumer target groups are all categories within the community, mostly the middle to upper level economic class. At Hermina Daan Mogot Hospital, the total number of beds has risen from 70 beds to 90 beds. The services are planned and provided based on the market demand. The patients come from the high economic class (20%), the middle economic class (60%), and the lower economic class (20%)

This hospital has run community social responsibility (CSR) programs since the establishment. The example of CSR activities are delivering medical service to disaster areas in West Sumatra and providing medical treatment for financially deprived patients who are entitled for health security/insurance from Jakarta Special Capital Province's scheme.

The full time (permanent) specialist physicians comprise 20% of all physicians working in the hospital, while the remaining 80% are non-permanent (part-time) specialist physicians.

Physician-owned non-state hospital in Jakarta, Indramayu, Boyolali, and Denpasar

These case studies aim to describe the dynamic of non-state hospitals owned by a doctor or group of doctors. This type of hospital often becomes community choice to obtain quality service because the community assumes that this type of hospital can give fast and better services performed professionally. This section will not highlight the service quality given by the hospital owned by doctor but will explore the issues of organizational management, so the hospital management is the main focus in this study.

SS Medika Hospital, Jakarta. SS Medika Hospital is a specialized hospital that carries the paradigm of a minimal invasive surgical center and has a vision to be a dignified specialized surgical hospital, to be one of the scientific references, and to have close contacts with its patients personally and professionally. SS Medika Hospital is equipped with three Operating Theater rooms equipped with the latest technology. The sterility of these rooms is also monitored continuously. The supporting facilities available at the hospital are 24 hour ER, radiology, pharmacy and hearing check-up (audiometric and tympanometry) facilities. Besides, there are 13 inpatient rooms (ranging from Class III to the suite class) with 29 beds.

PMC Hospital, Indramayu. The Hospital was established in 2005 and the holding company was founded in 2002. PMC has a bed-capacity of 30 and is a type-C hospital. The medical services consist of: 24-hour services (with in-patient, out-patient, pharmacy and emergency units), general services (with a general clinic, a dental clinic, a maternal & child health clinic, and a physiotherapy unit), specialist services (an obstetric & gynecological service unit, a neural clinic, an internal clinic, a pediatric clinic, and a mouth-and-dental clinic), and diagnostic services (with laboratory and Rontgen facilities). It can serve an average of 50-100 patients per day in its clinics and 25 in-patients.

Natalia Hospital, Boyolali. Natalia Hospital (NH) was established in 1996 as a maternity clinic. In 2001, the status was upgraded to a maternal and child care hospital. In its actual practice, it serves more as a maternity

hospital. The major reason for hospital establishment was that the town of Boyolali then did not own a representative private hospital. Another reason was the presence of the founder as an ObsGyn specialist was not supported by the local public hospital. The form of its organization is a limited company. The owner and shareholder is the same person, i.e. the hospital founder, who also serves as the hospital director. NH has no clear management system.

The NH market is expected of middle-down class. The upper class community chooses big cities hospitals in Solo and Salatiga, the neighboring municipalities. The consumers, however, respond well: there is no complaint on the service and approximately 80% of the available rooms in NH are always occupied. NH's social responsibility is in the form of the director's individual responsibility as the owner of the maternal and child care hospital. NH is not included in the list of referral hospitals for Public Health Insurance (*Jamkesmas*). The medical facilities owned by this hospital is still at the basic stage category. Its medical equipment is just an USG unit. The physical of NH building does not meet the physical standard of a hospital. The building is a house designed based on a hotel concept and developed into a hospital.

Manuaba Hospital, Denpasar.

Manuaba General Hospital was originally a maternity clinic established on 4th June, 1974, which then changed its status to a maternity hospital and, finally, with a complete range of service facilities, it has changed its status again to Manuaba General Hospital since 1980. Manuaba General Hospital is the first non-state hospital in Bali. Just like other general hospitals, Manuaba General Hospital has the duty to provide complete health service. To carry out this duty, the hospital has the missions to conduct medical services and health recovery; maintain and improve individual health through secondary and tertiary complete health care; provide education and training of human resources in order to improve capability in health service delivery; and conduct research and development as well as filtration of health technology in order to improve health service.

Currently, Manuaba General Hospital has an inpatient facility equipped with 50 beds, three surgical rooms (including one special surgical room for urological surgery), a maternity room, a nursery, and an intensive-care room with three beds. It has three full time specialists consisting of an internist and two specialists of obstetrics and gynecology. Other specialists are part-timers who serve at the local public hospital.

Discussion: Doctors Owned Hospital

These case studies are limited only on the exploration of data on several important issues concerning the development of hospital owned by medical doctors. The choice of the issue is focused only on the organization management aspect and ignores the patient satisfaction and service dimension. The explored dimensions include the motivation of hospital establishment, the hospital organization type, the governance, the management, the resources utilization, the identification of hospital development supporting factors (the market development, the capital availability, and the human resources availability), and the hospital destructing factors (conflicts and governance failure).

Doctors have various motivations in establishing the hospitals, ranging from concerns for the welfare of doctors and their families (as observed in PCM Hospital in Indramayu and Natalia Hospital in Boyolali), providing a workplace for retired doctors (Manuaba General Hospital in Bali), to providing the best service for society (SS Medika). This background of motivation is mostly due to economic reasons.

Ownership types also varies from a foundation (Manuaba), a corporation (SS Medika), to a family-owned enterprise (PCM Hospital in Indramayu) or an individual-owned enterprise (RS Natalia, Boyolali). Owners do not always seem to be aware of the implications of the different types of ownership. In most cases there is an overlap among the owners, members of the governance or management board, and the service providers in the institution. Those hospitals with more formal ownership structures (corporation and foundation) have clearer management structures and more

functioning executive directors; while those with more informal organizations tend to have part-time doctors as managers.

Some factors support the development of medical-doctor-owned hospitals, such as the specific selection of appropriate market segments based on an assessment of the hospitals' services rather than no on the specific target market; the workforce (more successful hospitals were able to attract additional specialists and full-time doctors, which improved the standard of care provided), and the capital investment (better structured and managed hospitals were able to attract additional capital investment). On the other hand, there are also some factors which inhibit the development of this kind of hospital, such as common internal conflicts among the staff or between the staff and the owner/manager, poor management; persisting conflicts because of the lack of clarity in the governance, conflicts of interest among the manager/owners, and conflicts between family members of the owner/manager.

Concluding note of the non-state hospital development

Based on the landscape, the development of non-state hospitals ownership can be differentiated based on three big mechanism: (1) the legacy of colonial-time hospitals; (2) the growth of clinicians' ownership after independence; (3) the modern hospital development in the end of 20th century, which is based mainly on for-profit corporation.

The legacy of colonial period

The development of colonial hospitals through the modern times has different endings. The first group of hospitals are able to survive and grow in the modern era. For example, Panti Rapih Hospital has the most rapid development with its hospital network, namely Panti Rapih General Hospital (331 beds), Panti Rini Hospital (52 beds), Panti Nugroho Hospital (50 beds) and Elizabeth Hospital in Bantul (27 beds). Yogyakarta Muhammadiyah Hospital has recently established a new hospital in Gampingan. In addition, the big family of Muhammadiyah Hospital has also built a new PKU Muhammadiyah Hospital in Bantul with 78 beds.

On the negative side, some big hospitals have experienced difficulties to develop. In Yogyakarta, Bethesda Hospital (504 beds) before the Indonesian Independence had several small satellite hospitals and treatment clinics. However, at present it has only one branch, that is Bethesda Lempuyang Wangi Hospital (50 beds). This negative growth is due to the political problem during the Indonesian Independence struggle. Cikini Hospital and St Carolus Hospital in Jakarta are experiencing their market share shrinking due to the tight competition with neighboring for-profit non-state hospitals.

Doctor- owned hospitals

The development of non-state hospitals in Jakarta, Denpasar, Yogyakarta, Jambi, Boyolali is clearly inseparable from the role of specialists in the establishment of non-state hospitals after the Independence. Doctors' involvement in hospital ownership can be a single or group ownership. The legal status can be in the form of a *Yayasan* (foundation), which is non-profit, such as that of Manuaba General Hospital in Bali, or a *PT (perseroan terbatas/*limited corporation/company), which is for profit, such as that of Prima Medika Hospital and MMC Hospital.

The process of establishment follows a similar path. Prominent specialists have a chance to build a hospital and to be the owner without abandoning their government-employee status. Specialists' dual practice is added with the third role: as the owners of non-state hospitals. This is an interesting phenomenon because the feeling of dissatisfaction, discomfort, distrust toward the system, or value disagreement with the state hospitals where they work have become a common reason of this emerging phenomenon. The fact that the owners of non-state hospitals remain to be part of the public hospitals where they are employed is an interesting phenomenon and has become a trend. In smaller towns, this big-city trend is also happening. Many medical doctors in district hospitals own their own non-state hospitals.

Empirically, the development of doctor-owned hospitals has some characteristics. The single ownership (of one doctor) is usually found in a

specialist hospital and small hospital, with a small number of beds. Big general hospitals are associated with specialists' group ownership. However, at the moment some specialists in the same specialties may develop a special hospital, such an eye hospital or a child hospital. The condition can be described in analogy of hotel industry, where there are several types of big hotels such as Hyatt and Santika, but there are also small but well-focused such as a boutique hotel. Hospitals are similar: some are big, while some others are small but specialist in certain cares,

There are some obstacles that hamper the development of doctor-owned hospitals, particularly from the aspect of facilities and finance, such as the limited building space, limited facilities, decaying buildings, and simple medical technology due to inadequate capital. The human resource regeneration tends to face some obstacles too. The case of Pura Ibunda hospital in Yogyakarta is a good example for understanding this problem. When the owner grows old and there is no successor, the best way is to sell the hospital to other people or to another hospital group. Therefore, such a hospital has a short period of operation since it only lasts for one generation. The conflict among doctors and the families who play the role as the owners may become obstacles too. In some hospitals owned by doctors, this conflict shows the limited understanding on good hospital governance. These phenomena might cause problems in the development of a hospital owned by a doctor as a single owner because the development is not as rapid as a hospital owned by a corporation. Besides, governance-wise, the structure of the organization is far from ideal, since the owner at the same time can serve as the manager and the operator of services.

Corporate ownership

The most recent development of non-state hospitals is their status as corporations. In this legal status, there are two types of hospitals: a solitary hospital and a chain hospital. Examples of solitary hospitals are Happyland Hospital in Jogjakarta and Prima Medika Hospital in Bali. The chain hospital system is adopted by Siloam hospitals. The chain hospital system is relatively new in the development of non-state hospitals. Actually the faith-based

hospital network can be managed using the modern technique of chain organizations. However, faith-based hospital networks usually do not employ this system, although some initial stage of chain hospital development has been implemented by Muhammadiyah and Yakkum. Learning from the hospitality industry in Indonesia and also from international hospital management, it can be projected that hospitals adopting the chain system will develop faster than solitary and non-profit hospitals.