Section 4
Analysis of Key Issues and Policy Implications

This section will examine the findings in chapter 2 and 3 in terms of the implications for governance and management of non-state hospitals. The first part is concerned with the governance of private hospitals.

The second part will focus more on the behavior of the medical profession, and how it affects the non-state hospital sector in providing services and in stressing the market segmentation further. A more detailed analysis on the relationship between doctors and hospital management will be presented.

The third part of this chapter will focus more on the issues of the regulatory environment and the role of the government in creating the appropriate incentives and controls in hospital operating environment.

CHAPTER 9
The Relations Between the Ownership, Governance and the Hospital Management

Some of the key findings from the previous chapters are interesting. First, despite recent growth in the 'for profit' (Corporate*/Perseroan Terbatas /PT*) group of non-state hospitals, the group of not-for-profit hospitals is the more dominant in terms of numbers of hospitals and beds. It consists of mainly those in the form of networks to religious institutions and also some individually-owned smaller charitable hospitals.

Second, these not-for-profit hospitals are facing a fundamental conflict between their charitable mission and values on which they have been founded, and of their owners, and the market forces in the operating and regulatory environment. This is creating significant financial pressures which threaten their viability and tend to drive them to take on aspects of more 'for profit' operation. These include the need to compete for clinicians to provide services in their hospitals, to compete for fee-paying patients to provide income for the clinicians and for their charitable services, and deal with the lack of government subsidy either directly or indirectly (through taxation relief) to compensate for charitable services.

Third, not-for-profit hospitals in particular also face management problems in dealing with the conflicts that arise between ownership, managers, service providers, and the community, particularly in the face of financial pressures. Moreover, some of these non-profit hospitals are branded as false non-profit institutions, whose legal status is non-profit but with the same behavior as that of for-profit ones.

9.1. The roles of the owner' values

This section addresses the issues of how the owner's values are expressed in the hospital's management and services; the issues of autonomy and accountability of hospital managers in different ownership models; and the issues of residual claimant status. Then, it will look at the implications of those issues to the non-state hospitals.

Our findings suggest that we have three types of ownership in non-state hospitals:

1. A hospital with a single owner or a group of owners who are usually also the director or part of the hospital management and/or the practicing physicians/specialists.
2. A corporation-owned hospital
3. A foundation-owned hospital, usually with religious affiliation.

Both the corporation-owned hospital and the foundation-owned hospital can be either:

a. A single model: in which a corporate/foundation only owns 1 (one) hospital.
b. A centralized model: in which a corporate/foundation owns several hospitals, and all the hospitals are managed in relatively the same manner or under the same set of policies. The guidelines, directives and decision-making authority are centralized. For instance, PERTAMINA (*Perusahaan Tambang dan Minyak Negara/*State Oil and Mining Company) owns 7 (seven) hospitals and 21 clinics and all are managed under one corporation, which is PT Pertamedika.
c. A network model: in which a corporation/foundation has several regional "branches" and each "branch" might own some hospitals within a certain region or locality. In this case, each "branch" has a different set of policies and every hospital might be managed differently; but in a way all "branches" are affiliated

with the central corporation/foundation. For instance, PELKESI (*Persekutuan Pelayanan Kristen untuk Kesehatan/*Christian Service Association for Health) is an association of independent churches which provides primary health care and clinical care. Altogether they own 22 hospitals in 5 (five) regions (a region consists of some provinces), in which each hospital is managed independently and has its own *Badan Pengurus* (Executive Board). The importance of identifying these different models of ownership lies in the different value that each model has, and how that value reflects in the hospital management behavior and what the implications are. The discussion will be focused on not-for-profit hospitals and physician-owned hospitals.

Discussion

For a hospital, there are three issues that directly related to the owner's values. One is on the entrepreneurial nature of the hospital, which addresses how the organization defines its product or service and target market. For not-for-profit organizations, this could include how broadly they conceptualize their community responsibility, which influences what services they provide, who they partner with, and who they serve. The second issue is developing an operational solution to the delivery of that particular service of the hospital. The last issue is the administrative fund structures and processes to direct and monitor operations. The primary objective is to enable effective management decisions which effectively manage resources to achieve the desired objectives. The ideal hospital has systems that ensure efficiency and reduce uncertainty while simultaneously allowing appropriate innovation. For not-for-profit hospitals, for instance, governance structures will often serve to monitor and ensure organizational consistency while watching environmental factors to consider strategic innovation opportunities and resource availability.

Firstly, we look at how the owner's values reflect how they conceptualize their community responsibility, which influences what services they provide and who they serve.

Not-for-profit hospitals in Indonesia are usually faith-based organizations. We identified the tangibly expressive ways that religion may be present in a hospital. It is concerned primarily with religion as it is expressed in observable and explicit phenomena such as language, symbols, policies, and activities. Such manifestations of religion may include mission statements, selection criteria for personnel and resources, administrative practices, programmatic activities, and service methodologies. This typology does not fully reflect the ways in which personal convictions and religious values, like mercy and justice, motivate and give deeper meaning to service work, although this is an important dimension of faith. We also noted the division of the typology into two sections: characteristics of organizations and characteristics of programs or projects. The organizational section focuses on features related to administration, personnel, sponsorship, and resources; while the program/project section focuses on the integration of religious content into service provision.

In terms of the hospital mission, the first characteristic concerns the extent to which a mission (or purpose or vision) statement uses religious language in defining the organization's identity and purpose. The mission statement can act as a screen to attract or filter out personnel and fund sources based on their identification with the expressed religious values. The mission statement may include explicitly religious language, such as references to Christ or to the Islamic principles. Religious language may also be found in other self-descriptive statements, such as the text in program brochures. Not-for-profit hospitals usually see provision of health services as a way to express their religious values

relating to giving, brotherly love, community responsibility and compassion.

On the other hand, for-profit hospitals are usually either physician-owned specialty clinics or private corporation investments with economic motivation as their main reason to exist. The development of specialty hospitals has accelerated recently, particularly as fees paid to physicians failed to keep pace with physicians' income expectations or the costs of practicing medicine. We acknowledge the fact that physicians are under many of the same financial constraints as public hospitals are. Investing in and self-referring to limited-service facilities is an appealing way to bolster incomes by supplementing structurally inadequate income they get from public hospital fees.

The different ownership model also implies differences in key aspects such as autonomy of management, provision of direction, accountability and residual claimant status.

In not-for-profit hospitals, usually there is some kind of separation between the owner and the management. The owner, i.e. *yayasan* (foundation), usually sets up a *Badan Pengurus* (Executive Board) as a representative of the respective *yayasan* and 'recruits' the hospital management team and gives them the autonomy to run the hospital. However, in a small *yayasan*, the founder of the *yayasan* is usually the director of the hospital as well.

The usual practice to ensure the conformity of the not-for-profit hospital management to its owner's values is to make a particular faith commitment as a requirement for senior staff. This could mean adherence to a set of beliefs, membership in a particular denomination, and/or demonstration of a lifestyle consistent with the agency's religious convictions. In non-managerial positions, they often share the faith, but this may not be an explicit requirement. As for religious practice, typically the staff, volunteers and/or board

members participate together in organized religious practices (not involving clients) such as prayer, chapel services, or other religious routine. Such activities may play a significant role in how the organization makes decisions (e.g., prayer at meetings), cultivates staff unity and morale, and explicates the relationship of faith to service.

Notably, another way for the owner to ensure that the hospital management reflects their values is to give some guidelines about the general policy for the hospital management. However, the hospital management usually has some autonomy for establishing and making decisions on the human resource management system (including policies on recruiting and retaining staff), the operational management and the clinical services (including recruiting health workers and designing how services are delivered). These guidelines are not necessarily in the form of a strategic plan. More often, it is the responsibility of the hospital management to develop and present the hospital strategic plan to the *Badan Pengurus*. While in the case where the owner and the management are the same, the guidelines and strategic direction for the hospital are embedded in the persons themselves. They rarely feel the need to have a written strategic plan.

Presumably, there is some kind of accountability mechanism of the hospital management to their *Badan Pengurus*. The most common way to do this is through evidences of prudent use of resources, such as assets, margin, and operating expense per discharge. It also might include other performance indicators as set out in the strategic plan.

In a single owner (or a simple *yayasan*-owned) hospital, usually the owner (or the founder of the yayasan) also is the director of the hospital, thus s/he has the full autonomy over the hospital management, and thus such accountability measures might be less rigid. In some cases, s/he even is a practicing physician/specialist in

that hospital. The multiple roles of physicians needs to be discussed further but suffice it to say at this point that the lack of distinction between the owner and the manager might lead to conflict of interest and other problems, in particular in a situation where the hospital has developed further into a bigger facility and provides more complex services.

Secondly, as we argued earlier, the values of the owner are also reflected in how the hospital selects its target market. The target market for not-for-profit hospitals is usually embedded in their charity mission, which first and foremost is to provide care to the poor community. On the other hand, our finding reinforces that specialty-hospitals (usually owned by individual or a group of physicians) engage in selection of favorable cases. Physician-owners of specialty hospitals are more likely treat low-acuity cases, or treat patients who are less severe. They also treat higher percentages of patients with generous insurance coverage or with stronger purchasing power through a self-referral mechanism.

This "cream skimming" practice is also seen in the lower numbers of Public Health Insurance (*Jaminan Kesehatan Masyarakat/Jamkesmas*) patients treated by specialty hospitals. Specialty hospitals typically do not maintain fully staffed, round-the-clock emergency departments whilst emergency departments are often the gateway to health care for *Jamkesmas* and uninsured patients, who generally have higher-acuity conditions. The absence of emergency services, then, is a passive but effective way to ensure favorable medical and economic patient selection.

Given the prominent role that hospital location could be expected to play in hospital choice, it would be reasonable to expect that the socio-demographic characteristics of the patients admitted to physician-owned and non-physician-owned specialty hospitals would reflect the socio-demographics of the neighborhoods in which

these hospitals are located, and it is another means of 'cream-skimming'.

In terms of decision making for financial management, both not-for-profit hospitals and physician-owned hospitals might have some restrictions from their owner in decision over assets, namely selling existing assets and/or acquiring new assets. In general, it is quite difficult for them to raise new capital to invest in medical technology, equipment, and facilities to support changes in medical practice, as reflected in the description of these hospitals in the case studies.

Another phenomenon occurs in the financial issues of not-for-profit hospitals. These not-for-profit hospitals are facing a fundamental conflict between the charitable mission and values on which they were founded and their owners lack of resources to provide funding for charitable services. For instance, there is little evidence that the owner has a systematic approach to finance their charitable hospital service through fund-raising events. What is more, there is less giving of funds for charity on a grand scale. Donations to hospital today come from a fairly wide range of the social scale, and many small donations have appeared in place of the few enormous ones. Proportionally, however, donations have come to account for a steadily declining percentage of total hospital income.

Hospitals cannot always adhere to their charity mission to serve the poor when they are not financially viable institutions. This is the crux of the problem in not-for-profit hospitals today: how can they continue to provide health care when charity and mercy must be replaced with bottom-line profits? This raises the issue of how 'not-for-profit' is defined[1]. Should 'not for profit' be defined on the

[1] Schlesinger M, Gray BH. How not for profits matter in American medicine and what to do about it ? *Health Affairs* 25 (2006): w287-w303

basis of 'ownership' (a not-for-profit owner), or on the basis of services provided?

This tendency is not specific to Indonesia. Literature suggests that organizations must be able to compete with "like" organizations, so they need to be equal in the marketplace. They refer to this phenomenon as *isomorphism,* which means that organizations will imitate other organizations in their environment when they face the same set of environmental pressures. The evolutionary pattern of hospitals confirms that organizations compete not only for market position and niche but sometimes also for political power, institutional legitimacy, and social and economic fitness. Whereas hospitals once were charitable organizations for the sick and injured, they have gradually adopted the characteristics of businesses. Hence, for-profit and non-profit hospitals exhibit similar attributes and espouse similar missions and goals[2].

However, the situation is worse in Indonesia for two reasons. One, as we mentioned in the previous chapters, the government does not provide subsidy or grant anymore to not-for-profit hospitals. There is also no tax exemption status given to not-for-profit hospitals, unlike in other countries. For not-for-profit hospitals, all incentives come from the opportunities to earn revenue, thus the incentives to behave commercially are relatively strong. This drives not-for-profit hospitals to complete exposure to a market to earn more revenue.

In addition, there is an indication that some of the owners no longer perceive hospitals as their charitable services unit, but rather see them as income generating. For instance, in one of the meetings with not-for-profit hospital directors, some of them indicated that although it was not admitted openly, the owner (in this case, their

[2] Raymon Dart. 2004. Being "Business-Like" in a Nonprofit Organization: AGrounded and Inductive Typology. *Nonprofit and Voluntary Sector Quaterly*, 33. 290-310

respective *yayasan*) expects the hospital to be one of the sources of income for the *yayasan*. This contradicts the very definition of their supposedly not-for-profit characteristic of the hospital. The distinction between for profit and the not-for-profit organizations essentially lies in the residual claimant status: charitable organizations reinvest excess revenues in the organizations, whereas investor-owned organizations share the excess revenues with their investors. Thus, not-for-profit hospitals should be able to retain all of their surpluses to invest back in the provision of services. In contrast, for-profit hospitals usually have to pay dividends or other forms of capital charges to owners.

Also, this betrays the nature of relationship between the owner and the hospital in terms of flow of fund: instead of the positive capital investment flow of fund from the *yayasan* to the hospital, the complete opposite is happening. To meet the expectation of their owner, i.e. the claim over the 'residual' or surpluses, not-for-profit hospital managers have to behave commercially, i.e. seeking a larger margin and even secure a portion of 'profit' from being taxable. Consequently, some of these not-for-profit hospitals have two sets of bookkeeping. As this is a serious breach of ethical conduct, one needs to question whether the hospital management needs to have a better accountability and transparency mechanism in place, in particular not only to the owner but also to the community and the government[3].

Implications

If not-for-profit hospitals are to survive the uncertainty and radical changes that are occurring in the architecture of health care delivery, more resources must be invested in the services they deliver in order to clarify the ways in which they are distinctive. How can a

[3] Survey of Tax Laws affecting Non governmental Organization. 2nd edition. 2003. International Center for Not-for-Profit Law.

charitable identity be quantified, measured, and distinguished from other ownership types? Does the presence or absence of certain services make an organization 'not-for-profit'? Is there something distinctive about not-for-profit services that results in perceptibly different patient outcomes? Is there something that the owner should do? Is there any policy that should be aimed to support these charitable services?

In other countries, not-for-profit institutions are entitled to tax exemption[4]. In order to earn that privilege, they need to provide evidence that they are consistently providing charitable services and community benefit, and that their books are audited by an independent auditor. While the mission statement of not-for-profit hospitals usually states that the hospital serves the poor community as part of their charitable service, there is not yet any definition at an operational level on what are 'charitable services' and what 'community benefit' consists of, and what is best to measure these.

If not-for-profit and for-profit hospitals behave in similar ways, and provide similar services, there is no justification for treating them differently in terms of regulation or government subsidy (e.g. tax relief). However Schlesinger and Gray[72] argue that 'ownership related differences in accessibility, quality, and trustworthiness' persist even in the American market. Whether it is also applicable in Indonesia remains to be seen. (So far, other research suggests that to lay people and patients in Indonesia there is no significant difference whether a hospital is for-profit or not-for-profit.)

In any case, the implication is that efforts need to be made by several parties to clarify and maintain the role of not-for-profit hospitals. The government should clearly define what a not-for-profit

[4] Dehne A, Friedrich P, Nam CW, Parsche R. Taxation of Nonprofit Associations in an International Comparison : a research note. *Nonprofit and Voluntary Sector Quarterly,* Volume 37 Number 4 December 2008. 709-729

hospital is and what kind of services they are expected to provide, as well as policy on any privileges and government subsidies or tax relief that might be available. Meanwhile, not-for-profit hospitals need to ensure that they are delivering these services and complying with their mission as a charitable institution. Before such privileges are given through a government policy, not-for-profit hospitals need to make efforts to show greater transparency, accountability and trustworthiness.

This is an opportunity for not-for-profit hospital institutions to play a bigger role as partners to the government in the policy-making process. The various not-for-profit hospital institutions should discuss and agree on a set of 'rules of the games' for not-for-profit hospitals and avoid further commercialism of their services. This also might include encouraging the owners i.e. *yayasan* to develop a more systematic way of fund-raising to finance charitable services delivered at their clinics and hospitals.

However, at the moment, one of the convenient ways out is converting a not-for-profit hospital to a for-profit one. Converting its legal status may be a natural adaptation to existing government policies and the market environment in which not-for-profit hospitals operate. The motivations for conversions are more difficult to summarize. They can be strategic (resulting from organizational efforts to gain a strategic advantage) or the result of a consolidation. Strategic conversions of not-for-profit hospitals to have a for-profit status might be undertaken to gain access to capital markets. Another potential motive for such conversion is an attempt to establish property rights to hospital profits. To overcome the legal prohibition against distributing profits, not-for-profit hospitals with sufficiently high profits might convert to be able to distribute profits to the owners.

RSB (Maternity Hospital) Bunda, for instance, was previously owned by Yayasan Bunda. In 1976, they had converted from a small

individual- and *yayasan*-owned hospital into a corporate hospital by shifting its asset. They also improved their facility from a maternity clinic to a maternity hospital. However, prior to 1992 the government insisted that all private hospitals should be managed/operated by a foundation, so they maintained their legal status and only 'froze' Yayasan Bunda's activities. But in 1992 Yayasan Bunda was dissolved, and PT Bundamedik was officially established, although in reality PT Bundamedik had been running the hospital since 1988. For PT Bundamedik, it seems that changes in their legal and regulatory environment, as well as in the nature of market competition have made it more conducive for them to survive and flourish further as a corporate rather than as a yayasan. They formed a Bunda Indonesia Hospital Alliance with other hospitals and were able to benefit from shared learning experiences of the maternity hospital members of the Alliance. As their legal status has changed, they are entering a different realm of business practices, adapting to more contemporary management principles, being subject to a different set of government regulations and having the relative flexibility to seek loan and investment. As a result, PT Bundamedik has managed to build 3 (three) new maternity hospitals and clinics.

This shows that, to some, converting to a for-profit form might be the only solution for survival. In particular, this option might be suitable for *yayasan* with no religious affiliation.

One might have concern over the diminishing services to the poor should most of not-for-profit hospitals convert to for-profit ones. However, there is little evidence in the literature about whether these conversions harm the services to the poor community, which supposedly makes up the biggest portion of not-for-profit target market. In order to verify this, further quantitative research needs to be done to accurately measure how much a not-for-profit hospital provides charitable services and community benefits especially to the poor, and how much of that would be gone if the

hospital converted to a for-profit hospital. In theory, as long as the government provides financial protection to the poor either directly or through the providers, the poor could go to any hospital and could still access health care. In the long run, when the government has fully implemented universal coverage as mandated in the National Social Security Act of 2004 this might not even be a problem.

9.2. Management issues

This section discusses some demands for hospital management and issues surrounding those demands in particular among not-for-profit hospitals and physician- or group-of-physicians-owned hospitals, and their implications.

Discussion

In its simplest definition, the modern hospital, whether it is a public or private one, is a special kind of public utility that uses multi-professions and relatively advanced technology to provide services to all the people. In addition to its high investment nature, it is also seen to be an expression of humanitarian concern, and service in its cause to elevate the social position of the individual. The larger hospitals serve many functions and combine the prestige of big business and scientific endeavor with that of the humanitarian arts.

Demand for hospital services is usually unplanned for, unwanted, and frequently bitterly resented as evidence of waning physical condition. Hospitals deal with people who are involved in crisis situations. The patient and the hospital employee are caught in a relationship which cannot be routinized. Emotional stress arising from acute human need, gratitude, worry, and, occasionally, personal outrage may influence behavior and understanding. The economic aspect of patient care is thus piled on top of a sometimes turbulent mass of feelings. This combination of factors brings about social

expectations which are so extreme as to be somewhat difficult for the individual institution to realize. The demand on the hospital management is thus far more complex than that to the other sectors.

Both not-for-profit hospitals and for-profit hospitals are operating in a similar environment. It means that not-for-profit hospitals are also dealing with market forces and competition. In urban areas, competition between not-for-profit and for-profit hospitals is intensifying, as for-profit hospitals seek market share in which service provision is profitable and as not-for-profit hospitals increase their fee-for-service activities in an attempt to diversify revenue sources. This creates significant financial pressures which threaten their viability, and tend to drive them to take on aspects of more 'for profit' operation practices. These include the need to compete for clinicians to provide services in not-for-profit hospitals by providing attractive incentive; to compete for fee-paying patients to raise income for the clinicians and enable them to continue providing charitable services and to generate income for their owners.

At the same time, many not-for-profit hospitals and single-physician-owned or group-of-physicians-owned hospitals face financial and human resources constraints that limit their ability to offer complex, large-scale programs as cheaply and efficiently as for-profit hospitals do. Our findings suggest that there are 3 (three) main areas of resource deficiency that are particularly relevant to not-for-profit and single-owner or group-of-physician-owned hospitals: (a) the lack of large-scale information technology and management experience, (b) the inability to absorb risk and raise capital, and (c) the difficulty in recruiting and retaining the very best management talent.

For one, most of the owners/managers are also practicing clinicians and presumably have little interest in the management as they are more likely involved in their clinical roles. By definition,

participation reduces the amount of time physicians have to devote to their practices and, thus, their income. Bureaucracy and paperwork are also seems to be dissatisfying to many physicians.

Only very few physician-owned hospitals actually made use of professional managers to operate their hospitals. Even in the case when they did want to hire a group of professional managers, they were reluctant to invest in management training for these new managers. Lastly, arguably these organizations are more prone to corruption/nepotism/favoritism practices. The employer-employee relationship is paternalistic, benevolent for the most part, but as with paternalism elsewhere the benevolence is sometimes lost sight of.

An extra problem due to lack of separation of owner and the management is succession. It is quite difficult for the owner/manager to hand over the hospital to his successor when the time comes, in particular when the owner/manager does not have any children who is a doctor (as the Hospital Act only allows a doctor to become a hospital director) or has an interest in managing a hospital. Assuming that the owner would like to retain some sort of control over the hospital, the owner needs to find a way or develop a system to recruit a successor that is not only capable of managing the hospital but also shares their values and can be kept within an arm's length.

Another problem that was mentioned in one of the case studies is simple or traditional management practices that include what might be termed a family-oriented management approach. In this case, most of the issues and conflicts were discussed and decided on an ad-hoc basis, without any written system of procedures and rules. This resulted in conflict that could be attributed to poor communication, but, in turn, it led to repeated conflicts which had to be resolved in court.

Traditional management practices also imply lack information on cost structure which in turn leads to inefficiency. In

addition, traditional management neither relies on nor invests in information systems and technology, which might be due to unavailable resource and skills, or the tradition of unstructured decision-making process.

One of the recurring problems that were reflected in many of our case studies is the lack of collective leadership. Especially in model where the owner is also the manager of the hospital, the decision making tends to rely on one person, i.e. the owner/manager. Size is an important variable influencing organizational culture and leadership, and the number of different elements that must be addressed simultaneously in an organization tends to be more complex as the size increases. Ideally, the optimal structure of a small-sized organization is more informal, and decision-making authority is often shared among the organization members. The decision-making authority of a large organization, on the other hand, is decentralized but more formal, and although it is dispersed to lower levels of the hierarchy, strict rules and regulations guide behavior. However our findings suggest that decision-making authority is very much informal and not shared, despite the size of the hospital.

Our findings show that among the physician-owned or small *yayasan*-owned hospital there was very limited delegation to middle managers or there was even no team structure where the owner/director would share decision-making authority to the vice directors. This created a bottleneck in decision making and might affect the effectiveness and efficiency of the hospital operation. This is one of the most prominent weaknesses in a single-physician- or group-of- physicians-owned hospital.

Furthermore, for-profit hospitals may have disposable resources at hand to enable them to lobby, which is often necessary to business negotiation. We found that lobbying and advocacy is not the strongest point of not-for-profit hospitals in Indonesia. As we

argued earlier, the changes in resources available to not-for-profit hospitals put significant pressures on them to behave in a more commercial manner, while at the same time they have less bargaining power to advocate for more supportive policies from the government or negotiate with third-party payers (insurances). Not-for-profit hospitals also have little, if any, experience in raising funds from the community, donor, or even their owners.

Meanwhile, both not-for-profit and for-profit hospital also need to be accountable to their owners and their customers (in a sense that they need to meet quality standards). If harsh measures are a way to meet performance goals more efficiently, then the espoused commitments of many not-for-profits place them at a clear disadvantage. In defining quality service, for instance, the provision of high *quality* services that are *accessible* regardless of an individual's ability to pay would be the concern of not-for-profit hospitals. For a for-profit hospital, pursuing the most advanced technology to portray a perceived quality service with a premium charge or selective attention to selected clients usually does not clearly challenge espoused values, which is clearly not the case for not-for-profit hospitals. In addition, not-for-profit hospitals would be less likely to let go their staff, or choose not to serve a certain socioeconomic group of patients, even for the sake of efficiency.

The last but not least problem is what some might label a "triple-dip": physician-owners are paid for (a) performing the procedure, (b) receive a share of the facility profits, and (c) benefit as the value of their investments increases.

Implication

There are at least two parties that need to take action to address the above problems. First, there should be a regulation in place to limit the conduct of physician-owned hospitals. However,

the government should determine what is feasible to be regulated and monitored and how it should be regulated and monitored.

On the other hand, we suggest non-state hospitals to adopt more contemporary management practices. According to modern management principles, which is now a common practice in other countries, a hospital should have a governing authority. This separates the owner and the management. The governing authority then should appoint a board of directors who is responsible for the performance of all functions of the institution and is accountable to the governing authority. The chief executive, as the head of the organization, is responsible for all functions, including the medical staff, nursing division, patient support services, technical support, and general services support, which will be necessary to assure the quality of patient care. It also includes requirements to recruit professional and qualified staff, provide a system for monitoring performance, and provide appropriate incentive enough to motivate them.

Another important feature of modern management practices is delegation and collective leadership. Generally, the chief executive attends board meetings in order to communicate ideas, thoughts, and policies that will support the hospital. The chief executive assigns the responsibility to prepare annual budgets to the chief financial officer, the director of nurses, and the assistant administrator. The budgets will then be presented by the chief executive and be approved or changed by the board of trustees. This process includes identifying services that need to be offered as well as equipment that needs to be purchased, negotiated reimbursement rates with third-party insurance plans, and monthly financial statements and statistical data to present to the board.

In addition, they should act in partnership with physicians and with other health-care personnel in the institution. Under the best circumstances, the hospital management has a mutual

understanding with, respect for, and trust in members of the medical staff. Communication is the key in modern management practices. Successful hospital management must be effective in keeping their medical staff members informed about organizational changes, board policies, and decisions that affect them and their patients. Hospital medical staffs, though ultimately answerable to the board and its management, are also self-governing and have their own bylaws.

Naturally, tensions would arise between the medical staff and the administration from time to time. Therefore, there must be a conflict-resolution system in place, and the hospital management must communicate effectively with the medical staff if. Ideally, the chief executive should attend the monthly medical staff meeting in order to foster effective communications.

As we have seen in a.1, values (or, in some cases, conflict of values) determined the hospital behavior in providing service and selecting target market, as well adapting to its regulatory and operational environment. We also have seen in a.2 that the lack of separation of owner and management led to some management issues. This brings us to the last part of this chapter, namely the governance structure.

9.3. Governance Structure

As we argued earlier, there is a third issue in which the values of the owner should define the structures and processes to direct and monitor operations. In this instance, the governing board will often serve to monitor and ensure organizational consistency with the owner's values, mission and vision, while at the same time they have to watch the environmental factors to consider strategic innovation opportunities and resource availability. This section attempts to discuss the issues around governance structure of non-state hospitals.

Discussion

Hospital governance can be defined as the process of steering the overall functioning and effective performance of a hospital, by defining the hospital's mission, setting its objectives, and supporting and monitoring their realization at the operational level. According to Jakab, Preker, Harding and Hawkins[5] "good governance" exists when managers closely pursue the owners' objectives, provided that these objectives are ethical and consistent with the vision and mission.

The Hospital Act of 2009 in Clause 36 has set out that each hospital should be operated according to good corporate governance and good clinical governance principles. In the appendix to the Act, explanation of Clause 36 states that corporate governance is defined as a hospital management system which is based on the principles of transparency, accountability, independency and responsibility, as well as equity and acceptability. This is reflected in the hospital bylaws.

The regulation on hospital bylaws has been enacted earlier in *Kepmenkes (Keputusan Menteri Kesehatan/*Health Minister's Decree) No. 722/SK /Menkes/VI/2002, which states that a hospital should have internal regulations regarding medical services, human resources, hospital administration and management. These regulations might include regulations on patient regulate, patient rights and duties, doctor' and hospital rights and duties, informed consent, medical record, *visum et repertum*, confidentiality, occupational health and safety, and management of contract. The regulations themselves can be in the forms of Hospital Standard Operating Procedures (SOP), Decrees, Information, Standing Orders or Memorandums of Understanding (MOU).

[5] Prekker A.S., Liu, X., Veenyi, E.V., Baris. E. 2007. *Public Ends Private Means: strategic purchasing of health services*. The World Bank, Washington DC.

On the other hand, the clinical governance has been later enacted in *Kepmenkes (Keputusan Menteri Kesehatan/*Health Minister's Decree) No. 631/SK/Menkes/ IV/2005. Clinical governance is defined as the practice of clinical management which include clinical leadership, clinical audit, clinical data, evidence-based clinical risk assessment, performance improvement, mechanism for monitoring clinical-care performance, complaint-handling management, professional development and hospital accreditation.

Hospital Act of 2009 further sets out that each hospital should have its own *Dewan Pengawas* (Supervisory Body) that oversees the hospital management to ensure that the hospital behaves in such a way that reflects the owner's values, complying to its mission and vision and strategic directive, ensuring quality and patient safety, being accountable, and so on. *Dewan Pengawas* is an independent body, responsible to the owner, and is formed by the owner. In its member composition[100], *Dewan Pengawa*s should consist of the owner's representatives, the professional association, the community, and the hospital association.

In the Indonesian context at the moment, such governing boards are rare. The usual patterns are (a) a separate owners and a sole hospital manager form a contractual relationship but relatively unclear in terms of the respective roles; (b) the owner and the managers are the same person..

In the event of a separate owner and management, not-for-profit hospitals might have something that is called *Badan Pengurus* or something similar. However, little is known about the key configurations of these governing bodies in terms of the structure and composition (who), their role (what) and their functioning (how). Literature suggests that placing physicians on the board could convey an image of physician control, as well as the pursuit of community service and quality of care.

We have argued that a lot of problems and issues around the not-for-profit hospital suggest that Badan Pengurus might not be functioning as it supposed to. At best there is limited and merely a basic/simple overseeing role which *Badan Pengurus* played. This might be due to the lack of understanding of the roles and functions of *Badan Pengurus*, in particular the 'know-how'. We do know that in selecting the composition of *Badan Pengurus* members, an explicitly-religious board is created either by the inclusion of religious criteria in the guidelines for board member eligibility (such as membership in a particular denomination) or by the direct selection of board members by a religious entity.

In sum, our findings indicate that there are a lack of shared mission and vision as well as strategic directives and objectives from the owner, a lack of fully-functioning governing bodies or a complete absence of governing body (when the owner and the manager are the same) and a lack of clarity of the roles of the governing body.

Implication

We suggest that non-state hospitals review their governance structure, not only their documents of hospital governance and clinical governance. In particular, we recommend separation between the owner and the management.

Compliance to the clause on *Dewan Pengurus* as stated in the Hospital Act would be the first step. The next would be ensuring that the owner has clear and non-conflicting objectives that are translated into specific, clear and measurable criteria for management performance. However, they need to establish a system not only to monitor the management performance but also to motivate them.

Then they would need to set up a supervisory structure which has clear responsibilities and accountabilities. It involves (a) the formal and legal responsibility for controlling the hospital and

assuring the owner and the community that the hospital works properly, (b) overseeing that the hospital acts in a fiscally responsible manner, (c) appointing and removing members of the medical staff, and (d) appointing a capable chief executive officer. They should also help to set hospital policies. These policies are general written statements or understandings that guide or channel the thinking and action of the medical staff and the administrator in decision making.

The governing board should operate under the bylaws of the hospital. The bylaws should spell out how a hospital board operates to attain its objectives. Literature indicates that typical bylaws include a statement on the hospital's purpose and the responsibilities of the board and a statement of authority for the board to appoint the administrator and the medical staff.

Additionally, bylaws should outline how board members are appointed and for what period. Literature suggests that board terms vary considerably, but the average term of membership is slightly above 3 years with a majority of hospitals stipulating no limit on the number of consecutive terms a board member may serve. Most bylaws indicate an elaborate committee structure. It is through these board-of-trustees committees that the governing board usually accomplishes its goals. Ideally, hospital boards should meet from 10 to 12 times a year, usually on a monthly basis to ensure the ongoing effective communication.

Since new patient demands, budgetary constraints and increased competition set the tone at the Indonesian non-state hospital scene, hospital governance will remain subject to increasing public interest. Hospital governance should embody both entrepreneurial dynamism and societal legitimacy. The challenge is to achieve a "fit" between the changing context of health care and the key configurations of these governing bodies: structure and composition (who), role (what) and functioning (how).

Organizational behavior suggests that organizations are inextricably tied to their environments, and that structure and behavior in organizations can be explained through an examination of the linkages that exist between organizations and the environments in which they operate. On the other hand, organizations are created by and reflect the development and elaboration of institutional roles and beliefs that are independent of structural or relational complexities and technical efficiencies.

Institutional theories emphasize that the survival of organizations depends on their conformity to these externally enclosed requirements and that "institutionalization" promotes stability and conformity in organizations as they seek to maintain legitimacy in the eyes of important external actors (e.g., the community, the state). In this context, governance and governing boards in hospitals serve a key role in linking the organization to important segments of its external environment. Whether or not boards engage in active management or policymaking in hospitals, their existence and structure show the community that hospitals are indeed conforming to what society believes is the best way to organize health-care services.

CHAPTER 10
Medical Profession in a Mixed Public-Private System

Understanding provider behavior is one of the keys to identifying the reason why there is a shortage of medical specialists in state and non-state hospitals in many regions as described in Section 2. This provider-behavior analysis may describe the reasons for physicians' ownership in many non-state hospitals. One issue that is often viewed in the context of the provider's behavior is a phenomenon of dual-practice[6]. The possibility for a doctor to work in multiple practice local very large. The main reason is the shortage of doctors serving the society. The ratio of doctor to population is still very unbalanced, especially in developing countries. If it is reviewed, at the level of specialists, the ratio becomes even more problematic. This situation encourages doctors to serve more patients in the wider society living in different areas.

In some cases, moreover, dual-practice develops even further, in which doctors become hospital owners. Many reports describe a doctor's role in relation with patients, hospitals and organizations of health insurance. According to Liu and Mills, provider behavior which is often highlighted is a doctor's behavior in making clinical decisions[52]. A clinical decision is a decision taken by a doctor at the stages of diagnosis, treatment, and post-treatment. However this clinical-decision making can be influenced by various factors. For example, it can be influenced by the dual practice based on the place of service, the target patients served, and the preferred method of payment. Furthermore, a doctor who is at the same time a hospital owner can influence clinical-decision making based on profit or hospital needs for survival and growth, not the patient's need.

[6] Jan S, Bian Y, Jumpa M, Meng Q, Nyazema N, Prakongsai P, Mills A. 2005. Dual job holding by public sector health professionals in highly resource-constrained settings: problem of solution? *WHO Bulletin* Volume 83, Number 10, October 2005, 721–800

There is a danger of collected of issues when doctors as also clinicians acts as hospital owners. Doctors have more detailed information compared to the one parties. If there are problems in the management of the doctors' information, then, the relationship within the system will surely become unbalanced and damaged. The damage frequently found is doctors' excessive action (supplier-induced demand), or inefficiency in the implementation of a medical procedure, or the unavailability of doctors in the health service system. This will be discussion more detail through agency relationship in hospitals.

This section will start with exploration of doctors' motivation to work, which will use many psychological and economic analysis. Then, the economic behaviour in the context of income maximisation will be explored further. At the end, the agency relationship will be discussed.

10.1. Doctors' Motivation to Work

An understanding of provider behavior is always associated with economic aspects, more precisely, ncentive[52]. The behavior observed becomes more focused on the production activities of a doctor. Doctors' motivation to work as a professional is associated with the motivation of services they provide. For that, it is necessary to understand the theory of motivation which is practically relevant to provider behavior. This section discusses Expectancy Theory by Porter and Lawler and the theory of Hygiene Motivation by Herzberg[7]. These theories have enormous power in their ability to explain various field phenomena related to provider behavior. The

[7] Steers RM, Porter LW, Bigley GA. 1996. *Motivation and Leadership at Work*. Mc Graw Hill International Edition, Singapore.

field findings, from a variety of research, can be explained systematically by using the framework of the two theories.

Porter and Lawler's Expectancy Theory[73]. This theory states that a person's effort and performance are not always related directly in the form of a definite cause and effect. Many factors influence individual performance, such as motivation and expectation on the effort done. The adaptation of these theories is very useful in observing doctors' behavior and the reason underlying such behavior. The following description is an attempt to apply these theories in explaining some phenomena associated with provider behavior.

A doctor has maintained his own values when he has finished his education. As a doctor, he has started to set his professional price since the beginning of his medical education. A doctor candidate who is still finishing his education has been thinking about a future career that will be pursued and begin to consider the type of specialization taken as a continuation of his education in the future. Preferred type of specialization is closely related to the professional expected value[52].

Prospective doctors actually have several specialist options at the moment their medical education is in progress. References used in connection with the professional values are their seniors' experience and actual information from the field regularly received during their education. Most medical students are trained in medical schools and teaching hospitals in big cities. Their training experience is limited in understanding the hard life in the remote areas. Their lecturers and professors are seen as successful specialists with the attributes of modern symbols of success, such as big houses, cars, extensive social network, and upper class life style. Moreover, the dual practice and hospital ownership become a strong context on medical students' residency training. These become the values of a successful doctor's life style. The relationship between the value of

appreciation and satisfaction is influenced by many internal factors. The reward system is one of the factors that affects performance, as shown in the figure of Porter and Lawler's model on work motivation.

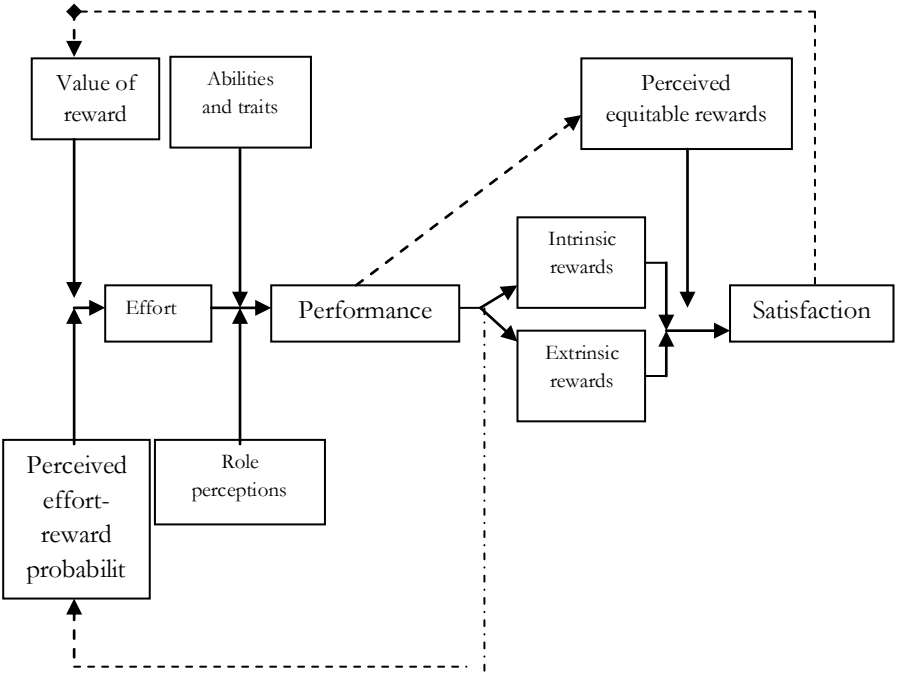

Figure 10. 1 The Porter-Lawler model of work motivation[73]

As doctor are preparing to enter the working world, they, then, consider finding a place that has the greatest possibility to give the reward in accordance with the values they have set. If the doctor sets a high economic value he will find a place with a high economic capability, or a place where there is a little competition to increase the chance of getting a big reward.

By the time the opportunity to work has been accomplished, then, the doctors will try hard to be professionals. This is related to their expectation to get the reward establish above. The doctors will

work with high capability and maximum professional standards. All these will lead to their performance which will be assessed by patients, colleagues, teammates, and the hospital management. If the performance carried out is as expected, then, they are entitled to an appropriate reward. They will feel satisfied with such a reward.

But in a dynamic economic situation and in the development of doctor satisfaction, the value of rewards changes, growing along with needs that should be met. Therefore, the reward value they set also moves up. If the reward given to them grows as they expect, they feel satisfied. But if the reward value does not move up, they tend to feel dissatisfied and are ready to seek a greater appreciation elsewhere.

This theory explains why doctors tend to work in areas with high economic capacity as described in Chapter 4. In accordance with the value of rewards, doctors will not seek organizations or areas which do not have the ability to pay in accordance with the limit they set before. Doctors tend to seek organizations or areas which are willing to give them the best rewards and opportunity to prosper, in relatively shorter period of time. Doctors seek the greatest opportunity to meet the value of the reward they have built since the time of education. Such opportunity can be found in areas with particular economic capacity or in areas which need their capability so that the doctors may carry out their practice without competition.

Herzberg's Motivation Theory[8]. The explanation of this theory is more easily done by looking at the illustration of the following cases.

Various studies conducted by graduate students at the Hospital Management Graduate Program, Faculty of Medicine, Gadjah Mada University, illustrate that doctors do not work as a medical professional solely for money.

[8] Nicholson S, Souleles NS. 2002. Physician Income Expectation and Specialty Choice. *Working Paper* 8536. National Bureau of Economic Research. Cambridge.

Bukit, Trisnantoro, and Meliala[9] found out that doctors who worked in South Bengkulu, Bengkulu Province, Indonesia, were not interested in money, additional incentives, or special incentives. Doctors in this district tended to leave the job when the mandatory duty has ended. The reason revealed was the unavailability of patients served as well as shortage in facilities for conducting clinical practice with the optimum professional standards.

Research conducted by Napitupulu, Meiyanto, and Meliala illustrates that the total revenue earned by doctors in Abepura City, Papua Province, was 10 times the basic salary of a government employee. Other facilities provided by the government were an official house and a car for each doctor to ensure the comfort of the doctors, who were mostly from outside Papua. However, despite the huge earning and a variety of comfortable living facilities, the doctors were not willing to continue working in Papua. They left Papua in accordance with the work contract they were obliged to agree with the government. Their reason for returning to Java island was the lack of service facilities to support their professional career in Papua.

Research by Mustikowati, Trisnantoro, and Meliala[10] shows that a doctor who signed a contract to work in remote area during the period of his education, retained the motivation to cancel the contract when they completed their education and their work time began. As many as 65% specialists wanted to work in Java and Bali and were willing to pay a contract termination fee with a very high amount of money. The main reason the doctors decided to cancel the contract was the limited opportunity for professional development in the remote areas. Doctors who have completed their education did

[9] Bukit BA, Trisnantoro L, Meliala A. 2000, Kepuasan Kerja Dokter Spesialis di Rumah Sakit Umum Daerah Manna Kabupaten Bengkulu Selatan dengan Pendekatan EMIC, *Jurnal Manajemen Pelayanan Kesehatan* Vol.06/No.04.2003, Yogyakarta.

[10] Mustikowati, Trisnantoro, Meliala. 2005. Faktor-faktor yang mempengaruhi penempatan dokter spesialis ikatan dinas, *Tesis Magister Manajemen Rumah Sakit*, Sekolah Pasca Sarjana Universitas Gadjah Mada, Yogyakarta

not see any chance for a career in areas with such limited clinical facilities.

Herzberg's Motivation Theory explains that one's motivation components are divided into two parts, namely motivator and hygiene. Motivator is the core of the impetus for someone to perform a specific job. While hygiene is the part which keeps the motivator alive and develops in a person. Job is a motivator and hygiene is salary. Someone needs an encouraging job and some reward to keep the spirit staying within him. This sequence cannot be reversed because a syntax error will occur in understanding this theory.

These theories explain why many of the above cases happened to the Indonesian doctors. If put in sequence, the work is a doctor's motivator with sequential elements. The doctor needs a "challenging" case to test himself, so the doctor needs proper equipment to examine the case. Then, the doctor needs a competent team to help him handle the case. Next, the doctor needs a drug having a certain therapeutic class and adequate efficacy so that the case can be treated. Or in the case of surgery, the doctor needs the latest equipment to help overcome the patient's unique problem. Upon successfully completing the case, the doctor will be recognized as a competent and successful one. His success story will be rewarded and will increase his welfare. Reward as a doctor is a part which keeps his spirit to solve cases. The obligation to provide adequate reward, good relationship with colleagues and all teams at the hospital, as well as the comfort of life are the keepers of the motivator.

The explanation above may reveal why doctors were reluctant to work in Bengkulu, Papua, or other remote areas although they had received some payment and incentive even before working there. Doctors require cases which can sharpen their capabilities. Challenging cases will improve their image. A good image will invite

more cases to take care of. The more cases to handle, the more reward they will receive. Principally, doctors identify reward dynamic with the presence of cases and perceive the possibility of significant increase. On the other hand, the reward attached to the pre-work incentive is viewed as a static reward with limited possibility to advance their career development.

10.2. Doctors' Economic Behavior

Non-state hospitals (both for-proft or non-profit) are important sources for government medical specialists to increase the income as described in Chapter 4. A strange situation happened in various faith-based hospitals. These faith based hospitals became the vehicle for medical specialists to increase their income as high as possible by maintaining their strategic position. Some faith-based hospitals experienced a difficult and bad situation when senior specialists rejected their juniors although patients demanded more specialist. One explanation of this bad situation is the medical specialists' behavior.

For a long time experts have made a doctor's economic behavioral model through a series of empirical research. A doctor's economic behavior is interesting to observe because a doctor has an important role which determines other parties' destiny. According to Reinhardt[11], a doctor utility function is accelerated by three important factors: the annual net income, the time spent for conducting medical practice, and the possibility to create artificial demands. Those three functions were influential factors in a doctor's behavior in giving service to the customers. The models of a doctor's economic behavior that have been long discussed are utility maximization, income maximization and target income. These

[11] Uwe E. Reinhardt. 1999. The Economist's Model of Physician Behavior. *JAMA*. 1999;281(5):462-465 doi:10.1001/jama.281.5.462)

behavior models represent various economic behaviors commonly found by the researcher on the health economic field.

Utility maximization theory was developed by Feldstein and Eastaugh[12]. In this theory, a doctor's satisfaction consist sof various elements, such as the net income, leisure time, professional status, internal ethics, complexity of case mix, study time to keep up-to-date, and number of supporting staff. The theory argues that a doctor's economic behavior cannot be explained solely by putting an emphasis on income. Other issues related to achieving income and using income are important to analyze to understand a doctor's economic behavior. Therefore, a doctor's behavior must be controlled by multiple approaches (multiple countermeasures).

Income maximization theory developed by Sloan and Baumol[73] argues that income is the main factor that affects a doctor's behavior. A doctor's behavior is similar to a business person's. Everything done by a doctor will be connected to the behavior that adds income. Things which are not related to income will be neglected. Thus, to manage a doctor's behavior, a remuneration system is needed to that gives a doctor chance to make the income.

Target income theory developed by Newhouse[73] is widely accepted by health economies. This concept is a combination of utility maximation and income maximation theories. This concept proposes that a doctor has an expectation of income and has made a limit toward income to achieve, which is in accordance with peer doctors' income in the system of the same health service. If a doctor's income is under the target income, the doctor will likely tend to behave with an approach of income maximation. After achieving the target level, the doctor's behavior will be driven by other factors, such as the leisure time, professional status, internal ethics,

[12] Feldstein, PJ. 1979. *Health Care Economics*. A Wiley Medical Publication. John Wiley & Sons. New York

complexity of case mix, study time to keep up to date. A doctor will think more of the balance at the time when the target income is achieved. The chief problem in this concept is identify. The sad answer is that there is no standard for a doctor's income in Indonesia.

Based on those theories, it is clear that medical doctors can set their income as high as possible. Medical specialists' economic behavior can influence non-state hospitals, including the non-profit ones, to pay the doctors based on the income preference. In some places, the power of hospital for fee negotiation is weak. As the result there is a contradiction in hospital operation. Certain hospitals might operate in poor economic condition, but the specialists enjoy high income. This is, in fact. also related to medical specialists' culture.

Doctor's fee and how to set it

Some non-profit-hospital managers lament the problem of paying high fees to doctors, but there is no standard for doctors' fees. One of the seminar conducted by a Gadjah Mada University research group mentions that there is no limit for the fee. In some places there are standards of fees but they are decided unilateraly by medical specialists. This economic behavior become problematic, will challenges hospital growth.

Discussing a doctor's fee is inseparable from the concept of supply and demand[73]. Doctors are service providers (supply side) and community and patients are service users (demand side). Supply and demand are formed by various elements which influence each other. The aggregate of both sides will interact with the price and the number of doctors in one area. This is the perfect market. However, the reality of life does not show a perfect situation. Doctors and their associations can influence the market and set their own fee standards. Some set very high fees thought some do not.

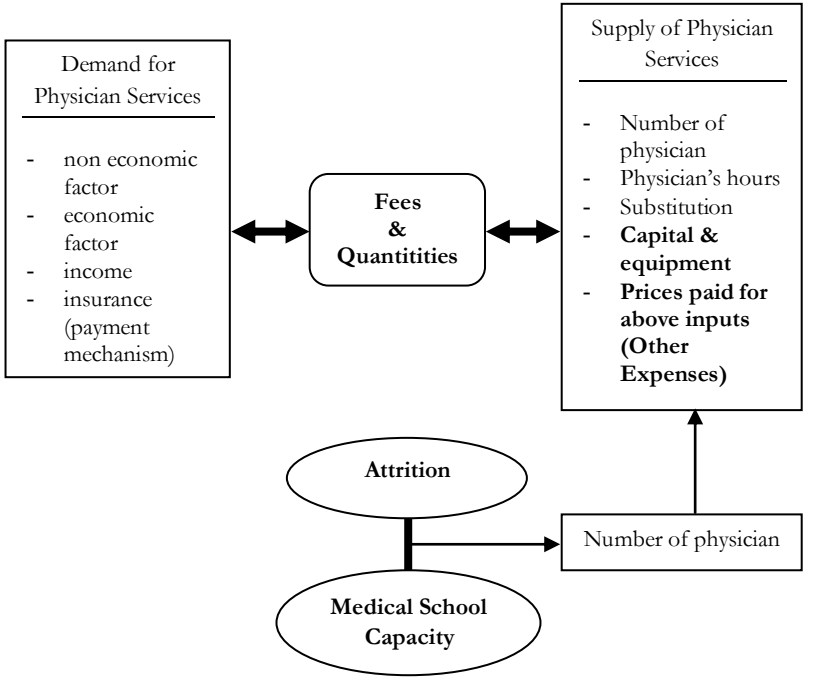

Figure 10. 2 The Market for Physician Services[73]

The biggest factors includes the fee size are doctor production and doctor migration, the supply of physician services (number of doctors, doctor's working hours, capital and equipment), and the demand for physician services (both economic and non-economic factors, income, payment mechanism). The framework in determining doctor's fees are the place and time in which these factors establish the price quality and doctor's availability.

Doctor production. Doctor production is determined by the number of universities which produce doctors and their productivity. It is interesting that in some places the university residency trainers also control the deployment of their graduates. Some university lecturers are also leaders of medical professional associations.

Therefore, they are very strong and might unintentionally act as a cartel in managing the supply of medical doctors.

Doctor migration. Another influencial factor is the doctor migration pattern. Doctors' migration dynamic is the number of doctors in particular place in a period of time or the number of doctors who leave particular area in a period of time (due to migration, retirement, or death). In remote areas of Indonesia, the dynamic of doctor migration is strong. As result, it is difficult to keep track of doctors' movement.

Supply of physician services. The supply of physician services consist of the actual number of doctors, the quantity of doctors' work hours, the capital availability, and the equipments available in one area. The actual number of doctors is a sub-component determining the supply side. The more the number of doctors, the lower the possibility for a doctor to set the fee personally. Doctors' work hours also lead to the lower possibility to set the fee personally, while substitution is a sub-component showing the existence of non-doctor service which can replace doctor service. The smaller the number of substitution services, the higher the possibility for a doctor to set the fee personally. Moreover, based on the fee-for-service principle a doctor's fee gets higher in accordance with the equipment used to support the service.

It can be interpreted that in the current Indonesian hospital sector the strongest player is medical specialist group. It is an imperfect market dominated by the supplier. Furthermore, the regulator of the market hardly exists. Monopolistic behavior in setting doctors' fee is observed in some specialties.

Demand for physican services. The demand side for physician services consists of various factors: culture, demographic characteristics, geographical characteristics, society's health seeking behavior patterns and some others. If these factors tend to suit

particular characteristics of doctors' service, doctors will have more opportunity to increase the service fee.

Doctors' fee is also determined by economic factors, such as the ability and the willingness of society to pay for medical service that doctors provide in one area. If the ability and willingness of society to pay for medical service is low, they will not pay the high price that doctors set. The ability to pay is closely related to the purchasing power, and the willingness to pay is related to quantitative matters leading someone to buy the service priced in a particular level. The society's ability and willingness are closely related to the society's gross domestic product or society's aggregate income.

The prevailing payment mechanism in one area is an important factor on the demand side. The fee-for-service principle determines a doctor's presence in a particular area and the price set to to serve the society. Doctors tend to choose the fee-for-service model because of the availability of fresh income in accordance with the price set for the patient and/or the payer.

Based on the above, in the recent years there has been a growing demand for doctors which is financed by (1) insurance/social security schemes, such as *PT Askes, Jamkesda, Jamkesmas*, and other groups of health insurance; and (2) unregulated (free) care systems. The first group of demand sets a limited fee for medical doctors service, while for the second group the fee is unlimited. It is clear that there is a big difference between these two groups of demand. State and non-state hospitals which operate in the remote and difficult area have to pay doctors mainly based on insurance schemes and government salaries. This type of demand need medical doctors who are willing to work under limited income.

Within the context of these two groups of demand, the challenge is to identify the strategic action to bring medical doctor to

remote-area hospitals. In the following, various factors which determine the number of doctors and doctors' fee that might retain doctors in particular locations, including remote areas will be presented.

Work opportunity and purchasing power. This factor refers to the opportunity to obtain additional income and to develop medical profession, such as private hospitals and the society's average economic ability to pay doctor service. *Dual-job-holding* is a phenomenon in which one worker can work in one place or more to get additional income. The more workplaces a location has,. the more attractive it is for a doctor[77]. The ability to pay and the willingness to pay are also attractive components for a doctor to work in a particular place[78]. A research by Trisnantoro[13] and Ilyas[14] shows the tendency for doctors to work in a higher economic power area. This finding strengthens the idea that work opportunity and purchasing power have a close relationship with doctor retention in one area.

Doctor migration from rural to urban areas is mostly due to economic factors. A recent research shows that 25% of doctors in America migrated from rural to urban areas because of economic demand. However, there are still doctors who did not migrate and chose to stay in rural areas. This decision was also influenced by economic factors because the market condition and regulation status had met the doctors' needs and wants[15]. The case in Indonesia shows that doctors living in an area with limited facilities and average economic power has a very strong reason to stay and work. One of the underlying reasons is the ability to persuade the decision maker not to increase the number of doctors for a particular period of time.

[13] Trisnantoro. 2001. Penyebaran Dokter Spesialis di Indonesia dalam Era Desentralisasi. Makalah Seminar. PMPK. Jogjakarta

[14] Ilyas. 2006. Determinan Distribusi Dokter Spesialis Di Kota/Kabupaten Indonesia, *Jurnal Manajemen Pelayanan Kesehatan* Vol.03/No.03.2006, Yogyakarta

[15] Rickets & Randolph. 2007. Urban Rural Flows of Phycisian. The Journal of Rural Health, vol 23, No 4 Fall 2007

The main purpose is to be the sole providers in the market of the area where they live. However, there are no convincing data to prove this assumption.

Available work facilities. Bukit, Trisnantoro, Meliala[75] argue that retention is also the result of institutional characteristics. Hospitals with sophisticated and complete facilities create high interest for doctors to work in. Although they receive high incentive, if the facilities in the work place do not suit their expectation[75], and hamper their professional development, they tend to move to another work place. Herzberg[73] motivation theory explains that doctors' motivation to work is not salary or compensation but the work or recognition. Compensation is a motivation- growing factor but not a motivation-maintaining factor. Doctors tend to choose to work in hospitals which provide opportunity for professional development than to work in hospitals with good conpensation but without advanced-technology facilities.

Compensation. A doctor's income is an influential factor in doctor retention. The income of a specialist working in one place must be set. This standard retains the specialist's presence in one area, particularly when there is hardly any attractive economic factor. Some underlying factors why an area does not have any power of attraction are the economic condition, population, geographical condition, sociocultural condition, tradition, career opportunity, available facilities, transportation and communication facilities, administration service, opportunity for training or continuing education, working period, and image of the area[77].

More evidences show that a specialist's presence in one area is greatly influenced by the economic condition of that area[73]. The regional economic potientials are often referred as Gross Domestic Product (GDP), Ability to Pay (ATP) and Willingness to Pay (WTP). If the GDB in an area is high, a doctor has more opportunities to set a higher service fee. If the opportunity to set the fee is high, there will

be more opportunity to provide medical services for more patients of different social levels. A similar phenomenon is also true with the ATP and the WTP. The higher the ATP and the WTP, the more attractive for specialists the area will be. The ATP and the WTP reflect society's flexibility to spend their money for seeking medical treatment[77].

The level of doctors' density in an area reflects the providers' competition level. The higher the density level, the tighter the competition is. Some areas provide flexibility for specialists to decide the number of doctors with whom they work. This is deemed as appreciation for them, so they decide to remain in those areas. Competition lead to the dynamic of doctors' income dynamic in a particular area[77]. One important question is whether we can have altruistic doctors in big number.

10.3. Agency Theory and Provider Behavior

The landscape of non-state hospital in Indonesia (Section 2) shows that many hospitals are owned by a doctor or a group of doctors. This raises the question on whether the dual role of medical specialist as a clinician and hospital owner is good or bad. A doctor (as a clinical service provider) acts as an agent trusted by a patient to cure a disease, or by a hospital to serve its patients. As a professional practitioner of health service, a doctor should play a central role in the hospital-patient relation. The three actors (patient, hospital, and payer) are classified as the principals, while the doctors is the agent. A doctor may become the agent of those three parties at the same time. This section discusses the agency theory in order to learn more about the dual role of doctor as a clinician and hospital owner.

The basic agency theory is proposed by Ross, Mirrlees and Stiglitz[73]. This theory provides the general framework to discuss the relationship between the provider behavior and the doctor payment mechanism. This theory assumes that the agent's satisfactory

function and the principals' in are divergent and they also trigger conflicts. Therefore, the agent is expected to behave as the principals want. The agent's incentive is given based on the efforts the agent has performed. The better quality, the more effort the agent has conducted, the higher incentive will be given. The agent is expected to serve the principals' needs and wants in order to receive sufficient remuneration. This theory helps to design the remuneration payment system for doctors which will bring direct impacts on their behavior.

This theory is implemented poorly under the condition of information asymmetry, outcome uncertainty, and dependent output. The unbalanced information owned by the agent and by the principals leads to a onflict affecting the between the agent and the principals. It is assumed that the agent will use the opportunity to provide excessive service for the principals under the motivation of obtaining higher remuneration. Through the agency theory, all of the agent's efforts should be adjusted with the principals' needs and wants. Avoiding excessive service and making efficient actions should enable the agent to get higher remuneration.

In the context of medical service, the final result cannot be guaranteed; so the best outcome of service given by the agent to principals is merely a promise. To minimize the decrease in service quality, the principals provide a particular standard for the agent as the guideline to perform the service. Standard increases the effort to improve the quality of services outcome by increasing the agent's compliance with the service standard that has been established.

Mills and Liu[75] describe the agency theory shorter and more concisely. There are two important actors in this theory: the agent and the principal. The number of principals can be more than one, depending on the mechanism of medical service performed in a hospital. A hospital's principals consist of the patients, the remunerators, and the hospital management board who hire the doctors. The principals hire agents to perform particular types of

service based on the norms, standards, and procedures the principals have established. The binding force between the agent and the principals is a work contract to pay the fee to the agent, which is called a remuneration contract. It describes the fee that the agent will receive and the prerequisites that the agent has to perform in order to receive remuneration.

A remuneration contract must be attractive for the agent to prevent him/her from finding other principals who offer higher remuneration. The agent's acceptance depends on the implicit satisfaction value. If the value of contract is too small, the agent will find other principals. If the value of contract is equal to other principals' or even higher, the agent will accept it. Arrow mentions that the agent's willingness to either accept or reject the contract can be explained with the concept of participation constraint[73].

Principals also have particular principles that the agent must understand and obey. The contract value given by the agent should be attractive and able to give the incentive for the agent if s/he performs services in accordance with the principals' expectation. The satisfaction value of both sides must be achieved and compatible with with the contract agreement. MacDonald calls this situation as incentive compatibility constraint[73].

According to Arrow, two possible conflicts in the relationship between the principals and the agent are moral hazards and adverse selection[73]. Information asymmetry in this relationship lead to the agent's stronger power than the principals'. As a matter of fact, the principals are the parties who hire the agent for a particular job. This situation triggers the agent to conduct illegal actions which violate norms and basic service guidelines that have prevailed for a long time. These illegal actions aim to increase the agent's personal benefits beyond the remuneration that that has been agreed.

Adverse selection is the principals' limited ability to assess the agent's competence before approving the contract. The professional standard that the principals use to assess the agent's competence is constructed based on common values. Therefore, the agent's true competence is concealed under these common values. Consequently, there is a possibility that the principals will hire a agent whose competence is below the principals' expectation.

Both conflicts can be solved by two ways, namely by monitoring[100] and bonding[16].. The principals can monitor the agent's overall activities by compiling information on every activity that the agent has conducted in a particular period of time and then analyzed them. This method had a weakness, namely the possibility that the principals do not understand what the agent should do in a service package[73]. As a result, the principals should conduct the monitoring by hiring peers coming from the agent's group in order that the agents' activities can be professionally justified professionally with the help of professional experts who have the same competence as the agent.

Bonding is a mechanism which regulates reward payment for the agent if s/he workes in accordance with the principals' expectation and standard. The bonding system also regulates sanctions that the agent will receive if s/he does not work in accordance with the agreement stated in the contract. However, bonding is not merely a reward and punishment mechanism but it is a more complex system. The agent is required to establish incentive for himself/herself, based on his/her interest. However, the established incentive should not exceed or violate the principals' interest. Usually, the incentive is given in the form of a compensation package. If the agent's behavior is directly connected with the

[16] Rokx C, Schieber G, Harimurti P, Tandon A, Somanathan A. 2009. Health Financing in Indonesia: a reform road map. World Bank

compensation package, the work performance will approach or even exceed the standard that the principals have established[73].

A criticism on the agency theory is its doubful ability to produce mutual satisfaction value. The peak value of the principals' satisfaction sometimes is to be the lowest value of the agent's satisfaction. Therefore, it is not easy to identify a compatible value for the two parties. Besides, the monitoring system on the process conducted by the agent, the outcome measurement and the agent's success indicator are difficult to establish, considering that the characteristic of medical service is time series and not product-based.

In the landscape of Indonesian non-state hospitals, it is common that doctors are also owners of their hospitals. This means the principals' structure breaks down. Under the information as symetry between doctors and patients, the break down of the principals' structure will change the relationship between doctors and patients. A doctor as an agent will act also as an owner. The doctor's clinical authority combined with his management authority may drive a clinical decision not based on his/her patient's need. As result, supplier-induced demand as medical doctors' negative behavior may be strengthened by hospital owners' profit maximation. This leads to inefficient use of resources provided for the service paid by the patient or the payer. Medical doctors' dual practice as a clinician and a hospital owner is not a violation of Indonesian regulations. However due to the nature of the agency theory, a tight supervision of these hospitals should be conducted by the Ministry of Health and Provincial/District Health Offices.

This theory might not be a concern for medical specialists due to their lack of awareness. Though medical specialists have a major role as agents, they do the practice without any consideration about the hazard of this role. Moreover, the health system, particularly the regulating mechanism does not have any specific measure to deal with it.

The curriculum of medical schools has rarely discussed this issue and its features. Medical school students have no understanding of being agents of three principals when they later work as practitioners, which in fact can cause an imbalance in the broader system. When they act as professional practitioners, they take the charge as agents without prior awareness. They naturally execute their role and find several benefits of being agents. They might be good agents or the opposite.

In real life, regulations do not have enough capacity for moderating the relationship between principals and agents. Agents have more information and power to influence the regulation system. On the other hand, hospitals, consumers, and payers have no choice in preferred medical specialists due to the lack of supply. Medical specialists' behavior has been identified to cause several problems in hospitals, inducing complaints from the consumers and causing inefficiency in the payment system. However, these issues have just becoming a classic unsolved story since the regulations have not made adequate intervention to address them.

The non-state hospitals gain benefits from the current circumstances. Medical specialists who have time and licenses are hired and paid to work in their organization as visiting staffs. Non-state hospitals may serve patients like the state hospitals within the same area but in different manners. Non-state hospitals can relatively control medical specialists' behavior through their internal payment mechanism. In this case, medical specialists become "different agents" for similar principals but are paid in different mechanisms and formulas. Therefore, inconsistent behavior can be identified in agents who work in both sectors.

The Indonesian Medical Act has a special clause to tackle the issue of this double-agent phenomenon. Medical practitioners may conduct a professional practice only in 3 places: a state hospital, a non-state hospital, and a private clinic. Theoretically, it will affect

their behavior since their work as agents in fewer locations. It will limit the number of places and provide more time in each practice place. The act tries to give an equal opportunity for medical specialists to work in the different sites in order to increase the opportunity to gain more patients and more earnings. However, in the current imbalance between the supply of medical specialists and the demand of the health care system, the act may be ignored due to lack of specialists to serve in particular areas. For certain specialists whose number is still low, the act may not be effective since the principals need their service at any rate. Moreover, the regulation system provides a privilege for them to work in more than 3 places.

Medical specialists in several areas are not satisfied with the facilities provided by their hospital to support their professional practice. The old-fashioned practice guideline, the out-of-date medical mechanism, and the limited types of medicine have been an issue for medical specialists working in hospitals, both state and non-state. As a reaction, medical specialists tend to set up their own clinics. With limited financial support and an inadequate management system, they set up a non-state hospital and serve the same patients they serve in their original institution (the state hospital). In this small-scale hospital, the medical specialists act as the owners, the managers, and the operators. This kind of phenomenon has been identified in several areas in Indonesia and is becoming more common. In this case, medical specialists become both the agents and principals (the hospital owners and directors) at the same time. The Indonesian Hospital Act has a special concern for this kind of multi-function role, which may lead to more damage to the health-care system. In this act, the role of owner and director should be separated in two different persons. It may take some more years to identify its effectiveness. In the other hand, the regulatory body should be more proactive to monitor this issue and take several

fundamental actions to prevent the negative effects of this phenomenon.

Basically, medical specialists' awareness as agents and the regulation system are two important factors in creating better relationship between agents and principals. Medical specialists may have no prior knowledge to take the charge as agents. They practice medicine based on their current awareness as medical professionals to serve patients. While they do their professional job, they may enjoy several benefits as agents, since information asymmetry occurs, which is taken as an opportunity. They might change their behavior and take advantage of this state of relationship. In terms of the practice site, medical specialists have an opportunity to be agents in both sectors, state and non-state hospitals, within the same area. This can be another opportunity for medical specialist to take advantage from the current situation. Medical specialists' motivation to have their own fancy clinics has been a driver to establish private hospital, and it creates more complex relationship between agents and principals. It is unclear who the agent are and who the principals are. Therefore, the role of an agent should be discussed earlier at the medical school to create more awareness among medical professionals about this sensitive matter.

Unfortunately, the regulatory body does not have any capacity to moderate the relationship between agents and principals. The health-care system may not be a priority issue to tackle. The focus may be still in the public-health program rather than individual health, the hospital operation system and medical specialist management. In the imbalance of the supply of medical specialists to the demand, the regulatory body provides privilege for medical specialists to conduct practice beyond the norms stated in the Medical Act. Medical specialists' power can influence the regulation system to allow more opportunities and advantages in the relation between agents and principals. Therefore, the regulatory body's

capacity and credibility should be improved; and on the other hand, the supply of medical specialist should be increased.

CHAPTER 11
The Government Role in Non-state Hospitals

11.1. Preface: the Circular Flow Model and the Role of Government

In hospital service the government's major roles can be differentiated into three functions[17]: financing, delivery, and regulation. In a decentralized country like Indonesia, there are multiple governments: national, provincial, and regental/municipal. These functions are distributed with a complex legal authority transfer, as mentioned in Government Regulation No 38/2007.

Based on the historical observation (Chapter 1), non-state hospitals in Indonesia experienced a transformation from military and philanthropic organizations in the 19th century. They became for-profit corporation in the end of 20th century. Non-profit hospitals such as some religious hospitals operate under for-profit principles. This situation is similar with that in the US[84]. It reflects the increasing market influence in hospital service. Due to the limited government financial capacity this development has increased the market failure in hospital service. The progress of medical technology and epidemiology increase the hospital service cost which can not be paid by the poor. For-profit corporate hospitals target the lucrative affluent community, while non-profit organizations serve the poor. The market has failed to provide hospital services for everybody. Moreover, medical specialists, who are limited in terms of number, prefer to serve the affluent groups and neglect the poor and remote communities. This section will discuss the role of government of Indonesia in overcoming the market failure. The approach of the discussion uses a circular flow which based on the following diagram:

[17] Kovner AR. 1995. *Health Care Delivery in the United States*. Springer Publishing

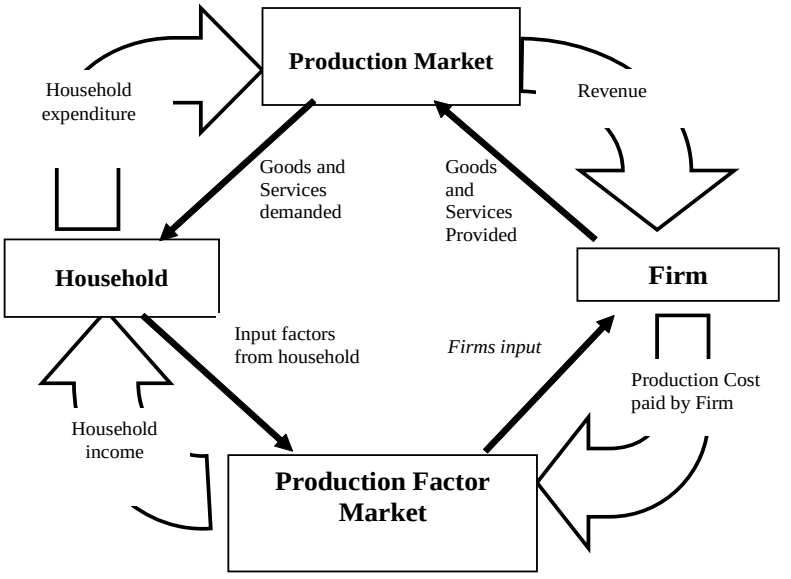

Figure 11. 1 Circular Flow Model[18]

The above diagram is a model of circular flow which shows that a hospital can be regarded as a Firm, in the form of for-profit or non-profit organization. Hospitals produce services to households. Households demand hospital services and use payment to buy the service in the product market. On the production factor market, households provide inputs for production. The input will be paid by hospitals. One important input is the medical specialist. Medical specialists are willing to serve in hospitals which have the capacity to pay.

Using this model, poor households who do not have enough financial resources for accessing hospital service will be left out from the market. This happens in Indonesia as concluded in Equitap research on Asia Pacific equity and the utilization of hospital service described in Chapter 3. Hospital service is more used by the affluent

[18] Mansfield, E. 1985. Microeconomics: *Theory and Application*. (5th ed.) W.W.Norton and Company. New-York. London

people. Non-state hospitals have more rich patients than public (or state) ones. This market forces fail to protect the poor people in gaining access to hospital care.

Moreover, some hospitals cannot have medical doctors because the fee is too high. Medical doctors as part of households are nor willing to provide services to hospitals which pay less than their expectation. It is clear that without medical specialists hospitals will stop their operation or operate below the capacity. This situation happens in many hospitals in Indonesia as described in Chapter 2 and 3.

11.1.1. Situation analysis of current Financing, Regulatory, and Delivery function

Based on good governance principles, there is a need for government intervention in the hospital market to overcome the market failure. The intervention can be in the product and in the production factor markets. In this section the current situation in relation to the role of government in the market of the hospital will be analyzed through three functions: financing, regulation, and delivery.

Financing Function

Supply side financing policy

The government's role in financing of the Indonesian hospital service has progressively developed over a long period, ranging from direct government subsidy to the hospital, community payment, charity financing to a new model of complex social security scheme in the late 20th century. Before the economic crisis in 1997, government financing to hospital was basically a type of subsidy for public hospitals. The intervention can be considered as a supply side

subsidy to a hospital as a firm. There was no subsidy in terms of social security directly to households, except for government and big company employees and military members.

At present non-state hospitals do not get subsidy although in the colonial period the government provided subsidy for missionary hospitals. The absence of subsidy to the households has resulted in the richer section of the population receiving more service and benefit from subsidized hospitals. This means that supply side subsidy is used for the rich. This has been reported in a series of Equitap research which show that the Indonesian rich use hospitals more often than the poor[19]. This is a different situation from what has been observed in public health centers, where the poor access the services more often than the rich.

The lack of subsidies and the declining charity funds for non-state hospitals (including the traditional Christian and Catholic hospitals), have gradually marginalized the poor from hospitals, including the missionary hospitals. Although missionary hospitals were established for charity purposes, the rich patients have gradually dominated the use of religion-affiliated hospitals.

Why has funding for charity services disappeared from the religion-affiliated and non-profit hospitals in Indonesia? In Christian hospitals, there has been a global change that has diverted church financing for hospital care. In this change, the charity donation should be channeled for community development, not the curative care in hospitals. Hospitals should survive from their own revenue. This has specially happened in various big faith-based hospitals in Yogyakarta. In practice, religion-affiliated hospitals have become firms which receive revenue from household users only. The interesting thing is that “owners” of some religion-affiliated hospitals

[19] Trisnantoro L. 2005. Aspek Strategis Manajemen Rumahsakit: Antara Misi Sosial ke Tekanan Pasar. Andi Offset

demand some financial support from charity hospitals. This financing flow is clearly the opposite of what happened during the colonial period. In the colonial period, religion-affiliated hospitals received charity fund from churches and other donations.

Another explanation is that there is no tax incentive for charity donation in the Tax Law. Tax incentives are only granted for university and research donations, while hospitals are excluded. An interview with the Indonesian Hospital Association, which was involved in drafting the Tax Law revealed that initially there was a plan to include hospitals as beneficiaries of the tax incentives. However, in the end of the legal drafting process, hospitals were deleted from the list.

A further explanation is that there is a wrong assumption in the community for charity financing. Many hospitals, including religion-affiliated ones have impressive buildings and activities. This image may provide the false impression that hospitals do not need charity donations. Furthermore, charity financing as a strategy of hospital financing has been forgotten. Many traditional charity donations for faith-based hospitals have gradually declined. As the result, hospital charity is not popular. However, in some recent years Moslem hospitals have been trying to increase charity financing using *zakat* (Islamic donation) principles.

As the impact of the declining charity donation and in the absence of government subsidies, non-profit religion-affiliated hospitals practically operate in the same way as for-profit hospitals. Their image has become similar to that of for-profit corporations. Many faith-based leaders use a cross-subsidy approach for financing poor patients. This approach means the use of the so-called “profit” from richer fee-paying patients in the VIP wards for financing the poor ones. This means that the “profit” originating from VIP patients will be used for financing the lower -class patients. This policy, although not formally written in the legal basis, was popular in 1980s-

90s. This is one explanation why non-profit hospitals have only slowly developed.

This cross-subsidy was also part of government policy in state hospitals. In early 1990s, the public-hospital policy was influenced by corporatization and new public-management movements. A new policy of financial autonomy (*Swadana/*self-funding) in public hospitals was issued through a Presidential Decree in 1993. This policy was actually intended for improving the quality of public hospitals through increased flexibility of financial management and the direct use of hospital revenue (rather than compulsory transfer of revenue to the government treasury). The hospital revenue could be used for increasing doctors' income through fee-for-service payments. The immediate impact of this policy was that many public hospitals built VIP wards, or formalized additional, previously illegal, payments to doctors. Medical specialists enjoyed an increase in income through this policy[20]. However, some government officials thought that financial autonomy (*Swadana*) policy should lead to a reduction of subsidies for public hospitals. A national campaign without any academic and legal basis for the so-called "cross-subsidy" was organized during the implementation of the Swadana policy.

The concept "cross-subsidy" from rich to poor patients has no scientific basis. Various cost-analysis studies conducted by Gadjah Mada University proved that there is no profit from VIP wards. Using accounting principles, the VIP wards in public hospitals and also some non-state hospitals, were in fact suffering losses. However, the revenue from VIP patients can be used directly for increasing doctors' income and hospital facilities. The debate of "cross-subsidy" became intense. Gadjah Mada University put forward the view that hospitals across Indonesia should be managed by a corporate-type

[20] Trisnantoro L. 2004. *The use of Economics in Hospital Management*. Gadjah Mada University Press

management system and should be subsidized by the government for financing the cost of treatment of poor patients. There is no place for cross-subsidies in hospital management. The use of "profit" from VIP wards has no academic basis and is ethically flawed. The rich can become poor because of illness. The cost for the poor should be funded with the government budget not by the rich who suffer from illness. The debate on cross-subsidies gradually disappeared when the economic crisis in 1998 induced a national policy on improving demand side, by providing health financing to poor household sin the form of social safety net in the health sector.

Demand-side financing policy

In 1997-1999, Indonesia suffered from a catastrophic economic crisis. For overcoming the financial impact for the poor the Government of Indonesia launched a massive national policy of Social Safety Net using ADB financing. The Social Safety Net covered health and hospital services and was thus a Health Sector Social Safety Net. This policy actually introduced for the first time the subsidy for households (the demand side).

This government intervention direct to households gained further political support and became the social security movement to support households for accessing health services. Social security in the forms of: Social Safety Net (1999) was replaced by *Askeskin* program (2004) and *Jamkesmas* (2005). This policy aims to lower the financial barrier for the poor by providing social security. The benefit of this protection policy is clear. The incidence of catastrophic out-of-pocket health expenditures is relatively low and has declined over time[21]. Equity in utilization of health services has improved over time, with significant improvements in access to public hospital services.

[21] Trisnantoro L. Somanathan A, Harbianto D. 2009. *Health care financing reforms in Indonesia: bridging health economics and policy, Equity and Financial Protection in Health Care*. IHEA Conference Beijing

The incidence of public subsidies for health care has also become more pro-poor over time.

However, regional inequalities in access to services have not improved over time. Comparison of trends in inequalities with the distribution of health service infrastructure across Indonesia, suggests that physical barriers to access may underlie the regional inequalities, together with shortages in inputs such as medical specialists and trained nurses.

Financial health protection policy allows non-state hospitals to treat poor and near-poor patients. The Benefit Package is broad, including high technology and costly medical treatment. The benefit packet increases the access of poor and near-poor in areas with access to services, such as urban areas and Java Island for non-state hospitals and high-cost medical care. Based on Provincial Data (33) and *Susenas* (Household Survey) data at the provincial level the higher the ratio of hospital beds to population in a province, the more the utilization of hospital is. The same pattern is found across SES quintiles in both public and non-state hospitals.

In summary, the national policy for financial protection has had a positive pro-poor impact. But, this is not enough. The regional inequity has not been sufficiently tackled during 2001 – 2008. Without any policy for improving medical service and medical-doctor distribution, it is projected that the central government budget for financial protection will be used mostly by urban and Java population. “Financial protection in health care” reform is a complex policy.

Imposing Tax and Levy Function

Using the circular flow concept, an important role of the government in the financing is to impose tax and levy policies. The use of taxation on product sales may reduce the household demand,

such as in cigarette or alcohol taxes. In an economy, tax incentives are usually meant to either reduce the tax burden on a particular segment of society in the interests of *fairness* or to promote some type of economic *activity* through reducing the tax burden on those organizations or individuals who are involved in that activity. Tax incentives can also be meant for both purposes.

Values exist in taxation policy. A nation's tax system is often a reflection of its communal values or the values of those in power. To create a system of taxation, a nation must make choices regarding the distribution of the tax burden—who will pay taxes and how much they will pay—and how the collected taxes will be spent.

In Indonesia, before the new Hospital Law of 2009, the tax policy is not supportive of hospital development, especially that of non-profit ones. There is no tax incentive for hospitals which provide charity care or social duties. There is no tax incentive for corporations which give charity donation to support hospitals. Alongside this, there are many taxes and levies which hospitals are required to pay.

This is one of the reasons why many non-profit hospitals now suffer from financial problems. In domestic competition, foundation-based non-profit hospitals must serve the poor due to their faith-based and humanitarian mission. Most foundation hospitals work in middle- and lower-class segments of the society which are funded by Jamkesmas. These market segments are loss-making for the hospital. On the other hand, for-profit hospitals operate in the higher economy group. This market segment is lucrative. The interesting issue is that non-profit and for-profit hospitals have the same tax treatment[22].

In this domestic competition, the same taxation for non-profit and for-profit hospitals is not fair. Charity hospitals will be less

[22] FGD, leaders of Christian, Catholic, Moslem, Local Government, and Indonesian Hospital Associations held in Granadi September 2009.

efficient than the for-profit. It is worsened by the fact that some religious leaders still use the idea of cross-subsidies for financing poor patients. In some big cities such as Jakarta and Surabaya, the market share of faith-based hospitals is shrinking. Another problem is the relatively unclear Foundation Law, which is applied for non-profit hospitals. Compared to For-Profit Corporate Law, the Foundation Law lacks good a governance arrangement and financial control system. As the result, some foundation non-profit hospitals act like for-profit ones.

In the international competition, the tax burden and also the high levy and custom tax for medical facilities increase the cost of running hospitals in Indonesia. Compared to Malaysia and Vietnam, which have tax and custom incentives for hospitals, hospitals in Indonesia should pay more. Up to 2009, the Government of Indonesia opted for the position not to promote the hospital sector as an economic *activity*. The heavy tax and various levies become burden on Indonesia hospitals and have made them non-competitive regionally.

However in 2009, after intense lobbying by faith-based hospitals and teaching hospitals associations the new Hospital Law has provided an opportunity for receiving tax incentives for public hospitals, non-profit non-state hospitals and teaching hospitals. However, this Law will have difficult implementation due to the fact that the Tax Law is not in the same direction. The Tax Law always mentions that the hospital sector is not like education or research. It is subject for taxation just like other industries.

The same tax policy for profit hospitals and non-profit non-state hospitals has forced these two types of organization to adopt similar management processes. It is difficult to differentiate between non-profit and for-profit ones. The same policy environment in the US has also often forced differing organization types to pursue similar

strategies[23]. As a result, regulatory changes and the implementation of similar strategies result in not-for-profit and for-profit hospitals having similar efficiency and community service outcomes. This means, there are more difficulties to distinguish for-profit and non-profit hospitals.

Regulation function

In the market-based Indonesian hospital system, the Ministry of Health is one of the important actors in regulation function. However, based on type and target level of management, the Ministry of Health holds a multi-function position as a steward authority, financier agent, health and hospital governance policy maker, and also operational management executor. This multi-function role is the responsibility of the Director General of Medical Service. This DG supervises more than 1400 hospitals across Indonesia, while at the same time operates around 34 central government hospitals. The supervising function is delegated to provincial and district levels, through the decentralization policy.

In a decentralized Indonesia, it can be seen that the efforts to improve public health status were not only a government, or especially Ministry of Health, domain. Regulations No. 38 Year 2007 and No. 41 Year 2007 emphasize that Provincial and District Health Offices should coordinate various agents in health-care sector. Decentralization of health care principally delegates responsibility for health to the regional governments. At the provincial and district level, the regulatory function is held by PHO and DHO respectively. Provincial and district public hospitals were separated from PHO/DHO. The policy of spin-off public hospitals from PHO and DHO is in line with an important concept based on the Good Governance as stated by the United Nations Development Program (UNDP):

[23] Potter S.J. 2001. A Longitudinal Analysis of the Distinction between For-profit and Not-for-profit Hospitals in America. *Journal of Health and Social Behavior* 2001, Vol 42 (March): 17-44

"The exercise of economic, political and administrative authority to manage a country's affairs at all levels. It comprises the mechanisms, processes and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences ...".

Using this definition, public hospitals are monitored and supervised by DHO/PHO and should be re-licensed every 5 years. This license policy is consistent with the non-state hospital re-licensing system. This policy reflects the political willingness of government to become the regulator of the health system which based on a market system.

The treatment of state-owned hospitals is similar to that of the non-state hospital in this matter. In Government Regulation No. 38 Year 2007, the district administration was in charge of (1) giving recommendation concerning licensing for certain health facilities provided by the central government and the provinces, (2) giving a license to health facilities including hospitals of class C and class D, equivalent non-state hospitals, group practices, general/specialist clinics, maternity clinics, family doctors/dentists, complementary medicines, traditional healing, and equivalent supporting facilities.

One of the consequences of Government Regulation No. 38 Year 2007 is the separation of government functions as a hospital regulator and an operator. In the regional level, it is clear that state-owned hospitals no longer act as integrated service unit offices (agencies of the local government) but they are separate operators (Law No. 32 Year 2004, Law No. 1 Year 2005 on public service agency, and Government Regulation No. 41 Year 2007). In the local-government level, Government Regulation No. 41 Year 2007 as a derivative of Law No. 32 Year 2004 firmly states that a regional hospital is not part of the official services (Government Regulation No. 41 Year 2007, Article 22). Local hospitals have undergone a process called corporatization, while the Health Office is expected to

undergo the process of becoming a regulator. Thus, in the future, Government Regulation No. 41 Year 2007 should give clear directions as to the relationship between the Health Office and state-owned hospitals based on the principle of good governance.

The provincial government was in charge of (1) providing recommendation to the government on licensing concerning particular health facilities, and (2) giving a license to health facilities including state-owned hospitals of class B, non-teaching hospitals, specific hospitals, non-state hospitals, and equivalent supporting health facilities.

At the central level, the situation has not changed yet. DG of Medical Services still manages the operational activities of big teaching hospitals and other central government hospitals. This multi-function costs dearly. Various hospital policies and regulation are not well managed by the MoH. There is a battle of turf on licensing, accreditation systems, and equipment procurement. Corruption in the area of medical equipment facilities has been increasing in the last 10 years.

The separation of the operator function from the regulator function is an important part of the governance principle and civil society. There have been some important milestones that could be learned from other sectors: the Case of the Ministry of Finance, where state-owned (*Badan Umum Milik Negara/BUMN*) companies have been separated to become the Ministry of State-Owned Companies; and the case of Department of Transportation with the aviation services. By changing the central state-owned hospitals into central public service agencies, there should have been a change in the Directorate General of Medical Services. The central state-owned hospital authorities should have changed into hospital operators that would receive treatment similar to that for non-state hospitals, local state-owned hospitals, and military hospitals. This is firmly stated in Government Regulation No. 38 Year 2007. Meanwhile, the Ministry

of Health should act as the regulator and policy maker. In the future it is expected that central hospitals will become non-bureaucratic institutions (in the sense that they will be institutions that provide public services) and will be separated from the authority of the DG of Medical Services. This DG should concentrate on the regulatory function of the hospital system in Indonesia.

Regulating the specialists

The commercial image of non-state hospitals has been influenced by the medical specialists' economic behavior. The specialists have become a very affluent and elitist group in the Indonesian society. It is interesting that medical specialists can earn without limit in the non-state hospitals, including the missionary hospitals. A doctor's power to set the price and to influence the hospital management system is big. A comparative observation in the Christian and Catholic hospitals shows some difference in medical specialists' power. In Catholic hospitals, the role of nuns is still important. They have supervisory and also executive power in managing the hospital, including managing the medical specialist. On the other hand, the Christian hospitals have no tradition of the role of the nuns in the hospital management. The decision is set by their medical specialists. It is logical that in the end there is a smaller number and less variety of medical specialists in Christian hospitals because the economic and monopolistic behavior has influenced recruitment decisions. In Catholic hospitals, there are more medical specialists available.

The most controversial regulation to control medical specialists' behavior is the Medical Practice Act. This Acts limits the number of practice locations for medical doctors. However, this Acts is difficult to implement due to the shortage of medical specialists. The case in Jambi shows that various non-state hospitals would close down if this Act were tightly executed. This Act should be executed

by the District Health Office, but this function has not worked effectively across Indonesia. District Health Office Heads face various problems in implementing this function[24] because some profession associations still practice monopolistic behavior.

Delivery function

The development of non-state hospitals cannot be separated from the national policy on state hospitals. The government at various levels has the delivery function in hospital service. Although the increasing number of non-state hospitals has exceeded that of state hospitals, most big teaching hospitals are owned by the government. Some degree of competition is observed although cooperation also takes place. The local governments provide most of hospital delivery in remote areas while non-state hospitals are clustered in big cities.

The policy on state hospital autonomy

In relation with non-state hospitals development, the government policy on state-hospital autonomy is important to discuss. In the circular flow model, a hospital can be regarded as a firm. Using firm theory, a state hospital is not a bureaucratic unit. It is a service organization, and operates within the health industry. The new paradigm of hospital as a service organization brings various policies in state-hospital autonomy.

There is a strange relationship between state and non-state hospitals. The poor management of state hospitals provides some "benefit" to non-state ones for having more medical specialists and better competitive position. The growth of public hospitals can be a serious threat to non-state hospitals. Therefore, an understanding of the public policy on state hospitals is important.

[24] Sundjaya D. 2010. Managing Change at City Health Office. *PhD thesis*.

After independence, gradually state-hospitals have been becoming more bureaucratic. The management of public hospitals has no conceptual framework. Medical doctors are not satisfied with their professional income and have multiple-practice in the private sector. Some prominent specialists have even established hospitals as this is the case in Yogyakarta City. The income is the main reason why specialists have dual-practice or more than two practice places. In some big cities, non-state hospitals cluster around the big teaching hospitals, owned by government specialists. This is not only a dual-practice system but it also shows the multiple roles of government specialists: as state-hospital doctors, as non-state hospital doctors, and as non-state hospital owners.

Due to the lack of good management system in the delivery function, public hospitals suffer from a downward spiral of poor management. State hospitals have become the inferior good when compared to non-state ones. To improve the quality of the delivery function, the limited financial autonomy (*Swadana*) policy was issued in 1993. This policy has developed year by year and in its latest development in 2007 local government hospitals were legally transformed into a regional Public Service Agency (*Badan Layanan Umum/BLU*) by Home Affairs Ministry Decree (*Kepmendagri*) No. 61. This decree is a final culminating point concerning the centralized policy on BLU that began in 2004 (Law No. 1 on State Treasury), which has been continued with the Government Regulation (PP) No. 23/2005.

In the regulated market environment the Government of Indonesia has chosen not to privatize the delivery of public hospital services. This is also stated in the Hospital Law which was enacted in the end of 2009. The chosen strategy is Public Service Agency (Badan Layanan Umum, BLU) that recognizes that hospitals provide quasi-public goods. Therefore, governmental revenues from Local Revenue & Expenditure Budget (APBD) and State Revenue & Expenditure

Budget (APBN) can be used for funding state hospitals, and this institution has authority to receive income from public health services paid by communities.

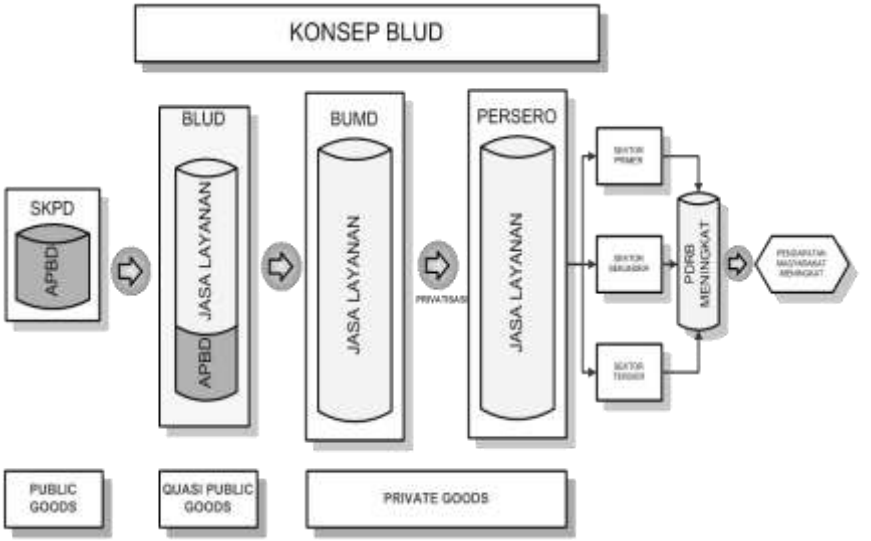

Figure 11. 2 Public Service Agency (BLU) Concept Coined by Ministry of Home Affairs

Referring to the diagram above, it is clear that the status of a hospital as a Public Service Agency (BLU) is a non-profit state corporation. This kind of hospital is managed the by central or local government, acts as a service unit but continues to be subsidized for providing services for the poor. By using a Public Service Agency (BLU) system, state-run hospitals avoid bureaucratic nature of services; however, it is neither a for-profit state-owned corporation nor a private corporation. In this context, the Public Service Agency (BLU) is not a for-profit Government-Owned Corporation. Diagrammatically, the position of a Public Service Agency (BLU) is in the middle between Non Tax State Reveue (PNBP) and for-profit BUMD (Local-Owned Corporation) or BUMN (State-Owned Corporation) as illustrated in Figure 11-3.

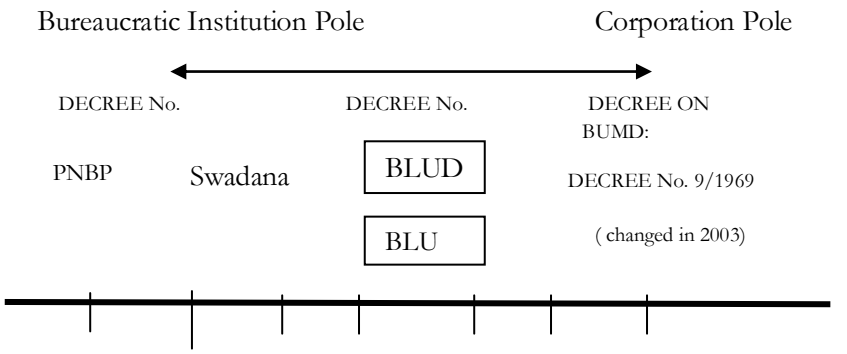

Figure 11. 3 A continuum between Bureaucratic Institution and BUMD

As a non-profit service institution, a Public Service Agency (BLU) cannot avoid an economic calculation in determining service tariffs. For certain poor communities, there is a zero-rate tariff to facilitate services. There is also a unit-cost tariff applied for better-off communities, for example, VIP ward services in hospitals. The Public Service Agency (BLU) needs to know unit-costs for services, for example, costs per nursing patients, the laboratory examination cost, and so on, as a basis for setting tariffs. In this matter, an understanding on subsidies is important to know the costs the state needs to expend due to market-cost disparities and the costs of certain products determined by the government to fulfill poor communities' needs. This development is not a privatization but more as a non-profit corporatization of public hospitals. The impact is increased competitiveness in state hospitals.

The existence of BLU makes the characteristics of a non-profit and social-mission institution vary. It is neither purely social nor commercial-oriented. Table 11-4 describes some social, commercial, and mixture of non-human and non-commercial institutions. The BLU autonomy policy puts the state hospital to become a mixed organization, not a purely social, but also not a purely commercial.

Table 11. 1 Some Characteristics of Social and Commercial Institutions

	Purely Social		Mixed	Purely Commercial	
Motivation, method and objectives		For goodness guided by a mission of social values		Mixed motivation guided by a mission and market values Social and economic values	Impressive for self-purpose guided by market values Economic values
Stake-holders Key	Benefited parties	Do not pay at all		There are subsidies based on economic backgrounds and those who cannot pay at all	Pay tariffs based on market value
	Capital	Humanity and grant funds		A mixture between humanity fund donation and market value capitals	Market value capitals
	Workforce	Voluntary		It is paid under market value or a mixture between fully paid voluntaries	Market value compensation
	Supply of materials	It is hoped that the supply of materials is based on humanity donation		Special discounts or a combination between donation of full-price supplies	The supply of materials is paid based on market value

Source: Dees, 1999[25]

Combined with the BLU national policy, a new policy has been enforced to assist some central teaching hospitals such as RSCM in Jakarta to gain modern technology by being granted government subsidies for the purchase of technology, as am internationalization project for hospital service. This policy impacts on the availability of technology. Non-state hospitals, including the luxurious ones are left behind in terms of technology. Using the new management system, and a flexible incentive system for medical doctors, some specialists prefer to stay in the teaching hospitals. This will be the new generation of medical specialists who do not want to have dual practice. The delivery system at some public hospitals, especially in teaching hospitals, can support the specialists' income.

In some districts the managerial improvement is able to transform state hospitals from being low quality service providers to be good ones. Well-managed state hospitals may become the toughest competitors for

[25] Dees J.G. (1999). *Enterprising nonprofits*. In Harvard Business on Nonprofits Harvard Business Press.

non-state hospitals. It has happened in Tabanan District and Banyumas District. However, most state hospitals are still behind non-state hospitals in terms of their service quality.

11.1.2. The market of non-state hospital

Based on the discussion, the hospital product market in Indonesia can be described as in the following matrix, which covers two factors: (1) household economic capacity; and (2) the level of medical technology. The household economy reflects the capacity of household for buying hospital services. The low and part of middle economic classes are supported by the national policy on health insurance (*Jamkesmas*) and/or the local government scheme (*Jamkesda*). The technology offered by hospitals reflects the input of hospital production. The three levels of technology are high, middle, and low technology.

Table 11. 2 The hospital market segmentation in Indonesia

	High Technology	**Middle Technology**	**Low Technology**
High Eonomic Capacity Household	• Overseas hospitals	• Overseas hospitals • For profit hospitals • Limited number of non-profit hospitals • Teaching Hospitals • Some Local Government Hospitals	• Overseas hospitals • For profit hospitals • Limited number of non-profit hospitals • Some Local Government Hospitals
	High Technology	**Middle Technology**	**Low Technology**
Middle Economic Capacity Household	• Overseas hospitals • Teaching Hospitals • Certain for-profit non-state hospitals	• For profit hospitals • Limited number of non-profit hospitals • Teaching Hospitals • Local Government Hospitals	• For profit hospitals • Limited number of non-profit hospitals • Teaching Hospitals • Local Government Hospitals
Low Economic Capacity Household	• Teaching hospitals	• Limited for profit hospitals • Non-profit hospitals • Teaching Hospitals • Local Government Hospitals	• Limited for profit hospitals • Non-profit hospitals • Teaching Hospitals • Local Government Hospitals

This market structure is important for analyzing the current issues in non-state hospitals. First is the fact that there is a lucrative market segment which attracts for-profit private hospitals and medical specialists. The attractiveness of this segment is reflected by the condition in some places: the rich enjoy the better service in non-state hospitals, while the poor receive poor treatment from state hospitals. Most state hospitals, especially the local government ones face this situation.

However, a limited number of success stories of some state hospitals with financial autonomy and high technology may change this condition. For example, Tabanan Hospital owned by the local government in Bali is more competitive non-state hospitals. State hospitals in this condition may attract high-income patients although at the same time they serve the poor. In this affluent market, regulation is difficult, including for setting the tariff and generic-drug policy. In the high technology segment, the big teaching hospitals owned by the central government enjoy substantial subsidies for technology. Teaching hospitals have better medical technology and also have better VIP wards than those of non-state hospitals.

For low-income households, the *Jamkesmas* and *Jamkesda* policies have been increasing the revenue for state hospitals and also for non-profit non-state hospitals. *Jamkesmas* and *Jamkesda* have been successful in replacing the "cross-subsidy" and have raised competition between state hospitals and non-state non-profit hospitals in various regions. This is the situation in which the public benefit culture in the government and non-government sectors is key to promoting planning-regulatory synergy[26]. The regulation of private providers and the constraint of private insurers can be performed effectively through the extension of social health insurance, but the technical demands are considerable and the political process of gaining consensus to support compulsion is essential. In this segment, payment regulation has a brighter possibility to be applied. The demand and supply

[26] McIntosh M. 2007. Planning and market regulation: strengths, weaknesses and interactions in the provision of less inequitable and better quality health care. *IKD Working Paper* No. 20. Open University, UK.

for the doctor market can attract some medical doctors to work in this segment. However due to the limited number of medical specialists who are willing to serve under health insurance in difficult areas, this possibility is diminishing.

The shortage of specialists is common in Indonesia. The situation in Jambi is one detailed example of specialist shortage. The monopolistic culture of specialists makes the number limited. As the result, the cost for specialist payment increases with limited time and attention for good medical practice. The power to make the price is in the hand of medical doctors which cover both affluent and poor markets. In some regions, it is reported that the payment for rare medical specialists such as anesthesiologists is very high.

The current issues for non-state for-profit hospitals mostly relate to high production costs in terms of land, buildings and facilities, high customs levies, human resources (especially medical specialists), and investment return. Meanwhile, the current issues for non-state non-profit hospitals are building and facilities, high customs levies for medical equipment, inefficient human resources, low-class patients' payments and the prospect of tax incentives.

Besides the above, some common issues in both non-profit and for-profit non-state hospitals are the international competition and the shortage of specialists. These issues are also faced by state hospitals. Some reports mention that hospitals in big cities in Sumatera Island face difficulties in competing with hospitals in Malaysia and Singapore. The problems of competition are associated with the government policy regarding hospital service in South East Asia. Vietnam, Thailand, and Malaysia have adopted the policy for increasing the growth of hospital services using industrial intervention.

Public-private partnership

The market structure and condition of non-state hospitals is interesting. Non-state hospitals serve two different markets: the poor and

the rich. This situation is different from that in Vietnam, Malaysia, and Thailand. In these countries, non-state hospitals tend to serve the affluent patients. In this aspect, Indonesian non-state hospitals should be carefully managed by proper policies. The challenge is how to increase the role of non-state for equity objectives of the health system, while at the same time some non-state hospitals should be strengthened for international competition. This situation demands a good public-private partnership in hospital industry. A fair financing policy and good government stewardship of non-state hospitals should be established.

Stewardship is defined as a "function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry". Preker et al[76] describe that the stewardship functions for guiding the health system along policies and for coordinating the various stakeholders and players within an established framework.

Regulation in the health sector is built on the concept that there are three types of services administered by the government: (1) original public goods; (2) semi (quasi) public goods; and (3) private goods. They deal with funding sources needed to support health services. If the services need original public goods, the state is obliged to finance them to the best of efforts

The understanding in the relation to these public and private goods is of paramount importance in analyzing health-financing policy. A welfare-state concept accentuates that public goods-oriented services should be financed by the state through a tax mechanism or other governmental revenues for all communities. This welfare state has an insight that all communities have rights to get free public goods-oriented services. In fact, this concept is used in some countries, particularly those of Western Europe and Scandinavia, Japan, and other small but socialist countries like Cuba.

There is also a partly-subsidized regulated health service market. As an illustration, in a normative way, all citizens have rights to get good health service because they deserve it. Indeed, it is an urgent need to access all

public goods-oriented health services. However, in reality it is difficult to achieve because medical technology and hospital service are costly, which is almost hard for the Indonesian government to finance. Some customers are able to pay every service provided for them, or make a token payment, but some others are not. Some countries, such as the USA, Singapore, China and Indonesia, apply a system that makes a separation between the rich and the poor communities. The rich will pay, and the poor are protected by the government through a safety net program. This is similar to the US experience. As hospital markets become more competitive and the opportunity for cross-subsidizing more unprofitable, collective-good activities will become increasingly difficult. Support for such activities, if they are to exist, will have to come from explicit public subsidies.

Using two different markets (the poor and the rich), the concern is what the future of non-state non-profit hospitals (belonging to *yayasan* [foundations] and *perkumpulan* [associations]) will be. Is there any role for small charitable single-owner hospitals? Is it more a historical legacy or a legitimate expression of philanthropy? In blunt expression, should the government protect non-state non-profit hospitals? A key issue in this concern is how to define 'not for profit' hospitals and how to ensure that their governance and management maintain a 'not for profit' ethos. Due to the similarity of the Indonesian and US hospital systems, it is important to learn from the US definition of charity and the policy to preserve the charity spirit.

In US, the charity care includes all costs and write-offs associated with services rendered to individuals determined prior to the service delivery to be unable to pay. The generic requirements for US non-state hospitals are a) operating for charitable purposes; b) demonstrating that neither earnings nor donations should benefit any private shareholder or individual; c) maintaining an open-access policy; d) having policies aimed to benefit the public; e) providing benefits to the community in excess of its annual property tax liability; and f) proving that hospital facilities reflect and support their mission

In Indonesia, hospitals have the possibility to finance the "unable-to-pay" patients. Some patients are unable to pay and become bad-debtors. In US, there is uncompensated care which covers the combined cost of charity care and the cost of bad debt. Unreimbursed care is the sum of pure charity care and the shortfalls and contractual allowances resulting from Medicare and Medicaid. Indigent care constitutes services provided to uninsured or underinsured individuals who are not expected to pay for those services. Community benefits are unreimbursed goods, services and resources provided by health care institutions that address community-identified health needs and concerns, particularly of those who are uninsured or underserved, and include health promotion and disease prevention.

For non-profit organizations, the disclosure of the financing and operating system is needed. This covers (1) a statement of program accomplishments; (2) a description of the relationship of the organization's activities to the accomplishment of the organization's exempt purposes; (3) a description of payments to individuals, including compensation to officers and directors, highly paid employees and contractors, grants, and certain insider transactions and loans; and (4) disclosure of certain activities, such as expenses of conferences and conventions, political expenditures, compliance with public inspection requirements, and lobbying activities (5) an audited financial statement and public access to tax return.

Another important issue is that the tax and financing policy should support the development of hospitals or health services in remote areas. In the current situation, remote areas suffer from the shortage of hospital and medical doctors. The challenge is how to have policies for pushing non-state hospital networks to operate in the remote area. In East Nusa Tenggara, at the moment, there is a plan for contracting hospital service in remote areas. The contractors will be the non-state or state hospitals that have large capacity of human resources and services.

A second issue is the appropriate 'mix' of state/non-state and for-profit/not-for-profit hospitals. Schlesinger and Gray[27] introduce the concept of 'locality' specific planning of the appropriate mix.

> 'Determining an appropriate ownership mix in communities depends in part on how sensitive each is to the other's presence. Only a smattering of relevant evidence exists. It appears that even a small for-profit presence (a share of 10 percent or less in the local market) induces greater efficiency among nonprofit competitors. The nonprofit presence required to induce greater trustworthiness in for-profit competitors appears to be larger market shares of at least 20-30 percent'.
>
> 'The optimal balance [mix] might vary by service, because the implications of ownership for organizational behavior differ so dramatically across services. It is also likely to depend on the proportion of consumers who have difficulty making informed choices and are at risk of exploitation'.

This aspect falls under the planning role and authority of provincial and district governments.

In Indonesia, the 'not-for-profit' sector remains a dominant provider among non-state providers, and potentially has a specific role in the sector. This role encompasses two aspects. First are the provision of 'public goods' services, such as provision of care to those unable to pay the full cost, the provision of services in under-served locations, and health promotion/disease prevention services which contribute to public health. Because of their 'mission', not-for-profit providers are much more likely to be engaged in these activities.

Second is the influence of not-for-profit hospitals on the wider health sector and on the behavior of 'competitor' state and non-state providers. Studies in the US[74] have suggested that:

[27] Schlesinger M, Gray BH. How nonprofits matter in American medicine, and what to do about it. Health Affairs (2006) : 25: w287-w303

> ‘The presence of non-profit providers influences the behavior of for-profit organizations, and vice versa. The more for-profit hospitals in a locality, the more nonprofit hospitals will respond aggressively to revenue-increasing opportunities, adopt profitable services, discourage admissions of unprofitable patients, and reduce resources devoted to treating the patients they do admit. Conversely, the presence of nonprofits in a community is associated with increased quality of care in for profit nursing homes, reduced mortality rates in for-profit dialysis facilities, and increased trustworthiness of for-profit health plans.’

Further research is needed in the context of Indonesia to identify whether similar effects occur, but given the already documented close inter-relationships among hospitals ‘competing’ in the same localities in Indonesia, and the linkage through ‘sharing’ of providers across sectors, it is likely that similar effects could be found.

Policy Options for Non-State Hospital

In the future, the policy options for the Government of Indonesia concerning non-state hospitals include the alternative of weak or no intervention or strong ones. The first alternative aims to have less government intervention for the non-state hospitals. Not-for-profit hospitals themselves need to improve financial capacity, governance, accountability, and financial viability. For-profit hospital will have no government intervention.

The second alternative is providing more government intervention. The government intervention can be in the areas of financing and taxation, ownership/governance regulation, requirements for the governance of hospitals run by *yayasan* (foundations), licensing tight conditions, determining conditions for receipt of government financial support (tax exemption, or supply/demand support), and also regulation of location which provide subsidies/tax exemption based on location.

There are ,any arguments for more government intervention for non-state hospitals. Government intervention for not-for-profit hospitals can scale up services to the poor or those in remote areas. The government could more directly subsidize any service provider to the poor or those in remote areas. The landscape of non-state hospitals (Chapter 3) shows that most of non-state hospitals' legal basis is a foundation (which is non-profit) and the locations are scattered across Indonesia. These hospitals can be used for improving geographical equity. By supporting these hospitals, the government also preserves and develops the value of philanthropy in health service. It is widely acknowledged that philanthropic values are diminishing.

The second reason for government intervention is to maintain a proportion of the market for not-for-profit hospitals. If not-for-profit hospitals develop well, it will provide competition and reduce some of the for-profit hospitals' excesses. The data shows that in the last 10 years the migration to a for-profit status from a non-profit one is much higher than the other way around. The third reason is that government intervention may improve non-state hospitals' competitiveness. By providing tax incentives or lowering the customs tax for medical equipment, the government may lower the hospital cost. In line with other input development, non-state hospitals can be more competitive.

Based on the financing perspective, government intervention could consider two options for non-state hospitals. First, non-state hospitals provide only 'private goods' services to be purchased by consumers and do not require any government subsidy or support. The second option is that non-state hospitals provide some 'public goods' services (for example, services to those unable to pay the full cost, services in underserved locations, and preventative/promotion services) and should be compensated by the government for the extra costs of these services.

In the case of the first option, regulation is mainly required to ensure a 'level playing-field' among state and non-state hospitals in the provision of 'private goods' services, and adequate information and protection provided to consumers.

Many issues need to consider in the first option. There should be a policy to ensure the services provided are effective, safe, and performed by competent practitioners at safe standards. Advertisement and information provided to consumers is not misleading; adequate information is provided to consumers to enable informed choice; there are avenues for complaint in the case of poorly provided services. Where state-funded purchasing occurs, as through state-supported insurance, that purchasing arrangements encourage competition, provision of cost efficient services, and prevent exclusion of high risk consumers. There should be also an adequate consideration on the impact of subsidies to state providers for purchase of equipment on the ability of non-state providers to compete.

If the case of the second option, in addition to the above, the state needs to consider how to compensate providers for the 'public goods' benefits of their services. The options include (a) tax exemption, (b) a demand subsidy policy, and (c) a supply subsidy policy, such as payment for provision of services through contracting, public-private partnership arrangements etc. The advantages of tax exemption are simple and it maintains flexibility. However, there are disadvantages too: difficulty to measure and difficulty to determine the outputs. The demand subsidy policy, such as social insurance payment, has advantages, such as being linked to provision of services. However, there are also disadvantages: it is difficult to ensure appropriate levels of reimbursement of costs and administrative costs, and it also induces geographical inequity if the supply is not well-distributed across the country. The supply subsidy policy has the advantage of being linked to provision of services, but it also disadvantages, such as the complexity of administration.

For non-state for-profit hospitals, the government can have a policy for industrial protection. In the current situation, it is impossible for non-state for-profit hospitals to compete with overseas hospitals without any industrial protection scheme.

Policy options for the relationship of medical specialists and non-state hospitals

There are two main issues in the relationship between medical specialists and non-state hospitals: (1) dual practice; and (2) doctors as owners of non-state hospitals. The policy options will be based in these two main issues. This section in particular will propose policy options for managing the growing complexity of the multiple roles of health care providers, and the failure of the current system to regulate.

The problems arising from dual practice have been documented in Chapter 3 and analyzed Section 5.2. The options for the government include (a) banning the dual practice or (b) accepting dual practice with caution. Banning dual practice is very difficult since it has been a very long history and there is a strong demand from public. If there is a ban, it will be difficult to enforce, unless public salaries increase sharply. This is likely to lead to unofficial user-fees in public facilities.

In accepting dual practice, many problems arise. The distribution of medical professions favors high income areas with many non-state hospitals. The differential engagement in public/private services tends to neglect public services in favor of private services. There is a tendency to adopt 'commercial' practices rather than professional practices. Conflict of interest interferes with role as patient agent, may erode trust, and changes the public perception of health care providers.

Currently the Government of Indonesia is adopting this approach by licensing and limiting practice locations only to three places. However, this is largely ineffective due to poor enforcement. Therefore, the future challenges are how to increase competition or reduce barriers to market entry, for example by allowing foreign providers, how to reduce ability of professional cartel-type associations to control new comers' entry, how to control the public sector provision, such by linking payments for work in the public sector to specific outputs in terms of time (sessional payments) or services provided (patients treated, procedures done) controlling the private sector

provision, and by controlling the service price, such as by requiring fee publication and agreement on standards for fees.

Institutional arrangements are needed to assist doctors in managing conflicts of interest. This institutional arrangement can be in the form of a hospital policy of working hours, a remuneration system, and a contractual working status. Professional organizations should assist doctors and the public in understanding how doctors manage conflicts of interest.

Policy options for non-state hospital owned medical doctors'

The landscape of non-state hospitals in Indonesia (Chapter 3) shows that many hospitals are owned by their doctor(s). This raises the question on whether the dual role of a medical specialist as a clinician and hospital owner is good or bad as has been analyzed in an earlier chapter. The policy options in this issue are (1) banning a medical doctor's hospital ownership or (2) allowing it. It is impossible for banning a medical doctor's hospital ownership. The logical option is allowing with a tighter supervision from other parties, or with regulation that imposes the ownership never to be on the hand of the doctor(s) only.

The supervision should use the basic agency theory. Using this theory, the patient position and patient right should be supported by a stronger regulator body to avoid the misuse of medical doctors' authorities and hospital owners' power in imposing unnecessary treatment. In this case, consumer protection groups and local government health offices should be strengthened. This regulation-strengthening program will benefit the medical doctors as well. The dual role of a medical specialist as a clinician and a hospital owner may become a detrimental factor in improving hospital quality. There is no internal control for improving the service quality. In the landscape, many doctor-owned hospitals face difficulties in the business development.

Closing

For the future, an interesting question is from which country the Government of Indonesia will learn more on hospitals policies on non-state hospitals. To answer this question, it is important for matching the general economy policy, the government's functions and the health system characteristics.

Table 11. 3 The Characteristic of Countries in Hospital Policy

Country	Structure	Economy	Health Financing	Regulation	Delivery	Taxation
US	Federal	Regulated Market	Multiple sources	Highly regulated	Big private sector	Incentives for charity care
UK	Centralized	Regulated Market	Tax based	Highly regulated	Small private sector	No non-profit
Indonesia	Decentralized	(un) regulated market	Multiple Sources	Low regulated	Big private sector	Still in the beginning
Malaysia	Centralized	Regulated market	Tax based	Highly regulated	Small private sector	All private are for profit
Cuba	Centralized	Communism	Government Revenue	Government	Government providers	No private

The above table shows that the most identical characteristic is the US. In the United Kingdom and Malaysia, the systems are totally different. In 1948 non-state non-profit hospitals were nationalized by the British Government after 200 years of existence. The establishment of the British National Health Service in 1948 was a watershed for the nonprofit sector, as the voluntary hospitals were taken into public ownership. In Malaysia, the non-state providers develop for catering the affluent community's need.

Meanwhile, the Catholic health-care providers still exist in the United States. When viewed from the national perspective, a collective group of institutions with a common mission represents a large private-sector effort to deliver medical care, long-term care, and related health services to persons in need[28]. This situation is the same in Indonesia. At the moment

[28] White K.R. 2000. Hospitals Sponsored by the Roman Catholic Church: Separate, Equal, and Distinct? *The Milbank Quarterly*, Vol. 78, No. 2 (2000), pp. 213-239

Christian and Catholic hospitals are the largest groups among non-state hospitals. The Moslem hospitals follow the development. These hospitals serve both the poor and the rich.

In Indonesia, the safety net system adopts typically the same principle as Medicaid and Medicare. Medicaid, the health care program for low-income families, which is funded principally with federal and state finance is similar with *Jamkesmas* (*Jaminan Kesehatan Nasional/*National Health Security). The US public hospitals and clinics, which are funded with a mix of federal, state and local tax dollars are in the same situation as Indonesian public hospitals. Publicly-funded charity care, which is also subsidized with federal, state and local tax dollars given to non-profit hospitals in the form of tax breaks, is now the subject for tax incentives in Indonesia. It is realized that the market system in US is experiencing many problems. However, Indonesia should learn from the US to prevent and to avoid the same mistakes.