Examining the degree and dynamics of policy influence: A case study of the policy outcomes from Hub-funded research into not-for-profit hospitals in Indonesia

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First draft – April 2013

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ACKNOWLEDGMENTS

The authors would like to acknowledge the following colleagues who provided contextual insights and methodological assistance that we have drawn upon greatly in this case study: Dr Kris Hort and Dr Tanya Caulfield from the Nossal Institute, Dr Laksono Trisnantoro from CHSM in Yogyakarta and Marion Brown from the Burnet Institute.
SUMMARY

This paper presents a case study examining the policy influence of research and related activities on not-for-profit (NFP) hospitals in Indonesia, undertaken by the Health Policy and Health Financing Hub at the Nossal Institute for Global Health at the University of Melbourne in collaboration with the Centre for Health Service Management (CHSM) at the University of Gadjah Mada in Indonesia.

In 2009, CHSM’s research found that non-state hospitals accounted for 50 per cent of the total number of hospitals in Indonesia, and NFP hospitals were the dominant non-state hospital provider, accounting for 82 per cent. CHSM also identified that in some provinces, NFP hospitals were the only health care provider located outside district capitals. However, they were struggling to remain financially viable and maintain charitable services for the poor. The drift to ‘for profit’ practices was widespread.

On sharing their findings with a then disparate network of NFP hospitals, CHSM learned that revenue was undermined by the large number of taxes for which NFP hospitals were liable. The intent was formed for CHSM and NFP hospital associations to lobby jointly for a tax exemption and for recognition of the charitable mission of NFP hospitals in law. Within two years, CHSM’s research contributed to observable changes in policy processes, structures and outcomes. The paramount policy influence was bringing policy attention to the major role of NFP hospitals within the health system for the first time.

A new delineation according to ownership type between public and private hospitals was enshrined in the Hospital Act, with ‘public’ defined as not for profit. A ‘right to tax exemptions’ for public hospitals was incorporated into the Hospital Act. A new Ministry of Health decree in 2011 allowed not-for-profit hospitals to apply to the ministry to receive non-monetary assistance. Government policy-making forums have been opened up to the non-state hospital sector. A peak body of NFP hospital associations was formed to strengthen their capacity and resource base for policy advocacy.

Factors facilitating the influence of the research were the drafting of Indonesia’s first Hospital Act and the relatively recent opening up of channels for civil society input. The researchers themselves were significant for their activist role.

While the research provoked a reappraisal of the role of NFP hospitals in serving the poor, there was scepticism about calls for tax exemption due to their recent for profit practices.
INTRODUCTION

This paper presents a case study examining the policy influence of research and related activities on not-for-profit (NFP) hospitals in Indonesia, undertaken by the Health Policy and Health Financing Hub at the Nossal Institute for Global Health. The Hub is one of four Knowledge Hubs for Health funded by AusAID over 2008-12, with the aim of providing evidence that influences policy or practice and communicating that evidence effectively to users and policy makers.

One of the research activities undertaken by the Hub was a collaborative study with the Centre for Health Service Management (CHSM) at the University of Gadjah Mada of the role and growth of non-state hospitals in Indonesia during 2010. Although the policy implications of this research are still the subject of discussion and advocacy, the period in which this discussion has taken place offered time to reflect critically on the degree and dynamics of the research’s influence on policy.

The specific focus of the case study is to identify whether the research had any policy influence and, if so, how that influence occurred, and any lessons learnt relevant to the process of influencing policy. The Hub and CHSM are distinguished throughout the case study, to aid understanding of the specific factors and actors that led to policy influence. The Hub collaborated with CHSM throughout the entire process, including in the development of research plans, analysis of findings and the preparation of reports. However, CHSM led communications and dissemination related to the research within Indonesia. This study therefore represents the Hub’s influence overall. The study presents decisions, events and perspectives in extensive detail, but its authors concede that it is likely to be a partially reconstructed account of the efforts of CHSM and NFP hospital associations.

METHODOLOGY

The Hub commissioned this exploration of research influence on policy as a case study. Gilson (2012) argues that health systems need to be reviewed in their local political and social context, and so case studies are valuable, being highly contextualised and canvassing multiple sources of evidence or interpretations. The approach is relevant for health policy investigation, given the formative influence of context and culture on health systems and the importance of examining the relationships, interests and behaviour of policy actors. Keene and Packwood (2000) contend that although case studies are labour intensive, they are useful ‘where policy change is occurring in messy real world settings’.

This case study uses a framework-based approach, drawing on the ‘policy influence template’ (or ‘framework’) that was developed by the Hub for use by all four AusAID-funded knowledge for health Hubs (Hort and Annear, 2012). The framework states that the aims of the case studies are to:

1. identify and describe policy changes (or where changes did not occur);
2. identify and describe research or knowledge evidence provided through Hub activities; and
3. evaluate the extent to which research or knowledge inputs are related to policy change in the specific context and identify factors which might have constrained or facilitated policy influence.

Based on an extensive literature review, the framework identifies the following elements as requiring consideration in the case studies:

- Policy context: type of decision; political context; policy maker interest in evidence & relation with the researcher;
- Knowledge or evidence input: type of knowledge and extent to which this is generalizable or context specific
- Communication: method and factors influencing communication
- Potential influence on policy: ranging from changes in attitudes of policy makers to procedural changes, and changes in policy content or policy implementation.

The framework’s implicit assumption is that answering the questions within each domain will generate sufficient evidence for forming a judgment about the policy influence of the research.

Because of the need for a high level of detail and understanding of context and actors in a single-
issue case study, the team comprised one ‘insider’, namely the lead Indonesian researcher, who had intimate knowledge of the actors and events, and one Australian researcher who had been independent of the research. The Indonesian researcher brought detailed knowledge of the chronology of research activities, the stated and informal objectives of the research and the efforts to engage particular policy makers. This researcher could draw on first-hand experience of context and relationships in order to assess whether the research had policy sway. The Australian researcher, being independent, offered the ability to explore disinterestedly the perceptions and assumptions of stakeholders on these same issues, particularly the extent, or lack of, policy influence.

The case study took 12 weeks, beginning 15 March 2012. The methodology comprised three phases:

1. Production of a timeline: At the outset, the team constructed a detailed historical timeline, narrated by the Indonesian researcher. Although the timeline is linear, the team did not assume that any influence on policy was sequential or cumulative. Rather the timeline was used as a summary of noteworthy interactions and decisions in the research, and as a vehicle for exploring stakeholder interpretations of their significance and meaning.

2. Document review, in both Indonesian and English, including:
   - research outputs from CHSM and the Hub, including policy briefs, published papers, books, draft regulations, minutes of meetings and other communications including stakeholder emails, focusing on major findings, authorship and audience; they served as the basis for the question guide on the influence of research outputs for policy and on the existence of a concerted communications strategy;
   - policy instruments and the text of draft regulations, which were compared against CHSM research findings and recommendations.

3. Semi-structured stakeholder interviews: These were undertaken with a total of 24 stakeholders who had had any contact with the research over the previous two years. This included representatives from parliament, NFP hospital associations, the ministries of Health and Finance, the national newspaper Kompas and the CHSM and Hub researchers involved.

Ethical clearance for the case study was given by the Ethical Committee of the Faculty of Medicine at the Universitas Gadjah Mada. Because the research activities were conducted exclusively by national researchers within Indonesia, it was decided that ethical screening by an Indonesian academic institution was appropriate.

**KEY EVENTS AND ACTORS**

**History of Non-State Providers**

Non-state providers have a long history in Indonesia. The first non-state hospital was founded by the Dutch East India Company in 1626. Religiously affiliated hospitals developed in the mid-19th century and ‘flourished’ by the early 20th under the sponsorship of so-called *zending* or missionary groups from Europe (Trisnantoro, Dewi et al 2012). Even in colonial times, these hospitals had a two-tiered ward system, some wards catering for fee-paying Dutch nobility. Donations from their parent organisations were cut off during the Japanese occupation (1943-45), when Dutch doctors, nurses and missionaries were sent back to the Netherlands.

It was only after Independence in 1945 that the Indonesian government established the state hospital sector. ‘For-profit’ or private commercial hospitals were permitted in the 1990s as the economy grew. The 1997 Asian financial crisis had a devastating impact upon Indonesia and created the impetus for social safety net schemes for the poor, including health insurance.

The policy environment in Indonesia has changed markedly in the past two decades. After President Soeharto stepped down on 21 May 1998, his authoritarian system was abolished. A free general election was held in June 1999. Indonesia shifted to a democratic system and embarked upon liberal reforms, including the guarantee of political freedom and participation. The liberalisation of political institutions brought about mixed effects, including political instability in some provinces. The government responded with what has been referred to as the “big bang” decentralisation in 1999. This systemic shift added further complexity to an already intricate policy
environment. At this time, the House of Representatives (DPR, the parliament) assumed charge of central decision making. For the first time, the DPR exercised its right to make laws and exercise authority over government. The DPR also played an active part in political processes through policy discussions and the approval (or rejection) of appointments of chiefs of government agencies.

The collapse of the Soeharto regime lifted the control of the state over society and opened up possibilities for freedom of speech, association and participation. Subsequently, social movements have developed and become more sophisticated, seeking for policy to respond to popular demands expressed through peaceful demonstrations, petitions and public hearings in assemblies. CHSM’s research and policy efforts were undertaken and must be read in this context.

Sequence of Events

An overview of the research and policy intent and of the main actions is provided here and is illustrated in Figure 1 below, a summary of the chronology of the research project.

In 2009 CHSM mapped the recent growth of the non-state hospital sector. Information was compiled from Ministry of Health hospital registration data from the previous 10 years, including the number, location, accreditation and ownership of state and non-state hospitals. This study revealed that non-state hospitals accounted for 50 per cent of the hospitals and 37 per cent of the beds, confirming their major role in universal health care coverage in Indonesia. A striking finding of the research team was that NFP hospitals were dominant among non-state hospitals, accounting for 82 per cent of all non-state hospitals. NFP hospitals were mainly run by foundations (yayasan) or networks of hospitals linked to religious institutions; but this category also included clinician-owned small hospitals. Importantly, the study found that the growth of NFP hospitals had levelled off, some even converting their legal status to ‘for profit’. The research identified that NFP hospitals were facing ‘a fundamental conflict between the charitable mission and values on which they were founded, and the lack of resources to provide funding for these charitable services either through the owner or through subsidies from the government’ (Trisnantoro, Dewi et al 2012). CHSM also found that NFP hospitals were sometimes the only health care provider outside district capitals, as is the case in Papua province. Added to the finding that the number of NFP hospitals in remote and rural areas was decreasing overall, CHSM concluded that if these hospitals decline, ‘there is a growing risk of the poor losing their access to health care’ (p. 9).

When CHSM shared its findings at a seminar with NFP hospital associations in June 2009, the associations identified the loss of funding from parent religious organisations and the lack of tax breaks as constraints on their growth. Additionally, they pointed to the increasing costs of medical services and drugs, and a proliferation of new taxes that were creating significant financial pressures on NFP hospitals and threatening their viability. These pressures included: the need to offer competitive doctors’ salaries to attract and maintain the minimum level of specialist services required for their operating licences;¹ the imperative to compete for fee-paying patients, to provide income for clinicians and offset delays and funding gaps in compensation schemes for charitable services, such as through JAMKESMAS (Jaminan Kesehatan Masyarakat or Social Health Insurance); and the lack of direct or indirect government subsidy for charitable services. As a consequence, NFP hospitals had emulated ‘for profit’ practices in the recent decade, such as the introduction of first-class or ‘VIP’ wards, fees and impressive modern hospitals to attract wealthy clients. CHSM identified that in other countries, such as Vietnam, non-state hospitals received tax exemptions. This comparison was noted by one researcher as a compelling rationale for Indonesia to be ‘fair’ (interview, 22 March 2012). CHSM’s policy intent and pursuit of a tax incentive, in particular, were formed at this time.

In 2009, Indonesia was drafting its first Hospital Act, and this presented an unparalleled opportunity to legislate the desired tax exemptions. CHSM lobbied the parliamentary drafting committee for the incorporation

¹ Chapter 4 in Trisnantoro, Dewi et al (2012) includes a case study of a 2006 survey on the incomes of government doctors from eight provinces of Indonesia by the University of Gadjah Mada, the Indonesian Doctors Association and Health Insurance Limited Corporation. The survey found that more than two-thirds of their income came from dual practice in the non-state sector, specifically salary (22.6 percent), incentives (35.1 percent) and private practice (14 percent).
of tax concessions and for a revised formulation of hospitals designated as ‘public’ to include NFP hospitals (alongside government providers). Within four months, these two elements were incorporated into the new Hospital Act, a swift conversion of research findings to policy influence. From this time, CHSM and NFP hospital associations engaged with the Ministry of Health to develop the regulations to implement these elements. Efforts began in early 2010 to produce and ratify regulations within the stipulated period of two years from the passage of the act. However, at the time of this case study, the regulations had not been approved.

**Key Stakeholders**

At the time of the case study, there were a number of associations that managed or coordinated networks of NFP hospitals.

Muhammadiyah is a Muslim foundation established in 1912. It owns and manages 457 general hospitals, mother and child hospitals, maternity clinics, health clinics and other smaller health posts. http://www.muhammadiyah.or.id/

PELKESI is an association of Christian church-owned hospitals, founded in 1983. The association comprises 124 general hospitals, mother and child hospitals, maternity clinics, health clinics, and other smaller health posts. http://www.pelkesi.or.id/

PERDHAKI, an association of Catholic church/convent-owned hospitals, was founded in 1972. http://www.perdhaki.org/

YAKKUM is a foundation owned by the Indonesian Christian Church and the Javanese Christian Church. Yakkum owns 12 hospitals. http://www.yakkum.or.id/

All of the above associations are members of PERSI, the Indonesian Hospital Association. Government offices were also involved. In the Ministry of Health, the Bureau of Regulation is responsible for drafting regulations, decrees and standing orders for the ministry, while the Directorate-General of Health Services oversees primary, secondary and tertiary health services. In the Ministry of Finance, the Directorate-General of Taxation oversees taxation regulations and their implementation, and the Centre of State Revenue, under the Fiscal Policy Agency, is closely linked to the directorate-general in overseeing issues of taxes and levies.
FIGURE 1. CHRONOLOGY OF CHSM RESEARCH ACTIVITIES AND POLICY DEVELOPMENTS RELATING TO NOT-FOR-PROFIT HOSPITALS

RESEARCH ACTIVITIES

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<thead>
<tr>
<th>RESEARCH ACTIVITIES</th>
<th>POLICY DEVELOPMENTS</th>
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<tr>
<td>CHSM mapping of non-state hospital sector</td>
<td>NFP hospitals invited onto parliamentary drafting committee for Hospital Act</td>
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<tr>
<td>CHSM holds two dissemination seminars with NFPS</td>
<td>Hospital Act passed including right to tax exemption for NFP Hospitals</td>
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<td>Policy brief on need for supportive policy for NFP</td>
<td>Multi-task stakeholder Taskforce on Tax Relief formed within Ministry of Health</td>
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<td>hospitals</td>
<td>Taskforce produces academic review</td>
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<td>Advocacy to parliamentary drafting committee for</td>
<td>Draft regulation on tax exemption produced, but not tabled.</td>
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<td>Hospital Act</td>
<td>Regulation on non-cash support for NFP Hospitals is enacted.</td>
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<td>CHSM engages with Kompas newspaper on findings</td>
<td>Formation of informal NFP Hospital association</td>
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<td>Launch of CHSM website on NFPS</td>
<td>Case study produced</td>
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<td>Multi-stakeholder study visit to Melbourne</td>
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<td>Formation of joint MoH-NFP working groups</td>
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<td>Kompas publishes feature article on financial burdens for NFP Hospitals</td>
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<td>CHSM converts findings to book manuscript</td>
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<tr>
<td>CHSM- NFP hospitals draft alternative regulation on tax deductible donations to NFP Hospitals</td>
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<td>Kompas publishes another report on financial burdens for NFP Hospitals</td>
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FINDINGS

This section provides a detailed account of the impetus, efforts and outcomes arising from the CHSM research to influence tax exemption policy for NFP hospitals. The findings are organised according to the six domains of the policy influence framework: policy issues, policy context, research inputs, communications, policy influence and implications. Within each domain, convergence or incongruity in perspectives is highlighted, as is information that contributes to an explanation of whether and how the research influenced policy. The findings are presented in three parts. Part 1 describes the policy context and basis for research decisions; Part 2 documents the research and dissemination process; and Part 3 considers the contribution of the CHSM research to policy changes.

Part 1: Context

This section describes the rationale for the research, the process whereby an intent to influence policy was formed and the significance and context of issues.
Policy issues

Definition and rationale of policy issues: The decision to research the role of NFP hospitals in the Indonesian health system and to pursue a tax exemption policy in particular resulted from a sequence of research ‘discoveries’ and was arguably influenced by the equity principles of the Hub and CHSM.

The research was first conceived by the Hub, in collaboration with CHSM, to support national research partners to examine the role of the non-state sector in health provision in middle income countries, specifically in Indonesia and Vietnam (Hort, Akhtar et al 2011). This scope was consonant with AusAID’s priority areas of health system strengthening in Indonesia and of ‘saving lives’ through increased access to health care for all, particularly to maternal and newborn care (AusAID Indonesia Partnership Priority 2). According to the Hub director, Dr Krishna Hort, the research was also in line with the Hub’s ‘interest in the poor and how services are available to them, rather than provision to the better off’ (interview, 3 April 2012).

The Hub director decided that it was important and fitting for CHSM as the Indonesian research leader to define further the direction of the research, according to its first-hand discernment of priorities. The Ministry of Health and NFP hospital associations were not involved in decisions on the research focus and policy options at the outset.

CHSM elected to focus on the non-state hospital sector for several reasons. CHSM was aware that other reviews had been undertaken on the non-state sector in Indonesia but not specifically on hospitals. CHSM identified that hospitals consume a substantial portion of the national health budget and government health financing schemes (e.g. out-of-pocket payments, non-state health insurance and social health insurance), increasing the government’s exposure for health (Trisnantoro, Dewi et al 2012). From a preliminary internal assessment, CHSM found that non-state facilities are a fast growing provider in Indonesia, stimulated by gaps in coverage by state sector facilities and the deregulated policy environment for the non-state sector. CHSM also reasoned that demand for hospital care will increase given that Indonesia is facing an epidemiological transition to the double burden of communicable and non-communicable disease and the higher care needs also associated with an ageing population (Trisnantoro, Dewi et al 2012).

However, the identification of the policy issue evolved as research findings emerged and in response to engagement with the stakeholders, particularly NFP hospital associations.

The initial finding of the high proportion of NFP hospitals within the non-state hospital sector prompted CHSM to engage with NFP hospital associations. Through this dialogue, it became clear that financial pressures on the non-state sector were undermining the capacity of NFP hospitals to fulfil their charitable mission and driving them towards provision of services for profit. Part of the problem identified was the large number of taxes for which NFP hospitals were liable, as well as the lack of any tax concessions.

As a result of this dialogue, it was recognised that the primary policy change needed was the introduction of tax concessions for not-for-profit hospitals. Related secondary policy issues identified were:

- the need for NFP hospitals to reaffirm their charitable mission and their not-for-profit operation, in order to justify tax concessions;
- the need for NFP hospitals to examine other aspects of the financial and operational pressures; and
- the need for government to recognise the role and contribution of NFP hospitals to public policy objectives and to include their role in policy development.

Current status of the issue in the policy cycle: When stakeholders were asked their views on the status of ‘the issue’ in policy making, to aid their response, they were shown an English or Indonesian version of a table describing a seven-stage progression of how research influences policy, as devised by the Hub (Appendix 1). The stages are: research priority setting; evidence-filtering and dissemination; expanding policy capacity and improving policy-making processes; agenda setting; policy formulation; policy implementation; and policy evaluation.

Interestingly, all stakeholders regarded the issue in question to be tax exemption for not-for-profit hospitals. Despite a potential range of options for tackling the...
financial sustainability of not-for-profit hospitals, after the inclusion of tax exemption in the Hospital Act, researcher advocacy concentrated largely on implementing this exemption.

There was also a consensus among the researchers, NFP hospital association representatives and the parliamentarian interviewed, that the inclusion of the tax exemption clause in the Hospital Act suggested that the issue had formally reached the policy implementation stage, but that it would not be effective until regulations were passed. In Indonesia, regulations to implement clauses in new legislation need to be passed within two years of the adoption of the act.

The most senior CHSM researcher was adamant that new strategies, such as the formation of a peak body for NFP hospital associations, would propel implementation of the tax clause (interview with Professor Laksono Trisnantoro, 27 April 2012). Another researcher was less sanguine that a regulation would be approved, and felt that it was better to pursue a new regulation recognising the charitable status of not-for-profit hospitals in order for them to be able to receive donations (interview, 27 March 2012).

However, in spite of the legislative changes, comments by representatives from the ministries of Health and Finance suggested that the issue was still at an incipient, agenda-setting stage and did not yet have sufficient endorsement. This was coupled with remarks suggesting that the tax exemption was accorded a low priority overall.

One official from the Ministry of Health remarked, ‘As long as we (the Sub-Directorate of Medical Services that oversees hospital issues) have money to conduct the meetings between the ministry, academics and hospital associations, we will keep following up this issue’ (interview, 26 April 2012). Another stakeholder said, ‘The Ministry of Health may be more inclined to provide a tax exemption to the teaching hospitals than the not-for-profit hospitals, because incentives to teaching hospitals address the supply of doctors—they are desperately needed. Workforce under-supply is a high priority’ (interview, 15 April 2012). An official from the Ministry of Health said, ‘If the policy has a political nuance, we can speed up the process; political interest is a powerful way to speed things up’. These remarks suggest that the tax exemption for NFP hospitals is still a comparatively low policy priority. For some, this was indicative of the low priority the non-state sector has in the Ministry of Health. One stakeholder supported this view by pointing to public statements made by the minister of health in the case of a high-profile negligence suit against a for-profit hospital in 2009; he said he wouldn’t intervene because of it being a ‘private’ (that is, non-state) hospital matter (interview, 22 March 2012, citing ‘Minister of Health: I cannot “pinch” Omni Hospital’s ear’, by Taufik Wijaya, detikNews, 4 June 2009).

**Anticipated outcomes of the research:** Through the research by CHSM in 2009 and 2010, specific policy objectives were formed. Despite CHSM’s long engagement in health systems research in Indonesia, the major role and scale of NFP hospitals was a genuinely surprising finding for both the researchers and the Ministry of Health. Once the findings emerged, the decision to support the tax exemption was a result of, rather than the motivation for, the research.

The CHSM study on non-state hospitals identified a need for the exposure and elimination of hospitals with ‘false non-profit status’—hospitals that claim to be not for profit but employ for-profit practices. The study urged that with the drift to for-profit practices, NFP hospitals ‘should also show a more humanitarian image’ by moderating the ostentation of NFP doctors and serving remote areas (Hort, Akhtar et al 2011).

The entitlement to tax exemptions hinged on the ‘distinctive characteristics’ of not-for-profit hospital providers and their ‘charitable services’. CHSM felt that the research should clarify the meaning of these concepts in order to defend the survival of NFP hospitals in the radically developing architecture of health care delivery. The research therefore considered the following questions: How can a charitable identity be quantified, measured and distinguished from other ownership types? Does the presence or absence of certain services make an organisation not for profit? Is there a distinction between not-for-profit and for-profit services that results in perceptibly different patient outcomes? Are there different standards of conduct and accountability of the owners of NFP hospitals? Is policy needed to support these charitable services?

Strategically, the researchers sought to use their findings to inform and galvanise the NFP hospital financial sustainability of not-for-profit hospitals, after the inclusion of tax exemption in the Hospital Act, researcher advocacy concentrated largely on implementing this exemption.
associations with regard to their distinctive status and mission. As one researcher stated, a secondary motivation arising from the research findings was to ‘remind not-for-profit hospitals of their social mission to provide charitable services to the poor’, and that it is on that basis that they are entitled to tax concessions (interview, 27 April 2012). Notably, through the course of the research, Muhammadiyah, PELKESI and PERDHAKI reconfirmed to CHSM their foundations’ commitment to remain not for profit.

**Involvement and attitudes of those involved**

Using research findings to influence policy has so far directly engaged representatives from the following: a cluster of NFP hospital associations, primarily Muhammadiyah, PERSI and PERDHAKI; the Sub-Directorate of Medical Services and the Bureau of Law within the Ministry of Health; the Ministry of Finance; parliamentarians (2009 sitting); Kompas newspaper; the Hub; and CHSM. Interestingly, the Kompas representative observed that citizens or the ‘end users’ were missing from those consulted and should be involved in the future.

CHSM engaged NFP hospital associations from the outset, sharing preliminary study findings with them in mid-2009, which opened the door for them to join CHSM as invited members of the drafting committee for the Hospital Act. CHSM supported NFP hospital associations to inform and advocate to the Ministry of Health.

The sequence of engagement by CHSM can be read as careful management of diverse views about other stakeholders and the issue. Based on past experience, stakeholders appeared to have conflicting expectations and interpretations of a number of issues. For example, there was disagreement between parties as to whether the NFP hospital associations, the Ministry of Health or even CHSM was responsible for leadership on the issue. One association stated, ‘The act dictates that the Ministry of Health should be in the leading role’, whereas the Ministry of Health looked to the hospital associations ‘to spearhead the process’.

The need for NFP hospitals to ‘restore their humanitarian image’, identified by the CHSM research, also appeared to prejudice stakeholders against tax exemption. A number carefully noted, in general rather than personal terms, that there was a distrust of the motives for the tax exemption. It was suggested that exemption could be interpreted as a means by which NFP hospital foundations could increase their profits. The current financial independence of foundations and the limited oversight by the Ministry of Health reinforce this suspicion. Lastly, it was apparent through interviews that there was a questioning of the Ministry of Health’s commitment and political will concerning issues connected to the non-state sector. The ministry’s ‘low understanding’ of the operational realities of NFP hospitals was cited as evidence of ‘low commitment’. However, in some ways this is a circular argument; it arguably underestimates both the complexity of the operating environment and that NFP providers have been a neglected issue in health sector development. It is not unreasonable for the Ministry of Health to have a low understanding at this time, so a lack of political will would need to be substantiated by other evidence.

A number of other possible reasons for the low understanding or low priority of regulation can be drawn from stakeholder statements. First, as one explained, the ‘right’ to tax exemption enshrined in the Hospital Act is not operational until there is a government regulation (peraturan pemerintah). A government regulation is the highest order of regulation and requires the relevant technical ministry to draft it and then obtain the president’s signature. The complexity with the tax exemption regulation is that the technical ministry is the Ministry of Health, since it falls under the Hospital Act, but taxation is under the jurisdiction of the Ministry of Finance. The two ministries are therefore required to collaborate in the drafting. Secondly, the Hospital Act has given rise to many other regulations over which the Ministry of Health has authority, and which it has prioritised.

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CHSM engaged NFP hospital associations from the outset, sharing preliminary study findings with them in mid-2009, which opened the door for them to join CHSM as invited members of the drafting committee for the Hospital Act. CHSM supported NFP hospital associations to inform and advocate to the Ministry of Health.

The sequence of engagement by CHSM can be read as careful management of diverse views about other stakeholders and the issue. Based on past experience, stakeholders appeared to have conflicting expectations and interpretations of a number of issues. For example, there was disagreement between parties as to whether the NFP hospital associations, the Ministry of Health or even CHSM was responsible for leadership on the issue. One association stated, ‘The act dictates that the Ministry of Health should be in the leading role’, whereas the Ministry of Health looked to the hospital associations ‘to spearhead the process’.

The need for NFP hospitals to ‘restore their humanitarian image’, identified by the CHSM research, also appeared to prejudice stakeholders against tax exemption. A number carefully noted, in general rather than personal terms, that there was a distrust of the motives for the tax exemption. It was suggested that exemption could be interpreted as a means by which NFP hospital foundations could increase their profits. The current financial independence of foundations and the limited oversight by the Ministry of Health reinforce this suspicion. Lastly, it was apparent through interviews that there was a questioning of the Ministry of Health’s commitment and political will concerning issues connected to the non-state sector. The ministry’s ‘low understanding’ of the operational realities of NFP hospitals was cited as evidence of ‘low commitment’. However, in some ways this is a circular argument; it arguably underestimates both the complexity of the operating environment and that NFP providers have been a neglected issue in health sector development. It is not unreasonable for the Ministry of Health to have a low understanding at this time, so a lack of political will would need to be substantiated by other evidence.

A number of other possible reasons for the low understanding or low priority of regulation can be drawn from stakeholder statements. First, as one explained, the ‘right’ to tax exemption enshrined in the Hospital Act is not operational until there is a government regulation (peraturan pemerintah). A government regulation is the highest order of regulation and requires the relevant technical ministry to draft it and then obtain the president’s signature. The complexity with the tax exemption regulation is that the technical ministry is the Ministry of Health, since it falls under the Hospital Act, but taxation is under the jurisdiction of the Ministry of Finance. The two ministries are therefore required to collaborate in the drafting. Secondly, the Hospital Act has given rise to many other regulations over which the Ministry of Health has authority, and which it has prioritised.

An important dimension of stakeholder involvement in this case study was variation in the capacity to engage. As one stakeholder remarked, ‘NFP associations are not created equal’ in size and capacity (interview, 3 April 2012). Some associations, such as Muhammadiyah, have a long history of political engagement, and others less so. One stakeholder also suggested that in the post-independence period, Christian-affiliated groups may have wished to stay outside the political realm (interview, 3 April 2012). There was agreement, however, that PERSI was best placed to serve as the
these differences also explain responses to the efforts to pass the regulation, including enthusiasm, wariness and frustration.

Relationship between researchers and policy makers

A prominent feature of the policy influence process has been the activist role of CHSM. CHSM strategised, facilitated networks and meetings, drafted regulations and advocated for the tax exemption. CHSM recognised that it had been the leader to date, but that NFP associations needed additional support to become stronger. Indeed, this has been appreciated by NFP hospital associations. A PERSI representative commented that the University of Gadjah Mada (CHSM) ‘is the only university that is concerned with not-for-profit hospital issues’ (interview, 27 April 2012). However, CHSM has been explicit in recent words and deeds about handing over responsibility to the NFP associations. Without this, two of the researchers raised the risk of ‘researcher capture’ ... [meaning the researcher may be] working in the service of the NFP hospital associations and the Ministry of Health’ (interview, 22 March 2012). An example is CHSM’s drafting of the tax exemption regulation for review by the Ministry of Health.

At meetings in early 2012, CHSM urged the NFP hospital associations to appoint a senior person from each hospital to form a peak body for pursuing the regulation. CHSM suggested that the associations could each contribute a small amount to hire professionals, such as lobbyists and legal drafters, to support their efforts. One further suggestion by CHSM was for them to petition for a judicial review of the tax law (distinct from the Hospital Act) to extend favourable concessions to the NFP hospital sector. This was pitched to the associations by CHSM as an investment in their future.

CHSM and the Hub expected that in the future, researchers would return to their natural role as providers of evidence to both NFP hospital associations and to the Ministry of Health, to get issues onto the government agenda. One researcher suggested that CHSM could investigate issues such as the low supply and utilisation of hospital beds in Indonesia as compared with other ASEAN nations, which impacts on the accessibility of care.

3 One interviewee relayed an anecdote from a Ministry of Finance official that during the drafting of the NFP Educational Institution Income Tax Exemption Policy in the late ’90s, a draft was also prepared to provide the same exemption for the NFP hospitals. When these two drafts were ready to be submitted for signing, it is alleged that the Directorate-General of Tax saw that while Ministry of Education and the NFP educational institutions were actively involved during the whole process, there was no representation from the Ministry of Health. On this basis, it was decided not to submit the draft on tax exemption for NFP hospitals.
The Kompas observer commented that CHSM’s engagement in policy deliberation was stronger with individual NFP hospital associations than with the Ministry of Health.

**Contextual influences**

A range of background circumstances explain the course of CHSM’s research influence on policy change. As CHSM embarked upon its mapping study of the non-state sector, the Indonesian parliament was drafting its first Hospital Act. The researchers knew this was an unparalleled opportunity to legislate recognition of the unique charitable role and financing needs of NFP hospitals. As the government intensifies its introduction of social protection and universal coverage schemes for the poor, the researchers felt the sustainability of NFP hospitals would resonate with parliamentarians on this basis. The parliamentarian interviewed for this case study, a veteran of hospital administration, agreed that the policy should distinguish not-for-profit hospitals from for-profit ones.

Another enabling factor was arguably the growing openness of the government to civil society input. Evidently commanding national respect as academics, CHSM was an invited member of the parliamentary drafting committee for the act. Upon seeing that only the state hospital sector was represented, CHSM invited NFP hospital associations to participate. The acceptance on the drafting team of a group that describes its historic neglect by government can be read as the government’s recent willingness to consider civil society input. One researcher commented, ‘In the newly democratised Indonesia, civil society is still learning and finding its roles ... The government is still changing from a bureaucracy to a more executive role and so it’s also learning new roles.’ Having a platform for the NFP hospital associations to express their views was unprecedented and an influential contextual factor.

There were also contextual factors that likely tempered momentum for policy change once the Hospital Act was passed. First, the act coincided with the end of a parliamentary term, so those representatives who had been persuaded of the importance of the tax clause then left office.

The current functioning of the Indonesian health system has also played a role. The deregulation of the health system in the early 1990s has been accompanied by fragmented governance between central and sub-national levels, as well as complexity in financing mechanisms. Specifically, there are limited regulation, information and reporting relating to the non-state sector, including on financial management, and no policy to regulate the distribution of new not-for-profit hospitals. NFP hospital associations consider that they have been neglected in policy, with a correspondingly limited understanding of their operating circumstances and contribution. However, some decision makers see NFP hospitals as beyond regulation and transparency, so their motives in pressing for a tax exemption were questioned.

A final contextual influence that has impinged upon acceptance of the tax exemption was ideological or at least jurisdictional. Stakeholders had opposing views on how best to redistribute funds for the poor and on whether a tax exemption was a privilege or a necessity. The Ministry of Finance’s position was that it is the responsibility of the government to collect revenue through tax which is then used to finance schemes for the poor (for example, JAMKESMAS). From its perspective, a tax exemption is not desirable, because it results in revenue losses for such schemes. One stakeholder commented that the Ministry of Finance thinks of the tax incentive as a “disincentive”, viewing tax as a due to the state rather than a burden.

On the other hand, NFP hospital association representatives argued that the Ministry of Finance view works only so long as the poor go to state hospitals. In reality, state hospitals are overcrowded, suffer from a lack of supplies and staff and are perceived as low quality. NFP hospital associations contended that they should be supported because they currently provide charitable services, as well as being expected to respond in times of emergencies and outbreaks (often without funding support), to compensate for shortfalls in state hospitals. The associations noted that they have previously tried to engage with the Ministry of Health to convey the burden they incur from the JAMKESMAS reimbursement scheme, whereby payments are late and do not meet the actual cost of providing the medical service since the costing model is based on the heavily subsidised state hospital.
sector. It is notable that through the operation of Law No. 34/2000, which allows regional taxes to be a source of local government income, NFP hospitals are currently subject to 30+ local taxes relating to hospital operations, in addition to central government taxes such as income tax, value added tax, land and building taxes and tariffs for medical equipment. The argument for policy change and tax exemption was therefore an issue of fairness, according to the associations.

The Ministry of Health intends to but has not yet begun a comprehensive hospital costing study that covers state and non-state hospitals, so it is unlikely that the gaps in JAMKESMAS reimbursement will be addressed soon. In the eyes of NFP hospital associations and the researchers, the tax exemption therefore remains crucial.

Part 2: Generation and Dissemination of Evidence

To identify whether the CHSM research had policy influence and how that occurred, it is necessary to examine the research ‘products’ that were created and how they were utilised. This section therefore describes the research outputs and the approach taken for their dissemination.

Research activities

Research outputs: The research products authored by CHSM took a number of forms (Table 1). The range, listed in chronological order below, is notable in its breadth, spanning academic, advocacy and legal formats.

Type of knowledge provided: The type, forms and conveyance of knowledge produced by any researchers will have a bearing on its comprehension and uptake by policy makers. Trisha Greenhalgh (2010) has suggested a distinction between data (an ordered inventory of items), information (organisation of data within a context and showing relationships), and knowledge (which judges the significance of that information). Policy analysts have also distinguished between theoretical and generalisable knowledge for policy influence, and practical and context-tied forms.

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4 The Indonesia Case-Based Groups (INA-CBGs) is a costing model similar to the Diagnostic Related Group (DRG) method.

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### TABLE 1. RESEARCH PRODUCTS AuthORED BY CHSM

<table>
<thead>
<tr>
<th>Date</th>
<th>Output</th>
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<tbody>
<tr>
<td>January-April 2009</td>
<td>Mapping study of the state and non-state hospital landscape. This identified the size but also the recent stagnation of the NFP hospital sector. It identified policy options for the survival of the sector and its services for the poor.</td>
</tr>
<tr>
<td>July 2009</td>
<td>Policy Brief #1, on the need for supportive policy for non-state hospitals. This brief proposed tax exemptions for “public” or non-commercial hospitals providing charitable services.</td>
</tr>
<tr>
<td>January-May 2010</td>
<td>Production of the monograph The Non-State Hospital in Indonesia with the research findings in Indonesian and English. In press as at June 2012.</td>
</tr>
<tr>
<td>August 2010</td>
<td>Policy Brief #2, on steps for implementing the tax incentive clause in the Hospital Act. The brief recommended that: (1) the Ministry of Health define criteria for what are NFP hospitals; (2) NFP hospitals take steps to provide evidence of good governance and accountability; and (3) there be a dialogue between the ministries of Health and Finance and NFP Hospital Associations to agree on the tax incentives needed.</td>
</tr>
<tr>
<td>August 2010</td>
<td>Policy Brief #3. This was authored by the Catholic Hospital Association, PERDHAKI. It focused on various tax incentive options including those relating to income tax, VAT, land and building taxes and import tariffs. The brief also reiterated the right of NFP Hospitals to receive a subsidy and grant from government, as per the Hospital Act.</td>
</tr>
<tr>
<td>December 2010</td>
<td>CHSM and NFP hospital associations contributed content to the academic review that was required to justify the regulation. Input was provided to the Ministry of Health. It has been under review by the Bureau of Law since then.</td>
</tr>
<tr>
<td>December 2010</td>
<td>CHSM produced a draft regulation for the tax exemption for submission to the Ministry of Health.</td>
</tr>
<tr>
<td>September 2011</td>
<td>In response to the limited progress of the tax regulation draft, CHSM drafted an alternative regulation for donations to NFP hospitals to be tax deductible.</td>
</tr>
</tbody>
</table>
It is clear that the research outputs were practical rather than theoretical in nature, specific to the context of the contemporary Indonesian health system, and culminated in policy options that were oriented to action. When CHSM embarked upon the initial mapping, it did not have an a priori theory. One researcher recounted the approach to the research:

We never had the need to prove any hypothesis. We never did a literature review prior to data collection [that is, analysing the hospital registration data]. Only when we started getting the data did we ask why the data was looking this way.

It can therefore be viewed that CHSM touched on all three of Greenhalgh’s ‘types’, progressing from a compilation of data to a realisation of causes of the stagnation of NFP hospital growth, and an accompanying appreciation of the consequences for health access by the poor.

The significance of findings: The findings of the CHSM research have been noted earlier, namely the dominance of NFP hospitals in the non-state hospital sector and the stagnation in their growth over the past 10 years. When asked whether the findings were new or unexpected, stakeholders highlighted different aspects, providing insight into the varying knowledge and policy stakes in the issue. The CHSM and Hub researchers, despite their long focus on health system development in Indonesia, noted, ‘[I]n terms of health care provision, it is not shocking but still unexpected to see how big the non-state sector is’. The researchers expected that for-profit hospitals would be the major provider. The researchers also felt that the size of NFP provision within the non-state hospital sector ‘really got the attention of the Ministry of Health. For the most senior CHSM researcher, what mattered most was the realisation of two different types of non-state organisations—for profit and not for profit—and the charitable duties attached to the latter.

One NFP hospital association stakeholder suggested that they were shocked to realise that other countries had tax exemptions for non-state hospitals. The Ministry of Health reported that the research findings crystallised the significance of NFP hospitals in health service coverage, ‘especially in rural areas’. They stated that it provoked recognition of small NFP hospitals that were ‘serving the people with their limited resources’.

They knew that some NFP hospital providers were facing ‘issues’, but the research revealed that the issues were ‘systemic and across the board’.

Engagement of potential users in design, process or analysis: Up until mid-2009, CHSM was the principal researcher and author of research outputs. However, from mid-2009, NFP hospital associations became a partner in the identification, analysis and presentation of issues, albeit to varying degrees between associations. To illustrate, in March 2009, CHSM held a seminar in Yogyakarta to present its initial findings to an audience of NFP hospital associations, which were asked to comment on the data.

However, at a second seminar in June 2009, CHSM sought a greater engagement of the associations. It was at this time that the associations shared their financial hardships and CHSM realised the reason for their stagnation. The academic review in December 2010 was regarded by one researcher as a particularly good example of CHSM-NFP hospital collaboration. There was attempted, but ultimately limited, engagement of the Ministry of Health in the production of these outputs. Some stakeholders were cautious about engaging the Ministry of Finance, and so it was marginal to the research process, but provided instructive critiques on the tax exemption regulation (described in section on Lessons below).

Communications

Strategy: The findings suggest that CHSM was very conscious of the need to package and target its research, and of the role of communications in persuading the policy community. CHSM in mid-2009 hired a communications officer who formulated and implemented a formal communications strategy. However, it is evident that the researchers themselves had a clear vision of whom to influence and when. This process ran parallel to the formal communications strategy, but the two converged in their trust of interpersonal communication as the most effective strategy for influencing Indonesians.

The NFP hospital associations were the first audience for CHSM’s findings. The intent was two-fold: to outline the extent of their role in health provision and to galvanise them on their mission to provide health care access for the poor. CHSM held seminars in March and
June of 2009 to share statistical findings and trends with NFP hospital associations and a small number of Ministry of Health invitees. By mid-2009, the strategy concentrated on influencing the parliamentarians drafting the Hospital Act. CHSM produced the first four-page policy brief at this time, and the communications officer distributed this directly to parliamentarians on their way into drafting sessions. Statistical analysis was minimised in this brief, but it included a full articulation of CHSM’s policy recommendations for NFP hospitals, including tax relief.

With the tax exemption clause in place from November 2009, the communications strategy subsequently centred on the facilitation of networks and online and print media formats. In May 2010, the Hub and CHSM organised a study tour to Melbourne for NFP hospital associations and the Ministry of Health, to foster collaboration between them and to expose them to equivalent not-for-profit organisations in Australia, thus increasing their knowledge, confidence and engagement in drafting the tax exemption regulation. In Melbourne, the study group brainstormed the next stage of the communications strategy. The communications officer was not involved in this visit, and instead concentrated on the development of a website and online forum and the hosting of a large dissemination event managed by the public relations company, PT Mirah Sakethi.

On the last day of the study visit, the group agreed to establish three multi-stakeholder working groups focused on aspects critical to NFP hospital sustainability. These were: (1) working group on tax relief, led by Muhammadiyah and with the participation of the Ministry of Health; (2) working group on NFP hospital governance, led by the Christian Association, YAKKUM; and (3) working group on tax-deductible donations to NFP hospitals, led by PELKESI. The working group on tax relief later became a formally constituted task force under the Ministry of Health. Although they varied in their effectiveness, these working groups became ongoing vehicles for small-group policy deliberations on the issues triggered by the CHSM research.

Materials and methods of communicating: The following communications materials and approaches were used to disseminate the findings and implications of the research, and elicit support for NFP hospitals having recourse to tax relief and financial support from government.

Effectiveness of the communications strategy: In effect, CHSM implemented a communications and

<table>
<thead>
<tr>
<th>Date</th>
<th>Material and Method</th>
<th>Audience</th>
</tr>
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<tbody>
<tr>
<td>July 2009</td>
<td>Policy Brief #1: email, hard copy distribution through seminars and direct to people.</td>
<td>Individual NFP hospital associations, parliamentarians</td>
</tr>
<tr>
<td>June 2010</td>
<td>Article published in Kompas, providing positive coverage of NFP hospitals, focusing on the perspectives of patients.</td>
<td>General public</td>
</tr>
<tr>
<td>August 2010</td>
<td>Policy Brief #2: email, hard copy distribution through seminars.</td>
<td>NFP hospital associations, Ministry of Health, Kompas</td>
</tr>
<tr>
<td>August 2010</td>
<td>Policy Brief #3: email, hard copy distribution through seminars.</td>
<td>NFP hospital associations, Ministry of Health, Kompas</td>
</tr>
<tr>
<td>August 2010</td>
<td>Launch of website and online forum to provide information and feedback opportunity on the policy briefs and series of seminars hosted by CHSM, <a href="http://kebijakankesehatanindonesia.net/">http://kebijakankesehatanindonesia.net/</a>.</td>
<td>NFP hospital associations, Ministry of Health, Kompas</td>
</tr>
<tr>
<td>August 2010</td>
<td>Task force on tax relief formally constituted within the Ministry of Health and meets for the first time.</td>
<td>Participants: NFP hospital associations, Ministry of Health, CHSM researchers</td>
</tr>
<tr>
<td>December 2010-September 2011</td>
<td>Task force meets a number of times.</td>
<td>Participants: NFP hospital associations, Ministry of Health, CHSM researchers</td>
</tr>
<tr>
<td>March 2011</td>
<td>Meeting called by CHSM to urge forming of an overall NFP hospital association.</td>
<td>NFP hospital associations</td>
</tr>
</tbody>
</table>
contract to change for NFP hospitals. Policy Brief #1 had a demonstrable effect on policy. The wording from the brief on the right of NFP hospitals that are providing charitable services to a tax exemption was incorporated directly into the tax exemption clause.

The policy briefs overall were the most substantial published products of the communications strategy. They were formatted for readability and eschewed “heavy” or “scientific” content. After the first, briefs 2 and 3 were rebranded in the distinctive colours of the University of Gadjah Mada so that the content would be associated with the university’s credibility, and contact details were provided to invite dialogue with interested parties. The series of briefs demonstrates an ongoing commitment to communications. The researchers noted that the briefs were a good way of ensuring consistency of message, independently of the forum or the messenger. However, they did concede that the briefs would need to compete for ministerial attention alongside ‘hundreds of other emails and websites that they receive’. Positive feedback was received from NFP hospital associations and the parliament, but it took some time before the policy brief was eventually circulated to the Ministry of Finance.

The website generated a stream of participant feedback via SMS text messaging for months after its launch, signalling that the site had reach and content worth engaging with. The website has since expanded to cover a range of issues relating to health service management in Indonesia, and, at 24 June 2012, some 42,841 visitors had been logged for the month.

Perceptions of the outcomes of the engagement strand of the strategy were mixed. The CHSM researchers conceded that they did not sufficiently engage with the Ministry of Health in the first two years, and so missed the opportunity to deepen the ministry’s understanding of the issues and support for the regulation. CHSM basically relied on Policy Brief #1 to reach it.

On the other hand, the formation of a formal Ministry of Health task force on the tax clause, which included NFP hospital association membership, was landmark. However, there was a high rotation of Ministry of Health representatives on the task force, and meetings were often instigated by CHSM. For one period, the task force was chaired by the head of the Bureau of Law, who was very knowledgeable and supportive of NFP hospitals but was transferred to another directorate before the regulation was passed. The Ministry of Finance was not invited onto the task force. As noted, this was partly because the Ministry of Health and the NFP hospital associations preferred to engage with Finance once a well-substantiated and supported regulation existed.

Bringing individual NFP hospital associations together for the first time to share research findings and decide on joint action was an important step. It raised the possibility of a collective identity and action. CHSM made concerted efforts to reinforce the message of the special mandate of the NFP sector and its entitlement to tax relief on that basis. CHSM felt that this both served as a reminder to NFP hospital associations of their charitable mission and opened up a dialogue around the need to actively ‘dispel the doubt’ about the good will and motives of NFP hospitals.

Lastly, it is worth contextualising CHSM’s communications efforts within academic norms. While there is an academic imperative to ‘disseminate’ research findings, this is typically through peer-reviewed publication. CHSM is an example of a university-based centre that led research into an issue and then converted that research for a communications and engagement strategy, as well as lobbying, legal drafting and facilitating networks and working groups for the research’s uptake. The next section examines the policy influence that the CHSM research contributed to, and should be read in light of this unusual level of academic activism.

Part 3: Policy Impacts and Implications

Policy influence

In contrast to reviewing the contribution to change of a three-year development program, the influence of research on policy does not necessarily have a definitive timeline or overt boundaries on how that influence filters. Weiss, Murphy-Graham and Birkeland (2005) describe the influence of evidence on policy makers as ‘subtle’, subterranean and progressive. They note the conceptual breakthrough provided by studies in the late 1970s and early 1980s that showed that policy makers may have found research to be useful, even if they didn’t act on it immediately. In more recent studies they found: ‘[D]ecision makers might not base their next decision on the evidence, but they
often found themselves influenced in more subtle ways in the longer term. This type of indirect influence was characterized as enlightenment.'

In the specific case of CHSM, efforts to influence policy for NFP hospitals were active and ongoing at the time of this case study. CHSM is embarking upon additional research to justify the entitlement of NFP hospitals to tax exemptions, and CHSM and NFP hospital associations are persevering with lobbying for the two draft regulations with the Ministry of Health. Examination of any influence of CHSM’s research is based on a review of the period January 2009-March 2012. It important to qualify that the changes discussed and dissected below do not necessarily capture the ultimate influence of the research. However, there are many to note at this stage.

It is pertinent to distinguish the two levels of change that the researchers sought: (1) Overall, the researchers pursued greater and sustained access to health services for the poor, especially in remote areas, through securing the financial viability and commitment of NFP hospitals as providers. (2) In particular, the researchers sought a tax exemption for NFP hospitals.

Policy changes possibly related to Hub activities or evidence:

(1) Changes in attitudes and behaviours of policy makers.

Of paramount importance, the research was not just an effort to influence policy, but brought policy attention to the major role of NFP hospitals for the first time. As a research centre, CHSM is respected by the Ministry of Health, which referred to its ‘sophisticated analysis’ and ‘using more scientific methods’.

The researchers noted that, over the course of the research process, ‘[T]here was a shift in the language and tone used to refer to NFPs by the Ministry of Health, from being private entities to being partners’. One researcher quoted the Ministry as saying, ‘We cannot rely on state hospitals alone. The private hospitals are our partners.’ In interviews for this case study, the Ministry of Health representative said that the ministry, the NFP hospital associations and CHSM ‘need to join forces … We complement each other in terms of what we do.’

Change was also noted in the attitude of the Ministry of Health to evidence-based policy for the NFP sector. The researchers felt that the ministry was now convinced of the importance of a focused and data-driven argument for the tax exemption, to enrich and strengthen the existing academic review. The ministry has asked the researchers to conduct additional studies and, despite not having any funding for these studies, they are willing to host meetings and discussions within the ministry for this purpose.

The researchers felt that over the course of the two years, the NFP hospital associations had become aware of the need to engage in policy advocacy for their own survival. There is now a willingness to address issues collectively. Some of the smaller Christian hospital associations were also observed to be more active, although still careful. As of April 2012, the previously disparate religiously affiliated associations were taking tentative steps to formalise cooperation and form an umbrella association. This contrasts strongly with the period after the passage of the Hospital Act. At that time, CHSM concentrated on the monograph and the NFP hospital associations did not meet at all. While it is likely that many factors have led to the intent to form an umbrella group, it is clear that CHSM’s actions were instrumental. The most senior CHSM researcher appealed strongly to the associations at a meeting in March 2012 that they needed to form a coalition and take the lead in lobbying for their own interests. It is also possible that the research findings from 2009, coupled with the prolonged deliberation on their financial hardships, convinced the NFP hospital associations that this action was needed. One stakeholder questioned whether CHSM’s leadership potentially delayed the NFP hospital associations from taking ownership and leadership. However, the formation of the umbrella group signals that this is now starting.

Serving as a proxy for the views of the general public, even the journalist from Kompas conceded a personal change in views through his involvement. He was persuaded by the CHSM’s position there should be ‘special treatment in the form of a tax reduction or a government subsidy’ for health care providers that serve Indonesians living in poverty or in rural areas.

Interestingly, the attitude and behaviour that the research team most sought to influence was the for-profit practices of the NFP hospital associations, especially their boards of management. The preparedness of some hospital associations to discuss their for-profit practices and to describe the expectations of boards.
and local governments that the hospitals be income-generating is significant. Indeed, one stakeholder said that ‘the non-state hospital is sometimes regarded as an ATM for the *bupati* [district chief]’. The researchers understood that the reason for this behaviour ‘derives from their need to survive’ but nonetheless stressed the need for their mission to be fulfilled. In recent months, a number of associations, including Muhammadiyah, have reaffirmed their commitment to be not-for-profit and to cease providing funds to their owners.

**Changes in policy-making structures.**

CHSM convened stakeholders to discuss and find options for the financial sustainability of NFP hospitals. It is clear that, as a result, NFP hospitals have played a direct role in changes in policy making structures. As noted, NFP hospital associations were accepted as members of the parliamentary drafting group for the Hospital Act, at CHSM’s suggestion, and they were later welcomed onto the Ministry of Health task force on the tax exemption. The opening up of government policy forums to the non-state hospital sector occurred during the research period. Previously, non-state hospitals had limited channels for representing their circumstances. They felt ‘disheartened at the lack of Ministry of Health interest in their reduced funding circumstances’ (interview, 26 April 2012). Typically, they were advised of new regulations, but seldom consulted on their needs. So their inclusion in these forums is both a positive shift for the non-state sector specifically and civil society in general. The Ministry of Health has been willing to work together with the NFP hospital associations in discussing the draft regulations and options.

The researchers felt that their contribution had been to ‘open the door for policy dialogue for the NFPs’ (interview, 22 March 2012). One NFP hospital association agreed, observing that the research had provided the ‘opportunity for people from different organisations who have the same concerns to gather knowledge and experience and put on a fight’ (interview, 26 April 2012).

The changes that took place in policy making networks and nodes are depicted in Figure 2. The two panels depict the organisations involved in policy deliberations on NFP hospitals and the relationships between them in mid-2009 and mid-2012. Organisations of similar type are shown in the same colour, and arrows depict either uni-directional or two-way communication.

Together, the two panels represent the change in stakeholder relationships over time. In 2009, CHSM was literally central to policy networking, and much of the communication was through ‘outreach’ to disparate organisations. Parliamentarians were a focus of networking in this period, but only up until the passage of the Hospital Act in November 2009. By mid-2012, two new collectives had formed within this network. NFP hospital associations had organised themselves into an informal interest group, which now included YAKKUM and HUSADA, and the Ministry of Health established a task force on tax exemption that included NFP hospital associations as members. Engagement of the Ministry of Finance occurred by this time, through direct advocacy by CHSM; however, it had participated in only one NFP hospital association meeting. By mid-2012, CHSM remained active but was no longer the intermediary.

**Policy options or strategies considered.**

As noted, the financial burdens experienced by not-for-profit hospitals and the call for tax concessions were not a new issue for the associations or the Ministry of Health. Muhammadiyah said that PERSI is thankful that the research gave renewed attention to these issues. However, in some ways, the research merely opened up the exploration of options. PERSI noted that all NFP hospitals want a tax exemption, but they have difficulty identifying which tax is most burdensome to them.

A tax exemption for not-for-profit organisations (*yayasan*) already existed under the Tax Act, but the regulation under the act excludes hospitals. A possible strategy being contemplated is funding a judicial review to annul the regulation on the grounds that it is inconsistent with the higher authority of the act. This would bring the exemption into effect for NFP hospitals, although it would be an expensive process without a guaranteed outcome.

**Policy articulation or policy instruments.**

The incorporation of tax exemption for NFP hospitals into Indonesia’s first Hospital Act is a remarkable accomplishment. Moreover, this feat is directly traceable to the research and in-person advocacy efforts of CHSM and NFP hospital associations with parliamentarians. Clause 1(h) in the act is taken from the very wording of Policy Brief #1 and recognises that all hospitals have the right to tax incentives.
FIGURE 2. POLICY NETWORKS AND NODES, 2009 AND 2012

A) PANEL 1: POLICY RELATIONSHIPS AT BEGINNING OF RESEARCH IN MID-2009

B) PANEL 2: POLICY RELATIONSHIPS AT TIME OF CASE STUDY IN MID-2012
Importantly, the act enshrined a new delineation of hospitals based on ownership. Whereas the term ‘private’ previously referred to all non-state hospitals, the Hospital Act has limited the term ‘private hospitals’ to “for-profit” non-state hospitals. NFP hospitals are now considered ‘public hospitals’. The exhortatory language on the right of public hospitals to tax incentives was compelling content for a policy brief but is problematic in legislation. A ‘right’ is reliant on a duty-bearer to fulfil his or her obligations, and it is less specific and enforceable than a clause which mandates government action by a certain date. However, it is nonetheless a coup in terms of the influence of the research on policy change.

As explained, after the passage of the Hospital Act, regulations were needed to implement it. CHSM drafted the tax exemption regulation for submission to the Ministry of Health in 2010, as well as a second draft regulation providing for donations to NFP hospitals to be tax deductible. The first regulation is currently under review by the Bureau of Law within the Ministry of Health. The progress of these regulations has been slow and, arguably, has stalled. The reasons for this are explored below, but CHSM’s authorship of the two regulations is worthy of note as an example of the direct influence of the researchers on policy instruments.

(5) Implementation of policy or changes in practice.

The changes enshrined in the Hospital Act were profound, but their conversion into changes in practice has been halting and has met with resistance. Despite the timely production of draft regulations, at the time of the study the regulations for the implementation of the tax concession had not been issued, although they are required within two years of the passing of any law. Several reasons for this are suggested:

First, the University of Gadjah Mada did not concertedly engage the Ministry of Health in its advocacy efforts at the time of the Hospital Act drafting. The researchers felt that, as a result, the ministry is less informed, and arguably less convinced, of the rationale for the tax exemption. The conversion of the tax exemption into a regulation requires the ‘good offices’ of the Ministry of Health with the Ministry of Finance; the latter expects Health, as its technical counterpart, to argue the case. The researchers bypassed both ministries and advocated directly to parliamentarians. This strategy worked, but the Ministry of Health was missing from the research engagement process, and this has been a critical gap.

Secondly, with the drift of not-for-profit hospitals to for-profit practices, there is a need for NFP hospitals to demonstrate a renewed commitment to their mandate. There is a government and public perception that the tax exemption is self-serving, especially given the high charges and VIP wards of the NFP hospitals that the decision makers see in Jakarta and other main urban centres. In order to justify the tax exemption, NFP foundations need to be financially transparent. As private foundations, they have not had such an operating environment to date, and not all support one.

Lastly, progress on the regulation has also been hampered by the fact that it crosses the jurisdiction of the ministries of Health and Finance, and also requires authorisation by the president, as opposed to a minister. As also noted, the Ministry of Health is prioritising the regulations arising from the act.

A separate development that can be linked to the CHSM efforts was the promulgation of a new Ministry of Health decree in 2011. The decree allows NFP hospitals to apply to the ministry for non-monetary forms of assistance. This decree was drafted with the help of the task force that was constituted for the tax exemption, and the wording of the decree can be traced to a recommendation in Policy Brief #3. However, to date, the decree has not been well publicised, and there is no mention of it at all on the Ministry of Health website.

Policy implications

Impact of the changes on health system performance: The impact of the changes in policy and policy processes associated with the CHSM research will take shape over the longer term. However, several items deserve note in relation to impacts on health system performance.

One outcome of the research was the establishment of a twinning program between well-resourced and poorer NFP hospitals in Nusa Tenggara Timur under the AusAID-funded Australia-Indonesia Partnership for Maternal and Neonatal Health. This arose through the Hub director’s role as a technical adviser to the partnership, after he became aware of the findings about the sparse distribution of state hospitals in the province.
Stakeholders agreed that the research highlighted the importance of non-state hospitals, especially not-for-profits, to the health system. The research also reinforced the shortcomings of JAMKESMAS for NFP hospitals. Add to this the meetings between the Ministry of Health and the NFP hospital associations, and it is possible to speculate that the research has shifted the Ministry of Health to appreciate better the role of NFP hospitals in services for the poor. There is now an opportunity for the NFP hospital associations to partner the government in policy making. The state sector, with its performance and quality issues, will be the undispersed priority for the ministry, but the ministry may now be more willing to consider non-state sector sustainability. As one CHSM researcher noted, ‘If these (NFP) hospitals cease to exist, then the poor won’t have a service’.

Conclusions about how these changes have impacted the capacity of the Ministry of Health to govern the mixed-provider health system can only be speculative. However, the research and policy outcomes are likely to have rendered the agency better informed and more receptive to the views of the non-state sector.

**Has the research made a difference?** It is fitting that the final word on findings goes to the leader of the CHSM research team. When asked whether the research has made a difference to the poor, he replied:

> It is difficult to say that there has been a direct impact for the poor, but we have reminded and convinced NFP hospitals that their mission is to serve the poor. We remind them that their not-for-profit status is not only on paper, but in reality. And it is on this basis that they are entitled to a tax concession.

**DISCUSSION**

Although the persuasion of policy makers on NFP hospital issues is still in progress, the case study enabled identification of an array of policy influences arising from the research process, and of the factors involved.

**Policy Influences**

Within the relatively short span of two years from the beginning of the research, there was evidence of policy influence at a range of levels.

**Changes in law:** The definitive influence was the use of research findings and products to enshrine supportive policy for NFP hospitals in the Hospital Act, namely the tax exemption and the revision of their status from ‘private’ to ‘public’ providers. Another influence to consider is the engagement of the CHSM researchers in the drafting of laws, as distinct from lobbying for them to be changed. Although the two separate regulation drafts are yet to be approved, they have constituted a vehicle for dialogue about appropriate further changes in law, and they represent the direct engagement of researchers to influence the letter of the law, whether ‘passed’ or prospective.

**Changes in attitude and behaviour of policy makers:** Findings on the proportion of NFP hospitals within the non-state sector provoked genuine surprise and an increase in policy maker interest. The research appears to have highlighted, if not legitimated, the importance of a traditionally neglected sector, NFP hospitals, to the whole health system. This has ushered in a greater acceptance of their role and needs, even if reservations endure about the underlying motives of NFP hospital associations. The recommitment of these associations to their charitable mandate, arising from dialogue with the researchers, was an important change from current for-profit practices, especially for the poor.

**Changes in engagement in the policy process:** The first level of influence worth noting is that the research prompted previously non-engaged actors to realise that they have a role to play in health policy. Through the research, the NFP hospital associations convened as a group for the first time to address policy issues in common. Given the diversity of faiths represented and their different histories and profiles, this cooperation is significant and provides a platform for sustained advocacy and input. The opening up of parliament and the Ministry of Health to NFP hospitals was unprecedented. It is also important that over the course of the research, CHSM shifted from being the intermediary between policy stakeholders to providing support to the NFP hospital associations only.

**Links between the research process and policy development:** The conclusion drawn by this case study is that the influence of CHSM and its research upon selected policy changes is vivid and easily traced. This was not the expectation of the authors, who were
prepared to disentangle the deeds of many actors and were expecting an interrupted transmission of the research’s messages.

While the influence of context has been examined above, CHSM clearly played a leadership role in the formulation and drafting of policy documents favourable to NFP hospitals. It was a trusted intermediary in bringing the NFP hospital associations and the Ministry of Health together. CHSM took this initiative because it appreciated the limited capacity of NFP hospitals to dialogue with policy makers and noted the perceived low prioritisation of the non-state sector within the ministry. It needed an external party to represent and champion the issues at that time. Instead of the challenge lying in how to determine the impact of research on policy development, it lies in determining how policy for NFP hospitals will be advanced from this point in time as CHSM steps aside and NFP hospital associations and the Ministry of Health assume rightful charge.

**Enabling Factors**

**Policy environment:** One factor that unquestionably facilitated the penetration of the research findings was the relatively recent openness of Indonesian democracy. Indonesia is still tentatively forging the channels for civil society contribution, and the access to parliamentarians by both CHSM and the NFP hospital associations established the foundations for all future steps and influence of the research.

Separately, the drafting of the Hospital Act was an incomparable opportunity to enshrine recognition of and concessions for NFP hospitals. Since an overall legislative regime on hospitals was being developed, the insertion of two clauses favourable to NFP hospital associations could be regarded as relatively minor. The astute timing and dissemination of the research findings by CHSM offered parliamentarians the opportunity to demonstrate their commitment.

**Researchers:** The activist role played by the researchers is significant in the research-to-policy episode described in this case study. CHSM saw the opportunity presented by the drafting of the Hospital Act to enhance service for the poor, and it has been the driving force engaging the policy makers. CHSM used its evidence on the proportion and geographic distribution of NFP hospitals to engage with NFP hospital associations and mobilise them on their social mission, and simultaneously to engage with the Ministry of Health to be informed and positioned to advocate to the Ministry of Finance for the tax exemption.

CHSM was also notable in the roles it played over the course of the research process, including the provision of evidence and of strategic advice to NFP associations and the drafting of research outputs and legal regulations. It is also clear that the quality and underlying motivations of its research, especially regarding access to health care by the poor, were respected by all of the stakeholders consulted. Trust of CHSM and the perceived calibre of its work definitely opened up doors and dialogue.

**Communication:** The strategies and skills applied to the communication of the findings were also an element in the influence of the research. In addition to pursuing the conventional academic route of publishing findings, the researchers also led the development of an engagement strategy to captivate policy makers. With the support of communications and public relations specialists, they produced a diverse range of materials tailored to audiences of differing interests and attention spans. The researchers had a broad vision of the platforms that reach and influence public and policy maker opinion, such as the newspaper Kompas and an interactive rather than static website.

**Constraints**

**A non-state and neglected issue:** Ambitiously and commendably, the research endeavoured to influence policy on a neglected issue, and moreover, strove to make a priority of a non-state sector issue with state-based decision makers. Not-for-profit hospitals were not on the agenda of the Ministry of Health, and so a related challenge for CHSM has been to bridge the large discrepancy in knowledge about the issue between CHSM and decision makers. This gap in understanding included: the role and distribution of NFP hospitals; why they matter for Indonesia to achieve universal coverage and a health safety net for the poor; the history and extent of their operating constraints, including licences, market forces and costs of new technology; and how NFP hospitals are compensating for challenges within state hospitals. The focus on a neglected, non-state sector certainly contributed to policy maker reservation.
or low prioritisation of issues affecting NFP hospitals.

Residual attitudes towards NFP hospital associations: While stakeholders displayed a reappraisal of the unique role and circumstances of NFP hospitals, there was a residual scepticism about their call for a tax exemption, based on their recent history of ‘for profit’ practices. The need for NFP hospitals to dispel this doubt was mentioned by all stakeholders, including NFP hospital associations themselves. Demonstration of a recommitment to their charitable mandate and to financial transparency will be key to NFP hospital associations overcoming the opposition and caution that stem from this doubt.

Uneven Engagement of Stakeholders: Of the stakeholders in the issue of NFP hospitals, some were missing and others were engaged late or little in the process. The Hub director contemplated that the ‘end users’ (patients) and the ‘payers’ (patients and insurance schemes) ideally should have been engaged in discussions at the outset. Additionally, one researcher concluded that the Ministry of Health was a crucial gap in the early steps. There was a sense that if the ministry had been engaged earlier, it might have had a positive bearing on its support for the regulation.

However, the researchers conceded that since the study was focused on a ‘neglected issue’, engagement of the ministry would have been challenging. Ministry of Health influence on research parameters might also curtail the academic freedom to bring light to issues of low priority or visibility, or to survey comprehensively an issue without or with minimal preconceived ideas, as was done in the present case.

Several stakeholders pointed to these gaps in the engagement strategy as explanation for the current limbo of the regulations. When they were asked to elaborate, it appeared that there was a consensus or assumption that engagement of a minister is the most effective starting point for policy influence. However, evidence perhaps suggests otherwise. In advocating directly to parliament, CHSM achieved legislative recognition for a tax exemption within 12 months. A policy platform of this kind might never have eventuated from systematic ministerial engagement.

Instead of ministers, CHSM engaged the ‘beneficiaries’ (NFP hospital associations) first and, together, CHSM and the associations convinced the politicians. They then worked on the evidence to influence the “technical” policy makers.

There has been little engagement of the Ministry of Finance. This partly stems from the consensus that the Ministry of Finance is opposed to the tax exemption in principle and effect, and that the Ministry of Health is reluctant to engage the former until it feels equipped with further evidence. Interestingly, Finance had an open mind as to the policy options that might best suit NFP hospitals, and that policy change was ‘do-able’, depending on how strong the case is.

Although admittedly in a position of supremacy with respect to tax, the Ministry of Finance said, ‘(We) are not some supra-body that understands everything. (We) may not know what kind of incentive would be effective to support a sector. That is why (we) need to hear from the technical ministry … and whether there are enough incentives or we need a new one.’ However, there were no immediate plans by any of the stakeholders to approach Finance.

The Distinctive Role of NFP Hospitals

The eligibility of NFP hospitals for a tax exemption, an issue raised rather than resolved by the research, is contingent on them consistently providing charitable services to the poor and some kind of community or social benefit. While the mission statement of NFP hospitals usually states that the hospital serves the poor as part of its service, there is not as yet any clear definition of ‘charitable services’ or ‘social benefit’ or how best to measure these concepts.

However, if the ‘not-for-profit’ and the ‘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. While the mission statement of NFP hospitals usually states that the hospital serves the poor as part of its service, there is not as yet any clear definition of ‘charitable services’ or ‘social benefit’ or how best to measure these concepts.

Efforts are needed by several parties to clarify and maintain the role of NFP hospitals. The government needs to define clearly what constitutes a not-for-profit hospital and what kind of services it is expected to provide, as well as corresponding policy on any subsidies or tax relief. Meanwhile, NFP hospitals need to ensure that they are delivering these services and
complying with their mission as charitable institutions. Before such privileges are given, NFP hospitals need to show greater transparency, accountability and trustworthiness.

Currently, the Ministry of Health has no clear guidelines on NFP hospitals. The various NFP hospital associations should agree on a set of rules for themselves, to avoid further commercialism of their services. They could then put this forward in their case for tax exemptions, based on evidence of their distinctive characteristics and behaviour.

CONCLUSION

Acknowledging the policy influence that was achieved in the review period, the case study authors concluded overall that the research was necessary but not sufficient to influence the introduction of the tax exemption clause. It is notable that after the inclusion of the exemption, researcher efforts concentrated largely on its implementation, to the neglect of other options for the financial viability of not-for-profit hospitals. To implement the tax exemption, the ministries of Health and Finance both require additional evidence, such as hospital costing studies, options papers and the identification of why a tax exemption, above all else, is what is needed. The tax exemption is one policy option, and a politically contentious one. There is a risk that it deflects attention from the broader issue of the viability of NFP hospitals.

The following general observations on the interaction between research and policy influence were derived from the case study:

(1) Policy influence operates in a complex environment, with multiple stakeholders, and in a non-linear way. A policy issue evolves and requires ongoing research inputs, communication and dialogue with policy makers.

(2) Policy impacts occur in multiple ways, including more subtle and perhaps critical changes that take place beyond formal policy documents. Changes in attitudes, relationships, and engagement of actors in policy may be more significant for long-term sustainable change than changes to policy documents, which can be ignored.

(3) Communication and relationships between researchers, stakeholders and policy makers are key in influence.

Lessons for the Hub on Influencing Policy

The policy influence embarked upon by CHSM was ambitious on two levels. First, the not-for-profit sector has long been a neglected issue in Indonesia. Secondly, the research led by CHSM aimed to make a priority of a non-state sector issue with state actors. Combined, these required a researcher to divert policy makers from the many state sector challenges of newly decentralised and democratised Indonesia, before even having a chance to influence policy. Although the research could be linked to many policy influences, major and marginal, it is likely that influencing policy on neglected issues puts a greater onus on educating stakeholders than was undertaken in the current case.

Decision makers interviewed for the study reiterated that policy change takes time, and that the more stakeholders an issue involves, the more time that change will take. The timing of the case study prompted some stakeholders to feel that, since the tax regulation had not yet been passed, the research had not had successful policy outcomes. However, it is clear that further but feasible steps are needed with the ministries, and so tax relief may yet be approved.

While research can be converted for policy effect, it is a skill. The researchers are still learning how to step outside of their natural role as academics and use evidence to persuade policy makers. Moreover, this was in the absence of capacity building or exposure to groups that had successfully lobbied and used health sector evidence in this way. It appeared that the NFP hospital associations and the Ministry of Health also lacked experience in taking ideas or issues and formulating good policy responses. It would be useful to incorporate skills building in these areas in a future phase of equivalent Hub work.

It was clear that the credibility of CHSM and its research was key to the receptivity of government and NFP hospitals to its findings. However, pivotal decisions were made through interpersonal encounters, including during the parliamentary drafting and the study tour in Melbourne. Relationships and forums for interpersonal exchange are crucial for arousing interest in issues and ideas, and for fostering a sense of shared purpose.
A final lesson for the in-country team was the need to form coalitions on health issues, so that health sector groups are more united and powerful, and that policy making comes to be seen as an important role for health service providers.

Specific decisions and actions were taken by the Hub itself, separately from the collaborative work with CHSM, which enhanced the potential for the research to have policy influence.

The first discernible factor is the spirit of trust with which the Hub encouraged CHSM to set its own direction for the research and to pursue the policy influences that CHSM saw fit. This allowed the research to be responsive to Indonesian health system priorities, rather than a predetermined agenda issued from Melbourne. This trust and interest in the partner and subject matter were also demonstrated to CHSM by the CHSM research experience being the first to be commissioned as a Hub case study.

The study visit to Melbourne in 2010 was a turning point for both the diversity of engagement on the issue and the conversion of the stakeholder focus from research to action. The study tour was the first substantive involvement of the Ministry of Health, albeit represented by the Planning Bureau, which was less directly relevant to the tax clause, and of the newspaper Kompas. It was also the forum for planning the next stage of the communications and engagement strategy, and for the formation of the three working groups, one of which later became a formally constituted task force under the Ministry of Health.

The Hub also provided ongoing technical input to seminars and meetings in Indonesia, including information on the Australian NFP hospital sector, and it contributed analysis and editorial to research products and strategies. It also ensured that CHSM was a regular participant in the regional and cross-Hub conferences, in order to nurture research and policy networks.

Long prior to the findings of this case study being available, the Hub director concluded his interview on this note:

This (research) is an important process, and we would do it all over again if we could. We want to keep it this way: not so much interference from outsiders, but rather give more autonomy to the in-country researchers to decide on what is strategic and who the important stakeholders are. We would not change a thing.
REFERENCES


Greenhalgh, T. 2010. Commentary: What is this knowledge that we seek to ‘exchange’? *Milbank Quarterly* 88, 4: 492-499.


**APPENDICES**

**APPENDIX 1. ASSESSING THE STATUS OF THE POLICY CYCLE**

This is the English version of the template developed by the Knowledge Hubs for Health to describe the progression of research influence on policy.

<table>
<thead>
<tr>
<th>No.</th>
<th>Purpose</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Research-priority setting</td>
<td>• Changes in research directions or priorities; or introduction of new research approaches, methodologies or capacity relevant to health policy priorities</td>
</tr>
<tr>
<td>2</td>
<td>Evidence filtering and dissemination</td>
<td>• New trends or emerging priorities receive attention from researchers and/or policy makers</td>
</tr>
</tbody>
</table>
| 3   | Expanding policy capacity and improving policy making processes | • Changes in the attitudes or understanding of policy makers in regard to particular policy issues  
• Changes in the engagement of stakeholders in government and civil society on health policy making  
• Changes in the use of evidence and knowledge in policy making or the engagement of local researchers in policy issues  
• Adoption of new approaches to measure and monitor policy requirements |
| 4   | Agenda setting | • Policy makers make changes in a) strategic direction and b) proposing priority technical themes  
• New ideas introduced to policy debates  
• New policy issues included in policy/planning discussion |
| 5   | Policy formulation | • Increased range and examination of the options and strategies for policy action  
• Improvements in coordination and alignment among policy instruments in the policy framework  
• Improvements in documentation and increased clarity in policy statements or instruments |
| 6   | Policy implementation | • Improvements in capacity of policy implementers and regulators  
• Improvements in the supporting materials, technical standards, guidelines and documents for policy implementation  
• Improvements in the attitudes and commitment of policy implementers to apply and implement policy  
• Changes in practices of service providers or health service managers resulting from policy  
• Increased allocation of budget and resources to the policy issue |
| 7   | Policy evaluation | • Identification of constraints, influencing factors and lessons learnt from the implementation of policy  
• Identification of impacts of policy on targeted services or behaviours  
• Identification of unexpected side effects or changes resulting from policy changes  
• Responses of policy makers to change policy in response to evaluation lessons |
## APPENDIX 2. ANNOTATED GLOSSARY OF AGENCIES AND TERMS

<table>
<thead>
<tr>
<th>Agency/Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>CHSM</td>
<td>Centre for Health Service Management. A research centre within the Faculty of Medicine, Universitas Gadjah Mada, focusing on health systems and health policy issues. Founded in 1997. <a href="http://chsm.fk.ugm.ac.id/">http://chsm.fk.ugm.ac.id/</a>.</td>
</tr>
<tr>
<td>Bureau of Regulation, Ministry of Health</td>
<td>The bureau is responsible for drafting regulations, decrees and standing orders for the Ministry of Health. <a href="http://www.hukor.depkes.go.id/">http://www.hukor.depkes.go.id/</a>.</td>
</tr>
<tr>
<td>Directorate-General of Health Services (Bina Upaya Kesehatan, or BUK), Ministry of Health</td>
<td>The Directorate is responsible for overseeing health services delivered at primary, secondary and tertiary levels. Separate from BUK, policy matters concerning hospitals fall under the Directorate of Referral Care/Hospital. The BUK has two sub-Directorates: the Sub-Directorate of Public Hospitals, and the sub-Directorate of Private Hospitals. Since the Indonesian Hospital Act (2009), not-for-profit hospitals have been categorized as ‘public hospitals’, while ‘for-profit hospitals’ are categorized as ‘private hospitals’. <a href="http://buk.depkes.go.id/">http://buk.depkes.go.id/</a>.</td>
</tr>
<tr>
<td>Non-state hospital</td>
<td>A hospital other than those owned by the government, military/police force or state enterprises.</td>
</tr>
<tr>
<td>YAKKUM</td>
<td>Yayasan Kristen untuk Kesehatan Umat (Christian Foundation for Public Health). A foundation owned by two major Christian churches: Gereja Kristen Indonesia (Indonesian Christian Church) and Gereja Kristen Jawa (Javanese Christian Church). Yakkum owns 12 hospitals. Although YAKKUM was not actively involved in the research over 2009-11, it has demonstrated interest in the formation of an umbrella group and has participated in meetings for its establishment. Founded in 1950. <a href="http://www.yakkum.or.id/">http://www.yakkum.or.id/</a>.</td>
</tr>
</tbody>
</table>
The Nossal Institute invites and encourages feedback. To provide comment, to get further information about the Working Paper series, or to download this publication please visit our Health Policy and Health Finance Knowledge Hub website: www.ni.unimelb.edu.au/hphf-hub or email us at: ni-info@unimelb.edu.au

The Knowledge Hubs for Health are a strategic partnership initiative funded by the Australian Agency for International Development.