The Growth of Non-State Hospitals in Indonesia: Implications for policy and regulatory options

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The Growth of Non-State Hospitals in Indonesia: Implications for policy and regulatory options

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SUMMARY

This paper is one of three published in the Working Paper series that summarise and explore the policy implications of studies undertaken in collaboration with partners in Indonesia and Vietnam by the Health Policy and Health Finance (HPHF) Knowledge Hub on the role of non-state hospitals in health systems. This paper focuses on studies in Indonesia undertaken by the Centre for Health Services and Management (CHSM), Universitas Gadjah Mada (UGM), which include an analysis of growth in the non-state hospital sector over the last 10 years. The studies were based on data reported to the Ministry of Health (MoH), an examination of the regulatory framework, in-depth case studies of governance and management in individual non-state hospitals and the practices and roles of doctors working in dual practice across state and non-state hospitals. The complete findings of these studies will be published subsequently in book format. The two companion Working Papers report on a similar study in Vietnam and present a compilation and comparison of the country studies to identify the lessons for policy makers more broadly.

The key findings of the CHSM Indonesian studies are:

(1) Non-state hospitals comprise 50% of the number of hospitals in Indonesia, and provide 37% of hospital beds. The majority of these hospitals (82%) are not-for-profit (NFP), run by foundations. While the number of for-profit (FP) hospitals has doubled in the last 10 years, growth in the NFP group has been stagnant, and NFP hospitals have taken on some FP practices in an attempt to maintain revenue.

(2) Factors behind these changes include:
   • growing demand for hospital services from a segment of the population with capacity to pay, in the context of a relatively low hospital bed/population ratio;
   • a taxation and legal regime that favours company ownership and FP management of hospitals;
   • the dominant role of the medical profession in a market where medical specialists are scarce and seek to maximise their income through work in the private sector, and in urban communities with capacity to pay.

(3) The implications for regional policy makers and development partners include:
   • the need for the government to consider the social benefits of providing taxation concessions to NFP hospitals, to enable them to contribute to the provision of hospital services;
   • the need for appropriate policy options to better regulate and manage dual practice in the health sector, and the potential negative effects on state hospital service quality, as well as the conflicts of interests that arise when physicians also become owners of health facilities;
   • the need for improved monitoring and regulation of the behaviour and practices of local non-state hospitals by provincial and district governments, as local markets vary and can lead to different behaviours among providers.
INTRODUCTION

This paper summarises the key findings from in-depth studies undertaken by the HPHF Knowledge Hub in collaboration with CHSM, Universitas Gadjah Mada, Indonesia, in regard to non-state hospitals in Indonesia. These studies form part of a broader examination of the role of non-state hospitals in middle income countries (MICs) of Asia being undertaken under the auspices of the HPHF Knowledge Hub, with further in-depth country studies also being undertaken in Vietnam. The aim of these studies was to examine the recent growth of hospital services in selected countries of the Asia-Pacific region, to identify factors contributing to and impacting on this growth and to explore the potential regulatory and policy responses.

The non-state sector is a significant provider of health services in many Asian countries. However, it is a complex area for analysis, and a contested policy area. Part of the complexity is due to the large variety of providers. In these studies, the non-state sector is regarded as ‘all providers who exist outside of the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease’ (Mills, Brugha et al 2002). State providers are owned and controlled by national, provincial, state or local governments. Non-state providers (NSPs) are those that work outside the direct ownership or control of the state.

Non-state providers differ by types of service, legal status, extent and type of training and institutional organisation, and may include employees or contractors who engage in both public and private practice (‘dual practice’). NSPs include individual providers (doctors, nurses, midwives, traditional healers and unqualified purveyors of medicines) as well as groups of providers or facilities (for example, clinics, nursing and maternity homes, hospitals, pharmacies, diagnostic facilities and non-government-organisation-run medical clinics) (Hanson and Berman 1998). Some NSPs do not have formal training and practise illegally (Bennett 1992).

While many studies have been undertaken on the role of NSPs in ambulatory or outpatient care (Lagomarsino, Nachuk et al 2009), there is less known about non-state hospitals. As Hanson, Archard et al (2001) commented, the hospital sector has been relatively neglected, despite its key role in the overall health system and its high resource consumption within the system. New financing mechanisms such as social health insurance increase the state’s exposure to financing treatment in non-state hospitals, while the epidemiological transition and rise in non-communicable diseases, together with increasing community demand for higher technology services, indicate the increasing importance of hospitals to the health system.

The Indonesia and Vietnam studies aimed to fill a gap in the knowledge about the role of non-state hospitals in low and middle income countries (LMICs) and to supply evidence and policy recommendations to policy makers within each country. These countries were selected because of reports of recent growth in new non-state hospitals and the interest shown by policy makers in addressing this growth through appropriate regulation and policy.

The studies aim to answer the following questions:

- What services are non-state hospitals providing, and what patients are they treating?
- What are the main factors determining the current role and future potential of non-state hospitals?
- What opportunities and risks require attention from policy makers, and what are the policy options?
METHODOLOGY

This paper is based on the studies carried out by CHSM, including:

• historical review of the role and development of NSPs in Indonesia, noting the importance of historical pathways in the development of health systems, institutions and policy;
• compilation of routinely collected data and mapping of numbers, locations, types of non-state and state hospitals over the last 10 years;
• case studies of developments in NSPs in the capital and main cities (Yogyakarta and Jakarta) and in provincial cities (Bima, Jambi);
• in-depth studies of management and governance, motivation and relations with doctors in some NSPs;
• review of regulatory environments and regulatory capacity—including an in-depth case study of one location.

The studies also incorporate other work being undertaken by CHSM, particularly a study of medical profession work practices, incomes and motivation. This paper begins with an overview of hospital services in Indonesia based on published literature. A selective literature search was undertaken, with a focus on the two key policy issues identified by the studies: not-for-profit providers and dual practice. The literature was searched electronically using common search engines (Pubmed), as well as a search of websites of organisations with an interest in this area (World Health Organisation, World Bank). The search focused on reviews, commentaries and conceptual and policy discussions, rather than on primary research. As well, the paper uses routine data on state and non-state hospitals with specific case studies of particular issues and locations for more in-depth exploration. The paper applies an analytical framework and policy approaches recommended by commentators and analysts internationally (see below).

The design, implementation, analysis and initial report preparation were undertaken by CHSM at the Universitas Gadjah Mada. The Nossal Institute for Global Health at the University of Melbourne provided comment and review, assisted in providing electronic access to international literature and participated in the discussion and analysis of the findings with the study team, stakeholders and policy makers in Indonesia.

REVIEW OF THE LITERATURE

The review of the international literature focussed on the role of not-for-profit hospitals and the behaviour of physicians.

Not-for Profit Hospitals

Is there a special role or contribution from NFPs in the hospital sector? A review of this literature demonstrates a great deal of variability in findings, but two conclusions emerge:

1. The services provided and patients treated by NFP hospitals are determined not just by ownership, but are influenced by incentives, local markets and competition from state and FP providers. Variability in the market in different locations and for different services contributes to the variability between NFPs and FPs. NFPs and FPs have similar performance in the same locality; for example, they offer similar low levels of care for poor. This may be because FPs tend to operate in wealthy areas, where there is less demand for care for the poor. The more FP hospitals in a locality, the more non-profit hospitals:
   • respond aggressively to revenue-increasing opportunities;
   • adopt profitable services;
   • discourage admissions of unprofitable patients;
   • reduce resources devoted to treating the patients they do admit.
Conversely, the presence of non-profits in a community is associated with increased quality of care in FP nursing homes, reduced mortality rates in FP dialysis facilities, and increased trustworthiness of FP health plans (Schlesinger and Gray 2006).

(2) Despite these variations, some consistent differences based on NFP ownership have been identified (Schlesinger and Gray 2006). These include:

- FP hospitals mark up prices over costs and seek to maximise revenue;
- NFP organisations appear more trustworthy in delivering services, being less likely to make misleading claims, to have complaints lodged against them by patients and to treat vulnerable patients differently from other clientele;
- NFPs may function as incubators of innovation using philanthropy to pioneer new services where there is no market;
- NFPs are slower to react to change, expanding capacity less quickly and stopping services less quickly in response to changes in the market.

Such characteristics have encouraged two principle claims about the benefits of NFPs (Horwitz and Nichols 2009). First, that the presence of NFPs and their standards of trustworthiness have ‘spillover’ effects by providing a standard against which FPs have to compete and constraining them from practices that are below that standard. Secondly, that NFPs are more likely to invest in aspects of quality of care that are not visible and not necessarily market enhancing, and thus provide a benchmark for competition with FPs, below which FPs cannot compete. However, as Deber (2002) points out, the impact of these effects depends on the extent of competitiveness in health markets. Such competition requires low barriers to market entry and exit, or the presence of excess capacity, and may accordingly increase costs through waste and duplication. In addition, the importance of factors such as expertise and a good reputation can be seen as inhibitors of competition, since they impede market entry and exit.

While there have been fewer studies comparing FP, NFP and state hospital services in LMICs in the Asia Pacific, those studies which have been reported provide findings consistent with studies in the USA. NFPs provide more responsive care and have better use of pharmaceuticals than state and FP hospitals in Bangkok (Tangcharoensathien, Bennet et al 1999; Pitaknetinan, Tangcharoensathien et al 1999); no significant differences in quality of care between FP, NFP and state hospitals were found in China despite lower staff to patient ratios and assets (Eggleston, Lu et al 2010). In both these contexts, the proportions of non-state hospitals, and of NFP within the non-state sector were much lower than in the USA, on the order of 10-20%.

**Physician Behaviour**

Dual practice and the ownership of facilities by physicians are both characteristic of physician behaviour.

**Dual practice**

Dual practice is widespread, in both low-income and high-income countries. There is a considerable literature and commentary on the practice, with some recent reviews, but few good studies providing evidence for policy decisions (Socha and Bech 2010; Eggleston and Bir 2006; Gruen, Anwar et al 2002). The literature identifies both potential benefits and potential risks from dual practice. Benefits include:

- attracting and retaining skilled practitioners in public service despite low public salaries, as they can top up their income through private practice;
- reduced demand on public services, because patients who can pay are treated privately.

Significant risks include:

- reduced quality of service and availability of services in the public sector, as physicians provide more attention and divert time to the private sector;
- self-referral of patients from the public to the private sector, encouraging over-servicing and physician-induced demand;
- using public facilities and staff to subsidise costs of services to those who could pay.
However, as the literature points out, studies have rarely used an appropriate comparator. If dual practice is banned, but investment in the public sector remains low, the quality of services could further deteriorate, rather than improve; and greater regulation and limitation of dual practice needs to be balanced with the costs of implementing and monitoring such regulation. It is possible that many of the negative effects of dual practice are the result of underfunded and poorly performing public services, and would continue in the absence of dual practice (Socha and Bech, 2010).

Thus the conclusion from the literature is that it is necessary to balance the benefits of dual practice (retaining staff in the public sector) and the costs (reduced quality and self-referral) in the specific circumstances of each context and the capacity to contract and regulate providers.

An interesting aspect that studies in some LMIC have also explored is the motivation for dual practice. As the literature points out, if profit maximisation were the sole motive, then dual practice would not be the selected strategy, because greater profit would be obtained by focusing on the best remunerated activity (private practice). It seems that dual practice is a compromise developed by practitioners to obtain the benefits of pensions and regular income from state service, and possibly to provide some public services, while being able to supplement income from private practice.

The key issue is how providers decide on this balance, and whether they have a ‘target income’ or seek to balance the income obtained from increasing hours of work with loss of leisure time. This balance may also shift with age and seniority, more senior doctors apparently being less willing to give up private practice, yet still retaining public positions. Understanding this decision making could assist in appropriate incentives, including non-financial incentives that may be important in the public sector (Eggleston and Bir 2006; Gruen, Anwar et al 2002).

Recent studies have confirmed the importance of supplier-induced demand but questioned the motivation or causation, at least in the context of developed economies. A recent study in Australia concluded that it was implausible that doctors were engaging in unethical behaviour on such a large scale as the studies indicate, and that alternative explanations, such as the uncertainty in medical decision making and the tendency to reduce the risk of poor outcomes by additional investigations or treatment, may be more plausible (Richardson and Peacock 2006).

**Physician ownership of facilities**

This clearly raises a conflict of interest and can lead to over-servicing, something which has been identified in the literature. However, it is probably fair to say that the concern over the possibility of lack of professionalism and excessive commercialism has been stronger than the evidence, particularly in the USA (Dowd 2008; Fins 2007; Kassirer 2007).

Conflicts of interests arise when one party acts on behalf of another—this person is termed the fiduciary. Situations that compromise the fiduciary’s independent judgment or ability to act on behalf of the principal are conflicts of interest. Physicians have an obligation to act in the interest of their patients (Rodwin and Okamoto 2000). Self-employed physicians are entrepreneurs in that they earn profits and bear the risk of loss from their practice. They have conflicts of interest arising from incentives to manage their practice and to advise, prescribe, refer and make clinical choices that promote their income, even at the patient’s expense (Rodwin 2007). Rodwin and Okamoto (2007) describes experiences in Japan, where physician ownership of facilities is common, and where provision of services closely responds to changes in payment incentives, demonstrating that facilities attempt to maximise their income.

Most developed countries have limited physician ownership of facilities where they practise or refer patients, through legal regulations and/or through standards of ethics established by professional organisations. As Rodwin and Okamoto (2007) observes, conflicts of interest can be controlled by appropriate payment mechanisms or by competing interests. Where the ownership of the hospital is separate from the doctor, then the hospital management has an interest in reducing costs from over-treatment, which competes with the physician’s interest in the patient’s welfare. This balance tends to control conflict of interest. In the United States, for example, professional associations created quite strong standards of behaviour over the first 50 years of the 20th century, limiting competition among doctors. When these standards were eroded by ending the exemption of medical practice from anti-trust requirements, more formal regulatory frameworks, through licensing and payment incentives, replaced them (Rodwin 2007).
HOSPITAL SERVICES IN INDONESIA

This review of hospital services in Indonesia is situated within the broader context of the health system and the health policy context. Recent reviews of the Indonesian health system have demonstrated an increasingly pluralistic and complex system that has had some success in addressing high child mortality and improving life expectancy, but faces new challenges of regional inequalities, growing non-communicable diseases and fragmentation.

Key health indicators, such as infant and child mortality, have improved steadily over the past several decades. Indonesia is largely on track to meet the Millennium Development Goals (MDG) targets for national child mortality (but note geographic variation in achievement, below). However, three indicators remain a cause for concern:

• maternal mortality rates, which remain high at 228 deaths per 100,000 live births, although the World Health Organization (WHO) estimates put the figure at 420 (Mize, Pambudi et al 2009). Despite the decrease, these estimates indicate Indonesia is unlikely to meet the MDG target of 102 per 100,000 by 2015.
• persistent high infant and child mortality in some provinces; and
• child malnutrition rates, which remain high at 25% for children under five and have largely stagnated since 2000 (Yavuz, Rokx et al 2008).

Table 1. Selected Socio-Economic and Health Indicators, Indonesia

<table>
<thead>
<tr>
<th>Indicator (year)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP per capita in US$ PPP (2007)</td>
<td>3570</td>
</tr>
<tr>
<td>Poor as % of total population (2005)</td>
<td>16.0</td>
</tr>
<tr>
<td>Life expectancy at birth in years (2007)</td>
<td>71</td>
</tr>
<tr>
<td>Under-five mortality rate/1000 live births (2007)</td>
<td>31</td>
</tr>
<tr>
<td>Total health expenditure as % of GDP</td>
<td>2.5</td>
</tr>
<tr>
<td>Total health expenditure per capita in US$</td>
<td>39</td>
</tr>
<tr>
<td>Public expenditure as % of total health expenditure</td>
<td>50.5</td>
</tr>
<tr>
<td>Out of pocket payment as % of private expenditure</td>
<td>70.4</td>
</tr>
<tr>
<td>Population covered by social health insurance as % of total pop.</td>
<td>38</td>
</tr>
</tbody>
</table>

Source: NHA database, WHO.

Despite impressive national progress, there are significant inequalities between regions and provinces, and between rich and poor. Infant and child mortality rates are more than four times higher among the poorest quintile. Due to longer life expectancy and fewer childhood deaths from communicable diseases, the demographic and epidemiological profile is in transition. In the decades to come, Indonesia will face a ‘double burden of disease’ from both communicable and non-communicable diseases (Rokx, Schieber et al 2009).

The health system is largely decentralised following decentralisation of government in 1999. It has three levels. The Ministry of Health (MoH) has responsibility for central hospitals and teaching facilities, as well as overall policy direction and technical oversight. The Provincial Health Office has responsibility for supervision and support of districts and cross-district functions (surveillance, epidemic response, labour power distribution). The District Health Office administers the network of primary health care facilities (Puskesmas).

Indonesia invested significantly in community primary health care service networks during the 1970s-80s, developing an extensive system of centres (Puskesmas) and district hospitals. This has been the basis of the progressive national improvements in population health outcomes, resulting in increases in life expectancy and reductions in infant and child mortality.

However, government funding for health services remains low, at 1.3% of GDP, and the state-funded network of hospitals and health centres is underfunded. While the central national government has recently increased budget allocations to health through the funding of a nationwide social health insurance scheme, funding of health facilities by provincial and district governments remains below the benchmark of 15% of budget.

Public financing is provided largely from the central national government, either through specific sectoral streams administered by relevant ministries, or through block grants direct to provincial and district governments, which are then allocated to sectors by local parliaments. This has resulted in a complex budgeting and financial flow mechanism, with a variety of earmarked and non-earmarked budgets with separate requirements for use and reporting.

Following the economic crisis of 1997, the national government established a social health safety fund, which has subsequently developed into a social health insurance fund (Jamkesmas). This is directly administered by the MoH; it reimburses fees directly to hospitals and provides a per capita annual tranche to Puskesmas for the treatment...
of those identified as poor (in 2009, 76.4 million). In the face of this under-funded government system, a parallel system of private services has continued to flourish. An important aspect is that providers in government services, notably doctors, are permitted also to provide services in the private sector. The private sector has now become the predominant source of income for medical providers working in the public sector.

This has led to a mixed system using significant private health facilities and providers, with approximately 50% of health expenditure from private funding and the majority of that (70%) as out-of-pocket expenditure. Even so, total health expenditure is estimated at about 2.5% of Gross Domestic Product (GDP), still a very low level. It is estimated that the private or non-state sector accounted for 40-50% of service utilisation from 1999 to 2004. More recent data demonstrate an increase in use of the public sector in 2005 to 2007, possibly associated with social protection and social health insurance (Jamkesmas) schemes introduced by the government. However, the private sector continues to provide about 30% of services (Wang, McEuen et al 2009).

Particularly in the wealthier and more populous islands of Java and Bali, private providers dominate in provision of antenatal care (60 to 90% across 10 districts) and delivery care (60-95%) (Heywood and Choi 2010). In a survey of 15 districts in Java, 90% of the health facilities identified were private (Heywood and Harahap 2009). In these islands, use of the public Puskesmas for outpatient services fell over 1997 to 2007 from 40% to 30%, while use of private providers, particularly nurses and midwives, increased from 45% to 50%. Similar changes are noted even in the poorest quintile (Rokx, Schieber et al 2009).

In an effort to improve their financial position and management performance, Indonesia has progressively introduced financial and management autonomy for state hospitals. This began in 1993 with a Presidential Decree on financial autonomy in public hospitals. This has resulted in a variety of official and non-official user fees and the establishment of higher fee-paying VIP wards to attract more affluent patients.

More recently, state hospital autonomy has been further developed through the Decree of the Ministry of Home Affairs 61/2007, under which public hospitals became public service agencies (badan layanan umum). This status enables state hospitals to use government funds and also to raise funds from the community through fees for services. However, the administrative requirements for this status are challenging, and many hospitals continue to operate under direct local government budgets, without the administrative controls that the status requires.

The system is further complicated by different lines of reporting and authority. State hospitals report directly to the relevant provincial and district government, and are not under the control of the provincial or district health offices. There continues to be some uncertainty about the way in which authority is divided among the three levels of government, despite the issuance of a revised regulation to clarify responsibilities. In particular, the central national government has been slow to delegate authority for regulation and stewardship to provinces and districts, yet has been unable to exercise this authority effectively itself. As a result, many of the regulations around licensing of health care providers and facilities, and limitations on private practice, are not applied.

The Indonesian health system exhibits many of the signs of commercialised health systems described in the literature. The WHO defined commercialised systems as commercialisation without regulation: ‘unregulated fee for service sale of health care regardless of whether ... by public, private and NGO providers’ (WHO 2008). Mackintosh and Koivusalo (2005) provide a more complete definition: ‘the provision of health care services through market relationships to those able to pay; investment in and production of those services and of inputs to them, for cash income or profit, including private contracting and supply of publicly financed health care; and health care finance derived from individual payments and private insurance’.

Other commentators (Mackintosh 2007; Bloom, Standing et al 2008) have described characteristics such as the following in commercialised health sector markets:

- marketisation: money transactions (payment of fees) as the dominant transaction for health services, in both government and non-government providers;
- poor regulation: many transactions take place outside the formal regulated framework, or in a regulatory regime that is poorly implemented or lacks clarity, and some are unofficial or under the table;
- porous borders between state and non-state, with staff moving across borders, undertaking recognised dual practice, or ‘moonlighting’;
- high out of pocket expenditure;
- a poorly funded and dysfunctional state sector, with distribution and access to services largely determined by the market and ability to pay.

These systems provide opportunities and challenges for policy makers. The next section reports on the findings of the studies, which examined in more depth how the hospital sector operates, and the regulatory and policy issues and options.
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FINDINGS

The Hospital Sector

Overall, Indonesia has a relatively low total hospital bed to population ratio (one of the lowest in South East Asia, below that of Vietnam or Laos), but a relatively high proportion (37%) in non-state facilities (Table 2). The bed occupancy rate is also relatively low, around 60% in 2006, but case flow rates are average for the region (40 cases/bed/year). In comparison, Vietnam has around three times the beds per population, a bed occupancy rate of 95% and case flow of 50 per year (Rokx, Schieber et al 2009).

Not surprisingly, expenditure on hospitals in Indonesia is also relatively low, at about 38% of public expenditure, compared to Vietnam 79%, Malaysia 71% and Thailand 88% (Rokx, Schieber et al 2009). Utilization of hospitals has increased since the introduction of Jamkesmas, especially by the poor, although utilisation by the poor is still lower than that of the rich, only 5% of poor households reporting use of hospitals in the previous year, compared to 10% of households in the richest quintile. However, use of public hospitals by the poorest quintile doubled between 2001 and 2007, while use by the richest quintile increased by 50%. In contrast, a higher proportion of poor households use public facilities for ambulatory care than the rich (10% compared to 5%), and similar proportions use private facilities (around 13%) (Rokx, Schieber et al 2009).

Distribution

A large proportion of both state and non-state hospitals are located on Java: 45% of state hospitals and 61% of non-state hospitals. However, because Java also has the highest population density, the ratios of beds to population in provinces of Java (2.8 to 5.7 beds per 10,000 population) are lower than in provinces outside Java (5.7 to 11.2 beds per 10,000 population). A recent review of maternity services noted that the availability of comprehensive emergency obstetric and neonatal care at provincial and district hospitals was below requirements in all but four of 27 provinces surveyed, although major cities such as Jakarta had an excess of capacity. As a result, caesarean section rates are below expected levels in rural areas (3.9% compared to an estimated minimum of 5%), while 11% in urban areas. This suggests an uneven distribution of hospital services and that lack of hospital capacity to provide such care was a significant contributor to persistent high maternal mortality (Mize, Pambudi et al 2009).

Regulation

Hospitals (both state and non-state) are classified by the number of beds and number of specialists into four categories:

- A: central teaching and referral hospitals, mainly in the capital (Jakarta) and large cities of Java and Bali. These are state hospitals, directly administered by the MoH, and are required to have at least 21 specialist doctors (four basic specialists, five medical support specialists, 12 other) and 13 subspecialists, usually with more than 400 beds.
- B: provincial teaching and referral hospitals, in the capital city of each province. State hospitals are administered by the provincial government, but may also be non-state; required to have 16 specialist doctors (four basic specialists, four medical support specialists, eight other) and two subspecialists, usually with more than 200 beds.

Table 2. Hospital and Population Indicators, Indonesia (2008)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (million)</td>
<td>226</td>
</tr>
<tr>
<td>Total number of hospitals</td>
<td>1320</td>
</tr>
<tr>
<td>Number of non-state hospitals</td>
<td>653</td>
</tr>
<tr>
<td>Non-state hospitals as % all hospitals</td>
<td>50%</td>
</tr>
<tr>
<td>Beds per 10,000 population</td>
<td>6.3</td>
</tr>
<tr>
<td>Total hospital beds</td>
<td>142,884</td>
</tr>
<tr>
<td>Number of non-state beds</td>
<td>53,288</td>
</tr>
<tr>
<td>Non-state beds as a % of all hospital beds</td>
<td>37%</td>
</tr>
</tbody>
</table>

Source: Data compiled from MoH reports.
• C and D: district hospitals, in the capital cities of each district, and administered directly by each district. This is the main category for private/non-state hospitals. Level C hospitals have at least four basic specialist doctors and four medical support specialists, with 100-200 beds; level D hospitals have two basic specialists and 50-100 beds.

According to MoH regulation 922/2008, hospitals require two types of licence, an establishment licence (issued by the local government and giving permission to construct the facility) and an operational licence (issued by the MoH, and based on the determination of the hospital class). Since the level of licence is closely tied to the number of specialist doctors, attracting and retaining specialist doctors is a major requirement for hospital managers. The MoH reported that many non-state hospitals fail to obtain the second form of licence because they are unable to maintain the required number of specialists (MoH personal communication April 2010).

As a result, the distribution of specialist doctors closely matches that of hospitals, with a much higher proportion in the islands of Java and Bali than in more remote areas. In the case of paediatricians, 69% practise on Java and Bali, home to 56% of the population. The distribution of obstetric-gynaecology specialists is similar, and in nine of the 33 provinces, there are fewer than seven obstetrics and gynaecologist specialists (Mize, Pambudi et al 2009).

Non-State Hospitals

Non-state facilities are nearly 50% of the total number of hospitals in Indonesia (653 out of 1320). This proportion increased over 10 years, from 45% in 1998. This is the result of the growth of non-state hospitals (increased 33% between 1998 and 2008) being faster than that of state hospitals (increased 13% over the same period) (Figure 1). However, the number of hospital beds in the non-state sector is smaller. The proportion of non-state hospital beds was 34.1% in 1998, increasing to 37.3% by 2008. This is mainly because the average size of non-state hospitals is smaller, and most of the growth in non-state hospitals was among those with fewer than 150 beds.

Figure 1. State and Non-State Hospitals Registered with the MoH, 1998-2008

There are two types of non-state hospital, based on the legal status of the organisation that owns the hospital: NFP hospitals, and FP hospitals. NFP hospitals are registered to foundations (yayasan) or community associations (perkumpulan). FP hospitals are registered to companies, either limited or open companies. Most hospitals are foundations (81.8%), with the remainder as limited companies (13.8%) and community associations (4.4%).
Religious charitable groups such as Muslim (many groups, the largest being Muhammadyah), Protestant (the successor of the zendung movement, the missionary Christian movement originating from Holland during the colonial period) and Catholic (many congregations) are the major owners of the foundation hospitals. However, there are also a large number of smaller foundations, established as charitable organisations by families or individuals, which operate many of the smaller hospitals. Many of these hospitals have long histories, being founded in the colonial period, with a mission to provide care to the native population, rather than the colonisers. While most (62%) are still in the large urban centres of Java and Bali, a significant number serve rural and remote areas. For example, there are still 24 non-state hospitals (compared to 64 state hospitals) in the poorer eastern provinces of Nusa Tenggara Barat, Nusa Tenggara Timur, Maluku, Maluku Utara, Papua and Papua Barat.

For-profit non-state health care organisations can be classified into hospital chains (Bunda, Hermina, Siloam and others), ambulatory and out-patient clinic care networks, emergency providers such as SOS, and single providers such as Yogyakarta International Hospital. These hospitals tend to be located in large urban centres in Java and Bali and to cater to the affluent and the middle class.

Recent developments in non-state hospitals

Most growth has been occurring in the FP company-owned hospitals, especially over the last five years. In 2003 there were 49 FP non-state hospitals. In 2008, this number almost doubled, to 85. Most new FP hospitals have been established in Jakarta and other big cities of Java, despite MoH Decree 1563/2003, which restricts the number of hospitals to a maximum of one state hospital and up to three private providers for each 100,000 population. In addition a number of foundation hospitals have converted to FP companies. Between 2002 and 2008, 25 foundation hospitals were converted to FP limited companies. On the other hand, only five limited company hospitals became foundations (Figure 2).

Figure 2. Growth of Non-State Hospitals Owned by Companies, by Hospital Size
In contrast, there has been little growth in the number of foundation hospitals over the last five years. While some growth occurred in the smaller hospitals during 1998 to 2002, there has been little increase since then, and virtually no increase in the larger hospitals during the last 10 years (Figure 3).

**Not-for-Profit Hospitals**

Consultation with NFP hospital providers identified issues related to financial sustainability and management and governance that were hampering growth and development of the NFP sector. Further in-depth study provided the following additional information.

**Financial constraints**

The main issue for the NFP hospitals was the lack of subsidies or additional revenue to enable provision of charitable services. In the colonial period, the charitable religious hospitals received subsidies from their parent organisations and from the government, to provide services to the poor and those who could not pay. But since independence, government subsidies have ceased. The parent organisations lost their capacity to provide subsidies, and rather were expecting the hospitals to contribute revenue back to them. Unlike charitable service providers in other countries, and education providers in Indonesia, health care providers are not entitled to any taxation concessions. Hospitals are treated in the same way as profit-making businesses.

Overall, hospitals are subject to 43 different taxes, levies and repayments, and receive no concession on charges for utilities and water. The only government support available is a 50% reduction on land and building tax for new private hospitals, and some government support for building construction and medical equipment, if at least 25% of the hospital beds are low-cost public wards. At the same time, foundation status restricts the ability of a hospital to use assets to raise investment capital, because under the foundation law, the hospital does not legally 'own' the assets and can’t use them as collateral for loans or sell them to raise capital. This is particularly a problem for the smaller physician-owned hospitals, which have not been able to invest in refurbishment or improvements in facilities and equipment.

The result has been not only stagnation in growth, but a change in the services and functions of many NFP hospitals. To raise revenue, they have introduced services aimed at fee-paying patients and have taken on many of the characteristics of FP providers as they compete for a share of the market.

**Management and governance issues**

In-depth case studies also identified a number of problems in relation to management and governance. A key underlying issue was the lack of effective governance mechanisms in the NFP hospitals, in particular the lack of separation between the owner and the manager roles. Although supervisory boards (badan pengawas) have been established as required under the foundation laws, the boards functioned more as management boards and did not fulfil their governance function. This has hindered the owners from recognising and responding to the shift away from their original missions.
The situation for smaller physician-owned hospitals is complicated by the same person functioning as both owner and manager, and failure to separate these roles. The case studies identified situations where this dual role had hampered decision making in relation to critical issues or problems, as well as problems dealing with succession when the founding owner-manager retired or died.

A further issue was the lack of expertise and application of modern management structures and processes in the hospitals. Management tended to be centralised in the control of the hospital director, with weak delegation and lack of collective leadership through an executive group. Investment in appropriate information technology and systems is also low, limiting the data available to management on which to make decisions.

**Role of the Medical Profession**

The medical profession, particularly specialist doctors, play a key role in the functioning of hospitals and in fulfilling the requirements for a licence. Medical professionals in Indonesia have long been allowed to undertake dual practice, to have their own private clinics or to work in private hospitals, while retaining their civil servant status and position in a state hospital. Recent estimates suggest that 80% of doctors in general practice and 90% of specialists work in both public and private sectors (Rokx, Giles et al 2009).

The main reason is that doctors can earn significantly more income in private practice or private facilities than from their state salary. The CHSM carried out a study in 2006 of 279 doctors (126 general doctors and the remainder specialists); it found that on average, only 15% of the doctors’ incomes arose from government salary and allowances, while 58% was contributed by salary and allowances for work in private hospitals and 14% was from private practice. The proportion contributed by government salary was even less for specialists: only 12.5% for surgeons, and 9.3% for obstetricians/gynaecologists. Private hospitals provide around 60% of specialist income, and private practice from 7 to 15% depending on the type of specialist (7% for surgeons, 15% for paediatricians).

In addition, the case studies in areas where non-state hospitals are continuing to grow demonstrated that medical specialists from state hospitals often had roles in the development of new non-state hospitals. Specialist doctors were often responsible for establishing new non-state hospitals and provided services in their area of speciality. In Yogyakarta and Denpasar, most of these new hospitals were NFP (foundations), while in Jakarta some were supported by investors and established as FP companies.

Even in provincial cities where the economic stimulus was less strong, local medical doctors play a prominent role in the non-state hospitals. In some cases specialist doctors have established non-state hospitals that focus on their area, particularly obstetrics / gynaecologist specialists who establish maternity hospitals. There are also general hospitals established by general doctors, some of which have subsequently become part of the larger religious association hospital networks (for example Muhammadiyah). Some have been established by doctors in retirement as a retirement occupation, while others have been established to improve the welfare of doctors, their families and their communities.

In these hospitals, medical doctors may have a triple role as providers, managers and owners. However, the governance and management issues noted above were of particular problem in the hospitals where physicians were involved in the ownership and in the management and provision of services, and where there was no clear governance framework. Management was often controlled solely by the physician-owner, with all decisions in their hands. This created difficulties in resolving some of the staff management issues, and sometimes led to ongoing internal conflicts. This was particularly the case when family members became involved in ownership or management as the founder owner retired.

With these multiple roles, there is a risk that the doctors, particularly specialists, may neglect their roles in state facilities and spend more time in their more profitable private practice or private facilities. A case study at Jambi, a province in Sumatera, explored the way in which 15 specialist doctors divided their time between the state hospital, six private hospitals and their private clinics. In addition to their work at the state hospital, the specialist doctors reported working in between two and five other locations, including private rooms and non-state hospitals. The total average number of practice locations (including the state hospital) was 4.7, ranging
from three to seven. However, under Law 29/2004, a doctor is required to hold a licence to practise for each practice location, and the maximum number of locations is three.

Medical specialists working at the state hospital are required by local government regulation to be on duty between the hours of 8 a.m. and 2 p.m. on work days, and be on call or on rostered call after that. However, the actual time that the specialist doctors reported spending at the state hospital was usually one to one and a half hours on the days they attended the hospital. The number of days they attended varied with the number of specialists with whom they were rostered, from one day per week to an average of three days per week.

This study demonstrated that the specialist doctors in Jambi were neglecting their duties in the public hospital and focusing more on providing services in the private sector, particularly in private hospitals. It also demonstrated that the local regulatory authority, the municipal health office, and the state hospital management had taken no action to enforce the national law limiting the number of practice locations or the local government regulations on minimum hours to be spent at the public hospital. The main reason was that the salary and allowances provided by the hospital are set by the local government and are below the expectations and market potential of specialist doctors. Consequently, they supplement their income through private practice, and this is tolerated by the authorities in order to retain the doctors in the locality.
DISCUSSION AND POLICY ISSUES

A number of policy issues arise from this review of the non-state hospital sector in Indonesia, including especially the role of not-for-profit hospitals and the behaviour of physicians.

Not-for-Profit Hospitals

The current policy context appears to favour FP hospitals against NFPs in the non-state sector. Should the government introduce subsidies or taxation concessions for NFPs?

Is there a social benefit from retaining NFPs in the hospital sector? The literature suggests that benefits are derived from retaining NFP providers in a competitive hospital market. In Indonesia, where there is already a high proportion of NFP providers, incentives (such as taxation concessions) to NFPs could lead to increased services for the poor, as well as the ‘spillover’ effects of constraining excessive profit maximisation by FPs (Horwitz and Nichols 2009).

Partly as a result of these studies, the Indonesian national parliament included provisions in the new hospital law (No 44/2009) that distinguished FP and NFP hospitals, and allowed the possibility of taxation concessions to NFPs. However, translating these provisions in the law into the necessary regulations will be challenging, as it will involve two ministries, the Ministry of Health and the Ministry of Finance.

An important policy implication of the provision of subsidies to NFP hospitals, is the need to monitor the quality and the behaviour of NFP providers, particularly their adherence to social welfare missions and to providing trustworthy services, in order to ensure that the incentives lead to the desired behavioural changes. This might well vary with the degree of competition in local markets, the capacity and willingness to pay of the local population and the revenue impacts of the taxation concessions.

Physician Behaviour

The studies in Indonesia demonstrate some of the negative impacts of dual practice reported in the literature, and profit maximising behaviour on the part of doctors in dual practice. Regulations to limit private practice to three locations do not appear to be effective, and regulations on hours of work in the public sector appear to be flouted. The additional role of owner of health facilities, being taken up by some providers, creates further complications and raises conflict of interest issues. In addition, Indonesia lacks strong standards from professional associations and a regulatory framework or control on payments to doctors. As noted in the section on NSP hospital management, governance and management structures in NSP hospitals are weak, and the physician owner does not face a countervailing governance board. This is likely to undermine the control of conflicts of interest.

Potential policy options to address these issues include:

Improving and clarifying the regulatory framework

The new hospital law and the law on licensing of medical professionals has provided a stronger framework for the licensing of individual physicians and the management of hospitals. These laws have led to the establishment of the Indonesian Medical Council, to manage licensing of doctors and respond to complaints of malpractice. The new hospital law requires the establishment of hospital governing boards and sets out their functions. However, regulatory capacity and the implementation of sanctions on non-compliers remain weak. Physician ownership of facilities and management of conflicts of interest have yet to be specifically addressed in legislation or regulation.

Improving professional standards and voluntary regulation

Indonesia already has a number of medical professional associations, both for doctors in general (the Indonesian Doctors Association) and for specific specialist groups. While the associations have generally acted to promote the interests of their members, there is a potential for greater involvement of professional associations in setting ethical and practice standards, and educating and encouraging members to comply.

State hospital management

A third policy option is the provision of better incentives for quality work in state and NFP hospitals, with clarity in contracts on expectations from state work, as well as private practice, and monitoring and management of compliance.
CONCLUSIONS

These studies have explored in depth the impacts of growing commercialisation of the health sector on hospital services in Indonesia. They have shown the strengths of the sector in the widespread network of state hospitals, the long established networks of NFP hospitals and the growing FP sector. But they have also demonstrated some of the challenges of managing this mixed sector, particularly the dual practice of physicians across state and non-state sectors, the underfunded and poorly performing state sector and the inequality in distribution across the wide geography of Indonesia.

Increased state funding to health through the social health insurance scheme provides opportunities for increased funding to both state and non-state facilities, and new laws and regulations are opportunities to strengthen the legal framework for management. But these opportunities risk being undermined by the fragmentation of the state system and the weakness in regulatory capacity, particularly of provinces and districts.

Management of providers and facilities in this environment entails a series of balances, rather than relying on traditional ‘command and control’ directives and regulations. Maintaining and exploiting the range of providers and facilities within the system can provide the checks and balances needed to encourage competition and constrain practices that undermine social benefit. Key strategies proposed for the Indonesian authorities in this situation are:

(1) Strengthen and increase funding to public facilities and provide incentives to encourage providers to remain within the public system and to provide quality services, particularly for those who cannot access alternative non-state providers.
(2) Provide appropriate incentives to retain and enable ongoing growth of the NFP segment of the non-state sector, to provide a benchmark for trustworthiness and quality service to the poor.
(3) Develop standards and expectations for private FP providers and for practitioners working in the private sector, to be applied through a combination of legal regulation, voluntary or self-regulation through professional associations and market competition.
(4) Improve the capacity of provincial and district health offices to monitor the behaviour and services provided by state, FP and NFP hospitals, and to take further regulatory action as required, depending on markets in different localities.
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