ISSUE BRIEF: NON STATE HOSPITALS IN INDONESIA
ROLES OF THE NOT-FOR-PROFIT SECTOR and SPECIALIST DOCTORS

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Studies undertaken by the Centre for Health Service Management, University of Gadjah Mada in collaboration with the Health Policy and Health Finance Knowledge Hub (Nossal Institute of Global Health, University of Melbourne).

Key messages

- Non-state (non-government) hospitals make up a significant proportion of total hospital resources in Indonesia, comprising nearly 50% of all hospitals and over one third (37%) of all hospital beds in 2008. The majority of non-state hospitals (85%) are owned by not-for-profit organisations (yayasan or perkumpulan), many of which have been providing services since the colonial period and are part of large networks run by religious charitable associations.

- Most growth over the last ten years has been in the for-profit sector, with little increase in the number of not-for-profit hospitals, and some conversion from not-for-profit to for-profit. The large number of taxes and the absence of tax-exemptions has discouraged greater investment in not-for-profit hospitals, and some have begun charging for services and seeking paying patients in order to raise revenue.

- Government policy has not focused on the development of the non-state sector, and, where regulations exist, such as in regard to dual practice, they are frequently not enforced. Yet there are significant risks to efficiency and quality of care in the absence of strong market regulation.

- The not-for-profit hospital sector needs government support if it is to be maintained; provisions in the new hospital law (UU 44/2009) reflect this, by allowing for tax-exemption for not-for-profit providers. Providing incentives to help retain and grow not-for-profit providers may lead to benefits such as increased services for the poor.

- The establishment and operation of non-state hospitals is often reliant on the interests of doctors, particularly specialist doctors. The reluctance of specialist doctors to work in rural or remote areas, and their interest in ‘dual practice’ to increase their incomes from private practice, has contributed to the growing disparity in access to health services between rural and urban areas of Indonesia and poor quality of care in government facilities.

- New policy approaches are needed to address dual practice and conflicts of interest for physicians working in hospitals which they own. Indonesian medical professional associations, who have not yet set ethical and professional standards for members, are in discussion with the study authors to explore their capacity to contribute to change through self-regulation.
Description of research

While there have been many studies of primary health care providers, this study has been one of the first to look at the hospital sector. It involved:

- Compiling and mapping the numbers, locations, and classification of state and non-state hospitals from 1998 to 2008 from data reported to the Ministry of Health.
- Case studies of non-state hospital growth and governance and management in cities of Yogyakarta, Jakarta, Denpasar, Bima and Jambi.
- Review of the current regulatory environment and regulatory capacity
- Case study of regulation of dual practice in one provincial city

Why is this issue important?

The Government of Indonesia has invested, since independence, in a network of state-owned hospitals and health facilities. Parallel to this state system is a network of private providers, who often work in both state and non-state facilities (dual practice), and who provide a significant proportion (50-60%) of ambulatory care in the country, particularly in Java and Bali. Government policy has to date focused on the state system, with policies providing greater autonomy to state hospitals (conversion to BLU or badan layanan umum) and financial protection for the poor (Jamkesmas). Despite overall progress in achieving key population health goals, such as reduction of under-five and maternal mortality, there are still wide disparities in access to health services and health status between populations in urban areas and on Java/Bali, and those in rural areas and/or other islands. Understanding the contribution of the non-state sector in provision of hospital services will assist in identifying its potential to support achievement of public health goals.
Research findings

(1) **Significant contribution of non-state hospitals.** Non-government-owned hospitals made up 50% (563) of the 1320 hospitals in Indonesia in 2008, and contributed 37% of total hospital beds. Non-state hospitals are generally smaller than state hospitals, and the majority (85%) are owned by not-for-profit organisations such as yayasan or perkumpulan.

(2) **Overall low ratio of hospital beds: population and disparity in distribution.** Despite the significant network of state and non-state hospitals, the overall hospital bed : population ratio in Indonesia at 6.3/10,000 is one of the lowest in Asia. A large proportion of hospitals are located on the islands of Java and Bali, with 45% of state hospitals and 61% of non state hospitals. Similarly, the distribution of specialist doctors who work in hospitals also favours the islands of Java and Bali; for example 69% of paediatric specialists are based on those two islands.

(3) **Growth of for-profit hospitals, but not of not-for-profits.** While the number of for-profit hospitals nearly doubled (from 49 to 85) over the period 2003–2008, there has been little or no growth in not-for-profit hospitals over the same period. There has also been a tendency for some non-state hospitals to shift emphasis from charitable care to profitable fee-paying arrangements. For-profit hospitals have developed mostly in wealthy urban areas of Java and Bali, although many not-for-profits continue to operate in rural and remote areas.

(4) **Social and economic factors behind this growth.** Factors contributing to this pattern of growth include (a) growing demand for hospital services from the wealthier segment of the population; (b) a taxation and legal regime which favours company ownership and for profit management of hospitals; and (c) dominant role of medical specialists in a market where there is a scarcity of specialists.

(5) **Specialist doctors play a large role in creation of new hospitals and rely on private practice for income.** Specialist doctors are usually involved in the establishment of both for-profit and not-for-profit-hospitals, in their operation, and sometimes in their management. Specialist doctors earn the majority of their income (80-90%) from private practice, with 60% coming from work in private hospitals, while continuing to work as public servants in public hospitals through dual practice arrangements. Some doctors have taken on a triple role, as health care providers, managers and owners of private facilities.

(6) **The policy and regulatory framework has gaps and is not always enforced.** Limits on the number of locations for dual practice were not enforced in many areas, and guidance on the number of hospitals required per population also appears to be ignored. There are no explicit policy directions governing the role of non-state hospitals or regulations addressing potential conflicts of interest for doctors in managing and owning facilities where they also provide services.
Implications for policy and recommendations

- Research suggests benefits in retaining not-for-profit providers in a competitive hospital market. In the Indonesian context, where there is already a high proportion of not-for-profit providers, the policy option of providing some incentives (such as taxation concessions) to not-for-profits could lead to increased services available for the poor, as well as a ‘spillover’ effect of constraining excessive profit-maximization by for-profits.

- There are significant risks to efficiency and quality of care if physician conflicts of interest are not regulated or regulations are not enforced. While medical professional associations are active in Indonesia, they have not yet taken an active role in setting ethical or professional standards for their members.

- The Indonesian Parliament has now included a provision for taxation concessions for non-state hospitals in the hospital law (44/2009), partly in response to lobbying by not-for-profit hospital associations armed with the findings of this study. The study team is working with the Ministry of Health and not-for-profit hospital associations to draft the regulations required to implement the provision in the law.

  - Provision of government support (e.g. in the form of tax concessions) to not-for-profit providers needs to be accompanied by a clear definition of not-for-profit providers, an outline of social benefits that they should provide, and improvements in governance and management arrangements.

  - The Government and donors need to examine options for engaging not-for-profit hospital providers in providing hospital services and to focus on building capacity and supporting hospitals in rural and remote areas of Indonesia as a strategy to address the current disparities in access to services.

  - While the Government is improving regulation of the medical profession through licensing provisions, existing medical professional associations could contribute to this regulation through the development and education of their members on codes of conduct and ethical standards, and how to deal with conflicts of interest. The study partners are working with some associations on these issues.

A working paper providing more information on these studies is available from the Nossal Institute

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