Charitable foundations and other not-for-profit groups operate more than one third of all the hospitals registered in Indonesia. Yet despite their vital role in delivering health services to the poor, these hospitals are widely neglected by the Government, which continues to tax them at levels comparable to profit-making enterprises. After research undertaken by the Health Policy and Health Finance (HPHF) Hub and its Indonesian partners highlighted significant financial pressures on not-for-profit (NFP) hospitals, researchers and hospital administrators successfully lobbied for the inclusion of provisions on tax concessions in the 2009 Hospital Law. Although progress on these regulations has been slow, recent years have seen a notable softening in attitudes among the Ministry of Health and NFP hospital associations – paving the way for more cooperative dialogue, and renewed hope of lasting policy reform.

Introduction

Indonesia still has a relatively low number of hospital beds per population: 0.6 beds per 1000 people, which compares poorly to neighbouring countries, such as Vietnam with 2.4 beds, Thailand with 2.1, and Malaysia with 1.8. While the number of hospital beds has increased significantly in the past few years, it remains a key priority for Ministry of Health (MoH) policymakers, who anticipate a rapid increase in demand with the proposed introduction of a national social health insurance scheme in 2014.

Of the 1372 hospitals registered with the MoH in 2008, 653 were owned by non-state entities, of which 85% were owned by charitable foundations and cooperatives. By 2012, encouraged by more relaxed registration requirements, the number of non-state hospitals had jumped to 1195, of a national total of 2083 hospitals – although most of this increase can be attributed to a sharp rise in private for-profit hospitals (from 90 to 468), with a much smaller rise in NFP hospitals (from 563 to 727).

Research by the HPHF Hub and its partners at the Centre for Health Service Management (CHSM) at Universitas Gadjah Mada showed much slower growth trends during 2003-08, when the country saw just 58 new state hospitals and 48 new non-state hospitals. The growth in non-state hospitals occurred entirely in the for-profit sector, which went from 39 to 90 hospitals during this period, while there was no growth in not-for-profit hospitals, which went from 567 to 563 (see Figure 1).

NFP hospitals under pressure

In March 2009, Hub-CHSM researchers consulted the major charitable hospital foundations, such as Muhammadiyah (Muslim) and PELKESI (Christian), which own and manage networks of NFP hospitals. Most of these groups reported increasing financial pressures, with loss of revenue from foundation owners, the cessation of government subsidies, and significant taxes levied by the Government. As a result, many were being forced to introduce more fee-paying beds – and to neglect their core mission of providing care for the poor.

The research team noted that in many countries not-for-profit hospitals receive support from governments for providing services to the poor, such as subsidies or tax concessions. But this is not the case in Indonesia, where hospitals are taxed as if they are profit-making businesses.

In June 2009, CHSM researchers presented their findings to the charitable associations that manage the majority of Indonesia’s NFP hospitals. The associations saw an opportunity to lobby parliamentarians who were debating a new Hospital Law, to promote the inclusion of provisions for government support to NFP hospitals. In collaboration
with the NFP hospital associations, the researchers consulted with lawyers and prepared a policy brief outlining a potential approach for such provisions.

This lobbying effort was largely successful, and the 2009 Hospital Law duly included a provision for ‘tax incentives’ to ‘hospitals classified as public’ (including state and non-state hospitals) – using wording almost identical to that in the policy brief.

A new engagement

While the provision in the new law was a significant breakthrough, enabling regulations were still needed for it to take effect. Initially the MoH took an active role and demonstrated a new willingness to engage with the non-state sector, inviting the NFP hospital associations and the Hub-CHSM researchers to join a taskforce charged with developing the new regulations.

In order to explore further policy options, the HPHF Hub hosted a study visit to Melbourne in May 2010 for a group of taskforce members, including NFP hospital administrators, MoH policymakers and CHSM researchers. Through dialogue with Australian charitable hospitals and government regulators, the group gained a new appreciation of the critical role of NFP hospitals – as well as a renewed sense of cooperation that transcended their political and religious affiliations. The group developed plans to continue collaborating on the development of the tax-related regulations, as well as on other policy issues such as hospital governance and charitable donations.

As a first step in the regulation process, the taskforce developed a series of ‘academic drafts’ that set out the rationale and options for reducing national level taxes for NFP hospitals. However, ensuing discussions with the Ministry of Finance (MoF) failed to obtain their agreement for the proposed changes. Further progress on developing the regulations has since stalled, as key MoH staff have transferred to new positions, and the MoH remains reluctant to confront the MoF. The MoF has indicated that it would like more evidence on the costs and benefits of changes to the tax regime in order to support it. CHSM and Hub researchers continue to engage with the MoH and NFP hospital associations in compiling specific information on the income and expenses of not-for-profit hospitals.
While this advocacy effort continues, there has been a positive change in the mistrust and lack of engagement that previously characterised relations between the MoH and NFP hospital associations. Ministry policymakers have formally acknowledged the role of NFP hospitals, and continue to engage them in key policy discussions. The associations have also recognised their ‘common cause’, and the importance of engaging with the Ministry.

In late 2012, the NFP hospital associations formed an umbrella association – ARSANI (Asosiasi Rumah Sakit Nirlaba) – which is now coordinating their campaign for tax concessions. ARSANI held its inaugural seminar in February 2013, with the participation and support of the CHSM. Articles in the national newspaper Kompas have also publicised the important contribution that NFP hospitals make to health care in Indonesia.

For its part, the MoH continues to broaden its view of hospital stakeholders, as it searches for strategies to increase the number of hospital beds ahead of the introduction of a social health insurance scheme. In 2012, the Ministry significantly softened its requirements for hospital registration, allowing the registration of greater numbers of non-state hospitals. The health insurance scheme, which is due to commence in 2014, will also provide opportunities for NFP hospitals to receive reimbursement from government funds for the treatment of insured patients.

The broad change in attitude at the MoH was summed up by one policymaker, who said: “We cannot rely on state hospitals alone. The private hospitals are our partners. We [the Ministry, the NFP hospital associations and CHSM] need to join forces... We complement each other in terms of what we do.”

At present, the Hub-CHSM researchers remain engaged with both the Ministries of Health and Finance to advance the development of regulations in support of tax concessions for NFP hospitals. The team is supporting the MoH and ARSANI to design a comprehensive ‘costing study’ to collect specific information on the income and expenditure of NFP hospitals, as requested by the MoF. In January 2013, the MoH directed NFP hospitals to provide this information to the researchers – paving the way for this critical study to be completed during 2013.

**Lessons and implications**

This is a story of change, and of stasis; of a ‘quick win’ with a change in the law, but an enduring failure to translate this into practical action. The impact to date suggests that it was easier to influence parliamentarians to change the law than it was to provide the evidence to convince skeptical bureaucrats of the need to implement that law.

For the Hub’s and CHSM’s researchers, there have been important lessons – not only in tempering our own expectations, but in the need to complement political advocacy with the nurturing of mutual engagement and understanding among policymakers and bureaucrats.

Perhaps this has been the key lesson for all concerned: that a positive change in formal policy is rarely an end in itself. Changing policy also needs a shared, long-term commitment and engagement among all stakeholders, both within and outside government. This invariably entails changes in attitudes, relationships and practices, which may in turn require ongoing support, liaison, and updated evidence.