Section 1

This chapter presents the current context (around the last 10 years) of non-state providers. The current context is classified as (1) current hospital environment in terms of economy, demography, and epidemiology; (2) the influence of decentralization policy; (3) health-sector governance issues; and (4) the changing role of the medical profession.

CHAPTER 1
The Origin of Non-state Providers in Indonesia

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The current situation of non-state providers is influenced by the history of healing and health service organizations in Indonesia. Boomgard[1] expresses the view that the history of health service and hospitals in Indonesia is inseparable from the progressive change from the traditional health system in Asia, which has been based on the Chinese system, and its transition to the Western system[2]. This change occurred slowly because the Western health service was initially intended more for the noble families. Purwanto (1996) notes that during the early colonial period hospitals in Indonesia were exclusively intended for European people.

Individual health care practitioners have been parts of in the Indonesian health system since the period before colonization by the Western. Individual providers practiced magical healing, herbal medicine, Indian-influenced therapy, and Chinese medicine. Every ethnic group in Indonesia has a name for such health providers, such as *dukun, saman*, etc.

1.1 Development of Institutional Providers during the Colonial Period

Modern medicine began to be known in Indonesia as the East India Company (VOC) hired surgeons to support their trading activities. Health care practices began to be more systematically

[1] Boomgard, P. 1993. The Development of Colonial Health Care in Java: An explanatory Introduction. *Journal of the Royal Institute of Linguistics and Anthropology.* See also Boomgard, P. 1996. Dutch Medicines in Asia, 1600 – 1900. In Warm Climates and Western Medicine*: The Emergence of Tropical Medicine.*

[2] Akira, O. 1996. *Introduction to the History of Disease and Healing in Indonesia*. Forum of International Development Studies.

performed when the East India Company founded a hospital in Batavia on July 1, 1626. This was the first hospital in Indonesia, which was also allowed for medical treatment for non-VOC patients. However, then only certain groups, especially the military, could enjoy the services.

Owing to the increased activity in the archipelago, the VOC was forced to build a township for its employees and also to set up two more hospitals in the Batavia area one in Bogor in 1779 and another in Weltevreden in 1800. Meanwhile, in cities such as Surabaya, Semarang, Cirebon and Banten, the East India Company set up a kind of institution that provided treatment for the sick. Outside Java (*buitenbezittingen*) limited-service health centers were established with a capacity of less than 50 beds.

During the 18th century, the East India Company established a number of larger hospitals in Java, and smaller outposts in other islands, mainly in an effort to control outbreaks of infectious diseases. Certain ethnic groups, such as the Chinese, also opened hospitals which were especially to serve their own communities.

By the 19th century, when the East India Company was taken over by the Dutch government, hospitals were classified into two categories, those for the military and those for civilians, but the main focus was still on the care of the military. However, with the increasing cases of civilian injuries, wards were opened in military hospitals to treat injured civilians. Hospitals were staffed by European doctors, but starting from the mid 19th century indigenous locals also began to be trained to serve as Javanese physicians *(Dokter Djawa)*.

In this period a civilian hospital (*stadsverbandhuis*) was no more than a house designated as a place to care for wounded civilians. In addition to treating wounded war-victim civilians from the war, a *stadsverbandhuis* was also used for detaining prostitutes

infected with venereal diseases who were sent in by the police. The municipal government provided physicians to treat the patients in a *stadsverbadhuis* and also those in prisons and orphanages[3].

Religion-Affiliated Private Hospitals

The next phase in the development of non-state health-care providers was the establishment of *zending* (Protestant Church mission) hospitals. These hospitals were founded by religious missionaries from the *zending* networks in the Netherlands. The hospitals were found in almost all areas of Java by the end of the 19th century, and provided treatment for civilians from all ethnic groups[4].

The operation of these hospitals was largely financed with government subsidies, while the doctors, nurses and drugs were sent by the *zending* organizations in the Netherlands. Before World War II, generally speaking, the financial support for *zending* hospitals was 44% from government subsidies, 20% from the churches in the Netherlands, 10% from patient payments, 8% contribution of local governments, 6% from private companies, and the remainder from private donations and other sources. In the early 20th century these Christian hospitals were followed by the establishment of hospitals by the Muhammadiyah Islamic organization in various cities of Java.

The Plantation Private Hospital

Under the administration of the Dutch East India Company, various plantations established hospitals to take care of their workers' health, with the primary aim to increase their productivity.

[3] These orphanages were founded by the church to take care of children who were abandoned by the Europeans.

[4] K.P. Groot, 1936, "De Medische Zending in Nederlandsch-Indie" in Feestbundel Geneeskundige Tijdschrift voor Nederlandch Indie, p. 237.

However, the workers had to bear the cost of their treatment through pay cuts or debts to be repaid to the plantation owner[5].

The role of private hospitals increased in 1916 when the Dutch Indies Civil Health Service began to expand health services for the general public, especially in Java. The Dutch Indies government then worked with the plantation companies in financing hospitals. That was why later in the year 1919 the Government made an agreement regarding the distribution of fund to private hospitals managed by these companies[6]. This resulted in the establishment of more hospitals and the expansion of existing ones.

Ethical Policy and Health Subsidy

The world economic crisis in the late 19th century led to a decreased level of prosperity of the population, especially in Java. Therefore, in the early 20th century the colonial government tried to find its causes by conducting a research, known as *mindere welvaart onderzoek op Java*. The research, which was conducted by Burger, indicated that the causes of this decreased prosperity included the large number of the then population of Java, the implementation of the *cultuur stelsel* (cultivation system), the liberal politics, and the penetration of industrial goods to the rural areas of Java[7].

On the basis of this report, prominent figures from the Ethical group, such as Van Deventer, De Wolff and van Westerrode Abendanon, called for the repayment of the "debt" owed by the Dutch Indies government to the local population. This could be implemented by improving their welfare with a famous triad

[5] Isti Yunaida, 1999, "Penyakit-penyakit yang menyerang Kuli-kuli perkebunan di Sumatera Timur (1931-1938)", Thesis S-1, Faculty of Letter, UGM.

[6] Verslag voor Burgelijke Geneeskundige Dienst, 1920, in Mededelingen Burgelijke Geneeskundige Dienst in Nederlandsch--Indie, p. 388

[7] D.H. Burger 1962, *Sejarah Ekonomis Sosiologis Indonesia I* (Jakarta: Pradnjaparamitha), p. 93.

"irrigation, education, and emigration", which served as the basic idea of the Ethical Policy[8].

To follow up these concerns, the Dutch East Indies government made several policy changes in the health sector. In the early decades of the 20th century, the Dutch Indies government reorganized the structure of health institutions in the Dutch East Indies, and separated institutions for military health care from those for the general public.

The policy that had a huge impact on the expansion of health services was the provision of subsidies to hospitals in the Dutch Indies. The purpose of this policy was to ensure that health services could be accessed by society members of any level who needed the service. Though theoretically subsidies were provided, the enforcement varied and depended on the generosity of the government[9]. Starting from 1906, subsidies were provided regularly in the form of cash, medicines, hospital equipment, and salaries of doctors and paramedics who worked at hospitals. Hospitals eligible for subsidies included indigenous private hospitals and local hospitals established by provincial, district or township governments and by December 1918 70 hospitals and auxiliary hospitals received subsidies.

In addition to health subsidies, other factors which affected the health condition of the general public was a paradigm shift in the colonial government's health policy which resulted in the reorganization of government health institutions. The concept of equitable health service was introduced, which aimed to provide subsidies for the poor who were unable to pay for services. In addition, the number of hospitals of all types continued to increase. By 1934, there were 64 hospitals managed by the central

[8] Suhartono, 1994, *Sejarah Pergerakan Nasional: dari Budi Utomo sampai Proklamasi 1908-1945* (Yogyakarta: Pustaka Pelajar), p. 16.

[9] Kolonial Verslag Tahun 1905.

government, 15 hospitals managed by provincial governments, 57 hospitals managed by regional governments, and 89 private hospitals which received government subsidies. In addition, there were also 35 company hospitals and 175 private hospitals which did not receive subsidies[10].

It should also be noted that during the colonial period doctors were permitted to run private practices[11]. With the salary received from the government and additional earning from private practice, doctors in the Dutch Indies administration were relatively rich, enjoyed an upper class life style and many medical doctors became political leaders.

1.2 The Development of Non-State Hospitals in Japanese Occupation Period

The heavy dependence of *Zending* hospitals on *Zending* foundations and churches in the Netherlands was a double-edged sword. On one hand, it ensured the flow of funds and medicine from the Netherlands. On the other hand, the dependence became the main obstacle when the relationship between the mother country and Indonesia was disrupted. This condition really occurred when the Japanese occupied Indonesia in 1942, which resulted in dissolution of the relationship between the foundations and churches in the Netherlands and the *Zending* institutions in Indonesia.

With the Dutch Indies colonial government' recapitulation to the Japanese in Kalijati on March 8, 1942, all *Zending* hospitals were taken over by the Japanese. Japan considered that all doctors who had run and managed *Zending* hospitals were spies for the Allied Forces. Therefore, they were detained and sent to concentration camps and not allowed to contact the hospital staff they had

[10] Peverelli, P. 1936 "De Ontploiing van den Burgelijken Genees----kundingen Dienst" dalam Feestbundel Geneeskundige Tijdschrift Nederlansch-Indie, p. 188.
[11] Observational data and some biography of colonial Indonesian medical doctors.

previously led. A year later they were returned to the Netherlands as prisoners of war.

1.3 The Development of Non-state Hospitals during the Post-Independence Period

In general, both government hospitals and private hospitals participated in the struggle for independence in the period of 1945 to 1950. All government institutions of Indonesia, including some parts of the Ministry of Health moved to Yogyakarta, and some were relocated within a Christian private hospital, namely the RSUP (Petronella Hospital).

After the transfer of sovereignty of Indonesia from the Dutch Government in 1949, the Ministry of Health relocated to Jakarta, but continued to subsidize the operation of the RSUP in Yogyakarta. The Ministry of Health also offered civil servant status to employees of the RSUP and other *Zending* hospitals in Java. As a result, nine *Zending* hospitals became government regional hospitals with their employees becoming civil servants too though staff in other hospitals refused. In fact, Law No. 18 of 1953 (on health care for poor families and poor people) and Law No. 48 of 1953 provided legal bases for assigning private hospitals to provide health care for poor families and poor people, but both laws were poorly implemented.

After independence in 1945, practically there was no provision of health services as public goods. Only a small number of Indonesians enjoyed free health services. The regulation applied during the Dutch Indies government continued in effect for civil servants, who were entitled to receive free-of-charge service from state hospitals and reimbursement of medical costs in private hospitals.

During the *Orde Lama* (Old Order) period (1950-1965), the government health policy focused more on preventive efforts than

curative. In 1953, Law No.18/1953 regulated the care of the poor by private hospitals. The Ministry of Health gave loans to expand private hospital buildings and for the expense of treatment to impecunious people[12]. In 1954, in Indonesia there were 108 private hospitals with a capacity of 14,036 beds, of which 20 hospitals received government funding. A number of private hospitals were also returned by the government to their former religion-affiliated owners.

However, the decreasing government subsidy to both state and non-state hospitals during this period, since the government did not have any access to foreign aids, resulted in all hospitals introducing user fees in order to support their operational expenses. Religion-affiliated hospitals were also forced to rely on user fees and to become more profit oriented by opening VIP and VVIP wards. Now hospitals were expected to generate funds for their parent organisazions, rather than to receive subsidies.

1.4 The Development of New Non-state Hospitals during the Orde Baru (New Order)

When the *Orde Baru* commenced in 1965, the health service policy and management in Indonesia were marked by the return of international donors like WHO and UNICEF. Those foreign institutions assisted in designing the master plan for the health service system in Indonesia. The health master plan in the *Orde Baru* era was designed by the end of 1969. Its essence was developing the concept of health service based on primary health service, where primary health service was the major choice.

State hospitals in Indonesia lacked fund, including fund to provide the appropriate salary and incentive to their doctors. The government subsidy for state-hospitals was especially intended for the staff's salary and the purchase of equipment. The payment for

[12] *Lembaran Negara Republik Indonesia (Republic of Indonesia's State Bulletin*) No.48, th 1953

the hospital staff, including the doctors, followed the scheme of public servants' salary. Doctors were considered as undergraduates and their salary was equal to that of other undergraduates. The bureaucracy of state hospitals was very rigid, and medical specialists had low incentives.

At this point a new development took place for non-state hospitals. In the first stage, many senior lecturers from state universities established small hospitals around the larger teaching hospitals. These medical-doctor-owned hospitals began with their private medical practice. Local medical school's prominent senior lecturers upgraded their individual practice into small hospitals with a capacity of fewer than 50 beds (See the case study of Yogyakarta). Although the senior lecturers became hospital owners, they did not resign from their posts as clinical staff members of state hospitals.

In a later development, Moslem organizations started to develop their hospitals, several were big and though many were small. Some were developed in collaboration with local medical doctors. Big Moslem hospitals were established in the beginning of 1970s in Jakarta. Between 1970s and now, hundreds of new Moslem hospitals the opportunity to become civil servants to established. The biggest social Moslem organization, Muhammadiyah, has 72 hospitals across Indonesia. Most of these are organized as foundations, although some hospitals are in the form of *Perkumpulan* (association). Legally-speaking, these two types of hospitals are non-profit. (See the case studies of Yakkum and Muhammadiyah).

The latest stage of non-state hospital development has been the introduction of a new policy which allows hospitals to be managed as for-profit companies (limited corporation*/Perseroan Terbatas*). One of the important moments in the history of hospital development in Indonesia was the change of the regulation on private hospital ownership as introduced by *Permenkes* (Health Minister's Regulation) 920/86. According to *Permenkes* No. 920/86,

private hospital ownership can be in the hands of an individual, a group, or a foundation. Further, *Permenkes* No. 84/Menkes/ Per/II/1990 adds another entity, namely 'other legal body'. Therefore, various legal bodies, including for-profit limited corporations, can become owners of hospitals. This for-profit corporation (*Perseroan Terbatas*) may be funded by a domestic investor or a foreign investor.

Permenkes No. 84/Menkes/Per/II/1990 is very significant because it legalizes a commercialized vision of the hospital service and reflects the increasing foreign influence to the hospital system in Indonesia (See the case studies in Yogyakarta and Jakarta).

This new policy has created a new breed of non-state providers. Some investors develop hospitals like RS Pondok Indah, whose approach is purely that of a commercial enterprise. The vision and philosophy are based on commercial business principles. Hospitals of this type have developed quickly, have been equipped with modern buildings and facilities, and have offered sophisticated services. Managers who run these hospitals graduated from both schools of business and schools of public health. In sum, hospitals have become an industry.

Senior lecturers' traditional way to run a private hospital as a foundation has changed as they have begun to run their hospitals as for-profit corporations. This structure has been pioneered by some senior lecturers from University of Indonesia's Medical School when they established MMC Hospital in Jakarta. In Denpasar, a group of lecturers from Udayana University's Medical School established Puri Medika hospital in the form of commercial corporations. A mix of investors and medical doctors was another option. RS Medistra in Jakarta is an example of a hospital which is owned by a mix of medical doctors and private investors.

Remarks on Policy Developments for State-Hospitals

Much has been presented about non-state hospitals. What about the development of state hospitals? Realizing the importance of subsidy for hospital to operate, the government in the 1990's provided an operational budget in the form of an *OPRS* subsidy through the Ministry of Health and an *SBO* subsidy through the Ministry of Domestic Affairs. Those subsidies did not reflect equity distribution[13]. The bigger the hospital, the larger subsidies were allocated. Both types of subsidies were not allowed to be used for incentives for doctors. Incentives for doctors in the hospital, which were in the form of additional incomes during the period of *Orde Baru,* was considered as a deviation from the rules[14]. As a result, specialist doctors working in state hospitals also worked in private hospitals or established their own private health service institutions to cater market demand. This fact indicates that specialist-doctor management has been a problem in Indonesia for years.

The tariff setting and service quality resulted in two layers of hospital service. Government hospitals were considered cheap but low-quality hospitals and the patients sometimes were not satisfied with their service. While private hospitals had the strengths which were the opposites of what were observed in government/state hospitals. Therefore, non-state hospitals attracted more doctors to work with them[15].

The World Bank started to step into Indonesia in the early 1990's with their development projects for health. In 1993, the World Bank selected health as an issue in its *World Development Report*[16]. At that time, economic ideas in the health sector were progressively

[13] Trisnantoro L. 1999. Evaluasi Terhadap SBBO. Mimeo

[14] Personal Communication with the late . Dr. Sudibjo Sardadi Dr Sardjito Hospital Director in early 1980s.

[15] Trisnantoro L. 2005. Aspek Stratejik Manajemen Rumahsakit: Antara misi sosial dan tekanan pasar. Andi Offset.

[16] World Bank. 1993. Investing in Health: World Development Report, Oxford University Press.

being applied. In the early 1990s, the corporatization of state-hospitals began with the stipulation of *Kepres* (Presidential Decree) No 38/1991. The Indonesian government legalized a new policy which converted state hospitals into semi financially-autonomous hospitals (*Swadana*), which was in line with the World Bank's framework of thinking. This policy was based on USAID's assistance in which the essence was that hospitals are permitted to spend their functional earnings directly. This policy has led to the financial autonomy in state-hospitals.

However, *Swadana* was a half-hearted policy because it was without an adequate legal change. This was obvious when there was a scandal regarding the diversion of state money in the Ministry of Mining and Energy which resulted in the cancellation of the autonomous hospital policy by the end of 1990s. This cancellation took place just about at the same time as the implementation of the health decentralization policy by the government. The autonomous hospital policy which was issued in the form of *Keppres* (Presidential Decree) was then suspended by the Indonesian government in 1998, especially that for general hospitals.

The policy on hospital institutional autonomy was then changed into a policy stating that the status of a state general hospital was changed into a *Perjan* (*perusahaan jawatan,* state corporation), which is less autonomous. In 2004, there was another change that converted the status of *Perjan* into *Perum (perusahaan umum,* public corporation) or *BLU (Badan Layanan Umum, Public Service Institution)* based on Law No. 1 of 2004 (and, later, Government Regulation No. 23 of 2005).

CHAPTER 2
Economic and Political Situation between 1990 and 2008

2.1 Year 1990 – 2008

In 1997, the Asian Financial Crisis that began in Thailand spread rapidly to Indonesia and created similar financial and macroeconomic problems like those in Thailand[17]. The GDP dropped drastically from 7.8% in 1996 to minus 13.2% in 1998 and the real income dropped from US$1,055 in 1997 to US$5148 in 1998. The inflation rate skyrocketed to 77.63% in 1998, as a result of the sharp depreciation of the rupiah and also the disruption of the distribution system as well as the high interest rates resulting from a tight monetary policy[18].

Inflation rose steadily up to 2006 when nearly 18% of the population lived below the poverty line, while 49% of the population lived on less than US$ 2 per day[19]. The "big bang" decentralization effort in 1999 added more complication to an already complex environment. It is said that to anticipate the challenges faced by Indonesia, there was a need to revitalize the regional government by shifting some of the authority previously held by the central government. However, the transfer of authority to the regional government has had some negative impacts in some regions because the local government tended to increase the local revenue by stipulating new local regulations that burdened the business community, using Law No. 34/2000 that opened up regional tax and retribution as a source of local government income.

[17] Dori, J.T. August 17, 1998. Indonesia's Economic and Political Crisis: A Challenge for U.S. Leadership in Asia. IMF's Response.

[18] WHO. 2008. National Health Accounts [electronic database]. Accessed via the web at http://www.who.int/nha/country/idn/en/ on January 24, 2009.

[19] World Bank. 2006. Making Services Work for the Poor. Jakarta: World Bank.

Efforts to exit from the economic crisis yielded favorable results by 2002, although progress has not been as rapid as expected. Interest rates were lowered significantly from 38.44% in 1998 to 12.99% at the end of 2002. The economy has grown approximately 6% per year since 2005, and rose by 6.1 percent in 2008, while foreign direct investment increased by 44%[20]. However, the recent global financial turmoil has forced the government to try to mitigate the effects of another economic crisis. Meanwhile the distribution of resources across provinces remains highly unequal, with provinces in the East of the country receiving substantially less than those in the West.

To anticipate future challenges the government through the Law No. 25 of 2000 concerning the National Development Program has formulated five national development priorities, namely to build a democratic political system and sustain the national integrity and unity, to create the supremacy of law and good governance, to accelerate economic recovery and to maintain sustainable development based on the people's economic system, to build people's welfare, to increase religious life quality and cultural security, and to foster regional development. In line with these priorities, the government has been committed to continue the process of reformation and democratization through clear frameworks and guidelines and by improving the respect for human rights, enforcing the law consistently, and implementing free and pro-active foreign policy.

After President Soeharto stepped down on May 21 1998, political laws that had served as the core of Soeharto's authoritarian system were abolished and free general elections were held in June 1999. With these events, it can be considered that Indonesia has abandoned the authoritarian system and shifted to a democratic

[20] USAID. Februari 2009. The vital role of the private sector in reproductive health. Policy brief. Private sector partnership for health.

system and political liberalization, which means that it guarantees political freedom and political participation, and decentralization of the presidential power[21].

The collapse of Soeharto's regime brought about the lifting of institutional state control over society, with the recognition of freedom of speech, association, and thoughts. According to[22] Manning and van Diermen (2000) the passage to social liberalization has caused two major changes: (1) the first is evolution of new state-society relationship, indicated by the rising number of cases of protests from the society against the state power. Later, social movements have become more sophisticated, seeking to get popular demands reflected in policy making through peaceful demonstrations, petitioning, and public hearings in assemblies; (2) the second change is the reorganization of social order at the level of residential communities. This social reordering occurred as state control of society was liberalized and the people were released from a uniform "nation" formation. In the *reformasi* (reforms) era, the government policy began to respect social cultural uniqueness of each region and community. For instance, the law on decentralization recognized village administration based on *adat* (customary laws).

2.2 Demographic and Epidemiology Trends

The World Bank projected a decline of population growth from 1.34% per year in 2005 to 0.11% in 2050, but the total population is still projected to increase from 206.3 million in 2000 to 273.2 million by 2025[23].

[21] Kawamura. 2000. "Political Reform in the Post-Soeharto Era", in Y.Sato ed. Indonesia Entering a New Era: Abdurrahman Wahid Government and Its Challenge, Chiba: IDE.

[22] Manning, Van Diermen. 2000. Indonesia in Transition: Social Aspects of Reformasi and Crisis, Indonesia Assessment Series, Singapore: ISEAS

[23] World Bank. 2009. *Health Financing in Indonesia: A Reform Road Map*. Jakarta, Indonesia: World Bank.

Table 2. 1 Population and Demographic Indicators and Projections for Indonesia (1961-2025)

Indicator	1961	1980	2000	2010	2020	2025
Total population (millions)	97.0	147.5	206.3	233.4	261.0	273.2
Women at reproductive age, 15-49 yrs (millions)	23.7	35.9	57.3	66.8	70.3	70.8
Women at reproductive age, 15-49 yrs (%)	24.4	24.3	27.8	28.6	26.9	25.9
Children age 0-14 yrs (millions)	41.0	60.0	63.2	60.7	62.4	62.3
Children age 0-15 yrs (%)	42.3	40.7	30.6	26.0	23.9	22.8
Working age population 15-64 yrs (millions)	53.4	81.9	133.1	160.2	180.4	187.7
Working age population 15-64 yrs (%)	55.1	55.5	64.5	68.6	69.1	68.7
Older population, 65+(millions)	2.6	4.8	9.6	12.4	18.3	23.2
Older population, 65+(%)	2.7	3.3	4.7	5.3	7.0	8.5
Dependency ratio (young)	76.8	73.3	47.5	37.9	34.6	33.2
Dependency ratio (elderly)	4.9	5.9	7.2	7.7	10.1	12.4
Total Dependency ratio (per 100 working age)	81.7	79.2	54.7	45.6	44.7	45.6
Rate of Population growth, %/year, past decade	1.80	2.30	1.40	1.27	1.06	0.92
Number of births (millions)	3.80	5.30	4.10	4.29	4.24	4.18
Number of deaths (millions)	2.20	1.90	1.60	1.47	1.69	1.93
Crude birth rate (per 1.000 population)	43.8	39.9	20.7	18.4	16.3	15.3
Indicator	**1961**	**1980**	**2000**	**2010**	**2020**	**2025**

Crude death rate (per 1.000 population)	22.7	12.9	7.8	6.3	6.5	7.1
Total fertility rate per woman	-	4.70	2.30	2.15	2.08	2.07
Net reproductive rate per woman	-	-	-	1.00	0.99	0.98
Infant mortality rate (per 1.000 births)	-	109.0	47.0	25.7	17.0	15.5
Life expectancy (years)	-	52.2	65.4	69.8	72.8	73.6

Source : World Bank 2009, using Bappenas-BPS-UNFPA 2005 data based year 2000

The demographic structure is also changing. The family planning program adopted since 1970s helped to decrease the fertility rate to 2.3 children per woman by 2000[25]. Contraceptive use among currently married women is high and has held steady at 61%[24] which helped not only to control the growth of fertility rate, but, also to curb the spread of sexually transmitted diseases. On the other hand, there is an increasing trend in the number of older persons (over 60 years) which will demand more personalized health care services; increased urban migration with future projections estimating that by the year 2020 over 50% of the country's total population will live in cities; and an increased commuting labor force that moves in and out of the cities[25].

In the meantime, the epidemiological transition indicated a rising double burden of disease. According to the WHO data as cited by the World Bank report (2009), the two main causes of death in Indonesia are cardiovascular diseases and malignant neoplasms. World Bank (2009) suggested that tobacco use, poor diet and lack of exercise, and traffic accidents are further contributing to the non communicable disease burden. The main causes of death across all

[24] IDHS. 2008

[25] Population Resource Center. 2004

ages of the population over five years old are stroke (15.4%), tuberculosis (7.5%), and injuries (6.5%). According to WHO, is chemic heart disease, lower respiratory infections, malaria, HIV/AIDS, and nutritional deficiencies also contribute significantly to mortality rates[26]. Meanwhile, communicable diseases made up 43 percent of deaths in Indonesia while emerging diseases, such as avian influenza and HIV/AIDS, add to the changes in disease patterns[25].

Key health indicators, such as infant and child mortality, have improved steadily over the past several decades. The infant mortality rate decreased from 36 deaths per 1,000 live births in 2002-03 to 34 in 2007, while the under-five mortality rate decreased from 46 deaths per 1,000 live births to 4431[27]. Life expectancy at birth is 66 for men and 70 for women[26]. However, three indicators remain a cause for concern: (i) high child mortality; (ii) maternal mortality rates which remain high at 420 deaths per 100,000 live births[28], despite increases in the number of deliveries attended by a health professional (from 66% in 2002-03 to 73% in 2007) and the number of deliveries taking place in a health facility (40% to 46%)[29]; and (iii) child malnutrition rates, which remain high at 25% for children under five and have largely stagnated since 2000[29].

Significant geographic disparities exist in health indicators such as life expectancy, infant and child mortality rates, and under-five malnutrition rates. For example, life expectancy in West Nusa

[26] WHO. 2007. "11 Health Questions about the 11 SEAR Countries." New Delhi, India: Regional Office for South-East Asia.

[27] Ministry of Health and BPS. 2002-03. "Indonesia Demographic and Health Survey (2002-03): Preliminary Report."

[28] Hill, Kenneth, K. Thomas, C. Abou Zahr, N. Walker, L. Say, M. Inoue, and E. Suzuki. 2007. "Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data." The Lancet 370 (October 13): 1311- 19.

[29] WHO, 2008. National Health Accounts [electronic database]. *Accessed via the web at* http://www.who.int/nha/country/idn/en/ on January 24, 2009.

Tenggara is 59 years compared with 72 years in Jogjakarta[30]. Infant mortality rates in West Sulawesi and West Nusa Tenggara are nearly three times greater than those in Jakarta and Central Java[31]. Significant variance in health indicators exists across socio-economic quintiles. Despite improving overall trends in delivery care, most poor pregnant women deliver at home and 40% continue to deliver without the benefit of a skilled birth attendant[29], and infant and child mortality rates are more than four times higher among the poorest quintile[26].

2.3 Indonesian Health System, Financing, and Decentralization

The Ministry of Health (MOH) had overall responsibility for national health policy. It recruits and allocates public sector physicians and other key staff and operates the main vertical programs. The MOH remains responsible for the allocation of key staff to the sub national regions, despite decentralization. However, while the MOH is responsible for the health system, various health insurance programs, the private sector, and local governments are also important financiers, and in some cases providers, of services, resulting in significant fragmentation of both roles and flows of funds.

Responsibility for implementation of health services was transferred to local governments at the district level by decentralization policy, resulting in the growing importance of the Ministry of Home Affairs in the health sector. However, although districts are now responsible for employment, deployment, and payment, regulations regarding authority to make decisions and budgets, and the capacity to carry them out, do not exist, largely

[30] Statistics Indonesia (Badan Pusat Statistik—BPS) and Macro International. (2008). *Indonesia Demographic and Health Survey 2007*. Calverton, Maryland, USA: BPS and Macro International.

[31] World Bank. 2005. "*Improving Indonesia's Health Outcomes*." Jakarta, Indonesia: World Bank.

because overall civil service reforms have stalled[32]. Ironically, public health facilities play an important role as economic enterprises for local governments.

Local governments officially "own" public health facilities and hospitals but have never been allocated the needed resources to manage them[33]. Since decentralization, province-level health offices have mainly been responsible for training and coordination efforts as well as oversight of provincial hospitals, but they have limited resource allocation responsibilities[34]. In contrast, districts have major responsibilities for delivering health services and allocating resources. At the sub district level, *Puskesmas* (health centers) have been the linchpin of basic health services and primary care since the 1970s, while curative services are provided by four types of hospitals ranging from teaching hospitals in the country's major cities to district-level hospitals where all main services are provided and referrals are made for more complicated cases to the higher level hospitals[31].

The Ministry of Health, the Health Working Group, and international donors have established the "Healthy Indonesia 2010" strategy, a national health development program. The vision has been established in hopes of increasing and using the resources and funding available in a more effective manner. Healthy Indonesia 2010 includes six main objectives: to reduce financial vulnerability, optimize the participation and efforts of NGOs, continue to decentralize the health care system, improve allocation and promise sufficient resources to priority health programs, ensure access to affordable quality care, and to engage a broad range of stakeholders to ensure system accountability[34]. As a follow up, MOH has developed a list of obligatory functions, essential health services and

[32] World Bank. 2005. "*Improving Indonesia's Health Outcomes*." Jakarta, Indonesia: World Bank.
[33] Trisnantoro. 2005. *Aspek Strategis Manajemen Rumahsakit: Antara Misi Sosial ke Tekanan Pasar.* Andi Offset
[34] Macroeconomics, 2006. *Macroeconomic and Health: Indonesia Country Report*.

associated minimum service standards through a consultative process.

According to the Indonesia Public Expenditure Review[28], health insurance coverage has started to increase significantly, largely due to rapid development of the Askeskin health insurance scheme for the poor. However, *Susenas* (household consumption and expenditure) data suggested that health insurance coverage has been very low at only about 27% of the population[28]. Almost all health insurance schemes allowed beneficiaries to seek services from contracted providers, regardless of whether they are public or private facilities. However, there is no accurate information to quantify how much insurance is utilized for services provided by private sector providers. For instance, *Jamsostek* (*Jaminan Sosial Tenaga Kerja*), established in 1992 as the social health insurance scheme for private employees, allowed beneficiaries to seek both public and private services. It required contributions of 3% (if one is single) and 6% (if married) of gross wages, paid entirely by the employer. However, participation in the scheme is not required, i.e., employers can "opt-out." In 2005 Jamsostek covers 3.1 million people or less than 5% of the intended target population[35].

Table 2. 2 Overview of Social Health Insurance Landmarks in Indonesia

Year	Initiative
1968	Helth insurance for civil servants – *Askes*
1974 – 90	Promotion and experiments in community-based health insurance (CBHI) – *Dana Sehat*
1992	Sosial security for private sector employees-*Jamsostek*, JPKM (HMOs) and CBHI
Year	**Initiative**
1997	Financial crisis

[35] International Labor Organization, 2008. "Indonesia: Providing Health Insurance for the Poor."

1999	JPS (Social Safety Net): financial assistance for the poor, Asian Development Bank (ADB) loan
2000	Comprehensive review of health insurance and amendment of constitution to prescribe the rights to health care
2001	Decentralization law implemented
2002	Amendment of constitution on the right to social security; president establish a task force on social security
2003	Parliament initiates a bill on National Social Health Insurance (June) Task force finishes drafting bill on National Social Security including health, occupational health, provident fund and pension and death benefits (December)
2004	Bill on National Social Security enacted (October 19)
2005	Preparation for extension of insurance coverage to 36.4 million poor people
2008	MoH cover 76.4 million poor and near poor through *Jamkesmas* program; National Social Security Council established (October 2008)

Health financing in Indonesia is further complicated by decentralization because direct payments of salaries and capital costs by all levels of government clearly impact the hospital reimbursement schedules used by insurers. Meanwhile, local government fiscal capacity depends on both local revenue-raising capacity and the flow of funds through the inter-governmental fiscal systems. In these transfers, some funds are earmarked by central level government while others are not, and formulas used for redistributing funds from central to local governments often do not reflect local need and fiscal capacity[34]. The complexity of the flows of funds, with some targeted to health while others are not, and with some payments made through insurance organizations while others

made directly to public providers, make for an intricate, inequitable, inefficient, and fragmented set of financing flows[31].

The table below displays the major health financing sources and their allocation mechanisms to health care providers in Indonesia.

Table 2. 3 Health Care Financing in Indonesia

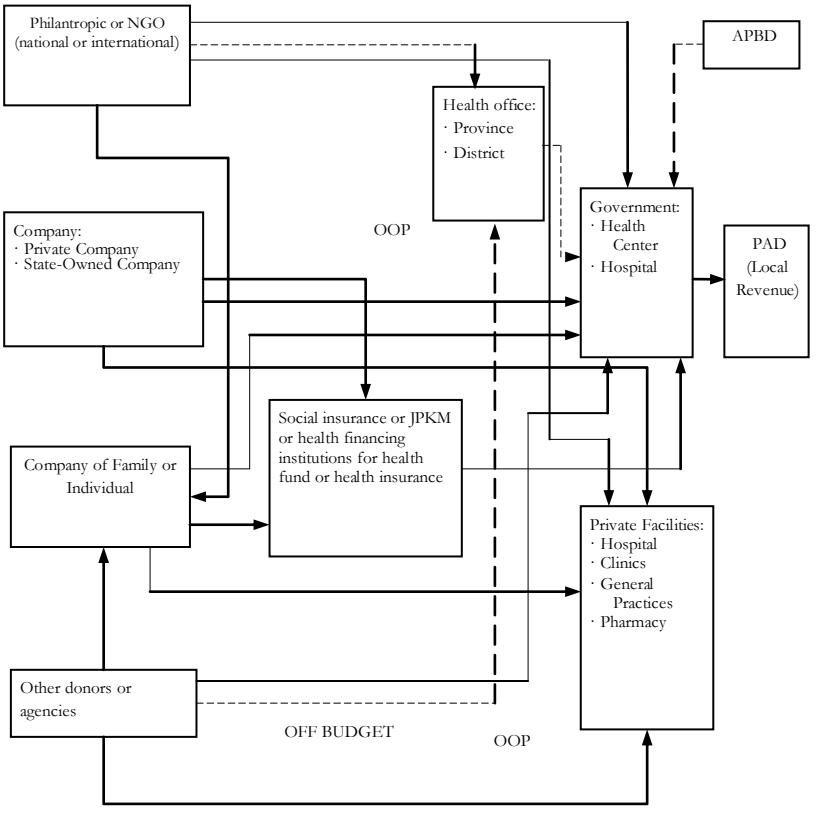
Financing Source	Fund management agency	Beneficiary	Health providers	Payment mechanism
Public financing through general taxation	Government	Total population	Public providers	Budgets: direct investment/subsidy to health care providers
Public financing through general taxation	Government	Targeted population	Public providers/private providers	Budgets/contract for specific health programs
Public financing through general taxation	*Askes*	Civil servant, military personel, pensioners and their dependants	Public providers	Capitation for primary care Reimbursement of fees paid
Public financing through general taxation	*Askeskin-Jamkesmas*	Health insurance for the poor	Mostly public providers	Reimbursement of fees paid
Private financing: employer/employee contributions	*Jamsostek*	Private employee	Public providers Private providers	Reimbursement of fees paid
Private financing: employer/employee contributions	JPKM (Community Medical Services Insurance)	Private employees	Public providers Private providers	Negotiated contracts with registered providers
Private financing: community member contribution	*Dana Sehat* (social funding scheme)	Rural communities	Public providers	Reimbursement of fees paid
Private financing: employer/employee contribution	Private insurance (commercial)	Private employees	Private providers	Reimbursement of fees paid
Private financing: individuals income	Out-of pocket payment	Total population	Mostly private providers	Fee for service

The latest report by World Bank (2009) indicates that private health expenditure has, historically, played a more important role than public health spending in overall health financing in Indonesia.

Out-of-pocket expenditures come not only from the uninsured but also the insured, due to high co-payments and very limited benefits[33], for example: *Askes* has very high co-payments and Jamsostek excludes coverage for catastrophic events. The average monthly health expenditures by facility and wealth quintile among those who utilized out-patient or in-patient services shows that even the poor population made most of their health expenditures in private facilities; 68% and 51% of out-patient and in-patient health expenditures were spent in private facilities[36]. Another study also suggests that the private sectors provided 67% of all in-patient care[37]. The report of World Bank[26] suggested that the trend also showed that public share of spending has continually increased due to the establishment of *Askeskin* in 2004. Figure 2.1 shows the fragmentation and complexity of Indonesia's health funding.

[36] Saadah et al. 2006. "*Private Health Sector: Update on Data and Trends and Policy Recommendations*."

[37] Ramesh, M. and Wu Xun. 2008. "Realigning Public and Private Health Care in Southeast Asia." *The Pacific Review* 21(2) (May): 171-187



Source: MoH, CHR-UI and WHO 2008

Note:
APBD: Regional Government (Anggaran Pendapatan dan Belanja Daerah)
OOP: Out of Pocket
PAD: Local owned revenue (Pendapatan Asli Daerah)

Figure 2. 1 Indonesia Health Funding

Source: World Bank, 2009, adapted from MOH, CHR-UI, and WHO, 2008

Decentralization Policy

Health decentralization has been carried out in Indonesia since early 2001. This policy is the consequence of political decentralization consequent to Law (*Undang-undang*) No.22/1999. In 1999 when the Law No.22 was enacted, the political pressure for decentralization was very strong. In the early years of implementing decentralization, a powerful euphoria occurred. Institutional structures at province and district levels underwent radical changes with the creation of new merged Provincial and District Health Offices (*Dinas Kesehatan Provinsi* and *Dinas Kesehatan Kabupaten/Kota*). Interestingly, the central government did not undergo any changes. The organizational structure of the Ministry of Health remained relatively the same with the same four General Directorates namely: Medical Services, Community Health, Communicable Disease Control and Environmental Health, and Pharmaceuticals Service (former POM).

The understanding of decentralization policy is important for analyzing the development of non state health providers. There are two important issues in regard to decentralization for non-state hospital growth: (1) the influence of decentralization on the general economic situation; and (2) the transfer of central government authority for controlling health service.

(1) The influence of decentralization on the general economic situation

One of the impacts of decentralization was the significant growth in the discrepancy in fiscal capacity among provinces and districts/ municipalities. With the availability of local government shared-funds, some provinces and districts/ municipalities suddenly became rich. Some local governments have Local Revenue and Expenditure Budgets (APBD) of about two trillion rupiahs with

population of less than 500,000 people, such as Kutai Kartanegara and Bengkalis. The strong local government fiscal capacity became an important factor for local economic growth, alongside the strength of the local community economy. In the following section, these two major determinants of the economic environment for non-state and government health services are described.

Local government fiscal capacity is measured by using data on the local government's revenue (local revenues + Fund for Public Allocation/DAU from central revenues and foreign aids) divided by local fiscal needs[38]. The local fiscal capacity is high this ratio is above (KpF+DAU/Needs >100%). Conversely, the local fiscal capacity is low if the ratio is below 100% (KpF+DAU/Needs <100%).

The community economic capacity is calculated by reference to the World Bank standard in the World Economic Indicator of 2002 that a Low GDP per capita is defined as below US$ 500 per capita. By adopting a rate of exchange US$1 = Rp 8.000,00 (2002), a cut off point can be achieved: the economic capacity of communities is high if the GDP per capita >Rp 4.000.000,00; and it is low if it is <Rp4.000.000,00.

[38] The reference used is The Enumeration of Local Fiscal Capability Year 2001/2002, The Directorate Jenderal of Central and Local Finance Equilibriums, The Indonesian Ministry of Finance, 2002.

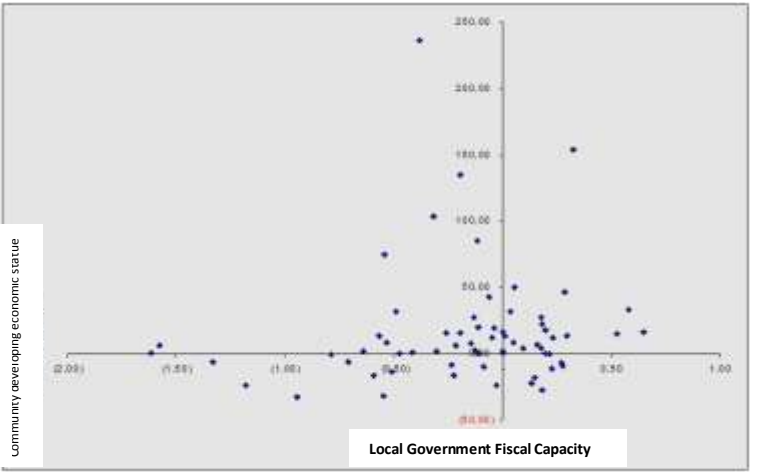


Figure 2. 2 Position of District/Municipalities in 8 Province

Comparison of these economic indicators in eight DHS-1 provinces showed considerable variation[39]. For instance, Bengkalis Regency in Riau was the region that had the highest fiscal capacity. The same condition occurred in almost all regions or towns in Riau province. In contrast, Gorontalo province had a different economic situation because its local governments' fiscal capacities were low primarily due to the low economic condition of its communities. The position of districts in the eight provinces is plotted on the figure above, with the indicator for local government capacity on the vertical axis, and the indicator for local community economic capacity on the horizontal axis. (See Figure 2.2).

The province of Bali has many district governments with high community economic capacity. Districts of Bali Province such as Badung regency are mostly situated in the upper right quadrant of the graph (Figure 2.3).

[39] Trisnantoro et al. 2009. *Decentralization on Policy in Health Care in Indonesia 2000—2006.* Gadjah Mada University Press

Figure 2. 3 Matrix of the Local Government's Fiscal Capacity and the Community Economic Capacity in Bali Province

The logical consequence of that high income was that the purchasing power of communities was high, including for health services. Bali had many hospitals, particularly private hospitals even before decentralization in 1999. Since then the number has increased by a further four private hospitals since then. The main driver has been the local economic capacity and the market.

A different condition occurred in Riau Province. The decentralization policy caused its local governments to gain increased revenues from Central Government Shared Fund. This revenue or income was derived from the profit sharing from the local petroleum and mining industry. One of the inevitable impacts of increased local government fiscal capacity was the increasing numbers of local government hospitals.

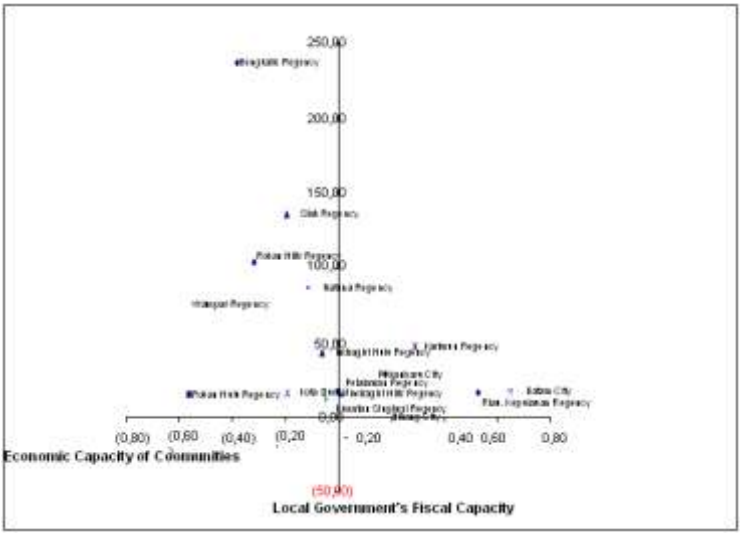


Figure 2. 4 Local Government's Fiscal Capacity and Community Economic Capacity of Districts of Riau Province

The impact of decentralization on the development of new non-state hospitals in Riau began in 2003. In 1998 there were 4 non-state hospitals in Riau. In 2003, a new non-state hospital was established in Pekanbaru. After 2003, three new non-state hospitals were built to make the total number eight. Two of the new hospitals are in the form of for-profit enterprises.

Gorontalo Province poses a different lesson. It possesses neither natural resources like Riau Province nor the community-based industries like the tourism sector in Bali. The detailed description of Gorontalo Province could be seen in the Figure 2.5.

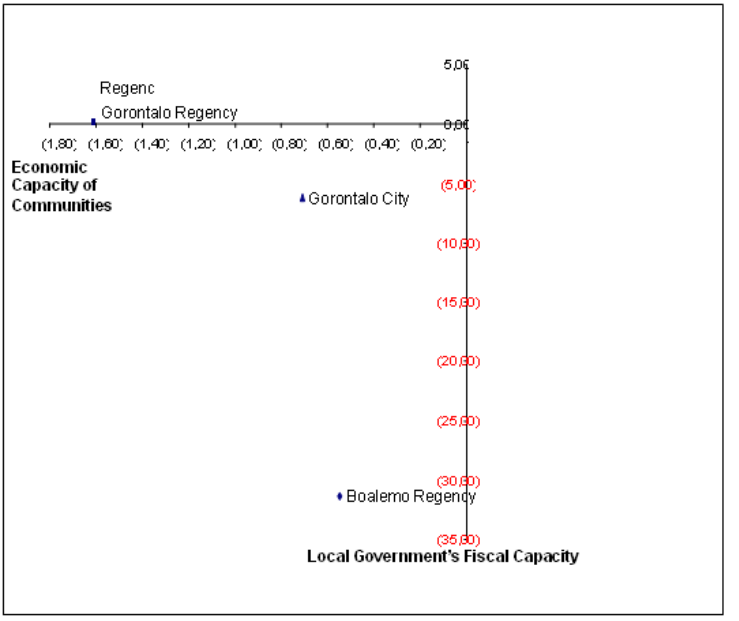


Figure 2. 5 Matrix on Local Government's Fiscal Capacity and Community Economic in District of Gorontalo Province

Most of the Regencies and Municipalities in Gorontalo are in the left lower quadrant position. As indicated by this condition, Gorontalo Province depends financially on the Central Government Revenue and Expenditure Budget (APBN). Communities could not contribute much to attract health services in terms of purchasing capacity. It is logical that up to 2008, there are no non-state hospitals in Gorontalo Province. Table 2.4 shows the average number of hospitals in various economic typologies. Logically, an area with strong community economy capacity, is likely to attract more private hospitals will be, compared to area having less community economic capacity.

Table 2. 4 Average Number of Governmental/State Hospital in Every District/Municiplity

	Weak Economy in Community	**Strong Economi in Community**
High Fiscal Capacity in the Local Government	2.5	2
Low Fiscal Capacity in the Local Government	0.5	0.31

Source: Primary data

Table 2.4 indicates that districts/cities having with high local government fiscal capacity have more state hospitals on average than district/municipalities with low local government fiscal capacity, irrespective of the strength of the local economy.

Table 2. 5 Average Number of Private Hospital in Every District/Municiplity

	Weak Economy in Community	**Strong Economi in Community**
High Fiscal Capacity in the Local Government	1.05	2.11
Low Fiscal Capacity in the Local Government	0.5	1.91

Source: Primary data

Table 2.5 demonstrates that districts/municipalities with strong local economies attract higher numbers of private (non state) hospitals on average than districts/municipalities with weak local economies, irrespective of local government fiscal capacity.

Those facts support the statement that the health sector in Indonesia is strongly influenced by a market mechanism, which is affecting the development of both state and non-state hospitals.

(2) Transfer of central government authority for control of health services: the re-centralization debate in hospital licensing

Between 2000 and 2003, central level health officials became disappointed with the national process of decentralization in the health sector. Such disappointment was largely because the amount of health fund allocated by local governments from their General Allocation Fund (DAU) and the Local Revenue and Expense Budget (APBD) was not adequate to pay for health services. Such circumstances even occurred in rich local government areas which in fact should have provided more to the health service.

The health sector experienced a fund shortage, the system became disrupted, and suffered loss of coordination. The Ministry of Health considered this as a threat to the national health system. With some strong goodwill, eventually the MoH increased the central funding.

This led to a "re-centralization" phenomenon. This phenomenon was supported by the amendment of Law No. 22/1999 to 32/2004. The amended law emphasized the role of the central and provincial governments compared to district/municipality government. The main result of Law No.32/2004 was a partial re-centralization, although the health sector remained decentralized.

This change was also reflected in the debate on regulation of hospitals within the health sector. In terms of support for regulation, the standpoint of the Ministry of Health was confusing. From the first steps of decentralization, some officials within the Ministry of Health were reluctant to formulate the decentralization of the regulation function. This was reflected in the National Health System document which had no regulation component. This was challenged by lecturers from the Universitas Gadjah Mada at the National Epidemiology Meeting held in Malang.

The debate did not result in any significant change because the document of the National Health System did not explicitly mention the concept of regulation. However, some parties agreed with the opinion from GMU so that they continued developing the regulation function in the health system. The parties which provided strong support in the development of the regulation function in the health sector during 2000-2007 were some sectors of the Ministry of Health (Directorate General of Medical Service, Legal Bureau, and Organization), various health system development projects (World Bank and ADB), The Association of District/Municipal Health Offices, and The Association of district hospitals. Some local governments supported the regulation function; however some declared that the Health Office did not need to have a regulation function.

There were some interesting cases in Local government. The logical argument was that regulation function would inevitably be needed for regions which had strong market influence. These regions were identified by the existence of strong growth in socioeconomic sector, the abundance of private hospitals, the practice of private doctors, and other medical services. However, this assumption did not happen. Many local government health officers felt that the duty of supervising the private sector was too difficult and it did not belong to their authority. For example, in an urban city "X", the head of health office was not interested in developing regulation function in his jurisdiction. Lack of support from the head of the district health office disrupted the smooth operation of the regulation function.

The weak support from the Head of health Office as a whole resulted in the weak implementation of regulation function. It should be underlined that Ministry of health was a stakeholder whose influence was strong nationally. However, there were only several Health Offices which developed the regulation function as it was seen in the annual meeting of Indonesian Health Service Quality Forum. The resulting impact was the inadequate number of legal products

and policy in the ministerial level which put an emphasis on regulation. The allocation of fund for the development of regulation was either inadequate. In some areas, the allocation of fund for regulation function was nearly zero percent. This phenomenon reflected that the culture as regulator had vanished. Historically, the Ministerial Office in the province during 1960-1970 was called as Health Inspectorate. The function became the responsibility of Territorial Office of Health and also Provincial health Office and Municipal health Office. However, it was clearly seen that the function tended to fade away.

Within the atmosphere of low support from Ministry of health, it was possible that most of regulation development programs came from foreign fund. The amount of regulation budget from Directorate General of medical service or Local Health education was inadequate. Another phenomenon was the lack of formal statements from the leaders at Ministry of Health in developing regulation function. Besides, the organizational structure of Ministry of Health showed that the unit responsible for regulation belonged to low position in the organization structure.

In the case of hospital licensing regulation, during 2000-2007, with confusing Government Regulation No.25/2000, there are some misunderstandings. The observation showed that some leaders in Ministry of Health still demanded for recentralize the licensing system. Meanwhile, some other leaders had tried to prepare for decentralizing the hospital licensing. In the Directorate General of Medical Service, there was preparation program to strengthen the licensing function of Provincial and District Health Office by arranging the licensing form of government hospital and private hospital. However, this program had not been implemented well. The development project should be continued by having socialization and training for all Health Offices in Indonesia in order to supervise and

process the hospital licensing as having been stated in Government regulation No.38/2007.

In the context of stakeholder analysis, the role of Ministry of Home Affairs was quite interesting. After the establishment of Law No.32/2004 which replaced Law No. 22/1999, Ministry of Home Affairs arranged the plan of government regulation which eventually became Government's Regulation No.38/2007. The process of formulation of government regulation plan was quite long since it needed three years to accomplish (2005-2007). In the process of formulation, the debates over the licensing were so interesting. For three years, the debates about the function of hospital licensing were reflected in decentralization annual meetings (Makassar 2005 and Bandung 2006). Some officers from MoH thought that the function should be centralized, while others thought that this function should be decentralized.

In the annual meeting in Bali on August 2007, the debates over the hospital licensing began to subdue with the establishment of Government Regulation No 38/2007. This Government Regulation which was mainly pioneered by the Ministry of Home Affairs was the regulation which provided the authority of hospital licensing regulation to central government and local government in stages. By examining this case, it was clear that the Ministry of Home Affairs gave more support on the implementation of decentralization in health sector than Ministry of Health.

Nonetheless, the debates over the hospital licensing had probably not come to an end yet. In 2008, the Ministry of Health had an initiative to propose the draft of law concerning hospital to the House of Representative. In this draft (2008), there were some ideas about the licensing in Chapter VII:

1. Every hospital must have licensing

2. Licensing has been stated in Article (1) consisted of licensing of establishment and licensing of operational.
3. Licensing stated in Article (2) was given for two years and it could be prolonged for 1 year.
4. The operational licensing stated in Article (2) would be given for 5 years and it could be prolonged as long as the hospital fulfilled the requirement.
5. The operational licensing stated in Article (2) would be given after the hospital fulfills the requirement as has been stated in this law.

The terms of establishment licensing and operational licensing had possibility to confuse community and private institution. Law No.32/2004 and Government Regulation No.38/2007 only mentioned licensing in one term without distinguishing between operational and establishment. Therefore, it was possible that debates over regulation would continue to happen in the future.

CHAPTER 3
Governance in the Health Sector

In describing the governance of the Indonesian health sector, this chapter uses the World Bank's report (1997) entitled *State in Changing World,* which emphasizes the state's roles in improving the distribution and market failure. The report mentions that a state might hold 3 levels of roles: (1) a minimum role, (2) a middle role, and (3) a role as activity executor. In the minimum role, a government performs as a public service provider, such as in the aspects of defense, law and regulation, copyrights, microeconomic management, and public health. Besides, the government should improve programs to overcome poverty, to protect the poor, and to handle disasters. In a higher role, within the activity of overcoming a market failure, a government should conduct a variety of activities, such as guaranteeing elementary education, protecting environment, regulating monopolies, overcoming matters related to unevenly-distributed information, and providing social insurance. At the level where the government acts as a service provider, some activities like coordinating private organizations are needed. The government is expected to prevent market failure and implement activities to overcome inequitable distribution. Another conceptual framework is the work of Kovner (1995), who expresses that the government plays three roles: (1) a regulator, (2) a funding agency, and (3) a service provider. This work is going to be used as a basis for analyzing the government's roles.

In addition to the government, there are also other actors in health-sector services in Indonesia. Therefore, the actors in the Indonesian health sector can be classified into the government, lawmakers, community and social organization, and private enterprises.

Government

The government consists of the Central Government, provincial governments, district/municipality governments, Ministry of Public Welfare, Ministry of Health, and Provincial/District/City Health Offices. In the health sector there are various operating governmental institutions. The role as the financier of health system can be performed by the central and local governments. The role as a service provider is carried out by the central or local government hospitals. The roles as a regulator and policy maker of health service are carried out by Ministry of Health and by provincial and district health offices. Lawmakers are important stakeholders in the health sector. It consists of the central, provincial, and district parliaments.

Community

The Indonesian community can be classified into the high economy level, middle economy level, and lower economy level, or in economic status quintiles. The community can be differentiated between rural and urban, or accessible, difficult to access, or in a remote area. In the community, there are many non-governmental organizations (NGO) and associations, such as ARSADA (Local Government Hospital Association, ADINKES (Local Government Health Office Association), and PERSI (Indonesian Hospital Association).

There are some large and well-known health professional associations in Indonesia, namely:

- Indonesian Doctors Association (IDI/*Ikatan Dokter Indonesia*)
- Indonesian Midwifery Association (IBI/*Ikatan Bidan Indonesia*)
- Indonesian Nurses Council (PPNI/*Persatuan Perawat Nasional Indonesia*)
- Indonesian Hospital Association (PERSI/*Perhimpunan Rumah Sakit Indonesia*)

- Indonesian Medical Council *(KKI/Konsil Kedokteran Indonesia*)
- Hospital Accreditation Commission (KARS/*Komisi Akreditasi Rumah Sakit*)

The professional organizational bodies in Indonesia arguably have limited roles. They do not for the most part certify standards, monitor quality or penalize providers (with the exception of the Indonesian Medical Council, which can revoke the license of a doctor); they offer little, if any, significant consultative advice to the government for standards and regulations; and they rarely provide legislative input and lobby the Ministry of Health for changes in the health laws.

For instance, PPNI has promoted national standards for nursing and sent them to the Ministry of Health for review and approval, but as yet no national common standard has existed (PPNI, 2006). At the moment, the authority for disciplining nurses and revoking their licenses remains at the provincial level with the Council for Disciplinary Health Staff (*Majelis Disiplin Tenaga Kesehatan*).

Corporation

Many non-state corporations work in the health sector. It can be for-profit or non-profit organizations. The examples are Health Insurance Limited Corporation (*PT Asuransi Kesehatan*) and other health insurance companies, health service providers (public and private hospitals), clinics, laboratories; drug industries, and health equipments, human-health resources educational institutions, such as the medical faculties, public health faculties, and nursing academies. There are also foreign donor institutions, such as WHO, World Bank, UNICEF, UNDP and ADB.

In governing the health system, some important contexts for non-state health providers in the last 10 years have been the development of the government as a financier agency, the

development of local governments as stewards of non-state hospitals, the cultural development of medical doctors, the fragmented health sector, and lawmakers' perception on non-state health providers.

The development of government as a financier agency

In the last 10 years, the government's enthusiasm has been shown in the significant effort to develop health protection for medical care. This enthusiasm is reflected in the following Table 3.1.

Table 3. 1 Expenditure of Health

Expenditure of Health	2001	2002	2003	2004	2005
Expenditure ratios					
Total Expenditure on Health (THE) as % of GDP	2.7	2.8	2.9	2.8	2.7
Financing Agents Measurement					
General government expenditure on health (GGHE) as % of THE	33.1	33.7	31.6	34.2	34.7
Private sector expenditure of health (PvtHE) as % of THE	66.9	66.3	68.4	65.8	65.3
General government expenditure on health as % of GGE	4.2	5.3	4.6	5.0	5.0
Social security funds as % of GGHE	8.9	10.2	11.7	10.8	21.3
Private household's out-of-pocket payment as % of PvtHE	75.1	75.3	76.0	74.7	74.3
Prepaid and risk-pooling plans s % of PvtHE	4.1	5.1	5.6	5.9	6.0

Source: World Health Organization, 2007

This trend is the result of various milestones in the development of health protection. In the early 1990s, the Program for Health Care Security for the Community *(Jaminan Pemeliharaan Kesehatan Masyarakat/JPKM)*, the principal Indonesian program of managed health care, was introduced. JPKM was a means of providing prepaid comprehensive and continuous quality health care. All prepaid health-care programs run by the government as well as by the private sector have to abide by its principles. Its payment

mechanism is through negotiated contracts with registered providers.

The *Askeskin* Program was introduced in 2005 to replace JPKM, with the national health insurance company (*PT Askes Indonesia*) contracted to manage the program. This national program targeted the poor and near-poor. It did reach many poor people, but met considerable problems with targeting and with the quality of service delivery. In addition, the *Askeskin* premium was underfunded on a per capita basis. Other problems included incomplete data collection on poor people, inappropriate charging by, and quality control of, hospitals, non-optimal claims verification, insufficient budgets for health services, and inadequate support for local governments in coordinating, monitoring and controlling the program.

In 2008, *Askeskin* was changed into *Jamkesmas* with the aim of providing access to health services for the poor and near-poor, by exempting them from user charges at the point of delivery. By 2008, the program had enrolled 76 million poor people with targeted recipients identified by local authorities. The health benefits were comprehensive and based on medical indications. The program has abandoned the insurance model. PT Askes Indonesia's role has been reduced to the operator of the system and it is now limited to covering the poor and the near-poor enrolled in the scheme. *Jamkesmas* is a social aid program, and is funded by the national budget (APBN) as social security in the health sector. The budget in 2008 was Rp 4.6 trillion. Alongside *Jamkesmas*, local governments in various provinces and districts have *Local Health Security (Jaminan Kesehatan Daerah/Jamkesda).*

The effect of the program has been positive for hospital utilization in that it has improved the access and utilization. The data showed that Social Safety Net-Health Division (*Jaring Pengaman*

Sosial Bidang Kesehatan/JPSBK) provided good effect as seen at the result as follows:

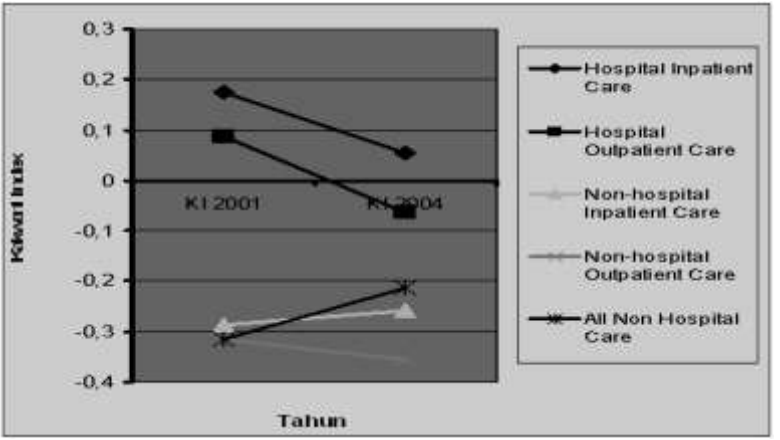


Figure 3. 1 The Effect of JPSBK toward the Kakwani Index

The *Susenas* data of 2001 and 2004 indicated that the Kakwani index showed its positive development. The rate of hospital and other health-service provider utilization showed that there were more poor households who used health facilities. Starting in 2005 the government has taken firmer stand to improve, finance and manage poor community health. The effect has been very clear. It has strongly increased the Bed Occupancy Rate/BOR of the third-class wards in hospitals up to 100%. The use of the health service by the poor drastically increased up to 392% from 1.4 million in 2005 to 6.5 million in 2007. The hospital inpatient care increased up to 432% from 562,167 in 2005 to 2,431,139 in 2007[40]. Although the program is strategic and the effect has been really felt by the low class of the community, it still has many constraints and problems that are quite complex.

[40] Mukti, A.G. (2008) Alternatif pengelolaan Askeskin 2008. Workshop oleh Kemetrian Koordinator Kesejerahteraan Rakyat Republik Indonesia. Jakarta

The problems can be classified according to different viewpoints: the poor community, hospitals, PT Askes Indonesia, and the central and local government. The problem related to the aspect of poor community includes the criteria and process of reporting the poor community. There have been many other cards passed around like *SKTM (Surat Keterangan Tidak Mampu), BLT* (*Bantuan Langsung Tunai/*Cash Direct Transfer), *Raskin* (*Beras untuk Rakyat Miskin/*Rice for the Poor) and others. Most of them live relatively far from a health-service center which causes transportation problems for the poor. The poor community depend much on their daily or weekly wage or agricultural products so if they get ill they have to leave their work. Some of them still experience discriminated service, different from that for those who paid. Another prominent problem is the lack of socialization so that many poor communities are unaware of their right and duty in relation to the health insurance for the poor.

In the aspect of hospital care, there have been many problems too. The payment of hospital claim is often delayed for months. The hampered money supply has caused a chain of problems. Hospitals have to be responsible for the medicines that are not in the formularies and have to struggle with many administration problems. Some hospitals have to cross check by themselves to find out if a patient is truly poor.

For the central government, the problems are generally related to the planning and slow implementation, especially the manual distribution. The implementation of control and supervision need to be improved, including developing manuals for local governments to improve the insurance system for the poor. However, the main problem at the local government is that they do not really function and are involved in the health insurance program for the poor. Roles, functions, assignment and distribution of affairs in financing and health insurance as regulated in PP No. 38/2004 and UU No. 32/2004 are not optimal yet. Some local governments

assume that financing of the poor community's health is the central government's responsibility. The local government has no sense of belonging toward the health insurance. Why have these happened? Can the good intention to provide health insurance for the poor and the positive output of health care access improvement be sustained continuously? Or will the health insurance program for the poor worsen?

The development of government as the financier agency

Two of the important roles of local governments are the regulation and stewardship functions. These functions are important aspects in the development of non-state providers but are neglected. Government Regulation No. 38/2007 on decentralization clearly mentions about the new authority of local governments for monitoring and controlling non-state health-service providers. Historically, these roles have been almost absolutely under the central government. Therefore, regulation is a new function for local governments. However, due to the central government's low commitment to nurture the capacity of local governments to implement this role, the development is slow. Not many provinces, districts, or cities are interested in developing the capacity for monitoring and controlling.

Case Study: Yogyakarta, an interesting case of health-care provider governance

The City of Yogyakarta has undergone a very rapid growth. The increasing numbers and types of health services have their own consequences in the competition among the institutions and the quality of their services. Moreover, the rise of public awareness concerning their rights to receive appropriate health services requires service-quality transparency. In relation with service quality, the licensing aspect has become an important issue but has not received

much attention from many health institutions and practitioners. Data of health service facilities and health practitioners can be seen in Table 3-2. It shows that not all health facilities and practitioners possess the required licenses.

Table 3. 2 Data on Health Facilities and Health Service Providers (2005)

Types	Number	Registered	
General hospital	7	7	
Specific hospital	8	8	
Public health center	27	24	
Mother and Child Health Center	5	5	
Maternity clinic	13	13	3 no license
Practice in groups	5	5	
Laboratory clinic	7	7	
Pharmacy	113	113	
Drug store	40	40	
Pest control	2	2	
Optician	28	12	16 no licence
General practitioner	118	98	20 no licence
Dentist	254	182	72 no licence
Specialist	69	25	44 no licence
Midwife	109	54	55 unregistered

Most of the existing licensing regulations were effectively applied. Most of incompliance occurred after the Ministry of Health

issued the operational license regulation. Examples of misuses were as follows: health practitioners and facilities performed unregistered practices; health practitioners and facilities ran practices without using standard equipment; health practitioners ran their practices beyond their authority (as doctors, nurses, or midwives); hospitals did not perform appropriate waste management system, and most facilities lacked hygiene and sanitation and could not guarantee their patients' security and safety.

Yogyakarta Municipal Health Office believes in the importance of developing a licensing system for health-care services and facilities due to various problems. The role of the Health Office in the licensing process needed to be improved with proper regulations. These regulations were aimed to achieve a sustainable improvement of quality so that health-care practitioners and facilities could provide a safe service. The government's task is not limited only to making health services more available and accessible but also ensuring that the services are performed properly.

The government's role in regulating the services was triggered by the rapid increase of private health-service providers, ranging from independent practices, group practices, laboratories, pharmacies, clinics, public health services, BKIA (maternity and child-care centers), maternity clinics and hospitals. These all encouraged the government to immediately move from its role as a service provider (with the consequence to compete with the private sector) into a role as a service regulator with the consequence of regulating both state and non-state service providers. The purposes of strengthening the regulatory role in the Yogyakarta Municipal Health Office are as follows: (1) to achieve a sustainable improvement of quality in order to provide a safe service to the public, and (2) to control, supervise and orderly administrate, and protect the public in obtaining health service.

Using the framework of cooperation between the Provincial Health Office and Faculty of Medicine, Gadjah Mada University in PHP 1, a design was created to contain the regulatory role in the new institutional structure of the Health Office. In this case, the role of Health Office as a regulator of health services was improved. On November 15, 2005, Regional Regulation No. 11 of 2005 regarding the Establishment of Organizational Structure and Work Order of the Health Office was issued. In the new institutional structure, there is a section to include the regulatory role and function, namely the section of Regulation and Health Resources. The inclusion has become a strong basis for the allocation of human resources and fund from the local government budget on the regulation function of the Health Office.

The development of health-service facility licensing in Yogyakarta in 2005 underwent several phases. The first phase was a diagnosis which consisted of the following activities: identification of human resources and job description in Yogyakarta Municipal Health Office, identification of standards and guidelines related to the regulation of health service facilities, identification of legal products, collection of data concerning the number of health service facilities in the city of Yogyakarta, identification of financing availability for the regulatory role, exploration on the perception of the role of regulation and its development needs, and formulation of the problems and the necessary interventions. Next, the intervention phase (second phase) was conducted with the following activities: (1) defining the implementation model of regulatory role, (2) conducting training on human resources that would be the surveyors; (3) identifying the need for regulation; (4) planning the institutional structure in the Yogyakarta Municipal Health Office. The third phase was the implementation of this health-care regulation.

In general, the activity of health-service regulation can be seen in various activities, which include licensing, certification, and

accreditation. Licensing is a process of giving permission by the government to individual practitioners or institutions to conduct health services or to be involved in a compulsory profession/job. The license is granted to individuals and health service facilities that meet the administrative and technical requirements (as a minimum standard). Accreditation is a process of recognition by an admitted institution (usually non-government) stating that a particular health-service provider has met the established and published (voluntary) standard, which is applied to the institution. The implementation of accreditation in Yogyakarta has been limited only for the purpose of credit grading for the functional officials.

Certification is a process of evaluation and recognition by the government or NGOs that a person or an institution has met certain criteria or requirements. It is voluntary and can be granted to an institution or individual. The certification issued by Yogyakarta Municipal Health Office was then limited to home-industry food products.

Based on the monitoring done by the Municipal Health Office in 2006-2007 there were several problems. The monitoring revealed various violations by doctors, such as conducting practice without a license or using another doctor's name, license letter and medical facilities of other doctors, dispensing medication, and selling drugs to patients. Similar violations occurred among nurses and midwives: practicing without proper authority, dispensing medicine, and practicing in inappropriate places. Studies on traditional healers found the following facts: moving practices in different places, performing medical actions, practicing without proper registration, using indicators of treatment success only depending on testimony, and using an academic degree without following an education process of an accredited education institution.

In the observation on pharmacies, some had no pharmacist or pharmacists never made a medication record. Among drug stores,

it was revealed that the pharmacist-assistant in charge never showed up in the working place, the stores sold unregistered medicines and had never made any medicine register. Among food home-industries, there were many that did not meet the standards of food quality. Moreover, the hygiene of the workers was inappropriate.

In the next development, law enforcement was needed in form of drafting a local-government regulation (*Perda/peraturan daerah/l*ocal government regulation) regarding licensing of health-service facilities in the Municipality of Yogyakarta. The draft was submitted to the plenary meeting of the legislation and expected to be approved by the end of 2007. In mid 2008, it was already approved as a local-government regulation. Besides, there had been an attempt to standardize the quality of Health Service Institution that would be manifested in the Regulation of the Mayor of Yogyakarta. Another activity was creating monitoring instruments in form of software.

The fragmented health sector

At present, de-medicalization has been happening in government offices which manage health. Ministry of Health and mostly Provincial/District/City Health Offices have lost their influence toward medical groups (medical doctors, especially specialists). As the result, two different cultures in the health sector exist: (1) medical culture and (2) public-health culture. Both have different frameworks in viewing a problem. One factor of this cultural difference is the fact that Provincial/District/City Health Offices operate under the coordination of *Ditjen Binkesmas* (General Directorate of Public Health) for years whereas hospitals are under the coordination of *Ditjen Pelayanan Medik* (General Directorate of Medical Service). As a result, there is a bureaucratic separation between the activities of Provincial/District/ City Health Office and those of hospitals.

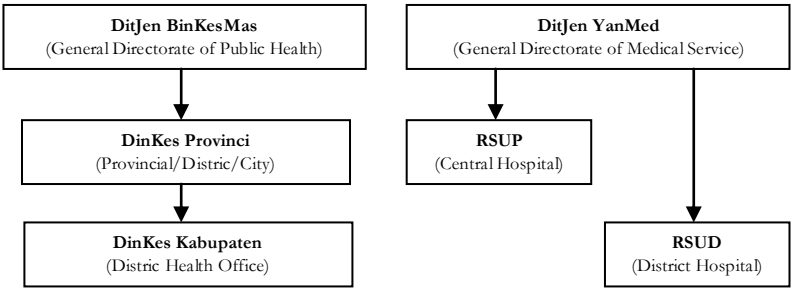


Figure 3. 2 Dichotomy between Provincial/District/City Health Office's Activities and State Hospital

Another fact shows that National Health System *(Sistem Kesehatan Nasional/SKN*) 2004 strongly differentiate between Public Health Attempts (UKM) and Individual Health Attempts (*Usaha Kesehatan Pribadi/UKP*)[41]. Within the fragmentation atmosphere between the UKM and the UKP, some features in the health sector have developed. Market influence due to neo-liberalism and cultural globalization has becomes stronger in the health sector. More fundamentalist market practices have been conducted in the health sector, especially in medical group.

The government has yet to stipulate any policies in forms of laws or government regulations in the relationship between health workforce and health insurance. Thereby, doctors as members of health workforce have never had any regulation dealing with health insurance. The health system gains more independence from the regulatory bodies. Provincial Health Office (*Kantor Kesehatan Provinsi*), which used to be called Health Inspectorate (*Inspektorat Kesehatan*) has been changed into Regional Health Office (*Kantor Wilayah Kesehatan*). The Government, in this case Ministry of Health and Provincial/District/City Health Offices, has no culture either as

[41] Departemen Kesehatan. 2004. *Sistem Kesehatan Nasional*.

policy-makers and lawmakers or as enforcement agencies[42], but many direct service-provision activities were conducted by Ministry of Health and Provincial/District/City Health Offices.

Meanwhile, PT Askes Indonesia has the condition of state-company (*Badan Usaha Milik Negara/* BUMN) culture with typical corporate cultures: white-collar shirts and suits, neat offices, and fancy corporate cars. The culture of PT Askes Indonesia has different characteristics from public organizations in the health sector. PT Askes Indonesia has never had any history of negotiation with the doctor associations. In the past, most tariff setting is conducted through joint decree (*Surat Keputusan Bersama/ SKB*) of three ministers. However, in the last three years, there has been an activity to negotiate the tariff with the hospital. State hospitals are still confused in searching the right organizational culture. The existing culture still tends to be bureaucratic. The community's culture has not moved to the adoption of health insurance. House-hold expenditure is still spent more on cigarettes rather than on insurance premiums.

As a whole, it may be concluded that the existing culture of health sector is not well-integrated. The fragmented culture of health professionals can be summarized as follows: Medical doctor's culture has little history of a managed and standardized system. Till now there is hardly any standard for a doctor's earnings and service standard. Doctor earns his living from fee-for-service practice[43]. The community's culture is not in favor of health insurance[44]. The culture of the health insurance company tends to stay in the atmosphere of a

[42] Trisnantoro L. 2003. *Penelitian mengenai perubahan fungsi pemerintah pasca desentralisasi*. WHO.

[43] Sanjana K. 1998. Hubungan antara Kompensasi, Iklim Kerja, Citra Kerja, Ciri Individu dan Kepuasan Kerja Dokter Spesialis di Instalasi Bedah Sentral RSUP Sanglah Denpasar. Magister Manajemen Rumah Sakit.UGM. Yogyakarta. *Thesis.*

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

for-profit company. Provincial/District/City Health Offices are not yet ready to be lawmakers and enforcement agencies in the health sector[45].

Potential in ASEAN region

ASEAN countries have a combined population of more than 500 million people, larger than the population of the European Union, and has a combined gross domestic product (GDP) above $1 trillion, which is the 11th largest in the world, ahead of Russia and India (ASEAN, 2009). It is a growing and potential market for private investment. ASEAN has identified its effort to establish "a single market and production base" through the "free flow of goods, services, investment and a free flow of capital" with an accelerated timetable for completion from 2010 to 2015 (ASEAN, 2007). However, ASEAN's average financial freedom score is only 36.7, which is 13 points lower than the global average, with most ASEAN countries (other than Singapore) are significantly deficient in investment freedom, with scores of less than 50, which means that their overall investment climates are dampened by government restrictions (ASEAN, 2008). According to the Mutual Recognition Agreement (MRA) treaty, Indonesia is obliged to open its doors to foreign health professional graduates in 2010. This calls for further regulation about quality standards, licensing and certification in Indonesia.

[45] Asih N. 2005. Hubungan Tata Kelola antara RS dengan Dinas Kesehatan. *Master Thesis at* MMR Graduate Program, UGM

CHAPTER 4
The Dynamic of Medical Practitioners

One important actor in non-state health service is the medical profession. It is widely acknowledged that Indonesian medical professions, especially specialists, have distinct characteristics: small in number, with a powerful association but not regulated. The development of medical specialist characteristics can be analyzed through a cultural perspective. This chapter use Trice and Beyer's[46] approach of professional culture in an organization, which includes (1) culture materials in the form of a system which is emotionally owned as an ideology, (2) cultural forms, i.e. things which are perceivable, such as activities preserving the culture and ways of communicating various cultural contents among members.

Schein expresses that an organizational culture can be identified from the group culture which is defined as "a pattern of shared basic assumptions that the group learned as it solves its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relations to those problems".

Further, Schein expressed that there are various cultural levels, i.e. (1) sub-conscious basic assumption, which becomes a strong belief in an organization, (2) values searched and expressed in various activities including compiling the organization's strategy, objective, and philosophy, and (3) visible artifacts shown in objects considered as cultural characteristics of a group.

By using this cultural concept, Indonesian doctors have shown some interesting developments since the colonial period. One characteristic of medical doctors' professional culture is the influence of market principles. Various researches have found that medical doctors (especially specialists) tend to work in high economy regions, may earn a high and 'unlimited'

[46] Trice H.M, Beyer J.M. 1993. *The Cultures of Work Organizations.* Prentice Hall. Englewood Cliffs, New Jersey.

income. Medical doctors may enjoy a high income as what has happened since the beginning of private practice in the colonial time.

Data indicate that the specialist distribution is very low in remote areas and those areas which do not offer any financial incentives for specialists. This situation reflects normal behavior in labor market. The research result conducted by Trisnantoro[47] concluded that the bigger the economy in a certain area, the more available specialists will be. The relationship is very strong, as shown in Table 4.1.

Table 4. 1 The Relationship between Regional Gross Domestic Product (Produk Domestik Regional Bruto/PDRB) and Poor Populatian Perentage with Specialist Distribution

Specialist	**Relationship with PDRB**	**Relationship with Poor Population Percentage**
General Surgical Specialist	r = 0,940	r = - 0,355
Internist Specialist	r = 0,890	r = -0,358
Obstetrics and Gynecology Specialist	r = 0,921	r = -0,332
Pediatric Specialist	r = 0,894	r = -0,328
Ophthalmology Specialist	r = 0,919	r = -0,337
Specialist	**Relationship with PDRB**	**Relationship with Poor Population Percentage**
Ear, Nose & Throat Specialist	r = 0,902	r = -0,326
Mental Specialist	r = 0,876	r = -0,332
Neurology Specialist	r = 0,890	r = -0,319

[47] Trisnantoro L. 2003. *Aplikasi Ilmu Ekonomi dalam Manajemen Rumahsakit*. Gadjah Mada University Press

Skin & Genital Specialist	r = 0,871	r = -0,321
Radiology Specialist	r = -0,321	r = -0,311
Anesthesia Specialist	r = 0,854	r = -0,341
Clinical Pathology Specialist	r = 0,923	r = -0,327
Anatomic Pathology Specialist	r = 0,882	r = -0,357
Cardiology Specialist	r = 0,744	r = -0,340
Lung Specialist	r = 0,858	r = -0,271
Neurological Surgery Specialist	r = 0,875	r = -0,355
Orthopedic Surgery Specialist	r = 0,968	r = -0,316
Urologic Surgery Specialist	r = 0,907	r = -0,302
Forensic Specialist	r = 0,812	r = -0,210
Medical Rehabilitation Specialist	r = 0,856	r = -0,311

Based on the table above, it is obvious that on average the number of specialists has a strong positive relationship ($r > 0.80$) with PDRB of a certain area. The result of a more thorough analysis at district level also shows a similar result, i.e. $r > 0.80$ for all types of specialization fields. This phenomenon means that the higher the PDRB in an area the more specialists work in that area. Meanwhile, if it is attributed to the poor people percentage, we will obtain a negative result (reversed relationship). This can be interpreted that the higher percentage of poor people, the fewer specialist works in that area. These data confirm that medical specialists as a professional group has the same characters as other professional groups, with the economic factor and life prosperity as the significant motivation for work.

The link with pharmaceutical companies

Fragmentation of professional economic behavior does exist. Doctors and professional associations show a materialism culture under the influence of the strong pharmaceutical industry and such is shown in their scientific activities and professional congresses or their family trips. In this relation, the Ministry of Finance has issued a decree for limiting the pharmaceutical marketing cost.

Moonlighting

Government doctors are not satisfied with their financial compensation which results in their work ethic: "According to the social status, they are government employees at state hospitals, but they receive major earning from private hospitals and individual practices." This raises another culture, namely shifting between public and non-state hospitals without a clear regulation and tending not to have trust for hospital management and managed care.

Cartelism

Some specialties unconsciously practice market fundamentalism in terms of monopolizing the supply. In some places, doctors may act as price-makers in fee setting. Why has this happened? Some explanation can be presented here. A small number of specialists, especially the subspecialists, may control the health sector, as shown in the case of pediatricians below. Most pediatricians work in Java and Bali. With a population of 118 million (56% of the total Indonesian population), the proportion of pediatricians in these two islands is around 69% of the total IDAI (Indonesian Pediatrician Association) members. The highest ratio is in DKI Jakarta (Jakarta Special Capital Region), followed by D.I. Jogjakarta (Jogjakarta Special Province), North Sulawesi, and Bali[48]. It is quite interesting that in the IDAI database of 2005, hardly any pediatricians are found in North Maluku.

[48] Sri Supar Yati. 2005. Keynote Paper in KONIKA 2005

Figure 4. 1 Pediatrician Ratio per 100.000 Population according to Province

Source: database IDAI

The life-style of doctor follows the global trend. This culture is not easy to be managed by non-state hospitals, except those which have strong bargaining power over their doctors. Medical doctors' culture has little history of a managed and standardized system. Till now there is hardly any standard for doctor earnings and service standard. Doctor earns his living from fee-for-service practice[49].

Case Study 1: Provider Behavior

Why till now does mal-distribution of doctors still occur in parts of Indonesia? Is such a condition related to revenue? How much is the actual revenue of Indonesian doctors? To answer that question, in 2006, the Executive Board of the Indonesian Doctor Association of (PB IDI), in cooperation with PT Askes and the Centre for Health Services and Management, Faculty of Medicine of Universitas Gadjah Mada, conducted a survey in 8 provinces in Indonesia.

The survey covered 279 doctors with the following details: 126 general practitioners, 43 specialists in internal medicine, 36 surgeons, 40

[49] Sanjana K. 1998. *Hubungan antara Kompensasi, Iklim Kerja, Citra Kerja, Ciri Individu dan Kepuasan Kerja Dokter Spesialis di Instalasi Bedah Sentral RSUP Sanglah Denpasar*. Gadjah Mada University Hospital Management Master's Program. Yogyakarta. *Thesis.*

specialist in obstetrics and gynecology, and 34 pediatricians. All the doctors were civil servants and had worked at least for one year by the time the survey was done. Those doctors were asked to answer the amount of their monthly revenue, the source of revenue, and the proportion of revenue obtained. Descriptive findings show the survey results and present the description of the condition of doctors' revenue as a professional work-power in the Indonesian health system.

The field findings illustrate a surprising situation. In general, the doctors' greatest revenue comes from non-state hospitals, in the form of salary (22.6%) and incentives (35.1%), as well as from private practice (14%); the revenue from state hospitals contributes only 11.2%, in the form of salaries, and 4.2%, in the form of incentives. This phenomenon indicates that most respondents, while maintaining the status as civil servants, receive their revenue from the non-state health-care providers. These results may explain why Indonesian doctors tend to work in two sectors, private and public, with a very unbalanced time division.

Revenue from the government sector

State hospitals, as the respondents' official institutions, contribute only 15.4% of the doctors' revenue. This contribution is almost equal to the revenue earned from their private practices. If specified, then, the incentives by the state hospitals provide only a small contribution, in the amount of 4.2%, while their salaries make 11.2%. For general practitioners, the revenue from this sector contributes a substantial value. Civil servant salary is only 19.4% of a general practitioner's revenue, equivalent to that earned from private practices, but is still below the revenue from the non-state hospitals, which can reach 29%. However, these salaries are fixed and change only rarely over time.

For internal specialists, the salary is only 10.2% of their revenue component, while the incentive from the state hospitals is 5.2%. The total proportion of revenue from the government, as the "employer" of civil servants, is only of 15.4%. Surgeons earn 12.5% of their total revenue from the state hospitals, lower than the proportion of internal specialists. This

proportion consists of 8.9% in the form of salary and 3.6% in the form of incentives. State hospitals provide only 9.3% proportion of obstetricians' and gynecologists' revenue, where the proportion of their salary is 6.6% and that of their incentives is 2.7%. Pediatricians' salary and incentives from the state hospitals are of 13.5%, consisting of 11.4% in the form of salary and 2.1% in the form of incentives.

Similarly, incentives from state hospitals become less important for doctors, particularly specialists. Incentives from state hospitals only contribute to 7.2% of GPs' revenue, 5.2% of internal specialists' revenue, 3.6% of surgeons' revenue, 2.7% of obstetricians' revenue and 2.1% of pediatricians' revenue.

Revenue from non-state providers

Revenue from the non-state providers consists of salaries and incentives. They contribute substantially to general practitioners and specialists' total revenue. On average, non-state providers contribute 57.7% of physicians' total revenue General practitioners earn the most revenue from non-state providers (38%): 9% in the form of salaries and 29% in the form of incentives. Internal specialists earn 60% of their revenue from the non-state providers. Surgeons earn 58.9% of their revenue from non-state providers. Non-state hospitals provide 68% of obstetricians' and gynecologists' revenue. Pediatricians earn 62.5% of their revenue from the private sector.

Incentives in the form of medical service compensation from the private sector contribute 29% of general practitioners' revenue, 44.8% of internal specialists' revenue, 28% of surgeons' revenue, 33.5% of obstetricians' and gynecologists' revenue, and 44.3% of pediatricians' revenue. For internal specialists and pediatricians, incentives of the private sector are very valuable, because they represent the biggest contributors to their revenue. For surgeons and obstetricians, non-state hospitals also provide salaries. This is probably related to non-state hospitals' effort to forge co-operation with medical professionals of the two types of

specialization that are considered rare and bring in a major contribution to their hospital revenue.

Revenue from private practice

In general, 14% of doctors' revenue is earned from private practices. This proportion is quite large and is the third contributor to the respondent doctors' revenue. Respondents with the status of general practitioners earn 19.5% of their total revenue from private practice. Internal specialists earn 14.7% of their revenue from this private practice, surgeons earn 6.7%, obstetricians earn 13.2%, while pediatricians earn 15.3% of their revenue from their private practice.

Surgeons do not earn high revenue from the private practice because the activities the surgeons perform in their practice are limited to consultation and minor surgery. Such condition also explains why the revenue of obstetrics and gynecology specialists earned from private practice is not high either. As for internal medicine and pediatric specialists, private practices substantially contribute to their revenue because they can perform complete service activities in the practice room.

Revenue from Health Insurance

Revenue earned from health insurance is very small (1.2%), as compared with that from other sectors. If compared with other sectors, then, the revenue from this sector is at the last position of physicians' revenue contributor.

General practitioners earn 4.2% of their revenue by serving insurance patients, either from *PT Askes* (3.9%) or *Jamsostek* (0.3%). For internal medicine specialists, *PT Askes* patients contribute 0% to their revenue. Surgeons earn 1.1% of their revenue from insurance. Obstetricians earn 0.2% of theirs from *PT Askes* and 0.2% from *Jamsostek.* For pediatricians, serving insured patients provides them with 0.8% from *PT Askes* and 0.1% from *Jamsostek.*

Other revenue sources

Indonesian doctors earn revenue from various sources, such as teaching salary, company honorarium, laboratory incentives, and so forth. These revenues, if combined, provide significant contribution, in the amount of 10.3%, greater than the revenue earned from the government. The amount of revenue from pharmaceutical companies and laboratories were not explicitly mentioned. Identifying the existence of the revenue contribution from these sectors was difficult to conduct. Theoretically, revenue from pharmaceutical companies and laboratories is obtained directly and indirectly (distributed by the hospital), in material and immaterial forms (course aid fees, seminars and so on).

Doctors as health workers who carry out the service at hospital are the core operators and service front-liners. Often, patients visit a hospital not because of the facilities available but because of the availability of certain doctor. Although a hospital offers various kinds of high-tech medical equipment, comfortable treatment rooms, or affordable rates, if there are no doctors who serve in accordance with the needs and expectations of the patients, no patients are willing to be treated in the hospital. Hospitals perceive doctors as partners as well as marketing salespersons to attract patients. Doctors' dual roles at the hospital make their position very strategic and are taken into account seriously by hospital management.

Often hospital management treats doctors excessively by giving them freedom to perform any medical treatment, even if not in accordance with the principles of efficiency and effectiveness. Effort to diagnose a patient's illness is conducted by doctors. Doctors' decision to perform specific examination procedures is often not reviewed by the hospital management. This situation occurs because hospitals put high authority on doctors. Hospitals do not mind such a situation because the patient and the insurance as payers take all of the financial consequences.

The hospital mechanism actually provides opportunities opens chances for the management to review all medical procedures selected by the doctor, of which not all are not in accordance with the principles of

efficiency and effectiveness. The hospital organization maintains a medical committee (techno structure) that directs and colors the medical services in a hospital. This committee is in charge of analyzing a variety of medical treatments performed at the hospital which provide no added value. The committee is also authorized to change various medical procedures which are not considered in accordance with the development of the medical world and the principle of patient safety. However, the members of this committee are doctors with different specialty backgrounds. Tolerance and a sense of colleagueship sometimes hinder the committee from working in accordance with professional standards. Hospital management feels that it has done the right thing by forming such a medical committee, in accordance with rules, both local and global. The existence of this committee will protect the organization and allow medical professionals to work in peace. The medical committee bridges the relationship between a hospital's management and its doctors. This relationship is an organizational one which indirectly restricts managerial actions on doctors' various professional activities. Therefore, hospitals and doctors need a third party to help doctors work effectively and efficiently, in accordance with the principles of management.

The modern health-care system provides an opportunity for a third party to bridge the relationship between doctors and patients and help to increase efficiency, especially in financing health services in hospitals. Patients pay service fee to the health fund (health-care financing institution) by mix in advance. The source of fund may come from individual patients or the government, depending on the health financing system applied in one area and on the ability of community to pay the insurance provided by the third party. For the health fund, health funds collected from the community are used as efficiently as possible to finance the health care of its members, with a limited level of severity on certain cases and with a limited level of payment. This efficiency concept is firmly held by the payer because the key of its "business" is the adequacy of their service fee with the agreement that has been approved by the provider and patients. Although the service charge is used to finance health service of a specific case and with a specific time deadline, sometimes the cost increases due to a number of medical

procedures carried out by doctors. The payer party should pay for all medical activities performed by doctors upon patients who have become members of the health financing organization.

Such complex relationship among various parties in the health-care system requires in-depth discussion in order to understand it fairly and equally. One aspects of this relationship which is the most widely discussed is the provider's behavior. As a party trusted by third parties to perform service functions, the provider's behavior determines the success story of a health service system. A provider’s positive behavior will improve the efficiency and effectiveness of the system, whereas a provider’s negative behavior will make the system totally impaired.