Section 3
Policies and Regulations for Private Institution Sector Providers

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Objective

This chapter aims to describe the current policy and regulatory environment by identifying key policies and regulations which affect the private hospital sector.

Methodology

This chapter uses document analysis as a method of research. Document analysis is the systematic examination[1] of policies documents such as *Undang-Undang* (Law), *Peraturan Pemerintah/PP* (Government Regulation), *Peraturan Menteri Kesehatan/PMK* (Health Minister's Regulation), *Keputusan Presiden* (Presidential Decree), *Keputusan Menteri Kesehatan* (Health Minister's Decree), *Peraturan Daerah* (Local Government Regulation) as well as related articles in order to identify the existing policies related to the private health-care providers, or those related to the public health-care providers that imply consequences to the private health-care providers. The focus of the analysis is a critical examination, rather than a mere description, of the documents.

The analysis is based on some of the key themes that Hanson and Berman raised on the roles of regulation in the health sector, which include:

- Altering market structure and functioning

[1] Rapley T, Flick U. 2008. *Doing Conversation, Discourse and Document Analysis - Qualitative Research Kit*. Sage Publication.

- Enforcing or controlling quality standards
- Improving Efficiency

The data sources are the existing secondary data, publicly available in print and/or online from the Ministry of Health (MOH) archives, the Ministry of Home Affairs (MOHA) archives, the Ministry of Finance (MOF) archives, and private sources, which are related to the themes above. Some of the limitations of using document analysis in conducting policy analysis are that documents or materials may be incomplete or missing or inaccessible and that data are restricted to those already exist. On the other hand, some strengths of document analysis[2] are:

1. Document analysis is a particularly good technique to collect some types of retrospective information, which is the nature of policy analysis.
2. Document analysis can be used to collect certain types of information or data easily, quickly, and inexpensively, and is usually less obtrusive.
3. Information gathered from documents is often more credible than information or data obtained via interviews, questionnaires, or observation, because the data are historical and often viewed as objective evidences.
4. Document analysis may be the only way to obtain specific data of Laws and Regulations.

[2] Berman, Peter and Dexter Cuizon. 2004. "Multiple Public-Private Job Holding of Health Care Providers in Developing Countries: An Exploration of Theory and Evidence." DFID Health Systems Resource Centre (www.healthsystemsrc.org).

CHAPTER 7
The Policy In Non-State Hospital

In general, Hanson and Berman state that policies regarding the market structures usually consist of regulation in the areas of:

- Market entry: such as policies surrounding the investment or requirement to set up a new establishment, the accreditation and licensing of both practitioners and premises;
- Geographical location: such as policies to ensure even and equitable distribution of health facilities and personnel
- Prices and payment mechanisms: such as rules established in order to limit the charges that may be imposed for services, or the mechanisms through which fees are levied.

This sub-chapter is organized according the above framework. However, the accreditation and licensing of the practitioners will be analyzed further in the next sub-chapter on policies regarding quality.

The long history of an almost exclusive focus on the public provision of healthcare services has not been conducive to the development of an understanding of economics or market forces by the MOH. The MOH is attempting to engage the private health sector in a dialogue about provision of services through Health Minister's Regulation No. 159b/Menkes/PER/II/1988 and Health Minister's Decree No. 378/Menkes/PER/1993 mandating its social function. However, there is an undercurrent of uneasiness due to the perception that "social" and "commercial" functions are mutually exclusive. What has emerged is an uneven pattern of interventionist policies, which attempt to divert private sector revenues directly into public sector activities rather than establishing a facilitative role and avoiding direct competition with the private sector.

7.1. Policies on Market Entry to the Private Sector

As the previous chapter suggests, the size and complexity of the private health sector is increasing in Indonesia; the health sector reform and dynamic in government health budgets have meant that private sector providers are playing an increasingly critical role in the delivery of healthcare[3,4,5]. This sub chapter aims to provide the possible underlying policies that affect the size and complexity of the Indonesian private health sector.

Requirements to enter the market

Private practice in Indonesia usually refers to physicians and midwife practices. Under the existing nursing practice regulation (Health Minister's Regulation No. 1239/MENKES/SK/ 2001 on Nurse Registration and Practice), nurses are not authorized to have private practices. In reality, nurses run private services particularly at the regency level. In Jogjakarta, for instance, around 10% of the 2,849 nurses were conducting private practices (Muhusan, 2007). Nurses also do not have a national competency exam except in two provinces, Central Java and Banten, which have started a pilot trial and have required all nurses practicing in those provinces to take a competency exam.

According to Law No. 29 of 2004 on Medical Practice which was elaborated further in Health Minister's Regulations No. 1419/MENKES/PER/X/2005, physicians are allowed to establish their own private practice, but they must have passed the national

[3] Brugha, R., and Zwi, A. 1998."Improving the quality of private sector delivery of public health services: challenges and strategies." Oxford University Press, *Health Policy and Planning,*vol. 13, no. 2, pp. 107–20.

[4] Bloom, G. and Standing, H. 2000. Pluralism and marketisation in the health sector: Meeting health needs in contexts of social change in low- and middle-income countries'. *IDS Working Paper 136*, Brighton: Institute of Development Studies

[5] Smith E, Brugha R and Zwi A. 2001. *Working with Private Sector Providers for Better Health Care: An Introductory Guide*. London School of Hygiene and Tropical Medicine and Options Consultancy Services, London

competency exam and have been approved by the Council of Indonesian Doctors. Consequently they are now able to establish private practices immediately upon graduating from medical school, provided that they have met the above requirements. The Council gives physicians three certified copies of licensure, and according to Health Minister's Regulation No. 512/MENKES/PER/2007 they are limited to run practices in no more than three healthcare facilities.

In a similar notion, Health Minister's Regulation No. 900/MENKES/SK/2002 on Midwife Registration and Practice permits midwives to have private practices, referred to as Private Practice Midwife (Bidan Pratek Swasta). However, contrary to the physicians, midwives must demonstrate that they have practiced for three years in another facility before opening a private practice. They also have to meet the requirement set by Health Minister's Decree No. 369/MENKES/SK/III/2007 on Standards for Professional Midwives.

Health Minister's Regulation No. 920/MENKES/PER/XII/1986 which has been revised by Health Minister's Regulation No. 084/MENKES/ PER/II/1990 on Private Health Service required private hospitals to obtain licenses and, if processed through Coordinating Board of Investment (BKPM), a investment joint-approval by the MOH and MOF. A sub directorate in the Directorate of Medical Service carried out this task.

The hospital licensing is elaborated in Health Minister's Regulation No.922 of 2008. The hospital license is differentiated into the *establishment* license and *organization* license. Establishment license is valid for 2 years and possibly extended once and is valid for 1 year, and is granted by the regency authority. These licenses include the IMB (building permit), the AMDAL (environmental impact assessment), the Environmental Health and Monitoring Letter, etc. The organization license is differentiated into a temporary and a permanent license. A temporary license is issued for 2 years and followed by the determination of the hospital class. After the

hospital class is determined, the hospital will receive a permanent license. A temporary license is given during the transition period when the hospital is completing the hospital equipment. The organization license includes a deep-well license, a lift-use license, an electric-generator-set license, a boiler license, a radiology license, a prophylactic lightning license, an electricity installation license and a fire installation license.

Foreign investment

Foreign investment regulations for the health sector were amended in 1998 and 2000, but these amendments represent only little improvement over the previous regulations and in some ways are even regressive. According to Presidential Decree No. 118 of 2000, the areas of the health sector that are open to foreign investment require a domestic joint-venture partner. The decree of Directorate General of Medical Care No. 0308/Yanmed/RSKS/PA/SK/IV/1992 on the Technical Guideline for Capital Investment from National and Foreign Sources for Private Health Sector limits the specific areas open to foreign investment to Pharmaceutical Manufacturing, hospitals of 200 beds or more in major urban areas, medical check up clinics, medical clinical laboratories, mental rehabilitation services, nursing homes, prosthetics manufacture and repair, managed care, medical equipment rental, repair and maintenance, medical evacuation services and hospital management services.

According to the BKPM data, over 65% of all previous health care investments and 94% of all the investment funds were confined to pharmaceutical production and hospitals. According to the foreign investors, some disincentives to invest were the requirement for hospitals to provide 10% of their bed capacity to the poor and/or provide monetary support for a local health center for the poor, as

well as the requirement that clinical laboratories must offer a lower price to the poor for laboratory examinations.

According to BKPM records (2009), seven to nine hospitals have claimed the right to use the label international, however only four to five hospitals are justified by BKPM in using the label, namely Bintaro International Hospital, Mitra International Hospital, Permata Hijau Hospital, and Brawijaya Hospital. Furthermore, only Surabaya and Medan are open to new hospital foreign investment for the time being, thus international hospitals can no longer be built in Jakarta and surrounding areas[6].

Under current regulations, foreign physicians and nurses are also prohibited from practicing in Indonesia unless they complete a course called "adaptation" (similar to matriculation) to demonstrate their competence. This might change dramatically as the Mutual Recognition Agreement (MRA) come into effect. According to this treaty, Indonesia is obliged to open its doors to foreign health professional graduates in 2010.

Tax and subsidies

Indonesia has relatively high taxes on corporate profits and capital gains. Law No. 36 of 2008, which was the fourth Amendment to Law No. 7 of 1983 on Income Tax, suggests that capital gains are treated the same as normal income. There is no tax exemption or reduction for the capital gain of a not-for-profit hospital as stipulated in the Circular Letter of Directorate General of Taxes No. SE-34/PJ.4/1995 on the obligation to pay income tax for hospitals owned by foundations. There are also no special social charges for utilities such as for electricity or pipe water or license costs.

[6] Badan Koordinasi Penanaman Modal. August 2009. Investment Summary Report.

The only tax break applied to hospitals is the 50% deduction on the Land and Building Tax as stipulated in Finance Minister's Decree No. 158/KMK.04/1991 on Land and Building Tax Reduction which was renewed by Finance Minister's Decree No 796/KMK.04/1993 on the Land and Building Tax for Private Hospitals. Overall, the private hospitals are subject to around 43 different taxes, levies, and retribution.

There are only small numbers of opportunity for tax policy incentives. The first is that the venture capital profits can be entitled to capital gains relief by the MOF in the form of a 0.1% tax on shares sold outside of the stock market if invested in small or medium businesses or in a "priority" sector (Law 1994 Article 4.3.j). The clause defined 'priority' as "high priorities on the national scale" to "facilitate national development." If "Health" were identified as a priority sector for taxation purposes, there would be substantial incentives for the much needed investment. The second one is Finance Minister's Regulation No.19/PMK.011/2009 on the Enforcement of Entrance Tariff for Specific Imported Products, which provides some relief for the health sector in terms of the raw materials for pharmaceuticals, however only few materials are included.

Essentially, Law No 18 of 2000 regarding Value Added Tax requires that all pharmaceuticals, disposables, lab reagents, and medical equipment are now subject to a 10% VAT (which is an increase from only 2% prior to 2000) which is scheduled to be increased again to 12.5%. The VAT is applied to the sales price, which incorporates the income tax liabilities of the importer, manufacturer, and distributor. It is estimated that the VAT on pharmaceuticals increases the price of drugs by 14%. Combined with the import tariffs on the raw materials and income tax, the consumer price of pharmaceuticals has increased averagely 22% higher than before the

enforcement of the additional costs of dispensing, service, and the associated taxes.

The only VAT exemption is on drugs administered to patients while hospitalized. These are considered an integral part of the "unit of care" and thus exempted under the provisions of Government Regulation No. 144/2000. However, VAT is charged on drugs received by patients attending an outpatient care clinic or emergency room. Also, any medications or disposables sold from the hospital pharmacy are subject to VAT.

Publicly funded private services and other incentives

Notwithstanding the existing rather restrictive policies, the government has made some specific arrangements aimed to encourage private expenditures on health. The Ministry of Health offers incentives to private providers for the provision of preventive care, such as supplying free vaccines provided that they are available free of charge for the community as end-user. Other examples of publicly financed private services include providing 'private' beds in state hospitals, contracting out public (usually non-clinical) services, and providing government purchased insurance that can be used for private services. For instance, Askeskin involves private hospitals to provide inpatient services to the poor. Another incentive is the enforcement of hospital social function. According to Health Minister's Regulation No. 159b/Menkes/PER/II/1988 and Health Minister's Regulation No. 378/Menkes/PER/1993, private hospitals are required to provide 25% of beds to the poor to supplement public providers. By complying, private hospitals may receive government subsidies in the form of cash, building construction, or medical equipment[7].

[7] Thrabany, Hasbullah, et al. 2003. "Social Health Insurance." Presented at the Social Health Insurance Workshop, WHO SEARO, New Delhi (March 13-15, 2005) and Thabrany, H. 2003.

7.2. Policies to Ensure Equity in Distribution

There has been a comprehensive human resource plan developed in line with the Healthy Indonesia 2010 Grand Strategy. However, this plan has not considered the skills and qualifications in par with new roles and responsibilities under a decentralized system at the national, provincial, and regental levels. Furthermore, the provincial/regental/municipal health offices have had to reduce their staff numbers due to lack of financial resources. In addition, there has been a persistent problem of low wage particularly among the peripheral levels, which effectively prevents the development of professional full-time cadres of health professionals and, in the long run, promotes overstaffing in urban and highly populated areas where private practice may be more lucrative. The government tried to improve this situation with Health Minister's Decree No. 1540 of 2002 and Decree No. 81/SK/I/Menkes/2004 on health personnel distribution with focus on priority areas such as those with inadequate numbers of health personnel.

The Health Minister's Decree No. 1452/Menkes/ SK/II/1998 also tries to provide more incentive for doctors who are willing to be allocated in the remote areas. The incentives could be chosen between financial incentives (additional allowance) or reduced obligatory service years.

Health Minister's Decree No 1563/MENKES/ IV/SK/2003 further restricts the number of hospitals in a particular region based on its population ratio. A region with a maximum of 100.000 populations should have at least one state hospital and up to three private providers. However, in Indonesia, the current distribution of public health facilities and personnel is closely correlated with income distribution. Health Minister's Decree No 1563/MENKES/

"Indonesia's national Social Security System: An Academic Paper." School of Public Health, Universitas Indonesia, Jakarta

IV/SK/2003 further restricted the number of hospital in a particular region based on population ratio. A region with a maximum population of 100.000 should have a minimum of one state hospital and up to three private providers. However, in Indonesia, the current distribution of public health facilities and personnel is closely correlated with income distribution[8]. In 1997, just under half of adults in Java Bali[9] (46%) and 19% of adults in Outer Java Bali lived in communities with no public facility that offered adult curative care[10]. A larger proportion of private physicians worked in Java Bali, while more private nurses worked in Outer Java Bali. These accessibility issues also may account for the large percent of Indonesian consumers that rely upon private nurses for health care services, even though nurses are not legally licensed to practice (see 4.1.1). Although Health Minister's Decree No 1563/MENKES/ IV/SK/2003 has been actually designed to regulate the number of *state hospitals* in a given region, it also implies that the regental health office has the authority to declare a region as open or closed to *private* providers considering that in order to set up a private clinic/hospital, they need a license from the government.

The inequities of distribution of health service providers have existed in multiple layers in Indonesia: between provinces, between the urban and rural areas, and between those areas which are affluent and those that are not. However, since most providers serve both the private and public sectors (see 4.3.2), and since the government has reduced its economic incentive program to attract

[8] Marzolf, James. 2002. *"The Indonesia Private Health Sector: Opportunities for Reform, An Analysis of Obstacles and Constraints to Growth*." Washington, DC: World Bank.

[9] Java Bali is the cluster designated by the Demographic Health Service and Government census bureau. They essentially divide the archipelago into three regions – Java-Bali, Outer Java (which is actually not the island of Java at all), and Outer-Outer Java, which refers to really remote regions and is a designation that is rarely used now.

[10] Barber SL, Gertler PJ, Harimurti P. 2007. Differences in access to high quality outpatient care in Indonesia: an analysis by clinical settings, regions, and household wealth. *Health Affairs;26(3): 352–66*. the District health office had the authority to declare a region as open or close to *private*

public sector physicians to the more remote areas, there also may have been a corresponding drop of private sector facilities in these remote areas since most of the health personnel are functioning in a dual capacity.

7.3. Policies Regarding Prices and Payment Mechanism

Health Minister's Decree No. 282/MENKES/SK/III/1993 on Tariff Patterns in Private Hospitals regulates the composition of tariff but did not regulate the maximum tariff that they can be charged. The absence of regulation on the tariff ceiling for the private providers implies a risk of skyrocketing prices as the private providers might use higher and higher medical technology to 'signal' the level of quality.

Law No. 40 of 2004 was initiated to reduce the financial barrier of access to healthcare by promoting a National Social Security System in which the government covers premiums for the poor. *Jamkesmas* is the example of this public-funded insurance. *Jamkesmas* can be used in public and private providers. When used in the private providers, the payment mechanism is reimbursement based on INA-DRG standard fee. An example is given at http://www.ina-drg-rr.net/cost_of_treatment.html.

7.4. Policies Regarding Quality

Hanson and Berman suggest that policies to control and enforce quality standards usually consist of minimum standard, inspection and non compliance mechanism, requirements regarding training and re-training of medical personnel as well as liability and malpractice laws.

In Indonesia, the literature suggests that there are clinical quality problems in both the public and private sectors. It is widely

recognized that there is little control over quality in the private sector, and the private sector is largely unregulated. The eroded quality of health care services in public facilities, in some instances linked to the absence of health care personnel, has contributed to the increasing shift by consumers to private sector facilities for both in-patient and out-patient services, or more recently, a shift to self treatment[59].

One study among private and public providers in 2007 found relatively low knowledge of evidence-based practices with less than half of both public and private providers were aware of the appropriate clinical guidelines[58]. However, in general, private physicians had the highest scores of quality for child and adult curative care. The study also revealed that private nurses offered below-average care for all scenarios and all regions, which indicated the level of care that the community in outer Java Bali received[11].

There have been some identified issues about the quality of nursing graduates. Hennessy et al found that there is no statutory regulatory authority for nurses and midwives, and consequently there are no regulatory standards for education and clinical competence.

Consequently, the majority of nurses and midwives have inadequate training and preparation for the role. In addition to that, many nurses and midwives practice with little or no supervision, and that they, under pressure from the mounting health demands of the population, may feel obliged to undertake clinical activities that exceed their education or their competence level[12].

With regards to continuing education, Health Minister's Regulation No. 916/MENKES/PER/VII/1997 on Licensing for Medical

[11] Government of Indonesia et al, 2008

[12] Hennessy, Deborah, Hicks C, Hilan A, and Kowanal Y. 2006. "The Training and Development Needs of Midwives in Indonesia: Paper 3 of 3." *Human Resources for Health* 4:10 (April 23).

Practitioners' Practice requires physicians to take a mandatory competency test in order to get their license. If they do not pass the test, they do not get a license and cannot practice legally. Furthermore, physicians are required to earn 250 continuing education credit units in a five-year period in order to be eligible for license renewal. Nurses and midwives have to renew their license every three years. IBI (Indonesian Midwife Association) has just completed a pilot project in four provinces (West Java, Central Java, Banten, and West Sumatra) wherein midwives have to pass a competency exam before they are given permission to receive and renew their license. However, there are no penalties or sanctions for practicing at sub-standard levels, except in the case of physicians where the Council of Indonesian Doctors can revoke physician's license. There will be presented a case study in Jogjakarta about the practice of Licensing by Provincial Quality Board that illustrates an advanced regulatory framework.

As for the accreditation for hospitals, it has been conducted by the Hospital Accreditation Committee (KARS). KARS assesses both public and private hospitals, but does not regulate private practices. The accreditation committee examines five categories according to its accreditation procedures: management and administration, medical services, emergency services, nursing, and medical records.

Stages of accreditation level:

Stage 1 (enacted in 1995): five services: administration & management, medical services, nursing services, emergency services, medical records.

Stage 2 (enacted in 1999-2000): plus seven services: Occupational health and safety, pharmacy, radiology, lab, surgical, high risk perinatal, infection prevention

Stage 3 (enacted in 2002-2003): additional services: Anesthetic, Medical rehabilitation, nutrition, central sterilization,

intensive care unit, equipment maintenance, library, other services (social insurance, blood bank, ASKES, etc).

Figure 7. 1 The Process Flow of Accreditation

Inspection by KARS usually involves assessing the services standard documents, nursing and medical services documents, service flow, decrees/other regulations, etc. Results of KARS inspection might be one of the following:

- Failing to pass accreditation criteria
- Accredited, with notes (with a total score average above 65% but below 75%, required to operate for one year before eligible for re-evaluation)
- Accredited (with a total score average above 65% and no item with a score below 60%, valid for three years)
- With special accreditation (given after three times being accredited, valid for five years)

Although the Director of KARS admitted that he did not know the exact number of hospitals in Indonesia, he stated that at the moment 75% of hospitals have been accredited already[13].

[13] Suara Merdeka newspaper, 13 July 2009

As for malpractice, according to the NGO data, from 1999 to 2009 there were 135 malpractice cases in Indonesia, however only one case went to trial. There were also 245 cases relating to the health sector, such as complaints from the communities that hospitals denied patients due to lack of financial resources and cases where a hospital took hostage of their patients due to their inability to settle the bills. The only related regulations about malpractices are Indonesia Medical Code of Ethics (Kodeki), Law No. 23 of 1992 on Health. Law No. 8 of 1999 on Consumer Rights unfortunately does not specifically mention about patient rights.

7.5. Policies Regarding Efficiency

Hanson and Berman argue that the objective of regulatory controls is to increase the efficiency and effectiveness of the health system operation. This might be reflected by regulations on these specific features:

a. Technology regulation e.g., limiting numbers of high-tech equipment such as MRI available within a specified geographic area. Health Minister's Decree Number 1333/ MENKES/SK/XII/1999 on the standard of service in hospitals does not regulate the limitation of high tech equipment. Nor does it regulate the kind of technology that the hospital should have.

b. Labor market issues e.g., number of years of public service which must be provided by publicly-trained practitioners; degree of collaboration in in-service training. According to Health Minister's Decree No. 1126 of 1998 physicians were required to fulfill their government obligation through a one-time, non-renewable contract of two to three years of government service which was called "PTT" or "Contract Doctors". After their period of service, they could seek a government job, however due to the "zero growth" policy in the public sector during 1992- 2002

there was a very limited number of job actually available. The "zero growth" policy was initially designed to contain the costs and to improve the target of limited government resources, while at the same time drove an increasing number of doctors to seek employment in the private sector[58.]

On one side, this was in line with the Ministry's statement to promote an expansion of the private sector to "encourage self-selection out of public facilities among those who were able to pay, and thus more efficiently target limited resources". The argument was that the Government fund was severely restricted during the recovery period of the post economy crisis and, thus, the government must turn to the private sector and community groups in the health sector[56]. It is widely acknowledged that the vast majority of publicly employed health personnel have second jobs in their own private practices or other private facilities[14].

The DFID report found that most doctors conducted private practice in addition to their respective positions with the government; specifically about 80 percent of general practitioners (GPs), 90 percent of specialists, 84 percent of health center personnel, 80 percent of hospital workers, and 93 percent of administrative personnel. Furthermore, 85 percent of those who had retired from civil service continued to treat private patients[15]. The World Bank Report on Indonesia's Doctors, Nurses and Midwives suggests that between 60% and 70% of the human resources have dual practices. The relatively small number of "pure" private providers is primarily found in

[14] Widyanti, Wenefrida and Asep Suryahadi. 2008. "The State of Local Governance and Public Services in the Decentralized Indonesia in 2006: Findings from the Governance and Decentralization Survey 2 (GDS2).

[15] Berman, Peter and Dexter Cuizon. 2004. *"Multiple Public-Private Job Holding of Health Care Providers in Developing Countries: An Exploration of Theory and Evidence."* DFID Health Systems Resource Centre (www.healthsystemsrc.org).

the urban areas of Indonesia or practicing with the extractive resource industries and functioning as company doctors[26].

c. Rules relating to the use of the health system, for example, requiring that patients seeing specialists are referred to by general practitioners, or that the use of the tertiary hospital is limited to those who have been through the referral system. Currently there is no clear rule on the referral system in the private health sector.

d. Reporting and generation of epidemiological monitoring information Government Regulation No. 25 of 2000 on the Authority of Central Government and the Authority of Provinces as Autonomy Areas, Chapter II Article 2 Clause 3.10.j states that one of government authorities in health sector is epidemiology surveillance and the arrangement for disease elimination as well as the treatment for epidemic diseases and extraordinary incidents. Meanwhile, Chapter II Section 3 article 5.9d states that one of province authorities in the health sector is epidemiology surveillance and the treatment for epidemic diseases and extraordinary incidents. Therefore, to achieve the vision of healthy Indonesia and the national goal in health sector as well as to achieve the goal of the local government in the health sector for local and specific development which needs the implementation of fact-based decision making concepts, the Government needs to conduct reliable epidemiology surveillance systems so that health managers are able to decide which program will be effective and efficient for solving the existing problems.

   Health Minister's Decree No. 1479/MENKES/SK/X/2003 on the Establishment Guideline of Integrated Epidemiology Surveillance System for Communicable and Non- Communicable Diseases and Health Minister's Decree No. 1116/MENKES/ SK/VIII/2003 on the Guideline for Establishing Surveillance System of Health

Epidemiology further elaborated some surveillance activities to provide epidemiology information useful for decision making which cover the Integrated Surveillance System, Community Health Service Surveillance, Tetanus Neonatorum Surveillance, Nosocomial Infection Surveillance, HIV/AIDS Surveillance, Crisis Impact Surveillance, Disease Outbreak and Natural Disaster Surveillance, non-epidemic disease surveillance, as well as health environment surveillance to support the implementation of disease prevention and elimination program and the Early-Warning System for Extraordinary Incident Program and Research. These regulations require submission of monthly ICD tallies to keep track of overall disease patterns in the country.

Health Minister's Decree No. 468/MENKES-KESOS/SK/V/2001 has proposed the policy and development strategies for the National Health Information System. However, at the moment there has been no technical guideline in which non-government providers are integrated into the national health information system.

Although data are being collected, the integration of information is somewhat inadequate, there is overlap and duplication, and many areas for improved quality and efficiency can be identified[16].

Summary

Overall, regulation of private healthcare investments is somewhat confining and protectionist, especially for foreign investment. There is virtually no opportunity for foreign investment in prevention, promotion, and primary care, either independently or as a partner with an Indonesian enterprise.

[16] HMN (Health Metrics Network). 2007. *"Indonesia Health Information System Review and Assessment."* Draft consultancy report, MoH, BKKBN, BPS, MoHA, Jakarta

In many ways, it has been indicated that there is a lack of dialogue and inconsistencies in the implementation of the existing policies and regulations and this problem may prove to be both the most critical and the most difficult to remedy. Part of this problem derives from the organizational structure of the Ministry of Health. In keeping with its long tradition as a National Health Service authority, there are few structural components in the MOH, which have any responsibilities for direct interaction with the private health sector.

Another major concern is that despite recognition of deficiencies in dual practice, there is not yet an organized effort to change this. The legitimacy of dual practice without proper oversight hinders the effectiveness of the system in Indonesia. Proper oversight mechanisms are required to ensure accountability for public working hours and maintain quality standards. Unfortunately, it has been indicated that the policy and regulation are not dynamically consistent. Dynamically inconsistent policies are not credible because providers will know that the sanctions implied in these policies and regulations are empty.

The distribution of health service providers, including private providers, is inequitable and favors urban areas. Currently, there is no effective policy to regulate the distribution of private service provider, specifically to foster accessibility in remote and less urban areas. Neither is there any adequate policy to provide incentive to promote redistribution of health workforce to remote and less urban areas.

The provincial, regental and municipal governments have low capacity to establish a quality framework and to exercise power and authority for ensuring quality and enforcing the registration, licensing, and accreditation system. The role of professional health associations in ensuring quality of doctors, nurses and midwives is also very limited.

Non existing governance of national health information system and minimum regulation about sharing information and reporting requirement also means that there is little that the government could capture from the private sector expansive information. And finally, although there is generic regulation on consumer protection, there is lack of specific regulation of ensuring patient rights.

CHAPTER 8
Reflection: The In-Depth Analysis of Physician's Dual Practice Pattern at the RSD Raden Mattaher, Jambi and the Power of Regulation

In improving the quality of medical service at the hospital, or in this case the professionalism of medical specialists, the main key is medical specialists' performance in providing medical service. Therefore, in their service to patients medical specialists must be able to allocate, use and optimize their time in accordance to the responsibility and authority bestowed by the state hospital, without neglecting activities or work outside of the state hospital, or in this case work at a non-state hospital and private practice rooms.

For that reason, it is deemed necessary to find out how medical specialists manage their practice schedules at the RSD (*Rumah Sakit Daerah/*Regional Hospital) Raden Mattaher Jambi in order that in the future a better regulation can be formulated to arrange clinical practices at the RSD Raden Mattaher Jambi.

Furthermore, in conducting their work, medical specialists should assume a sense of responsibility in working at the state hospital, and strive to improve the quality of health care service provided at the RSD Raden Mattaher Jambi.

The study aims to measure the length of time medical specialists spend their working hours at the RSD Raden Mattaher Jambi; the number of licenses to practice they hold and number of locations where they practice; and the incentives and factors which influence their choice in where to spend their working time.

Methodology

This research was conducted at the RSD Raden Mattaher Jambi. Respondents in this research were medical specialists who worked and

performed practice in one of the six specialization units at the RSD Raden Mattaher Jambi.

Background

Jambi Province comprises nine regencies and one municipality, which is Jambi City. In each of the regencies there is one state hospital, and in the municipality there are one state hospital, which is the RSD Raden Mattaher Jambi, and six non-state hospitals. RSD Raden Mattaher Jambi is the highest level or center of medical referrals for all hospitals located in each of the regencies in Jambi Province.

Up till July 2008, the human resources or staffs working in RSD Raden Mattaher Jambi totaled 833 persons whose statuses were either permanent civil servants (PNS), contracted employees (PTT), or volunteers or honorary workers.

In terms of human resources, doctors, or more specifically medical specialists, are professionals who greatly determine the development of the hospital, and are considered as the front leaders in the provision of clinical service at the hospital. If the doctors do not show enthusiasm in working and developing the hospital, then it will affect the work performance of other professionals such as the nurses. In RSD Raden Mattaher Jambi until July 2008 there were 36 medical specialists with 18 types of specialization.

At the RSD Raden Mattaher Jambi, the work schedules of medical specialist are arranged based on Jambi's Regional Government Regulation. In this case, medical specialists are expected to be actively working in their shift starting from 08.00 am until 14.00 pm, and basically medical specialist must be ready 24 hours as on call emergency service.

Results

The total number of medical specialists working at this hospital during this research was 15 persons, or more specifically two surgery specialists, six internal medicine specialists, three pediatric specialists, two ENT specialists, one dermatologist, and one radiology specialist. Basically all

medical specialists had the status as local civil servants (*Pegawai Negeri Sipil Daerah/PNSD*) at the RSD Raden Mattaher Jambi.

Table 8-1 shows the result of observation conducted by the researcher towards medical specialists in the six specialization units at the RSD Raden Mattaher Jambi. The table shows that all medical specialists conducted practice in the one and only state hospital in Jambi, which is the RSD Raden Mattaher Jambi. However, these medical specialists also ran practice in non-state hospitals. Some only worked in one non-state hospital whereas others might work in up to five non-state hospitals, such as medical specialist 06. Only four medical specialists conducted practice in one non-state hospital, whereas the others in either two to four non-state hospitals. Table 5 shows that from the three types of practice rooms, which were the state hospital, non-state hospital and private practice rooms, it seems that there were four medical specialists who ran practice in only three practice rooms, whilst one medical specialist worked in up to seven practice rooms. The other medical specialists worked in either four or five practice rooms each.

Table 8. 1 Total Number of Practice Rooms for Medical Specialists in the Six Specializations at the RSD Raden Mattaher Jambi viewed from State Hospital, Non-state Hospitals and Private Practice Rooms.

Spesialist	**Hospital**		**Private Practice**	**Total**
	State	**Non-state**		
Spesialis 01	1	2	2	5
Spesialis 02	1	1	2	3
Spesialist	**Hospital**		**Private Practice**	**Total**
	State	**Non-state**		
Spesialist 03	1	2	2	4
Spesialist 04	1	1	2	3
Spesialist 05	1	3	2	5
Spesialist 06	1	5	2	7

Spesialist 07	1	3	2	5
Spesialist 08	1	2	-	3
Spesialist 09	1	2	2	5
Spesialist 10	1	3	1	5
Spesialist 11	1	4	1	6
Spesialist 12	1	1	2	4
Spesialist 13	1	4	-	5
Spesialist 14	1	3	-	4
Spesialist 15	1	1	1	3

According to the laws and regulations on medical practice in Indonesia, each and every medical practice must hold a practice license (*Surat Ijin Praktek/SIP*). In 3 to 7 practice rooms managed by a medical specialist, some specialists practiced without a practice license.

Practice locations

To know more about the private practice rooms and practice rooms in non-state hospitals, the researcher also observed the location of these practice rooms because location is one of the major factors that need to consider when opening a practice room, especially for a private practice. Observation of the locations of eight practice rooms operated privately by medical specialists demonstrated that they were similar in terms of the location features: located in Jambi city, close to the main road, within a densely populated area, and in location where the cleanliness of the environment was continually maintained.

Similar findings were found in the observation the location of practice rooms in the six non-state hospitals in Jambi city. The six non-state hospitals are all established in Jambi city, of which four are close to the city center, close to business centers and also close to the other competing non-state hospitals. The buildings of the six non-state hospitals are located not

far from the main road, and the surrounding is a densely populated area whose cleanliness is continually maintained.

Working hours

According to rules and regulations in state hospitals, medical specialists who have status of a regional civil servant (PNSD) at the RSD Raden Mattaher Jambi must allocate more time in working at the state hospital than the time they allocate for working and opening practice at non-state hospitals and private practices.

In general, the specialist doctors worked for 1 to 1.5 hours on working days at the RSD Raden Mattaher, arriving at between 10.00 or 11.00 am and leaving at 11.00 or 12.30 pm. However, many did not work every day at the hospital, some only 2 or 3 days per week, or only in certain weeks of each month. Most also worked for 1 to 2 hours in non-state hospitals before and after working in the state hospital, and then they worked for 1.5 to 3 hours in their private practice rooms, starting from 17.00 p.m. until there was no patient.

Private Practice

The facilities provided in waiting rooms in the private practice rooms of the specialists varied, but often included a parking space, a TV set, and a playground for children. Observation over 3 days produced an estimate of the average number of patients visiting the specialists' private practice each day, which varied from 6 to 29, with most in the range from 10 to 20.

Discussion

Factors which seem to influence the specialists' behavior and the time they allocated to work in different practice locations included:

a. Gender of the specialist. Female specialists, in their practice, tended to have higher compliance in following and executing the law on medical practice in the Republic of Indonesia than male specialists did. The number of patients visiting the female specialists' practice place was

fewer than those visiting male specialists. The average number of patients in female specialists' practice place was 15 patients each day while in male specialists it was 15 -29 patients each day.

b. Regulation of licenses and practice location. In Indonesia, the medical practice has been regulated in Medical Practice Law No 29 Year 2004, Article 36, which states that every doctor and dentist who runs practice in Indonesia is obliged to have a practice license. Article 37 in sub-article 2 states that a practice license for doctors and dentists is given only for three practice locations. Sub-article 3 mentions that one license is only valid for one practice location. The practice license issued by Health Office of Jambi Municipality is only valid for practice locations in non-state hospitals and private practices. Meanwhile, for practice in the state hospital, such as RSD Raden Mattaher Jambi, Jambi Municipal Health Office does not issue a practice license because it is regarded that the specialists working in the hospital are civil servants and they do not need to have a license when working for the hospital. The research observation indicates there was some deviation on the part of Jambi Municipal Health Office in implementing the above law.

   From the perspective of the Medical Practice Law and the Regulation of Health Ministry, in Jambi indeed there were still some specialists who did not obey these regulations. It was ironic since the Medical Practice Law of Medical had been then in effect for 4 years after being issued in 2004. However, the health office of Jambi ignored this fact, gave no warning, and took no action to close some practice locations which had no license. The poor implementation of the regulations indicated the Health Office's high tolerance to the doctors or medical specialists for the hospital due to the fact that medical specialists were still rare and the local people desperately needed for their skills.

c. Regulation of working hours. According to Health Ministry Regulation No 81/MENKES/SK/I/2004 on human resources planning, medical specialists must spend at least 8 hours in each day in state hospital. At RSD Raden Mattaher Jambi, the regulation of working hours and of hospital

attendance is stated in Jambi Governor's Regulation No 8 Year 2008 and the Circular Letter of the Raden Mattaher Hospital Director No. 800/0928/UP/RSD. These regulations clearly mention that the productive hours start from Monday to Thursday until 2 pm, while on Friday the working hours last until 11.30 a.m. and on Saturday until 1.39 p.m. The circular only focuses on the routine obligation to fill the attendance list when employees arrive or leave. There is no item which mentions the sanction for an employee who violates the working hour regulation. Therefore, the employees can be somewhere-else after signing the attendance list or might ask another employee to sign for them. Medical specialists at Jambi routinely arrived late for work, and left after working for 1 to 1.5 hours, before the official time. The medical specialists' late arrival was also due to the fact that these doctors had to practice in 3 to 7 places before coming to RSD Raden Mattaher. Early in the morning, they ran practice in a non-state hospital; and in the afternoon, the doctors left the hospital outpatient room early because they had to practice in another non-state hospital and perform their private practice.

The poor implementation of the work regulation in RSD Raden Mattaher Jambi and the poor hospital management led the specialists to ignore attempts to enhance the quality of medical treatment and it seemed that these specialists only performed and fulfilled their obligation for routine activities. There was also little commitment for co-operation between medical personnel and hospital management in improving the quality and the personnel's work productivity which should have benefited all parties involved in hospital organization.

d. Facilities at private practices. Health Ministry Regulation No. 920 of 1986 concerning medical service provision sets out the requirements for specialist's individual practice room in Article 13, Section 1. Most medical specialists observed in this research fulfilled those requirements in terms the possession of a practice license and the condition of the examination room, waiting room, and bathroom/toilet for their private practice. However, some doctors did not meet the requirement to have a practice

license and the waiting rooms for their private practice were often very small.

e. Number of patients. As for the number of patients who received medical examination and treatment from the specialist doctors on each day, it was clearly found that more internist, pediatric, and gynecological patients came to the medical specialists' private practice than to the polyclinic or the outpatient room of RSD Raden Mattaher. Approximately 8 to 29 patients visited a medical specialist's private practice everyday while only 7 to 11 patients visited RSD Mattaher because of the limited time spent by the specialists at the hospital. As a result, most hospital patients were examined by general practitioners.