

International relations within Indonesia's hospital sector¹

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This paper offers a general description of the Indonesian health sector and the Indonesian hospital-care business in relation to foreign or international bodies. It reflects the writers' personal views as well as information obtained from other academic experts, government officials, and hospital managers and administrators.

INDONESIA'S POPULATION AND ECONOMY

During the past twenty-five years, the Indonesian population has almost doubled in size from 119.2 million in 1971 to 206.4 million in 1998. Efforts to control the population growth are paying off. The rate of growth was 2.32% during 1971-1980 but it decreased to 1.69% in 1990-1997. This was the result of a consistent and comprehensive family planning program offered by the government and also the indirect outcome of increased education and more employment opportunities for women.

Indonesia's large population is not equally distributed over the national territory. In fact, 58.6% of the population is concentrated in Java Island, which occupies only 7% of Indonesia's total land territory. Jakarta, the capital city located in Java, has the highest population density, with 15,888 persons per km², while on the eastern part of Indonesia the population density is less than 100 people per km².

Before the Asian economic crisis started in 1997, Indonesia's economy was booming. After three decades of continuous growth fostered by political, social, and macroeconomic stability, the Asian economic crisis of 1997 sowed the seeds of a major change in Indonesia's economy and political system. The crisis and subsequent fall in GDP, the largest among Asian countries, revealed underlying weaknesses in Indonesia's economic and financial structures, which prompted calls for reform.

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In 1992, the GDP per capita (adjusted as 1985 prices) was US\$ 2,102. From 1994 to 1996, the real GDP grew on average by 8% annually. Although economic activity started to decelerate in the second half of 1996, the financial crisis of 1997 pulled the Indonesian economy into a serious recession. In the first half of 1998, the GDP shrank by 12%, and was expected to fall by 10-15% for the year as a whole. In addition, inflation climbed from an average of 10% in the years of high growth to an estimated rate of 80-100% at the end of 1998, with the sharp devaluation of the rupiah playing a role in it, particularly because of the higher prices of imported foodstuffs.

During the last few months of 1999, the Indonesian economy showed signs of recovery. The inflation rate went down and the rupiah exchange rate became much more stable than the year before. However, the growth rate was still predicted to be zero, or slightly negative.

HEALTH NEEDS

Indonesia's health indicators have shown a moderate to poor level of health among the population. For example, in 1998, the infant mortality rate (IMR) was calculated at 48 per 1,000 live births and the maternal mortality rate (MMR) at 650 per 100,000. Life expectancy at birth for Indonesians was 63 years for males and 67 years for females. While the numbers show average achievement among the other World Health Organization SEARO countries (Bangladesh, India, Maldives, Thailand, PDR Korea, Myanmar, Nepal, Sri Lanka, and Bhutan), comparison with closest neighbouring countries

shows inferior achievement. Malaysia's IMR and MMR in 1998 were 11 and 80, respectively, while Singapore achieved astonishingly lower corresponding rates of 5 and 10.

Disease patterns in Indonesia have changed during the last two decades. While the majority of the population is still affected by the traditional Third World disease patterns such as diarrhea, tuberculosis, respiratory tract infections, and other infectious and parasitic diseases, the chronic- and degenerative-type diseases have become more common. In 1995, diseases of the circulatory system ranked among the top 10 causes of death.

HEALTHCARE IN INDONESIA: AN OVERVIEW

The Indonesian health care sectors represent a mix of public and private providers. The government provides primary health care centers known as *puskesmas* to all of the subdistricts. There are more than 7,200 *puskesmas* all over Indonesia. Each *puskesmas* has at least one medical doctor and other assisting health service personnel. The government has been trying to provide a midwife as well to every village. The private sector also contributes primary health care services, mostly delivered by physicians in private practice and allied health personnel.

Secondary health care services are provided by 1,089 hospitals all around Indonesia.³ Three hundred and forty two (33,9%) of them are government-owned. Available beds total 121,996, but these are distributed unevenly

³ Data from December, 1998.

across the country. The largest number of hospital beds is in the capital city of Jakarta, which has 161.2 beds per 100,000 population. By contrast, Lampung province can only provide 25.6 beds per 100,000.

In 1998, the estimated physician to population ratio was 1:6,875. In government hospitals, the ratio of medical specialists to population was 1: 27,000.

Figures from 1995 indicate that the proportion of the GDP spent on health was 1.8%, of which the public sector accounts for 0.6%.

In spite of the increasing use of insurance-based financial schemes in the health sector, the majority of Indonesians are still paying out-of-pocket for their health care. It is estimated that out-of-pocket payments constitute 70% of the total health care expenditures in Indonesia. Generally, the government provides financing for primary health care centers, government hospitals, and preventive and promotional health measures. However, due to lack of government funding, users of government services still have to pay often for part of the cost. In other words, the funds that the government provides may only subsidize the cost incurred in delivering the health services.

INTERNATIONAL TRADE WITHIN HEALTH SERVICES

In general, Indonesia has been a net importer of health-care services. This can be observed in the four different modes of international trade identified by the GATS Agreement:

- cross-border trade;
- consumption abroad;
- commercial presence, and

- temporary presence of natural persons as suppliers of services.

Cross-border trade

Trade across national borders in health-related services was taking place long before the World Trade Organization (WTO) Agreement took place. Indonesia has been a substantial importer of medical equipment, medical supplies, and pharmaceutical commodities to fill the needs of the huge Indonesian population. However, in spite of Indonesia's immense market potential, no local manufacturers of medical equipment or medical supplies have yet noticeably developed.

Pharmaceutical commodities are also heavily dependent on import-based drugs. Most pharmaceutical manufacturers in Indonesia import their basic ingredients from abroad.

Traditional medicines are both imported and exported. Indonesia imports traditional Chinese and other Eastern medicines from China, Taiwan, and Korea, while it exports Javanese traditional medicine, known as *jamu*, to neighbouring countries.

There has been an effort to adopt and implement the use of telemedicine. It is considered very important for the future of the country, taking into account the naturally widespread distribution of population in Indonesia with its 14,000 islands. Telemedicine would greatly reduce the need for experts, both local and from overseas, to travel to Indonesia's rural areas and islands. Several attempts have been made to provide foreign medical expert assistance to Indonesian medical personnel, but they were unsuccessful, mostly because of the extremely high costs incurred in the application of such technology. The monetary and economic crisis has played a leading

role in delaying the use of telemedicine.

Another technology, radio-based telemedicine, has also been developed. This method offers low-cost applicative technology in remote places where medical expert assistance is needed. Related pilot studies have been conducted in the eastern part of Indonesia. However, this method can only be applied to intercountry situations and therefore would not have any effect on foreign trade.

Consumption abroad

During the 1990s, the pattern among wealthy Indonesians has been to seek health care abroad. Although no specific data are available, it is commonly known that, when this segment of Indonesian society needs medical assistance, it is cared for at hospitals in Singapore and Australia. In most Singapore hospitals, the majority of nonlocal patients are Indonesian. Japan, Germany, and the United States are other places where they go to avail themselves of high-tech medical care. Although the economic crisis has reduced the number of people seeking health care abroad, the practice has continued.

As for patients from foreign countries seeking health care in Indonesia, the number has been minuscule and limited to alternative traditional medicine. There are several hospitals, such as the Dharmais Cancer Hospital, that actually have the potential resources to provide international standard care. However, present hospital operations and expertise do not meet the expected international standards.

Commercial Presence

The presence of foreign international firms has penetrated health and

hospital care in Indonesia and international pharmaceutical industries have established branch offices and factories in the country. Since the beginning of the 1990s, hospitals have also been built and operated by foreign investors, a topic that merits further elaboration and to which we will return later on in this paper.

Temporary presence of natural persons as suppliers of services

Due to the presumed lack of high quality services, many Indonesians and international firms in Indonesia make use of foreign human resources. The same phenomenon has also been observed in health and hospital care. Within hospitals, foreigners usually exercise two categories of skills as medical and allied health specialists and hospital managers.

Foreign medical and allied health specialists can be legally registered only as consultants and are not allowed to practice permanently in Indonesia. Medical experts also include nursing specialists who are needed to improve the capacity of local nursing, as this area has been a major weak point in Indonesian hospital services. Some hospitals in Indonesia also employ foreign managers to administer operations.

Indonesian physicians have not played much of a role in international health services. Lack of global competitiveness, such as foreign language proficiency, has been a major obstacle in their path.

On the other hand, Indonesian allied health professionals have performed remarkably abroad, especially the nurses. Many private firms arrange for Indonesian nurses to provide services in hospitals in the

Middle East. Their number is quite significant and the higher level of income they command working overseas continues to be a magnet.

Foreign investment regulation

Investment in Indonesia is regulated through the National Investment Coordinating Board (BKPM). This is an institution set up by the government to coordinate all necessary steps related to investment in all sectors, both domestic and overseas.

Indonesia has been a Member of the WTO since its inception in 1995. While Indonesia has made several commitments with regard to the Organization, no commitment has been made by the government in the health services area. Commitments to the WTO in 1999 were limited to telecommunication, architecture and engineering, construction, and travel-tourism.

A 1998 presidential decree stated that some business areas were to be denied to foreign investors. Within the health sector, foreigners are not allowed to invest in medical clinics, delivery clinics, specialty clinics, or dental clinics. This is interpreted as a prohibition against foreigners investing in small-size health care establishments. However, health care investments other than those listed, such as hospital investments, are available to foreigners. It is clear that although no GATS commitment has been made within the health sector, in reality part of the practice is already taking place in Indonesia.

Prior to the foreign endowment of any planned hospital, the investment proposal has to get a formal recommendation from the Ministry of Health. Proposed foreign investment hospitals should accommodate at least

200 beds. Foreign investors may build a whole new hospital or operate an existing local hospital jointly with a local investor.

Foreign personnel in hospitals are limited to consultant's roles and they do not give direct medical services. A recommendation from the Ministry of Health would be necessary for them to do so.

The National Investment Coordinating Board has the right to approve investment proposals. In the case of hospitals, the Ministry of Health will later issue a licence to the institution to operate in accordance with current Indonesian standards, which apply to all hospitals built in Indonesia.

FOREIGN PRESENCE IN INDONESIAN HOSPITALS

Foreign investment in Indonesian hospitals has not been uncommon during the 1990s. Table 1 lists the investments approved by Indonesian authorities through the National Investment Coordinating Board during the 1993-1999 period.

Major investors in hospital services come from Australia and Singapore. However, investors from Malaysia and Japan also have made their presence known or expressed their desire to invest in the Indonesian hospital sector. Another type of foreign presence is represented by a number of hospital managers. The management of a hospital can be given over to a foreign company to run its operation, according to some special financial arrangements.

Foreign investment is fairly common in major Indonesian cities like Jakarta, Surabaya, Java, and Bali. Jakarta has been the center of foreign-investment hospitals, as it is the center

Table 1. Foreign investments in Indonesian hospitals approved by the National Investment Coordinating Board during 1993-1999^a

Company	Location	Investment (US\$)	Type of service	Year
PT Nusautama Medical Indonesia	North Sumatra	28,000,000	Hospital services	1993
PT Gleneagles Hospital Corp.	Jakarta	40,593,000	Hospital services	1994
PT Health Care of Surabaya	East Java	17,965,000	Hospital services	1996
PT KPJ Medika	Jakarta	18,846,614	Hospital services	1996
PT Lima Jamrud Nusantara	West Nusa Tenggara	1,200,000	Health care for the elderly	1996
PT Medika Jayaperdana Internat	Bali	36,612,300	Hospital services	1996
PT Tritunggal Sentra Utama	East Java	2,500,000	Medical check-ups	1996
PT Regency Laguna Jasamedika	East Java	29,744,000	Hospital services	1997
PT Ciputra Ricovale	Jakarta	30,000,000	Hospital services	1998
PT Gesa Assistance	Jakarta	250,000	Emergency aid assistance	1998
PT Medika International	Jakarta	27,000,000	Hospital services	1999
PT Bando Bali	Bali	900,000	Health care for the elderly	1999

^aPlease note that these data represent only the investments approved. Some of these have not been actually implemented by the investors.

of economic activities in Indonesia. At least five hospitals are owned or managed by foreign firms and individuals within Jakarta, Indonesia's capital city. Surabaya and Medan have also attracted foreign investors as the cities have huge upper-class market potential. Bali and West Nusa Tenggara are also objects of interest to investors as those are the areas where tourism plays a great role in the economy.

Parkway Group Healthcare, a Singaporean based firm—with its Gleneagles Hospital chain—has hospitals in Jakarta (328 beds), Surabaya (148 beds), and Medan (243 beds hospital). Health Care of Australia, the leading hospital operator in Australia, has also made its presence felt in Indonesia with its Jakarta and Surabaya hospitals.

Concentration of foreign investment in hospitals in those large cities and tourism centers seems appro-

priate, since in those areas there is a need for more sophisticated, high quality, and luxurious services. Some perceive this as only a matter of supply and demand in health services. Where there is high demand for "upper class" and quality health and hospital care services, the hospital supply will try to fill the need. Foreign investors will be attracted to those areas, since local capital is not sufficient to meet the demand for services. Clearly, a proportion of Indonesia's population demands superior quality health services. This may be easily seen in the number of Indonesians seeking health care abroad. Although exact numbers are not available, it is well known that the figure is quite high. Hospitals in Singapore and Australia are the primary places for wealthy Indonesians to seek care but they also favor Japan and Germany, especially for the care of cardiac diseases and cancer.

Supporters of foreign investment policies argue that high technology and luxurious hospital services are necessary to catch up with these high-level market services. Instead of spending Indonesian money in overseas hospital services, it is better to utilize the money within Indonesia. By building high-tech hospitals in Indonesia, the use of more Indonesian resources is to be expected. For example, although a hospital might be foreign-owned, it would still use local nurses, doctors, logistics, management, and other resources.

These findings have made academic and government officials fear the so-called *cream-skimming* phenomenon. Critics say that private investors are only concerned with the profits they can generate. They would likely come from the upper to middle level income proportions of the community, which live mostly in big cities. This is the cream that they target their services to. The government and charity/religious hospitals would have to care for the other segments of the population, which are less wealthy and generally sicker.

The situation described creates a two-tier hospital system. The first system is the market-oriented hospital care system, which incorporates high-tech, high quality, and high-cost services. This system is mostly controlled by the private sector, both at home and overseas, and concentrated in areas where the wealthier population resides. It usually offers services for a spectrum of diseases that are mainly either degenerative or those that appear at the latter stages of epidemiological transition.

The second system is for the rest of the population that cannot afford high-cost services. This system delivers

basic services to the population. It offers simple, un-sophisticated service, which is highly subsidized and mostly underqualified.

HOSPITAL BUSINESS OPPORTUNITIES

Before the economic crisis struck, hospital investment was a promising venture. Indonesia's upper and mid-level income population was growing substantially. Quantitatively, it is estimated that the upper market of health care encompasses about 5% of large-city inhabitants. Considering the extent of the Indonesian economy, the potential for hospital investment is enormous. This is further supported by the demand for higher quality and high-tech medical care.

Two Indonesian hospitals have been listed in the stock exchange. The first hospital to open its shares to the public is a Singaporean-investment hospital. The other one was formerly an Indonesian private hospital and, after it was listed in the stock market, some of its shares were acquired by foreign holders.

During the economic crisis, business weakened. Some investors decided to stop or cancel investment decisions previously made or planned. Increased production costs and shrinkage of the market ability to pay reduced profits.

As of 1999, one foreign firm decided to stop its hospital-managing operations in Indonesia. However, the foremost reason for that decision seems to have been related to internal company factors in its original country rather than to the Indonesian investment atmosphere.

Interviews with several foreign hospital administrators suggest that they believe the market for upper to

mid-level hospital care in Indonesia is still promising. It is true that the recent economic and political crises have hampered its growth. Nevertheless, Indonesia's economic recovery and political stability are bringing the investment atmosphere back to normal.

The strength and availability of capital from foreign investors have been major factors interesting Indonesian parties in finding foreign partners. Foreign investors can see that, due to recent economic conditions, nominal profits from hospital investing are not gigantic. Even so, capital costs in Indonesia are relatively low due mainly to the low labour costs. Technology costs are roughly similar to those in other countries, as most of the medical equipment used in Indonesia is manufactured overseas. In sum, investing in Indonesia might mean relatively lower profits but the costs incurred would also be relatively lower, which balances things out realistically.

HUMAN RESOURCES

Foreign-investment hospitals sometimes employ foreign medical personnel and managers. As mentioned earlier, Indonesian investment regulations restrict foreign personnel to consultant roles and they have to be recommended by the Ministry of Health. From 1994 to 1999, the National Investment Coordinating Board formally granted 120 licenses to foreign personnel to work in Indonesia. Most of the grantees (85%) have been working for foreign-investment hospitals in Indonesia.

Despite common fears that foreign personnel can be a threat to the local health personnel supply in the market, experts are not worried about this. It is true that the presumed better

training and higher quality of service that foreign personnel provide would rival those of lower paid local workers. Still, it also opens up the possibility for local personnel to work overseas, so that the local health-care work force market would not be too affected by the foreign competition.

The issue might be explored further in terms of the lack of medical specialists. Presently, medical education can only produce a limited number of specialists for the market. The reason is, mainly, that the medical specialist education system is too restrained to grow. It is up to the national medical education system to take advantage of the opportunities that lie ahead by providing more high-quality medical specialists to the health care market.

As mentioned earlier, allied health personnel, especially nurses, can also play a big role in the overseas labor market. Improved nursing care skills and foreign language ability would strengthen their bargaining position in the global market. At present, the competition for nursing care providers comes from the Philippines, Thailand, and China.

QUALITY OF CARE

The quality of services is deemed to be most important in creating a higher demand for hospital services. The Ministry of Health of the Republic of Indonesia has set standards of care and all hospitals managed in Indonesia have to comply with the National Accreditation Committee requirements set up by the Ministry, regardless of their investment background.

In the light of that policy, foreign-investment hospitals tend to bring further quality to their services after having gained accreditation recog-

dition from the Ministry of Health. For example, several foreign hospitals have successfully won the International Standards Organization 9002 quality evaluation from an independent surveyor.

Some top private Indonesian hospitals have already made efforts to increase the quality of their services, but most of the other Indonesian hospitals are still struggling to improve. This makes the market segmentation in hospital care more obvious, as private foreign and top local hospitals provide high-quality services and leave the rest of the market to other hospitals. In general, the presence of foreign-owned and foreign-managed hospitals influences the overall drive to improve the quality of hospital services in Indonesia.

USE OF HIGH-TECH MEDICAL EQUIPMENT

Foreign-investment hospitals tend to use high-tech medical equipment to attract more profits. While this is normal, there are two issues here to look at. One is that most of the high-tech medical equipment is produced overseas. This means that investment is overly dependent on foreign currency stability. During the past few years, the rupiah has been unstable and this creates difficulties for financial strategies, as hospitals must also consider the market's ability to pay as well as competing providers. There is also the question of spare part requirements that become unavailable at times of economic instability.

The second issue is that private hospitals in general tend to employ high-tech medical equipment without doing comprehensive financial feasibility studies. This might later result in a low utilization rate of such

equipment. The issue of supply-induced demand then arises. Some hospitals try to ensure high use of high-tech medical equipment by offering financial incentives to physicians. While this is commonly seen as unethical, the practice is not unusual.

The government of Indonesia has been expecting some kind of technology transfer to come about in the hospital sector. Although Indonesian personnel has been operating the equipment, the transfer of technology has not happened yet. One reason for this is that Indonesian personnel has learned only how to use the equipment, and Indonesian engineers and industrialists have not put their minds to designing and making it.

EQUITY CONCERNS

Concerns on the equity of access to hospital services arise from the fact that the majority of Indonesian people do not have access to the highest-quality hospital services. The government's policy is to allot 10% of hospital beds to be used for third-class services. This policy rule covers all hospitals in Indonesia regardless of their ownership status. While this is an attempt to give less wealthy people the opportunity to have access to hospital services, it is limited to inpatient services only. The policy does not apply to other services such as the prescription of drugs. Actually, the utilization rates of these third-class inpatient services are low in most for-profit hospitals, due to sociological and moral factors that rise as barriers both intentionally and unintentionally.

Most experts agree that this policy is not effective in providing equal access to all. For-profit hospitals are not motivated to provide such services

since, by doing so, they stand to lose money. What knowledgeable advisors suggest is to set up a better national system for health-care delivery and better health-financing mechanisms.

The current system of health financing has not been successful in providing more equal access to health services for all. The government has been working on endorsing the development of JPKM, a managed health-care style of financial system. However, the development of this initiative has not extended much beyond the starting point.

Many believe that a better taxation system should be implemented regarding for-profit and foreign-owned hospitals. These establishments would be released from the obligation to provide third-class services and taxed instead, according to revenues or profits, with the money given to the hospitals that provide services to the poorer population groups.

However, another serious problem to consider is that high-quality services from foreign and other for-profit hospitals would only be available in the big cities and important economic centers. The majority of Indonesian people that live in rural areas and scattered islands would still be unable to access hospital services. It is then the duty of the government to provide them with services or to stimulate private sector participation in this endeavor.

POLICY RECOMMENDATIONS

From the Indonesian point of view, it would be advantageous to have more foreign-investment hospitals in Indonesia. For one thing, it would limit the drain of economic resources that

flow out of the country through consumption of health care abroad.

Many believe that foreign-investment hospitals and foreign experts should not be seen as a threat. Instead, they should be seen as an opportunity to enlarge the underdeveloped Indonesian health-care market. The Indonesian administration should further elaborate current investment policies regarding hospital investment in order to attract foreign capital while still ensuring some kind of cross subsidy to attain better equity.

The Government should develop measures to bring about more equitable access to hospital care. This could incorporate a comprehensive countrywide health financial and taxation system, which at present is not fully developed.

Indonesia has also the potential to balance the health-care trade deficit by promoting the supply of Indonesian human resources to the global market. Care must be taken to dismiss all doubt that such an attempt would not create a brain drain problem.

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