CHAPTER 5
ANALYSIS

5.1 Organization Assessment

There are five essentials and relevant questions needed to be answer for a not-for-profit organization (Peter Drucker, 2008): What is the mission? Who is the customer? What does the customer value? What are the result? What is the plan?

5.1.1 Vision and Mission Assessment

RSUD Koja's current understanding of their vission and mission is to comply with DKI Jakarta's mission for 2007-2012 -"Jakarta yang Nyaman dan Sejahtera untuk Semua". They are one of five public hospitals own by Local Government in DKI Jakarta that oblige to support government in implementing Good Governance organization, empowering community and serves the community. That is why their objective is to achieve excellent service in order to comply with Jakarta healthy vission. In the end, RSUD Koja must be remember as the one hospital that people refer to when they want to have assurance whenever they are sick and affordable in those health care services.

Before we discuss about their vission and mission, first we evaluate their challenges and opportunites. Most significant challenge face by RSUD Koja is due to goverment mandate to make them as public service organization (BLUD) where they have financial management dependency without have to rely on government subsidies. The implementation of this mandate cause a lot of changes that includes the entire process of work program activities because financing system of local government subsidies will be decrease gradually resulting in the need for a careful calculation of budget planning activities in the future. Other challenges they have to face due is increasing number of private hospitals who also have a social orientation in providing affordable services with better infrastructure and less birocracy in administration. However, RSUD Koja have an oppotunites that they need to take advantage of. They have government support to improve their health care technologies and better access in partnership or

collaborating with third parties as one way to increase their income and thus cross subsidizing service payments of poor patient without sacrificing their unit cost. RSUD Koja also need to pay attention of the emerging critical issues such as market share rising cost of health care and use of information technologies for hospitals. One of factors that determine a success of health care system is health management subsytem succes, where information technologies have an important role. Information technologies act as a backbone due to its function to gather, send, process, analyse, publicise and give feedbacks of informations to all stakeholders. Accurate, reachable information and data availability in a timely matter are becoming the absolute requirements for evidence-based desicion making in order to achive their objective.

Vission : RSUD Koja Dambaan Seluruh Masyarakat (Yearning the whole community)

Mission : Provide wholehearted, professional and affordable service

Table 5.1 Mission Assessment Checklist

Indicators	Vission	Mision
Short and Sharply focused	X	√
Say why the organization do what they do and not by the means by which they do it	X	**X**
Broad, even eternal	√	X
Directs personnel to do the right things now and into the future	X	√
Clear and must inspire	X	√

Source data as processed by researcher from RSUD Koja

Looking through their external and internal challenges or opportunities and issues, vission and mission of RSUD Koja need to be redefined because although its mission already reflects their commitment, it has not reflects their opportunities and competence. In particular, their vission is unclear, does not sharply focused, too broad and not at all inspire anyone to live it. Their mission is

better because it is direct and can make even a staff person say “this is something I wanto to be remembered for”. To rewrite their vission and mission statement, there are few things we need to consider:

- It can not be impersonal and has to have a deep meaning
- Make sure everybody knows the vission and mission, understand it and lives it.

RSUD Koja can create a vission that can embodies why they exist and what is their commitment to their communities. Vission such as “RSUD Koja strives to be the premier regional health care provider with professional and affordable services to residents of its service area within North of Jakarta” is more powerfull because with these statements in mind, management, medical staff and employees of RSUD Koja will maintain a unified effort in providing high quality patient focused services to their community. Through this vission we can relate more to their mission of “Provide wholehearted, professional and affordable service” in addition with hospital values and strategic goals such as the following:

- People: Be the employer of choice in the region.
- Service: Provide the highest value health and wellness services and continue to enhance our community stewardship.
- Responsibility : We accept personal accountability for the work we do.
- Quality: Assure safe, efficient, and effective health care services.
- Innovation: Committed to a supportive environment that encourages new ideas and creativity.

Hospital does not take care of health; they takes care of illness. We have to know what really went on. Translating the mission into action meant that everybody who came in was seen by a qualified person in a less than a minute. The hospitals isn’t going to sell shoes, and its not going into education on a big scale. Its going to take care of the sick. But the spesific aim may change. Things that are of primary importance now may become secondary or totally irrelevant very soon. With all the limited resources they have, where can they dig in and make a difference? Where can they set a new standard of performance? What really inspires their commitment? These new vission and mission statement can answer

those questions. It provides the glue that holds an organizatiom together as it expands, decentralizes globalizes and attains diversity.

5.1.2 Customer Assessment: Target and Value

Their primary customer whose lives are changed thtough the organization's works are:

Table 5.2 Target Primary Customer and Value

Type of Customer	Value Provided by Hospital	Value Perceived by Customer
General Patient	Low cost service rate, good hospital or clinic environment, integrated care	Low cost service rate, Lacking customer service
Patient from Third parties insurance companies	Financial assureness when having treatments in hospital, patient communication, integrated care, good hospital or clinic environment	Heavy birocracy in administration, integrated care
Patient from Companies who has an agreement with RSUD Koja	Quick response of treatment, patient communication, integrated care, hospital or clinic environment	Heavy birocracy in administration, Lacking of customer service

Source data as processed by researcher from RSUD Koja

While their supporting customer both inside and outside the organization must be satisfied are:

Table 5.3 Target Supporting Customer and Value

Type of Customer	Value Provided by Hospital	Value Expected by Customer
Medical health care specialist, paramedics, Surgeons, Nurses and sAdmin Staff	Welfare programs (rewards, remuneration), Learning and Training Programs	Welfare programs (rewards, remuneration), Learning and Training Programs
Government (Pemda DKI)	Improve their community health condition	Health Investment
Pharmaceutical companies	Long term commitment,	Access to Hospital Specialist
Other hospital surrounding RSUD Koja	Act as a reference hospital	Rivalry
Third Parties Companies	Quality of hospital programs	Quality of hospital programs

Source data as processed by researcher from RSUD Koja

Now if we look from a patient point of view, the challenge is the way RSUD Koja was perceived by its community. The perception is because they are govenment hospital, administration must be full of birocracy; long waits for patient to have experience for having a treatment, especially in emergency room and policlinics; or it was a “dirty hospital”; there is no customer care available for patient to get information or to submit a complaint. These kind of issues demanded immediate action and because they had existed for so long, they were excepted as normal condition for management nd medical staff. From the description above, RSUD Koja has not yet identified in a clear manner what are the values for their primary customer and supporting customer. What satisfied their needs, wants and aspirations? And finally when they have identified those values, RSUD Koja must be integrate it into their organization plan.

5.1.3 Result Assessment

5.1.3.1 Service Performance Analysis

RSUD Koja is located at North of Jakarta precisely in off shore Tanjung Priok. Geologically, the mainland surrounding the hospital is lower because it is surrounded by rivers and sewage that flows into the sea edge. Without good sanitation arrangement and amount of sewage in the river, this could lead flood during rainy season. Based on the data by North Jakarta's Statistic Center (BPS), the number of people in North of Jakarta for year 2006 is 1,180,967 people where 51.21% of them is male and 48.79% is female.

Koja district in general is dominated by workers, small traders and fishermen. It is related with their education level which mostly just high school or junior high school graduates. Only few of them are university graduates and it is insignificant compared to total population residing. Other than that, the existence of the population outside the region also affect conditions around the hospital which are usually a seasonal resident card holders of their respective regions. They work together with the local resident as workers, labours or fishermans. In general, as it is seen from the large number of Tanjung Priok low-income residents, they are classified as "poor families".

Factors related to public health is very influential in determining the service at RSUD Koja, especially if associated with the purchasing power of society towards the cost of medicines and action treatment taken by the hospital. Based on data from Dinas Kesehatan DKI Jakarta, in July 2008 there are 39,686 poor people in north Jakarta and 53,182 families has received direct income support (bantuan langsung tunai). These factors themselves will be affecting the types of service offered, nature of positioning and market segmentation strategies, and pricing strategis in RSUD Koja. We will see how much of these factors affect performances of 3 major units: Outpatient Unit, Inpatient Unit and Emergency Unit.

5.1.3.2 Service Performance for RSUD Koja

Income for a not-for-profit government hospital like RSUD Koja is consist of income from government subsidies and income from public service enterprise

(BLUD = Badan Layanan Umum Daerah). Government subsidies is based on the budget formulation propose by hospital two years before the actual year, but it can be revised periodically. Income from public service enterprise (PSO) is total actual income from inpatient unit, outpatient unit, emergency unit and other incomes. Income from ambulance facilities, pharmacy unit and training and development are included in outpatient income.

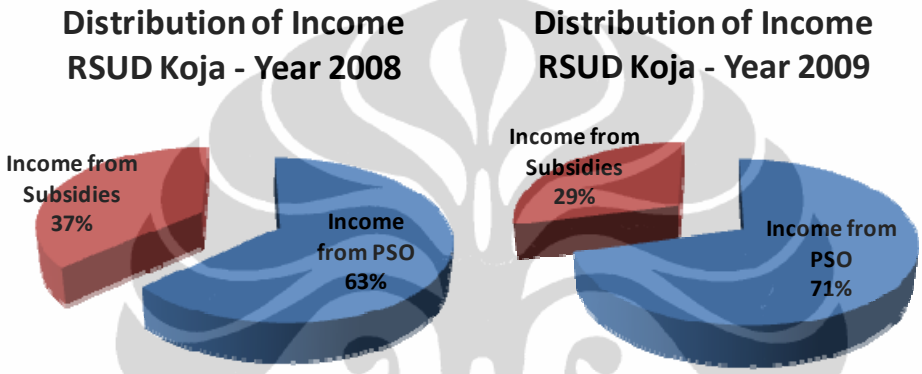


Figure 5.1 RSUD Koja Distribution of Income for 2008 and 2009

Source data as processed by researcher from RSUD Koja

Subsidies for RSUD Koja in 2009 was decreasing 8% from the previous year since PSO Income was increasing for 52%, quite a significant improvement. Since RSUD Koja is own by DKI Jakarta Government, the existing rate is set to increase hospital cost recovery because subsidies provided by government will be gradually reduce over the years as can be seen from the graph above. They do not have an obligation to generate profit for owner like other public hospital and thus service rate is set as low as possible to provide access to the poor people. In 2009, income from these service rates has prove successfull enough in increasing hospital income by 52% from 47 billion to 72.07 billion. However, does these service rate can generate income with profits in consideration that government subsidies will be gradually decrease and operational cost still exist? The answer can be evaluate by calculating cost recovery.

Table 5.4 RSUD Koja Key Financial Result for 2008 and 2009

Income	Y 2008	Y 2009
Income from PSO	47,355,232,867	72,069,036,187
Income from Subsidies	27,336,432,834	29,345,027,810
Total Income	**74,691,665,701**	**101,414,063,997**

Cost Expenditures	Y 2008	Y 2009
PSO Income		
Public operation cost	46,047,967,584	63,878,330,697
Total Cost from SPO	**46,047,967,584**	**63,878,330,697**
Government Subsidies		
Personnel Salaries	8,102,092,574	8,932,643,763
Bonus and Allowances	6,148,274,000	6,087,325,000
Daily Workers	502,480,000	186,475,000
operational cost	3,674,174,724	4,781,881,731
Capital	8,826,158,430	9,096,320,052
Total Cost from Subsidies	**27,253,179,728**	**29,084,645,546**
Total Cost	**73,301,147,312**	**92,962,976,243**

Profit / Loss	Y 2009	Y 2009
Profit from PSO	1,307,265,283	8,190,705,490
Subsidies to be given back to Government	83,253,106	260,382,264

Source data as processed by researcher from RSUD Koja

Nowadays, hospital financing shift from dependency to governments to self-relience. To achieve self-reliance is the local government's role as the "guarantor of last resort" to ensure that hospital is sufficient to meet the needs of current and potential users. Since rate is set to increase cost recovery, we will evaluate how far PSO income can cover operational cost for hospital. Beginning with identifying all the costs associated with an activity and matching these with all the available sources of funding. There are two types of cost expenditure: those that comes from government subsidies and those that comes from PSO income. Profit generates by PSO will be use to improve quality of service delivery and 60% is for employee's wealth in forms of remuneration for doctors, dentists, pharmacists, paramedics, management, non-medics staff, incentives, fixed costs, hospital savings and medic committe. Fixed cost here includes non-government officials salaries, rice allowance for non-government officials, Jamsostek for non-government officials, staff insurances, daily workers wage and external development. There is no dividen in a not-for-profit hospital like RSUD Koja,

however should there is a deviation from government subsidies, then hospital must return back the fund to government.

Classifies as expenditures paid by government subsidies are salaries, operational cost and capital. Personnel salaries, allowances and bonus are subsidies by the government due to the fact that they are state officials. Operational cost consist of office supplies; maintenance and usage for operational car; and office service expenses (water, telephone, electricity, warehouse maintenance, garden expenses and others). Capital expenditure is not only for medical equipment procurement, but also office and facilites equipment such as computers, fire drill, kitchen wares, and waste installation construction. While Income from PSO are spent for pharmacy medicines; learning and development; usable medical tools or equipments; supporting activities to support services; and maitenance costs. Because procurement expenditures and personnel salaries was spent through government subsidies, those costs including depreciation cost does not put into consideration when RSUD Koja calculate rates of service, thus make them possible to set such a low rate in pricing strategy.

After identified those costs, we then calculate cost recovery for RSUD Koja. There are basically two types of cost recovery: full and partial. Full cost recovery simply mean that all costs directly and indirectly attributable to an activity are regained. Partial cost recovery would be anything that falls short of reclaiming all the costs of an activity.

Table 5.5 RSUD Koja Full Cost Recovery for 2008 and 2009

Category	2008	2009
Income from PSO	47,355,232,867	72,069,036,187
Total Expenditure	73,301,147,312	92,962,976,243
Cost Recovery	**64.60%**	**77.52%**

Source data as processed by researcher from RSUD Koja

Table 5.6 RSUD Koja Partial Cost Recovery for 2008 and 2009

Category	2008	2009
Income from Tariff	47,355,232,867	72,069,036,187
Total Expenditure	68,746,237,242	85,460,596,281
Cost Recovery	**68.88%**	**84.33%**

Source data as processed by researcher from RSUD Koja

With full cost recovery, 64.6% of total expenditure can be finance by income from PSO in 2008, the percentage is even bigger in 2009 with 77.52%. Because standard of a good cost recovery for hospital is more than 50%, then 80% result in 2009 can be define as excellent. If we put aside expenditures for medical equipment, because it is government's obligation to improving medical technologies for health care in Indonesia, the percentage is even bigger and even over 80%. Therefore we can conclude that their pricing strategy is sufficient enough to meet the needs of current and potential demand without having to rely much on government subsidies. The question now is how much of each unit in RSUD Koja can participate to generate value in the future?

5.1.3.3 Service Performance for Emergency Unit

ER is a unit that serves patients with emergency conditions for 24 hours every day. Various types of diseases addressed by doctors who are certified by ATLS / ACLs and nurses with BTLS / BCLS certificates. Confectionery process of patients coming to emergency room is based on the standardized operating procedures, through a triage process that separate them into three stages: mild, moderate, and heavy and all treatment undertaken in accordance with service standards available. However, due to limited space available, sort out process is only done for surgical and internal medication cases.

Looking through recent trend, patients in emergency room are not there for emergency cases only but as simple as if they want to check their physical health conditions. This is possible because service rate in RSUD Koja is cheaper than other hospital.

Table 5.7 RSUD Koja Service Rate for Emergency Unit

Patient	Registration	Consultancy	Cat 1	Cat 2	Cat 3	Cat 4
General	15,000	15,000	15,000	25,000	35,000	50,000
Third Party (askes)	16,500	16,500	16,500	27,500	38,500	55,000
Third Party (Company)	16,500	16,500	16,500	27,500	38,500	55,000

Patient	Cat 5	Cat 6	Cat 7	Cat 8	Cat 9	Cat 10
General	75,000	100,000	150,000	200,000	250,000	300,000
Third Party (askes)	82,500	110,000	165,000	220,000	275,000	330,000
Third Party (Company)	82,500	110,000	165,000	220,000	275,000	330,000

Source data as processed by researcher from RSUD Koja

RSUD Koja categorize their service rate into three categories: general patient; third party patient from Askes or Jamsostek; and third party patient from company that already has an agreement with the hospital. The price range from IDR 15,000 up until IDR 300,000 for general patient and IDR 16,500 until IDR 330,000 for third party patients. If we compare to other hospitals, RSUD Koja's rate is much more cheaper. For example for registration, in RSUD Koja, we just have to pay IDR 15,000 per visit while it can cost us IDR 20,000 – 35,000 in other hospitals. Another example is to put on a cateter or poly cateter is only IDR 35,000 for general patient and IDR 28,500 for third party patient, while in other hospital we must pay around IDR 50,000 – 90,000.

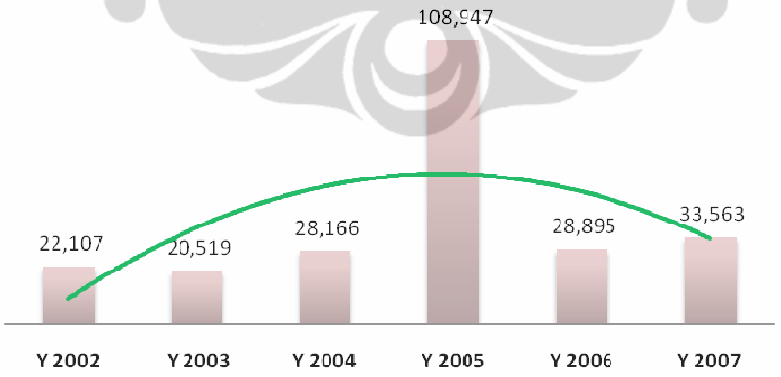


Figure 5.2 ER Patient in RSUD Koja

Source data as processed by researcher from RSUD Koja

Number of patient visiting the emergency unit is fluctuating over the past years. The biggest was in 2005 when ER visitor reach it peaks with 108,947 people, which was about 50% from the total number of patient visiting RSUD Koja. Then the number dropped to 21% in 2006 just to slowly inreasing in 2007 for 23% (33,563 patient from total of 147,679). Since 2002 until 2007, the percentage of people visiting the emergency unit is never below 10% from the total number of patient. Other than low rate of service, the reasons behind this is because most of them, especially poor people, refuse to be referred to other hospitals due to full capacity for treatment room. That was why these patients stayed in the emergency room, which in actual such circumstances is not allowed, because it would interfere with overall implementation of emergency room unit functions.

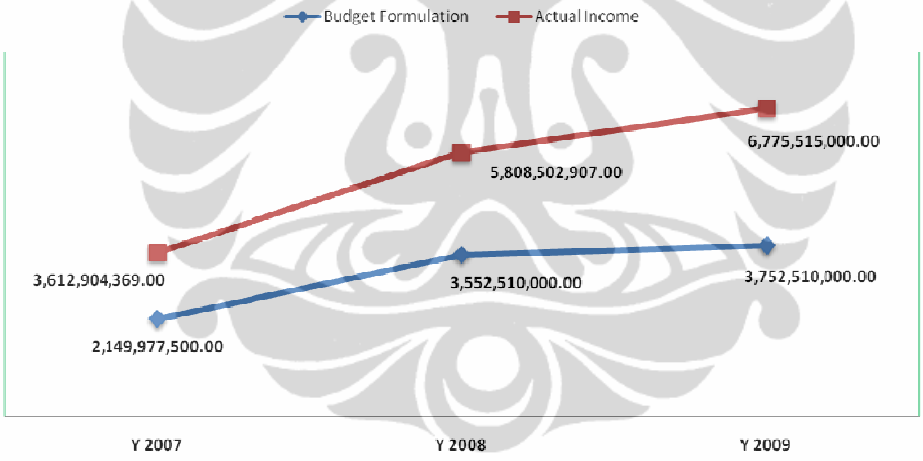


Figure 5.3 RSUD Koja Budget Vs Actual Income for ER

Source data as processed by researcher from RSUD Koja

For the last three years, RSUD Koja has experiencing increment of the Emergency Unit's income for 88% from 3.6 billion in 2007 to 6.7 billio in 2009. Unfortunately, researcher could not define the distribution of this income coming from which type of patient due to limitation of data. If we know how many percent it comes from general patient, or in this case most of the poor people, and how many percent it comes from third parties patient or from those who

participated in Jamsostek, Astek and Insurance, then we can evaluate further whether pricing strategy in the hospital is working. However just to get a general basic of how the strategy works, researcher will try to make a simulation with several assumption. First, based on the historical data from outpatient unit in 2006 and 2007, the percentage of patient coming from third parties were around 23%-24%. Then from total number of patient visited emergency unit in 2007 (33,563 number of patient), researcher try to distribute it to each service rate categories based on the assumption that most of patient is having just a light and moderate treatment. If we generate a simulation from those assumptions, we found that around 32% from Emergency Unit Room income are coming from the third party patient while 68% is coming from general patient.

Table 5.8 Simulation of Income Distribution for ER

Facilities	Rate for General Patient	Rate for Third Party (Company)	Number of General Patient	Income from General Patient	Number of Third Party Patient	Income from Third Party Patient
Registration	5,000	22,500	25,508	127,539,400.00	8,055	181,240,200.00
Consultancy	10,000	22,500	25,508	255,078,800.00	8,055	181,240,200.00
Cat 1	15,000	22,500	11,843	177,644,164.29	3,740	84,147,235.71
Cat 2	30,000	16,500	4,859	145,759,314.29	1,534	25,316,091.43
Cat 3	45,000	33,000	2,915	131,183,382.86	921	30,379,309.71
Cat 4	60,000	49,500	2,429	145,759,314.29	767	37,974,137.14
Cat 5	80,000	66,000	2,082	166,582,073.47	658	43,399,013.88
Cat 6	110,000	88,000	1,041	114,525,175.51	329	28,932,675.92
Cat 7	150,000	121,000	338	50,755,475.51	107	12,929,289.55
			TOTAL INCOME	1,314,827,100.20		625,558,153.35
			Total Income from All Patient	1,940,385,253.55		
			% of Income	68%		32%

Source data as processed by researcher from RSUD Koja

If this simulation is at least near with actual implementation in RSUD Koja, then it is safe to say that service rate in emergency unit has indeed successful in cross subsidizing the treatment between the rich and the poor. Whether that strategy works without sacrifying their unit cost still need further in-depth research. In addition, emergency unit in RSUD Koja can become priority considering these factors below:

- Highway in front of RSUD Koja is very dense, consisting of container vehicles, trucks, public transport, private cars and other transportation vehicles. Not to mention its very strategic access to suburbans area like Bekasi, Bogor, Tangerang and the toll lane in the city. Cases of traffic accidents often occur either during working hours or outside working hours.
- Surrounding the hospitals are several warehouse complex and textile manufacturing industry, it is a high possibility that there will be accident cases. More cooperation and agreement with those companies would be neccessary in the future to increase the percentage of patient from third parties that eventually can cross subsidized the income from the general patient. If the percentage is increasing, the rate for general patient then can be re-evaluate to more accomodize the purchasing power of the poor people. Also, if the income from services in increasing, subsidize from government can be slowly reduce or transfer to another investment such as improvements in health equipments technologies or man power quality.

5.1.3.4 Service Performance for Inpatient Unit

To evaluate service performance for inpatient unit, we can see from Bed Occupancy Rate (BOR) or Length of Stay (LOS) and to support it, we can also use Turn of Interval (TOI). BOR show actual utilization of an inpatient health facility in a year, while LOS is commonly used to measure duration of single episode of hospitalization. Inpatient days are calculated by subtracting day of admission from day of discharge. However, persons entering and leaving a hospital on the same day have a length of stay of one.

Since 2002, occupancy rate for VIP class was around 35% and slowly increasing just to reach 64% in 2007, which is consider quite good. However they still need several improvement to be able to reach 70%, which is equilibirum rate of an excellent service quality. LOS for VIP room is also getting better since 2002 with 5.56 days to increase until 7.01 days and eventually decrease to 4.31 days, which means that on average, a person in VIP room stays for 4 days in the hospital. Moreover, since TOI is also decreasing from 5.23 days in 2004 to 2.45

days in 2007, hospital have utilize bed capacity well enough for VIP rooms since it just need 2 to 3 days in average for them to wait for another patient and one patient will stay for 4 to 5 days for treatments. By reducing number of days spent in hospital, and save bed days thus increasing capacity and saving money. In conclusion, we can say that RSUD Koja has becoming better at treating people in VIP and increasing their service quality as well as service efficiency because their utilization level is quite high.

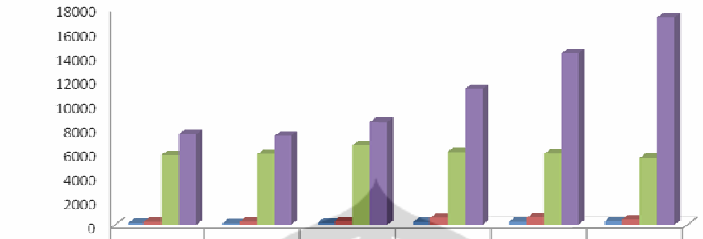
Table 5.9 RSUD Koja Inpatient Unit Key Indicator

	VIP	1st Class	2nd Class	3rd Class
Incoming Patient Treated	276	438	5,542	17,247
Patient Alive	265	420	4,863	16,875
Patient Passed Away	5	15	148	288
Passed Away < 48 Hours	2	12	140	174
Passed Away > 48 Hours	3	3	-	136
Time Period for Inpatient	1,241	2,374	23,465	71,679
Days of Inpatient	1,209	2,187	21,117	68,014
ALOS (day)	4	5	5	4
TOI (day)	2	3	4	0
BTO (day)	54	44	44	93
BOR (%)	64	60	51	101
NDR (%)	11	7	12	8
GDR (%)	19	34	30	17
Average of Bed Occupancy	3	6	58	186
Days per month	365	365	365	365
Number of Bed	5	10	114	185

Source data as processed by researcher from RSUD Koja

Different condition applied for first and second class room where BOR is actually decreasing but LOS is quite stable with improvement in TOI. For first class, BOR has reached 73% in 2006 just to decrease again in 2007 with 60%, while for second class is even worst since the highest BOR was 61% in 2005 and slowly decreasing to 50.75% in 2007. This decreasing number of BOR for first and second class can be easily caused by decrease in number of patients for about 15% from previous year. However the facts that the number of bed is also increasing must be really put into consideration because even though the LOS is

quite good (around 5 for first class and around 4 for second class), and RSUD Koja has not been able to optimize their utilization of those facilities yet.



	Y 2002	Y 2003	Y 2004	Y 2005	Y 2006	Y 2007
VIP Room	149	121	154	223	246	276
First Class	242	262	327	563	589	438
Second Class	5,794	5,883	6,603	6,063	5,907	5,542
Third Class	7,541	7,415	8,544	11,321	14,270	17,247

Figure 5.4 Number of Patient in Inpatient Unit Based on Class

Source data as processed by researcher from RSUD Koja

A lot of improvement must be done for this two classes because if we take a look at Gross Death Rate (GDR), there is a significant increase. GDR in 2007 for first class was 34.48%, while in 2006 was only 5%. Similar case applied for second class where it was increasing to 29.54% in 2007 from just 11% in 2006. This high number of patient who died less than 48 hours since they were first coming to the hospital is one of main indicator of service treatment delivered to them and can result a decrease of patient number for this two class, which means reduce hospital income. If the trend keep on continuing with the same pattern, maybe reducing bed capacity for these clasess could be one option for alternative.

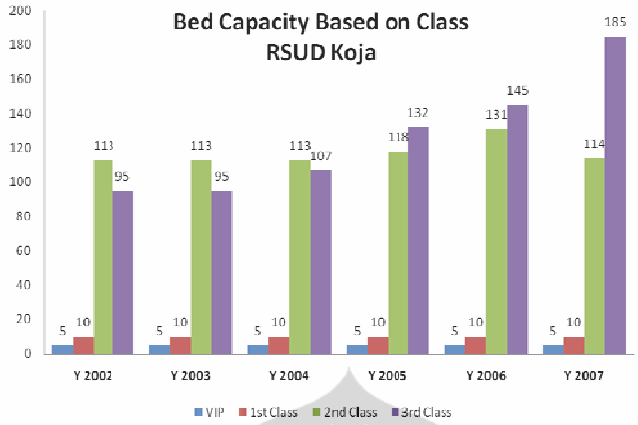


Figure 5.5 Bed Capacity Based on Class in RSUD Koja

Source data as processed by researcher from RSUD Koja

Entirely different scenario can be found for third class rooms where BOR's percentage increase from 84.62% in 2002 to 100.72% in 2007 and TOI in 2007 is just 0.03 even minus in 2006, which means it only need 0.03 day for the hospital to get a new patient. These are not a good indicator of an excellent service. Instead, on the contrary it is safe to say that utilization level for third class room is not optimal along with low service quality and efficiency, even though LOS was quite good and stable (average on 4 days). BOR should be kept below 85% to help keep a grip on hospital infections and it was important to keep a grip on bed occupancy. One of the reason why BOR for third class has reached 100% is that since 2006 RSUD Koja has been experiencing exceptional events (KLB) for Dengue Fever and Diarrhea due to great flood where number of patient for this unit reached 1000 people, way above the previous years. Another reason was that number of patient using SKTM and Gakin who used third class facilites increase significantly and outnumber bed capacity available in the hospital. When hospitals have high occupancy rates and short stays, provision of care has to be investigated in detail to see whether admissions can be reduced by promoting other types of care (for example, day care, home supervision). Increasing the number of beds should always be the last resort after every other option has been ruled out. Purchasing mechanisms can be used to promote alternative treatments to reduce inpatient care. Budget funding, in contrast, might promote adding capacity.

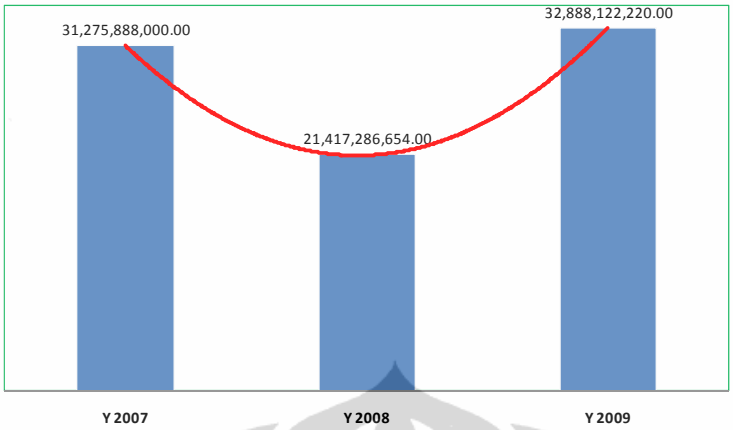


Figure 5.6 RSUD Koja Income for Inpatient for 2007 - 2009

Source data as processed by researcher from RSUD Koja

For this past three years, RSUD Koja has a fluctuated income from 31.2 million in 2007 and dropped down by 31.52% in 2006 and increase by 53.56% (32 billion) in 2009. There are several factors that may be cause of these trends:

- Decreasing number of patient
- Rate for rooms and treatments are to low

Put into consideration that in 2007 there was an exceptional events such as Dengue Fever and diarrhea epidemics where number of patient was quite extraordinary. We could argue that the income for the next years is surely will be decreased. However the fact that it begin to increase for more than 50% in the next year shows that the trend is coming back to its pattern.

The price for rooms and treatments in RSUD Koja are indeed lower than other public hospitals. For VIP rooms, rate per night is only IDR 300,000 for general patient and IDR 330,000 for third party patients. While in most hospitals at North of Jakarta, minimum rate for VIP is 425,000 at Sukamulya Hospital. For third class, rate is only IDR 20,000 and IDR 22,000, when other hospital can charge it for at least IDR 65,000 per night.

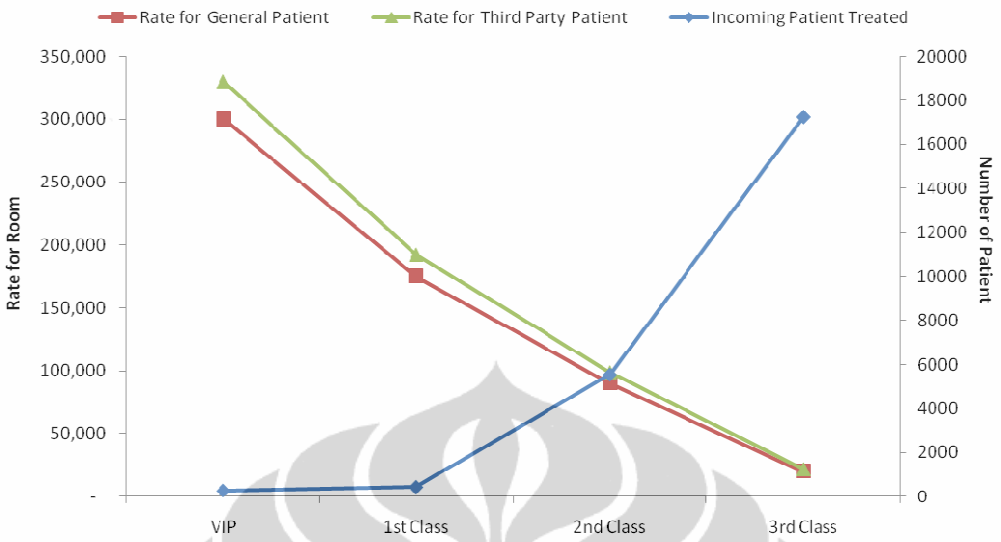


Figure 5.7 Inpatient Room Rate Vs Number of Patient in 2007

Source data as processed by researcher from RSUD Koja

Table 5.10 Hospital Rate for Hospital in North of Jakarta

NAME	SP.VIP	VIP	MAIN	I	II	III
RS. Atmajaya	---	570	---	350	190 S/D 250	65s/d95
RS. Gading Pluit	940	690	---	550	245	85
RS. Islam Jakarta Utara	---	---	---	250	145	75
RS. Mitra Keluarga Kelapa Gading	1600	1150	---	510	295	120
RS. Pluit	1100	780	---	375	280	100
RS. Royal Progress (d/h. RS Medika Gria)	980	800	---	420	267	98
RS. Satya Negara	700 s/d 850	550	400	275	165	75
RS. Sukmul	---	425	300	210	150	---
RSIA. Hermina Podomoro	---	775	675	400	250	100

Source data as processed by researcher from RSUD Koja

If we compare their rate with public hospitals own by private who charge their VIP rooms for more than IDR 450,000 per night and at least IDR 150,000 for their second class room is another thing. Currently treatments rate for VIP are ranging from IDR 39,000 until IDR 1,943,000. Only Orthodonti treatments rates that can be consider quite expensive since they charge it from 4,8 Million to 7,7 million due to high cost to maintain the technology and the specialist. Since RSUD Koja main target customer is people surrounding hospital area, we could

not increase rate for second and third class rooms too much. Besides government has made a regulation about pricing rate for those classes to ensure that poor people still have purchasing power. But hospital still have a room to evaluate their VIP rooms rate alongside with several treatments rate, in exception for Orthodonty treatments.

To evaluate this, RSUD Koja need to answer whether or not to increase VIP rooms can lead to another increase in income? And does the rate for VIP can also increase hospital income? Since 2002 there are only 5 VIP rooms and see how good are indicators for VIP unit, the time has come for RSUD Koja to improve this particular unit because through the income receive from this unit, the hospital could cross subsidize the rate to other class or treatments without sacrifice their unit cost. With improvement in BOR, LOS and TOI, growth for VIP unit can be implemented. By looking through 2007 financial performance for inpatient unit, total income was 31 Billion rupiah and only 0.68% (212 Million rupiah) that came from VIP section. Only 6.34% of the inpatient income came from rooms rate income and more than half (58.38%) was coming from pathology clinic treatments. By comparing these facts with indicators above, RSUD Koja has not yet fully utilize their VIP rate sections.

5.1.3.5 Service Performance for Outpatient Unit

To analyze gross hospital outpatient services data will not reveal diversity of services within a hospital. It is difficult to collect data to show how much of hospital outpatient care should have been provided. Fee-for-service policy has favored the extension of outpatient services to meet popular demand. Outpatient services are a significant source of income for hospitals. Moreover, outpatient services generate a good bit of inpatient and diagnostic business. Hospital outpatient care can be efficient, if right-sized and highly qualified staff resources are not squandered on scraped knees. Hospitals play a major role in providing outpatient care to address health care priorities. This role might expand, if economic barrier posed by pricing policy is significantly diminished. Special attention should therefore be paid to gatekeeping mechanisms to avoid misuse of specialized care.

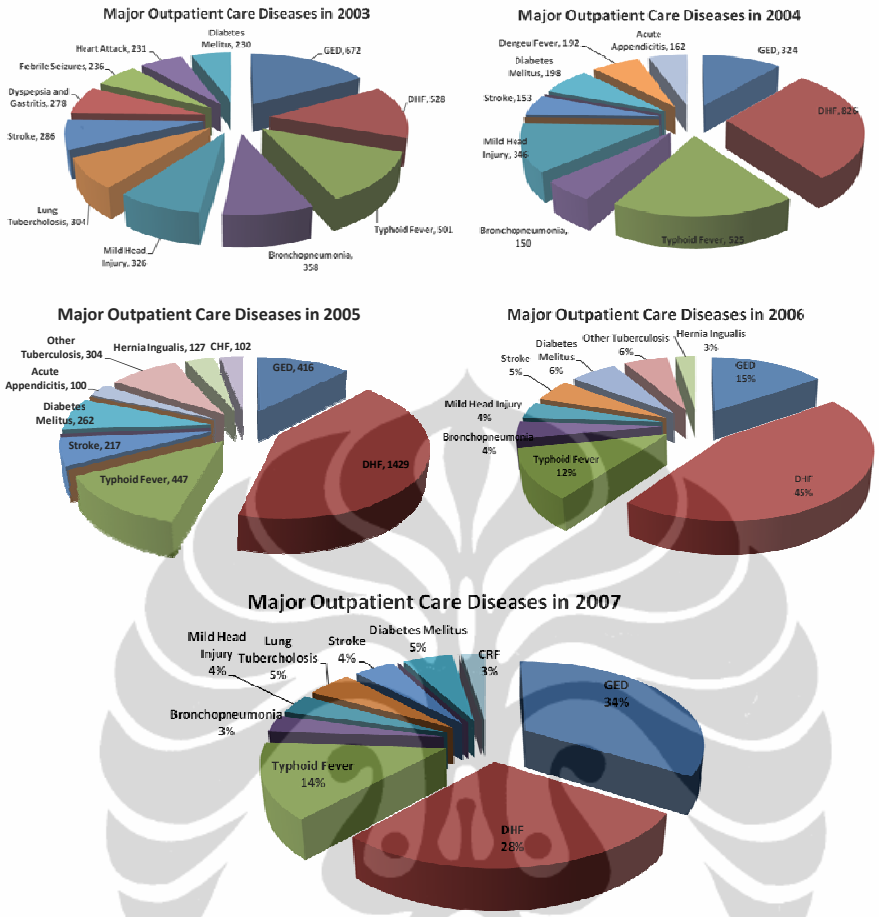


Figure 5.8 Major Outpatient Care Diseases in 2003 - 2007

Source data as processed by researcher from RSUD Koja

Based on datas from 2003-2007, there is a very high increment of 184.5% for GED diagnosis since there was an outbreak in 2007. While the other top four diseases (DHF, typhoid fever, stroke and diabetes melitus) was also increase between 34% to 56.95%. As we can see, communicable diseases such as dengue fever and typhoid fever are always among the first reasons reported for attending outpatient care and is also significant for inpatient services. GED stroke and CRF treatment is the upcoming challenges. Since health equipment is a factor that helps doctors diagnose diseases in patients enforcement and since through the graphs above, number of patients who suffered a stroke and CRF increases, utilization of medical equipment (EEG, TCD, CT Scan and hemodialysis) will also be increasingly larger. Hospitals have to play a major role in launching and

monitoring those treatment, which will take a huge part of their resources. Financing will largely determine what hospitals can do about this new challenge.

Based on the outpatient elektromedical diagnostic data in 2006 and 2007, there was increment in utilization of medical equipments such as EKG, hemodialisa, USG and audiometrist. Whereas ESWL decreased quite drastically to 57%. Seeing the decreasing utilization of electronic diagnostic equipment that was not fully operated like endoscopy, RSUD Koja should put into their considerations to have an efficiency and cost reduction for those equipment. Therefore, to increase their income, RSUD Koja can conduct a joint cooperation with other hospitals near them who do not have ESWL and re-operate endoscopy equipments.

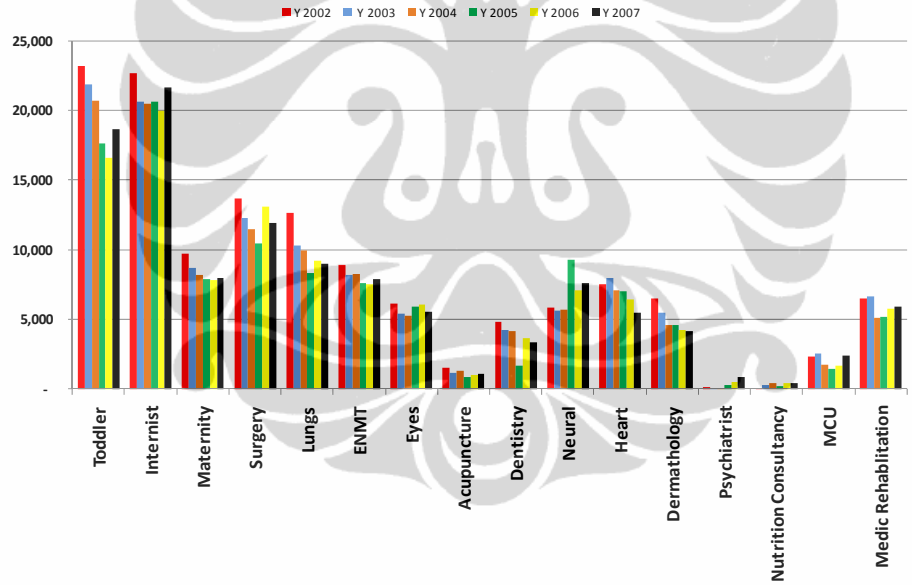


Figure 5.9 Number of Patient for Outpatient Unit in 2002 - 2007

Source data as processed by researcher from RSUD Koja

From the graph, we can see that there was increment on number of patient for about 2.17% up until 72.18% in 2005 to 2007 for several policlinics like Toddler, Internist, Maternity, ENMT, Accupuncture, and Medical Rehabilitation. However a whooping jump can be found in Phyciatrics and MCU unit who have respectively 72.18% and 41.66% increase in 2007 from previous year. The reason

behind these increment was due to admission of state officials and promotion of daily workers to permanent employee in RSUD Koja who needs HIV counselling. On the contrary policlinics such as Surgery, Lungs, Eyes, Dentistry and Dhermatologist was having a decreasing trend with the biggest decrease in Heart policlinics for 14.76%. Referring to those condition, RSUD Koja should improve their MCU and phyciatrict section seeing that RSUD Koja has becoming better at their clinic services and has the advantage to become a reference hospital for medical check up for state officials admission, those who are applying for a job and those who would like to continue their education.

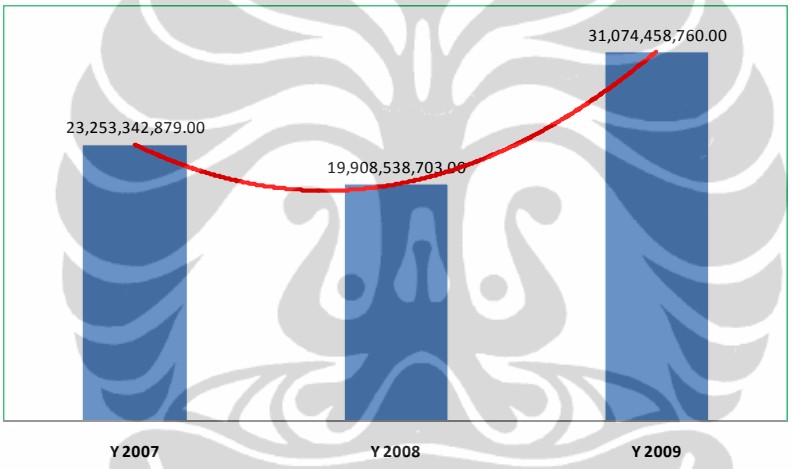


Figure 5.10 RSUD Koja Income for Outpatient in 2007 - 2009

Source data as processed by researcher from RSUD Koja

For this past three years, Outpatient unit in RSUD Koja has a fluctuated income from 23.2 billion in 2007 and dropped down by 14.38% in 2006 increase again by 56.09% (31.07 billion) in 2009. There are no sufficient data that can show distribution of this income. However, as can be seen from the table below, in 2007, 43.91% of its income was coming from service treatments, 18% from morning policlinic and 16.25% from surgery.

Table 5.11 Distribution of Income for Outpatient Unit in 2007

Service Type	Total Income
Morning Policlinic	4,222,393,967
Treatment	10,209,519,363
Daily Isolation Treatment	43,500,024
Daily Neonutus Treatment	27,247,923
Daily Blue Light Treatment	19,693,033
Clinic Pathology	1,720,848,362
Anatomy Pathalogy	67,031,873
Diagnostic Radio Examination	222,386,713
Electromedic Examination	341,215,383
Maternity Room/Outpatient / Mild Inpatient Treatment	763,696,262
Operation Room Usage	2,990,107,601
Third Class Maternity Room Usage	540,779,626
Dental and Mouth Treatment	377,995,355
Medical Rehabilitation	27,150,810
Corpse Treatment	45,224,923
Outpatient Surgery/ODC	788,956,276
Health Service Usage	142,424,318
Ambulance	133,061,067
Training and Development	570,110,000

Source data as processed by researcher from RSUD Koja

Since there are limitation of data available, we will again create an assumption to compare number of patient with service rate offered by each policlinic to confirm whether or not the bigger the patient, the bigger also the income it generates. There are several consideration when generating a simulation for this:

- Data for patient number are taken from 2006 and 2007 data
- Admission rate will be put into account in calculating total income since we must pay for this cost whenever we are going for a treatment in hospitals.
- The service rate used is average service rate in 2009 from a ranging rate in respective policlinics.

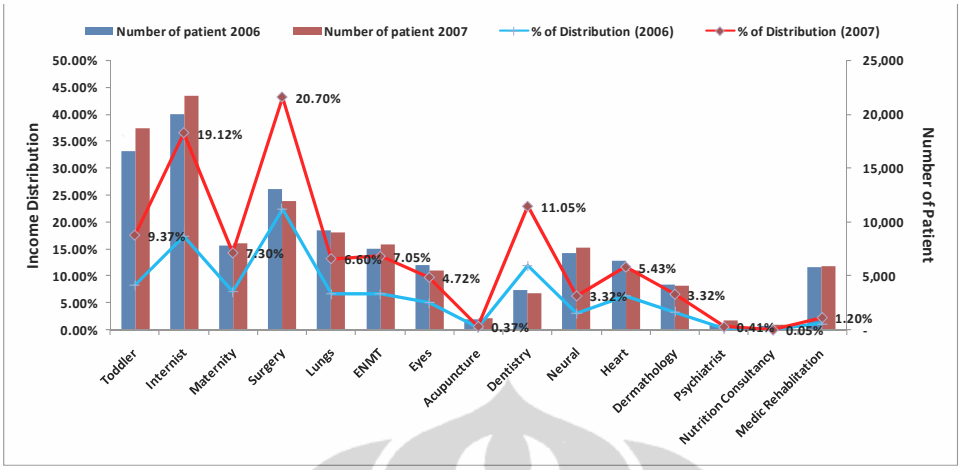


Figure 5.11 Simulation for Policlinic Income Distribution Vs Number of Patient

Source data as processed by researcher from RSUD Koja

The results shows that both in 2006 and 2007, 20% of income are coming from surgery service then followed by internist (17% and 19% respectively) and dentistry (both are 11%). While if we compare with number of patient visiting, surgery is only on rank three of the most visited policlinics in RSUD Koja for those years. Surgery here is only minor to moderate surgery, or usually known as minor operation, in which inpatient treatment does not neccesarily needed. The price range for this policlinic is starting from IDR 30,000 for just a simple GV, small aspiration or less than five stiches removal and IDR 250,000 to IDR 500,000 for Varises Injection, Nectrectomi, Gipsing, local circumsission and Large Tumor Extirpation. Even with just a moderate number of patient, this section can generate almost one third of income for hospital. RSUD Koja should be looking through this particular section carefully. Improvement in service quality, medical equipments technologies, expertise man power, and efficiency must become their priority. It is important because we can see that there is a reduction in number of people visiting this sub unit. If we look further, the reduction is cause by lack of new patient coming and slowly decreasing pattern for old patient to re-visit the hospital. This pattern is not applied just for surgery unit, but also for almost all policlinics for about 1.5% to 30.4%. There are several new public hospitals owned by private for these past years such as Suka Mulya

Hospital, Pelabuhan Hospital, Islam Hospital and Port Medical Center, and even new puskesmas which have improve their service delivery could be the reason why these pattern of decreasing patient, both new and old, occured. Those private hospitals may be offered a better service even though the price may be much more expensive than price at RSUD Koja. But it is sure that Puskesmas have a competitive price with the hospital. The question is now, whether the hospital will keep their strategy in service rate while slowly improving their service delivery in consequence that they have to rely too much on the government subsidy or they will implement a sound pricing strategy that is competitive with consideration of unit cost from each respective unit, so that the subsidy from government can gradually decrease. New innovation and grand breaking strategy must be develop in order to achieve an independent competitive hospital in DKI Jakarta.

5.2 Developing Grand Strategy for RSUD Koja

Based on data analysis result we can develop a competitive strategy by identify internal and external analysis.

5.2.1 Internal – External Analysis

We will be adapting balance score card perspective for determining key opportunities, threats, strength and weaknesses for generating EFE and IFE Matrix. Researcher will use indicators for financial, customer, business process and learning and development which has been idetify by RSUD Koja in 2007 with adjustment on several factors related to the finding.

5.2.1.1 External Analysis for Emergency Unit

The result for key opportunites and threats based on balance scorecard indicator are :

Table 5.12 Key Indicators for Opportunites and Threats for Emergency Unit

EFE - Opportunities			
Factors	Rating	Weight	Weighted Score
Increasing trend of Income	4	0.13	0.52
Old patient loyalty	3	0.10	0.30
Role as reference hospital is increasing	3	0.10	0.30
Increasing cooperation with education Institution	3	0.13	0.39
Total Score			1.51

EFE - Threats			
Factors	Rating	Weight	Weighted Score
Uppredictable APBD support	2	0.06	0.12
Regulations tariff policy is still below the unit cost	1	0.13	0.13
Increasing customer demand	2	0.13	0.26
Number of poor patient is increasing	1	0.10	0.10
KLB happened every year	1	0.13	0.13
Total Score			0.74

Total EFE	2.25

Source data as processed by researcher from RSUD Koja

Total weighted score for emergency unit is 2.25 indicates that RSUD Koja is responding in an adequate way to existing opportunites and threats in its industry.

5.2.1.2 External Analysis for Inpatient Unit

The result for key opportunites and threats based on balance scorecard indicator are :

Table 5.13 Key Indicators for Opportunites and Threats for Inpatient Unit

EFE - Opportunities			
Factors	Rating	Weight	Weighted Score
Increasing number of cooperation with education institution	1	0.13	0.13
Act as reference hospital	4	0.25	1.00
Total Score			1.13

Table 5.13 Key Indicators for Opportunites and Threats for Inpatient Unit (continued)

EFE - Threats			
Factors	Rating	Weight	Weighted Score
Uppredictable APBD support	2	0.13	0.26
Government rate policy still below the unit cost	2	0.25	0.50
High number of customer complaint	1	0.25	0.25
Total Score			1.01
		Total EFE	2.14

Source data as processed by researcher from RSUD Koja

Total weighted score for inpatient unit is 2.14 indicates that RSUD Koja is not fully responding to existing opportunites and threats in its industry, they need to have more strategies to capitalizing on opportunites and avoiding external threats.

5.2.1.3 External Analysis for Outpatient Unit

The result for key opportunites and threats based on balance scorecard indicator are :

Table 5.14 Key Indicators for Opportunites and Threats for Outpatient Unit

EFE - Opportunities			
Factors	Rating	Weight	Weighted Score
Customer loyality	3	0.11	0.33
Increasing trend of Income	3	0.11	0.33
Account Receivable <4%	3	0.11	0.33
Reference hospital	4	0.14	0.56
Lower rate compare to other hospital nearby	3	0.11	0.33
Total Score			1.88

EFE - Threats			
Factors	Rating	Weight	Weighted Score
External Customer Satisfaction <80%	3	0.14	0.42
rate is lower than unit cost	2	0.14	0.28
Drug usage is different with the formula >20%	1	0.14	0.14
Total Score			0.84
		Total EFE	2.72

Source data as processed by researcher from RSUD Koja

Total weighted score for outpatient unit is 2.72 indicates that RSUD Koja is responding in an adequate way to existing opportunites and threats in its industry.

5.2.1.4 Internal Analysis for Emergency Unit

The result for key strength and weaknesses based on balance scorecard indicator are:

Table 5.15 Key Indicators for Strength and Weaknesses for Emergency Unit

IFE - Strength			
Factors	Rating	Weight	Weighted Score
Increasing trend of Income	3	0.04	0.12
Old patient loyalty	3	0.03	0.09
Inexpensive rates	3	0.04	0.12
Service Efficiency is improving	3	0.04	0.12
SOP Compliance from employee is increasing	3	0.04	0.12
Intra-unit communication still need to be develop	3	0.04	0.12
Good team work	3	0.03	0.09
ISO is in-process	3	0.04	0.12
Good competency development program	2	0.04	0.08
Technical training is working well	2	0.04	0.08
Total Score			1.06

IFE - Weakness			
Factors	Rating	Weight	Weighted Score
Changing rates	1	0.03	0.03
Patient still feel unsatisfied	1	0.04	0.04
Service time is not measurable	2	0.03	0.06
Uncomfort room	2	0.04	0.08
Serpentine Birocracy	2	0.03	0.06
Facilities and inframstructure still need to improve	2	0.03	0.06
Lack of cleanliness and comfort	1	0.04	0.04
SIRS not optimal	2	0.04	0.08
Internal communication still need to be develop	2	0.04	0.08
Unscheduled activities	1	0.04	0.04
Work culture is still low	1	0.04	0.04
Medical equipment utilization is unoptimal	2	0.03	0.06
Low delivery of service for specialize case	1	0.04	0.04
Lack of Health promotion	2	0.03	0.06
Employee selection is not based on competency	1	0.04	0.04
Unoptimum work dicipline	2	0.04	0.08
Lack of commitment	1	0.03	0.03
Decreasing work motivation	1	0.04	0.04
umoptimum Customer care	1	0.03	0.03
Rewards and Punishment system is not maximum	1	0.03	0.03
Total Score			1.02

Total IFE	2.08

Source data as processed by researcher from RSUD Koja

Total weighted score for emergency unit is 2.08 indicates that for internally this unit are quite weak in service and need improvement.

5.2.1.5 Internal Analysis for Inpatient Unit

The result for key strength and weaknesses based on balance scorecard indicator are:

Table 5.16 Key Indicators for Strength and Weaknesses for Inpatient Unit

IFE - Strength

Factors	Rating	Weight	Weighted Score
Increasing trend of Income	3	0.05	0.15
Inexpensive rate	3	0.05	0.15
career planning system for nurses has been develop	4	0.02	0.08
High level of discipline from nurses	3	0.03	0.09
competitive rate with nearby hospitals (agreement with third party)	3	0.03	0.09
Act as reference hospital	3	0.05	0.15
Total income higher than expenditure	3	0.02	0.06
Total Score			**0.77**

IFE - Weakness

Factors	Rating	Weight	Weighted Score
Evaluation system and monitoring for retribution income has not been provide	2	0.05	0.09
Lack of Service delivery and preciness	2	0.05	0.10
inmeasureable ILO and INOK	2	0.05	0.10
serpentine service adminstration	2	0.05	0.10
Security system	1	0.05	0.05
specialist doctor service system is not optimal	2	0.05	0.10
SIM RS not optimize	2	0.05	0.10
Unit maintanance cost is not optimize	1	0.05	0.05
Pharmacy service system is not DOSE yet	2	0.05	0.10
lack of medical equipment and logistic	2	0.05	0.10
Human resource quality and quantity still need to improve	3	0.05	0.15
employee's wealth still need to be develop	2	0.05	0.10
coaching and evaluation for employee still need to be optimize	2	0.03	0.06
lack of customer service	2	0.03	0.06
Unimproved efficiency	1	0.03	0.03
room condition	2	0.03	0.06

Table 5.16 Key Indicators for Strength and Weaknesses for Inpatient Unit (continued)

Rewards and punishment system has not reach maximum level	1	0.03	0.03
Marketing system still need to be maximize	2	0.03	0.06
Total Score			**1.44**
		Total IFE	**2.214**

Source data as processed by researcher from RSUD Koja

Total weighted score for inpatient unit is 2.214 indicates that for this unit are quite weak internally and need several improvement.

5.2.1.6 Internal Analysis for Outpatient Unit

The result for key strength and weaknesses based on balance scorecard indicator:

Table 5.17 Key Indicators for Strength and Weaknesses for Outpatient Unit

IFE - Strength

Factors	Rating	Weight	Weighted Score
Service efficiency (medical record) at the registration still need to be improve	4	0.04	0.16
Policlinic is comfortable enough	3	0.05	0.15
Medical equipment need to be purchase and maintain	3	0.04	0.12
All Gakin patient is well treated	4	0.05	0.20
SOP has been provided	3	0.05	0.15
Billing system is available	3	0.05	0.15
Integrated policlinic is available	2	0.04	0.08
100% rigestrated clinical man power	4	0.04	0.16
Policilinc serves by specialist doctors	4	0.04	0.16
High Level of dicipline from nurses	3	0.05	0.15
Waiting room is comfortable enough	3	0.04	0.12
Human resource capacity is already optimal	2	0.04	0.08
Total Score			**1.68**

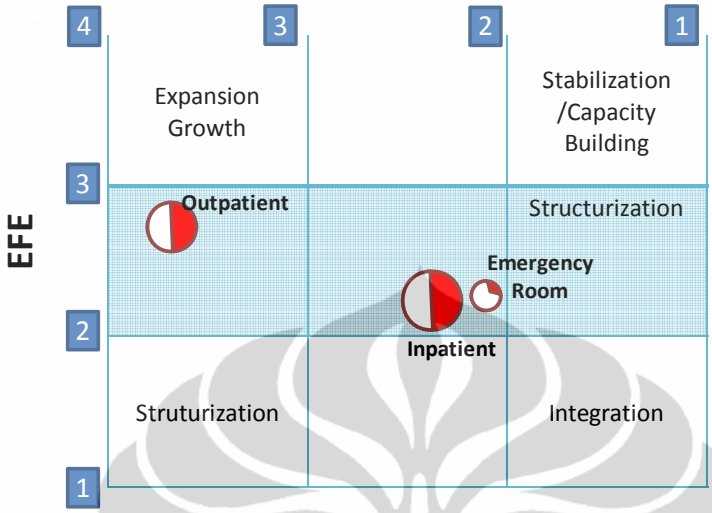
Table 5.17 Key Indicators for Strength and Weaknesses for Outpatient Unit (continued)

IFE - Weakness			
Factors	**Rating**	**Weight**	**Weighted Score**
customer care is not exist	2	0.04	0.08
Waiting Period for Outpatient >1.5 hour	2	0.04	0.08
Serpentine Birocracy	1	0.04	0.04
Cleanliness still need to be improve	1	0.05	0.05
SIMRS is unsatisfactory	2	0.05	0.10
Employee satisfaction <100%	2	0.05	0.10
Medical record complited <95%	2	0.04	0.08
Executive policlinic is not yet available	3	0.04	0.12
Health and safety still need to be develop	2	0.04	0.08
number of employee training in a year <36 hours/person	2	0.04	0.08
No program for customer service	1	0.04	0.04
Radiology result > 24 hour	2	0.04	0.08
Lab result > 24 hour	2	0.04	0.08
Medicine at Drug store < 45 minutes	2	0.05	0.10
Facility accuracy <100%	2	0.04	0.08
ISO has not been implement	3	0.05	0.15
incompetitive wealth system	2	0.05	0.10
Medical equipment need to be purchase and maintain	2	0.04	0.08
no centralize documentation	3	0.04	0.12
Coaching and evaluation for employee is not exist	2	0.04	0.08
lack of dicipline from other staff	2	0.05	0.10
100% delay facilities due to unprepare equipments	2	0.05	0.10
Cost Recovery Hospital <60%	3	0.04	0.12
Total Score			**2.04**
		Total IFE	**3.72**

Source data as processed by researcher from RSUD Koja

Total weighted score for Outpatient unit is 3.72 indicates that for this unit have a strong internal position.

5.2.1.7 Internal – External Matrix



Unit Care	Income	% Income	EFE Scores	IFE Scores
Inpatient	32,888,122,220.00	46%	2.14	2.214
Outpatient	31,074,458,760.00	44%	2.72	3.72
Emergency Room	6,775,515,000.00	10%	2.25	2.08

Figure 5.11 Internal – External Matrix for RSUD Koja

Source data as processed by researcher from RSUD Koja

As indicated by positioning of the circles, grow and build strategy is appropriate for Outpatient Unit. Hold and Maintain strategy should be done by Emergency Unit and Inpatient Unit. Inpatient unit contributes the greatest proportion of RSUD Koja total income and thus is represented by the largest circle.

5.2.2 TOWS Matrix

After we identify what kind of strategy that best fit with a unit, we develop it further and develop TOWS Matrix by matching external opportunites and threats with internal strength and weaknesses.

5.2.2.1 TOWS Matrix for Emergency Unit

Table 5.18 TOWS Matrix for Emergency Unit

SO Strategies		WO Strategies	
1	Service Quality Improvement (S2, S4, S5, S6, S7, S8, O1, O2)	1	Service Quality Improvement (W2, W3, W5, W7, W8, W9, W10, W13, W16, W17, W19, O1, O2)
2	Marketing Hospital Improvement (S1, S9, S3, S4)	2	Investment in Human Capital (W2, W9, W11, W15, W16, W17, W18, W20, O1, O2, O3)
3	Service and Product Development (S1, S4, S7, S8, S9, O2, O3, O4)	3	Facilites and Infrastructure Improvement (W2, W4, W6, W7, W19, O2)
4	Joint cooperation with companies sorrounding hospital (S1, S3, S4)		
ST Strategies		**WT Strategies**	
1	Market Penetration (S1, S2, S7, S8, S10, T1, T2, T4)	1	Rate Evaluation by Unit Cost (W1, W6, W12, W20, T1, T2, T5)

Source data as processed by researcher from RSUD Koja

Based on IE Matrix, strategy fot this unit is hold and maintain; market penetration and product development are two commonly employed strategy for these unit. In order to be a competitive hospital that can generate more profit, there are several strategy that can be done by RSUD Koja, the most important is to improve service quality. Service quality improvement can only be entirelly successfull when hospital has develop a pricing rate strategy by calculating their unit cost, which they have not fully implement. Pricing strategy by unit cost needs a comprehensive study and information about production cost, clearly thorough cost analysis is needed here. Market penetration is also can be competitive strategy for RSUD Koja since the usage rate of presents customer could be significantly increase due to their strategic location. That is why joint cooperation with companies sorrounding hospital may be the best solution because they can get more income through those cooperation.

5.2.2.2 TOWS Matrix for Inpatient Unit

Table 5.19 TOWS Matrix for Inpatient Unit

SO Strategies		WO Strategies	
1	Service and Product Development (S1, S2, S4, S5, S7, O1, O2)	1	Improvement in inpatient service quality (W2, W3, W4, W5, W6, W9, W10, W11, W12, W14, W16, W17, W18)
2	Increase marketing activities (S1, S2, S6, S7, O1, O2)	2	Improvement in reward and punishment system (W2, W3, W6, W9, W11, W12, W13, W17, O2)
3	Improvement in inpatient service quality	3	Improvement and evaluation for Income and Budget (W1, W7, W8, W15, O1, O2)
ST Strategies		**WT Strategies**	
1	Improvement in inpatient service quality (S1, S5, S6, S7, T3)	1	Improvement in inpatient service quality (S2, S3, S4, S5, S6, S9, S10, S14, S15, S16, S18, T3)
2	Improving relationship with the city government (S6, S7, T1, T2)	2	Improvement in human resource quality (S2, S11, S12, S13, S17, T1, T3)
3	Rate evaluation through Unit Cost (S1, S2, S5, S6, S7, T1, T2, T3)	3	Improvement in remuneration system (S12, S17, T1)

Source data as processed by researcher from RSUD Koja

Similar with emergency unit, efficiently and utilization in this unit are not fully optimize. Improvement for VIP class and third class must be prioritize since these unit can generate most profit and has the biggest possibility to attract number of customers. Service and product development is needed to be done because for VIP class currently there is only 5 rooms with high BOR and LOS. RSUD Koja should make use the room to innovatively play with this class price rate. However, by re-evaluation its rate, improvement in service quality then become a must and since inpatient unit need a special care due to its very spesific characteristic, it become more important. To create a condusive environment for patient and expedite their healing process, improvement in facilities and infrastructure is not enough, but RSUD Koja also need to improve their human resource quality. Patient mostly judge hospital service quality by health care deliveries from its staff. If hospital staff welfare is not good enough, it can be difficult to maintain their quality of service delivery. However, if RSUD Koja implement a comprehensive rewards and punishment strategy, measurement to

evaluate good performer and just a so-so performer can be done objectively and thus make them a competitive hospital.

5.2.2.3 TOWS Matrix for Outpatient Unit

Table 5.18 TOWS Matrix for Outpatient Unit

SO Strategies		WO Strategies	
1	Improvement in outpatient due to service efficiency (S1 to 11; O1, O2, O4, O5)	1	Increase customer satisfaction by simplified the birocracy (W1 to 11; O1, O2, O4)
2	On time Delivery (S1, S5, S7, S10, S11,O1)	2	Provide executive clinic (W1 to 11; O1, O2, O3, O4)
3	Product Development (S2, S5, S6, S7, S8, S9, O1, O2, O4)	3	Provide customer care (W1, O1)
4	Improve promotion (S1, O2, O4, O5)		
ST Strategies		**WT Strategies**	
1	Evaluate pricing rate with consideration of unit cost (S1, S3, T1, T2)	1	Improve patient waiting period by providing facilities and infrastructure (T1)
		2	Provide reward and punishment

Source data as processed by researcher from RSUD Koja

Customer care here is our top priority because it is still not fully utilize and to the fact that staff never have any customer care program after some time. And since RSUD Koja has an opportunity to becoming reference hospital, due to the facts that other hospital nearby do not have policlinics and services as integrative as they are, they should improve their service delivery. The birocratic administration must be reduce and simplified, more flexible and off course provide customer care. If they could done this, the RSUD Koja can increase their promotion activites to introduce hospital image to larger customer.

5.2.3 Grand Strategy

Looking through their strength, weaknesses, opportunities and threats, RSUD Koja located in the first quadrant. Therefore, they need to continued concentration on current markets (market penetration and market development) and service development. There are the appropriate strategies. However, forging strategic alliances also needs to be done by doing horizontal integration. Horizontal alliances exist between complementary or competitive organizations at the same level of distribution. Here we propose several types of horizontal alliances: Professional Associations, Promotional and Collaboration. RSUD Koja may collaborate with proprietary chains (pharmacies), with other hospitals, with insurance companies or with companies sorrounding their area. For example, RSUD can collaborate with their rivals in providing such services that can be beneficial, especially in this era of reduced funding and rising costs. Act as a reference hospital towards one another. If you want to survive, the more areas of collaboration we can find, the better. RSUD Koja can also do a lot of promotional activities by collaborating with education institution, act as the place for research and trainings for young doctors-to-be. Horizontal alliances with professional association may beneficial in the future to grab more market. Another kind of alliances is internal alliances as what are otherwise known as "teaming" efforts. The interdisciplinary team providing hospital services has long been an innovative entity, shunning professional jealousies and striving to value individual contributions for the total support and well-being of patients. However, as hospital undoubtedly is slated to become mainstream "big business," it is apparent that they will have to work just as hard at maintaining and even building such teaming efforts as any other business. Human investment programs plays a major role here. As a government owned hospital, RSUD Koja does not need to think much about investing in health care technologies, however to improve their service to become excellence, investing in their human resource must become priority. Rewards and remuneration program must be develop as well as learning and development programs. Goals must be create integrated with their mission, organization goals must be agreed on and make it absolutely clear where they will concentrate resources for result.