HOSPITAL AUTONOMY (UNIT SWADANA HOSPITAL) POLICY: WAS THE OBJECTIVE ACHIEVED?

Soewarta Kosen*

Suatu studi untuk menilai pencapaian tujuan kebijakan rumah sakit swadana telah dilakukan oleh PusLitBang Pelayanan Kesehatan, bekerja sama dengan Universitas Harvard. Lima rumah sakit pemerintah yang telah melaksanakan kebijakan swadana, tiga rumah sakit pemerintah yang belum melaksanakan swadana dan dua rumah sakit swasta telah dipilih sebagai sampel. Tujuan utama kebijakan rumah sakit swadana adalah memberi keleluasan dalam mengatur pembiayaan rumah sakit dengan hak untuk menyimpan dan menggunakan pendapatan rumah sakit secara langsung, sehingga efisiensi dan kualitas pelayanan dapat ditingkatkan tanpa mengurangi akses penderita yang kurang mampu.

Hasil studi ini menunjukkan meskipun terdapat peningkatan pendapatan asli rumah sakit setelah menjadi swadana, tingkat ketergantungan pada subsidi pemerintah tidak berkurang. Perbaikan sistim insentif telah meningkatkan sistim manajemen dan tingkat kehadiran karyawan rumah sakit; tetapi terdapat kecenderungan peningkatan tarip dan pengurangan jumlah tempat tidur untuk penderita kurang mampu, sehingga mengurangi akses penderita miskin terhadap pelayanan rumah sakit. Peningkatan kualitas pelayanan mulai dilakukan melalui upaya Total Quality Management, *sedangkan peningkatan efisiensi belum dapat dibuktikan secara kuantitatif.*

BACKGROUND

History and Reasons for Hospital Autonomy

Indonesia as well as other developing countries has less resources than those required to meet all the health needs of the population. Since 1974, the government of Indonesia has reorganized the public health infrastructure, to assure equity in health care.

More than 7,000 sub-district health centers and 20,000 sub health centers have been constructed and equipped to deliver basic health services to local community.

At the same time provincial and district hospitals have also been improved to deliver referral services. For a long time public hospitals are heavily subsidized by the government in various levels. According to the ICW Law (originate from 1925), all

*Pusat Penelitian dan Pengembangan Pelayanan Kesehatan Badan Penelitian dan Pengembangan Kesehatan DepKes RI

government institutions should submit all earned revenue to the government exchequer.

The system gives no financial incentives to hospital managers to operate more efficiently or to generate more revenues; since all of those have to be submitted. The rising expenditure of public hospitals put more burdens to government in the last decade.

In 1990 the Ministry of Health carried out a Hospital Diagnosis Study with summary of the findings as follows:

- Quality assurance activities of health services at hospitals were not exist
- The currently medical records could not be used to evaluate the quality of services
- Many hospital facilities were not function at optimal levels due to inadequate maintenance
- The staff attitude, behaviour and environmental situation in public hospitals could not support the role of the hospital as a socioeconomic unit that emphasises productivity
- The current organizational structure did not facilitate the financial performance
- Lack of awareness on the relationship between real unit cost of services, tariff and revenues
- The cash basis accountancy system of hospitals is not in accordance with the development of hospitals into a socioeconomic unit
- The public hospitals provide services mainly to low and middle-income group of the population. Hospital management does not have authority to manage resources efficiently (Rukmono et al, 1990)

In 1990 the Ministry of Health proposes the Unit Swadana (Sanskrit: swa = self dana= financed) concept that urged the public hospitals to be converted from a historic charity role into self sufficient production unit With financial autonomy, the hospital are able to operate like private hospitals in improving their efficiency and quality.

The primary objectives of the policy is to give greater autonomy and more flexibility to public hospitals, so that it could:

- Improve hospital efficiency by utilizing the resources optimally
- Improve the quality of health services delivered by the hospital
- Promote social equity
- Reduce the government subsidy, since the autonomous hospitals could retain and use the hospital revenue and adjust the tariff

The policy allows the public hospitals to generate, retain and use their revenues for operation and maintenance activities, while reducing the government subsidy gradually over time; thus enables the government to reallocate the resources for promotive and preventive activities. By allowing the autonomous hospitals to utilize the revenues they earn to pay for their operational and maintenance expenses; thus create the situation in which the hospitals will be more exposed to market forces and if properly managed can constitute a major factor to improve managerial efficiency and quality of health services (Departemen Keuangan R.I, 1993).

In 1991 the central government accepted the concept and issued the Presidential Decree No 38/1991 on Unit Swadana and financial management guidelines that cover public hospitals as well as other public facilities. The decree authorized the designated autonomous public hospitals to retain their own revenues and use it directly for the following expenses: operational cost, maintenance of equipment, manpower development and selected capital investment after securing permission from the higher authority.

The rational of the policy is that if the autonomous institution could increase its revenue, the government subsidy could gradually be diminished. It is emphasized that the autonomous institutions remain as public facilities, with their assets are belong to the government and their employees salaries are paid by the government.

The earned revenues are still considered as public money and the managers are accountable to the rules and regulations that apply to the national budget system. The autonomous hospitals should maintain their social obligations to the poor and tariffs adjustment for the lowest class should be agreed by the higher authority in this case the Director General of Medical Care, Ministry of Health or the Regional Health Director. The left over revenues that are not spent at the end of a fiscal year could be carried over and re-used in the following budget year.

In order to qualify to become autonomous, public hospitals should meet certain criteria set by the Director General of Medical Care in 1990 that is:

a. The Bed Occupancy Rate in central public hospitals should not be less than 70 % and for provincial/district hospitals not less than 60 %.
b. The average length of stay should not exceed 10 days.
c. There should be a positive trend of cost-recovery in the last three years.

KEY ISSUES OF IMPLEMENTATION

Quality of Hospital Services

The quality of services of public hospitals were notoriously rated as lower than private hospitals. Since the autonomous public hospitals have to compete with private hospitals in rendering services, the public hospitals need to improve the quality of services that are customer oriented.

An efficient incentive system is needed to assure personnel motivation in rendering good services. The autonomous hospitals are in good position to improve the incentive system of their personnel.

The total quality management activities have been introduced to encourage better participation and motivation of hospital personnel in delivering high quality of services.

The Hospital Information System

The existing recording-reporting system is not sufficient to support decision-making process of the management. In autonomous

hospitals, the information system should be able to compile, classify, analyze and transform the hospital data into information to be used in decision-making process.

The Financial System

Before became autonomous, the accounting system of hospitals was a cash based system supported by a single entry booking system. The autonomous hospitals need an accounting system that could monitor and evaluate financial performance accurately and produce financial reports at any time.

This includes an accrual accounting system supported by a double entry booking system. In the transition period, both systems were applied simultaneously.

The tariff of autonomous hospitals should be based on the actual unit cost, the ability to pay of the community and the market conditions (demand, competition, etc). VIP patients should pay more than the unit cost and the tariff of the lowest class should be lower than the actual unit cost.

Organization of Autonomous Public Hospital

Management of Autonomous public hospitals is expected to be more efficient and independent than before. Thus, the organizational structure of autonomous hospital should be improved as follows:

a. Medical doctors are organized in a functional unit: Functional medical staff. Among them several doctors will be selected to form a medical committee that will assist the director in setting up medical standards and coordinating hospital services.
b. An accounting unit is formed to manage financial matters and evaluate financial performance of the hospital more accurately.
c. The medical records department is placed under Associate Director for Administrative and Financial Affairs and is authorized to issue regulations, standards and procedures to produce good records.

The improvement is targeted to prepare the autonomous hospitals to withstand market forces, to perform efficient financial management, to deliver needed financial reports and to produce information that reflect productivity of the hospital that is important for policy making.

OBJECTIVES AND METHODOLOGY

Objectives

The general objective of the study is to describe and evaluate the hospital autonomy process in Indonesia, using the general approach of the DDM Methodological Guidelines for improving Hospital Performance Through Policies to increase Hospital Autonomy (Chawla, Mukesh and Peter Berman, 1995).

The specific objectives are:

a. To describe the political process by which hospital autonomy was established

b. To describe the organizational characteristics and degree of autonomy of decision established by law and decree in those hospitals.
c. To select sampled hospitals and evaluate the empirical impact of autonomy on organizational structure, resource mobilization, efficiency, quality of care, equity and accountability

Selection of Samples

Five autonomous hospitals that experience the new system for at least two years were selected purposively. These include:

- Persahabatan Hospital, Jakarta (central)
- Dr. Kariadi Hospital, Semarang, Central Java (central)
- Tegalyoso Hospital, Klaten, Central Java (central)
- Pasar Rebo Hospital, Jakarta (provincial)
- Tangerang Hospital, Tangerang, West Java (district)

As controls, two non-autonomous provincial hospitals: Abdul Moeloek Hospital, Lampung and Tarakan Hospital, Jakarta were selected.

Besides, one non autonomous district hospital: Magelang Hospital and two private hospitals (large and small) were also selected as control.

Methodology

All documents and information, including financial data related to the implementation process of hospital autonomy from central and local level were identified, collected and analyzed.

In depth interviews using structured and unstructured instruments were carried out to those involved in the technical and political process of the autonomy that included political actors that formulate the policy, hospital directors and staff and patients. Interviewers were recruited from the National institute of Health Research and Development. Ten hospitals in the sample were visited to gather primary data and to interview the hospital managers. The results were discussed and validated with other sources. The final results were presented in a seminar attended by decision makers in the Ministry of Health, directors of sampled hospitals, researchers and other health officials.

THE FINDINGS.

The Degree of Autonomy of Decision

Autonomous hospital has been granted some degree of financial autonomy. The autonomous hospital is authorized to set all tariff of hospital services, with the exception the tariff for the third class beds. The tariff for the third class beds were set by the Director General for Medical Care, MOH for the central hospital and by the Regional Health Director for provincial and district hospitals.

The hospitals have also been authorized to retain and use their own source revenues (from patients) directly, within the loose control of the government; such as for

operation and maintenance (drugs, food, laundry, small renovation. procurement of routine supplies) as well as for staff incentives and hiring certain personnel (accountant).

Capital investment (construction of new buildings and purchasing expensive hospital equipment) is not allowed and will be provided by the government through ordinary budget mechanism.

The hospital is required to plan the budget of the next fiscal year from their own source revenues and this will be discussed with the authorities during the planning process. The hospital could spend the budget within the line items with some flexibility. In one autonomous district hospital, a foreign medical equipment company is allowed to set up and operate concessions of radiology unit.

Management of hospital manpower is still restricted, since the government its power of hiring and bring the hospital employees that are civil servants. This situation limits the hospital management in meeting the real need of their hospital.

In most of large autonomous hospitals, the trend towards specialization become more obvious after became autonomous and includes the number and type of specialist physicians, uses of specific equipment, allocation of budget and allocation of beds.

For example at Persahabatan Hospital the new and autonomous department: Dept. of Thoracic Surgery was formed and was equipped with equipment, in-patient facilities and staff in all autonomous hospitals, standard operating procedures in various unit were also made or improved.

The Empirical Impact of Autonomy

Impact on Organizational Structure

Before autonomy, the organizational structure of public hospitals is based on the Minister of Health Decree No 134/19S5 that emphasizes the social function of public hospitals to deliver good quality of services at tariffs affordable to the community. With the implementation of autonomy, almost all autonomous hospitals followed the Minister of Health Decree No 983/1992, which stated that:

a. The Functional staff is separated from structural staff. The physicians are organized in a group called the Functional Medical Staff and concentrate their work on medical matters. Several members of the Functional Medical Staff will be selected to form the Medical Committee that is responsible directly to hospital director and will coordinate the health services in the hospital as well as setting up medical standards and ethics.
b. Division of Planning and Medical Record are directly under the Director (Class C and D Hospital) or under the Associate Director for General Affairs and Finance (Class A and B Hospital). The Division of Medical Record is given the authority to issue regulations and standard operating procedures to improve the quality of records.
c. The new structure enables the formation

of accounting Unit, Legal Unit and Marketing Unit. The accounting unit will enable the hospital managers to monitor, evaluate and analyze financial performance more accurately and timely.

In general the new structure gives more opportunity to meet the needs of autonomous hospital management.

Impact on Efficiency

The autonomous hospitals showed some improvements in general maintenance of building and hospital equipment, availability of supplies and improvement in health information system and staff productivity. The length of stay of hospitals before and after become autonomous did not show any decreasing trend and the bed occupancy rate did not show significant increase. Since data on unit cost is very limited, the data could not be used to analyze changes in efficiency

Impact on Quality

For the study, several indicators of quality has been determined, e.g. patient satisfaction, nosocomial infection rates; however such data are not available in most of sampled autonomous hospitals and the trend analysis could not be carried out. Some qualitative indicators were also collected and majority of autonomous hospitals have formed nosocomial infection committees and total quality management committee and have conducted at least once the patient satisfaction survey. The total quality management that employs quality circles facilitates the participation hospital personnel in improving the services.

Pasar Rebo provincial hospital showed some success in implementing the quality circles About 23 quality circles committees were established and many quality problems could be solved.

Improvement in employee's productivity measured by decrease of absenteeism due to changes in incentives has also been noted by the hospital managers as well as hospital staff.

Almost all autonomous hospitals actively made and applied the improved standard operating procedures of services.

Impact on Accountability

There were not any changes in accountability to the community after the hospital become autonomous. The hospital managers are still appointed by authorities (director general for central hospital, governor for provincial hospital and bupati head of the district for district hospital) and independent to public scrutiny.

Impact on Equity

Preliminary assessment on equity issues after implementation of autonomy policy showed an adverse impact on equity due to substantial increase in hospital tariff of almost all hospital services. Besides, there was some reduction in proportion and absolute number of Class III Beds that restricted the opportunity for the poor to utilize the services. This phenomenon was

more obvious for central autonomous hospitals than for provincial and district autonomous hospitals. Visits to outpatient department in general were slightly affected for few weeks that might be due to the significant increase of the tariffs.

Impact on Resource Mobilization

Autonomy policy has improved the ability of hospitals to mobilize resources, in Indonesian case by increasing tariffs significantly. Another sources included subsidy from the central and or local government and others. At Tangerang Hospital, the private sector invested in the construction of a new ward, installing CT Scan and other new equipments to be operated together with the autonomous hospital.

Implementation of autonomy policy and the calculation of unit cost of services enabled the autonomous hospitals to have more bargaining power against financial institution, such as insurance companies.

Impact on Staff Motivation

Observation of hospital director concluded that absenteeism among hospital employees decreased after become autonomous, showing improvement of personnel motivation. There was no assessment of staff satisfaction with working environment before and after become autonomous. The improved staff motivation was attributed to the changes in incentive system that gives incentives to all hospital personnel based on the general consensus.

Impact on Financial Management

Financial management in autonomous hospitals improved a lot. All autonomous had their personnel trained in new accounting system (accrual based) and apply accrual as well as cash based system.

Based on unit cost calculation, the autonomous hospitals increased their tariffs.

DISCUSSIONS.

Autonomous hospitals could spend their own source revenues in accordance with the agreed plan in general it includes manpower development/training, staff incentives, operation and maintenance and supervision.

All sampled autonomous hospitals contracted out to private parties some of supporting services, such as laundry, cleaning, supply of food material, dispensary and cafeteria. After became autonomous, the financial management is generally improved: accounting section is formed, computerization of the billing system, uses of the bank services at the hospital and internal auditing activities The cash based accounting system is replaced gradually by the accrual based accounting system.

Similarly the management information system is also improved. The information personnel were trained intensively in using computer and information produced is in accordance with the management need. The personnel incentives were improved

and in most of autonomous hospitals include medical, paramedical and non-medical personnel. The amount of incentives is based on consensus and the agreed work-load.

Majority of autonomous hospital directors feel the personnel motivation improves after autonomy and absenteeism decreases.

Information on patient satisfaction is not available in all of the sampled hospitals, although most of the autonomous hospitals have started the patient satisfaction survey (in patient and out patient) as well as providing customer suggestion boxes. Several autonomous hospitals stressed the importance of competition with other hospitals (public and private) that include the area of quality of services, equipment, tariff and type of physicians.

All autonomous hospital directors felt that after autonomy could maintain their facilities better, since they could use directly the revenues for operation and maintenance activities. Own source revenues in autonomous hospitals increased after they gained the new status. This is mainly due to the increase in tariffs of services, especially the room charges.

For example, the Persahabatan Hospital, immediately after became autonomous increased the tariff of its 1st Class Beds by 44.4%, the 2nd Class Beds by 15.4% and the 3rd Class Beds by 100%.

Similarly the Kariadi Hospital that became autonomous in 1993, increased the room charges as follows: VIP Beds increased by 142.9%, 1st Class by 103.7%, 3rd Class (type A) by 45% and 3rd Class (type B) by 100%. An increase in type B seems significant, due to a very low tariff in the past (Rp 1,000 per day).

In real term, measured in 1995 prices, revenues in autonomous, non autonomous as well as private hospitals increased at the rate higher than the inflation (the estimate of inflation rate is 10% per year during the study period).

It is worth noted that Pasar Rebo Hospital, an autonomous hospital that belong to Jakarta Government and doesn't have any VIP or 1st Class Beds, still experienced 40 to 50 % increase of its own source revenue every year (in real term).

Applying the 1995 prices as a base

Table 1
Percentage Increase of Hospital Revenues by Year 1996

No.	HOSPITAL	1992/93 (%)	1993/94 (%)	1994/95 (%)	1995/96 (%)
1	RSUP Persahabatan	30,9	15,2	21,4	(10.5)
2	RSUP dr. Kariadi	(6.6)	15,5	53,7	(11.3)
3	RSUP Tegalyoso	50,5	23,1	14,2	(5.6)
4	RSU Pasar Rebo	30,5	41,7	50,5	11,4
5	RSU Tangerang	9,9	16,4	21,9	10,8
6	RSUP Abdoel Moeloek	(7.9)	38,6	71,6	(17.3)
7	RSU Magelang	24,2	9,3	14,7	2,8
8	RSU Tarakan	-	-	26,5	13,0
9	Large Private Hospital	8,4	12,7	17,2	24,9
10	Small Private Hospital	20,3	13,9	13,3	16,9

year, tariff of in patient services did not increase much, even several decreased Tariff of 3 d Class (type B) at Persahabatan Hospital decreased from Rp 6,050 in 1993/1994 to Rp 5,000 in 1995/1996.

At Kariadi Hospital, tariff of the similar class increased from Rp 1,210 to Rp 3,850 after became autonomous. In large and small private hospitals, the tariff of in patients also slightly increased. Despite of significant increase in own source revenues the autonomous hospitals are still far from self sufficient.

All autonomous and non autonomous hospitals keep receiving larger subsidy from the local and central government every year. Persahabatan Hospital, a large central hospital, received 6,2 billion rupiahs as subsidy in 1991/1992 (before become autonomous). After become autonomous, the hospital received subsidy: 6,5 billion rupiahs in 1992/1993, 6,7 billion rupiahs in 1993/1994, 7,6 billion rupiahs in 1994/1995 and 8,9 billion rupiahs in 1995/1996.

Tegalyoso Hospital also experienced similar situation, however Magelang district hospital (non autonomous) has to survive without large subsidy, except salaries of civil servants and limited operation and maintenance fund from local and central government

An increase in own source revenues did nc enable the autonomous hospitals to hav better cost-recovery. The cost recovery fc VIP Beds at Persahabatan Hospital wa about 1.1 and for the lowest class was 0.1 and at Tegalyoso Hospital, there were 0.6 for VIP Beds and 0.63 for the lowest clas (Table 2).

Table 2
Room Charges per Unit Cost by Class and Year

No.	HOSPITAL	1993/94					1994/95					1995/96			
		VIP	CLASS				VIP	CLASS				VIP	CLASS		
			I	II	III	IIIb		I	II	III	IIIb		I	II	III
1	RSUP PERSAHABATAN	0.00	0.00	0.00	0.00	0.00	0.97	0.39	0.34	0.29	0.11	1.11	0.49	0.31	0.20
2	RSUP TEGALYOSO	0.48	0.69	0.75	0.13	0.50	0.00	0.00	0.00	0.00	0.00	0.86	0.90	0.94	1.57
3	SMALL PRIVATE HOSPITAL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.58	2.21	1.86	0.52

From these figures we could rough conclude that cross subsidy was happeni at Persahabatan Hospital and less so Tegalyoso Hospital. Figures from priva hospitals showed a stronger and mc obvious cross subsidy: the cost recovery 3.58 for VIP Beds compared with 0.52 the lowest class beds. It is surprising th the data showed, certain hospitals s subsidize the VIP Beds and 1st Class Be in spite of the government encouragem to autonomous hospitals to cross subs the services for the poor. The ratio of o source revenues to subsidy tended increase in all autonomous hospitals.

At Persahabatan Hospital, the ratio 1992/1993 (before autonomy) was 69.6 After autonomy, the ratio increased into 7 % in 1993/1994, 82.9% in 1994/1995 a 86.7 % in 1995/1996.

The ratios at Pasar Rebo Hospital w 104.9% in 1991/1992, 172.8%

Table 3
Total Expenditure per Bed in 1995 Prices by Year

No.	HOSPITAL	1991/92		1992/93		1993/94		1994/95		1995/96	
		Total Expend	Expend/ Bed	Total Expend	Expend/ Bed	Total Expend	Expend/ Bed	Total Expend	Expend/ Bed	Total Expend	Expend/ Bed
1	RSUP Persahabatan	10.647	21	12.728	24	13.199	25	13.258	25	16.071	31
2	RSUP dr. Kariadi	13.624	19	12.773	15	12.976	15	12.612	15	17.584	21
3	RSUP Tegalyoso	4.700	11	5.046	12	5.944	19	5.600	17	5.173	16
4	RSU Pasar Rebo	2.703	22	2.562	18	2.418	17	3.538	25	4.154	26
5	RSU Tangerang	6.420	21	4.358	14	3.702	12	3.702	11	5.933	18
6	RSUP Abdoel Moeloek	5.373	10	5.304	10	5.051	9	5.726	10	5.172	9
7	RSU Magelang	380	3	589	4	601	4	584	4	1.101	7
8	RSU Tarakan	-	-	-	-	1.273	17	1.296	17	1.789	24
9	Large Private Hospital	17.279	46	17.822	47	17.475	46	20.285	54	29.013	63
10	Small Private Hospital	2.731	17	3.245	14	3.603	15	3.175	13	4.207	17

*) In Million Rupiah

1992/1993, 206.1% in 1993/1994, 284.6% in 1994/1995 and 564.5 % in 1995/1996. Revenues per bed showed an increasing trend at all hospitals. The data showed that charges other than for the room play important roles for hospital income. There was no significant difference of increased revenues per bed between autonomous and non autonomous hospitals.

After became autonomous, the amount of subsidy per bed in all sampled hospitals did not decrease. At Persahabatan Hospital, the subsidy per bed before autonomy (1992/1993) was 12.3 million rupiahs and became 12.7 million rupiahs after autonomy (1993/1994). At Tangerang District Hospital the amount of subsidy per bed was significantly higher than the other hospitals in the sample it was 12.7 million in 1993/1994 (before autonomy) and increased into 15.2 million rupiahs in 1994/1995 and 20 million rupiahs in 1995/1996. Total expenditures showed increasing trend over the years for autonomous as well as non autonomous hospitals.

In autonomous hospitals, increase in expenditures is largely due to higher incentives given to hospital personnel. Persahabatan Hospital spent 1.3 billion rupiahs in 1992/1993 (when it gained the autonomous status) and became 2.8 billion in 1995/1996.

Thus the expenditure per bed also tended to increase after autonomy.

At Persahabatan Hospital, the expenditure per bed was 14 million rupiahs in 1991/1992

Table 4
Collected Revenue Over Expenditure by Year

No.	HOSPITAL	Collected Revenue/Expenditure				
		1991/1992	1992/93	1993/94	1994/95	1995/96
1	RSUP Persahabatan	47,50%	47,3%	47,80%	53,90%	48,30%
2	RSUP dr. Kariadi	44,10%	39,90%	41,20%	59,30%	47,20%
3	RSUP Tegalyoso	27,60%	40,60%	26,80%	29,20%	36,70%
4	RSU Pasar Rebo	49,90%	62,40%	85,20%	79,70%	89,30%
5	RSU Tangerang	70,90%	104,40%	130,10%	144,20%	117,90%
6	RSUP Abdoel Moeloek	30,00%	25,50%	33,70%	46,40%	54,20%
7	RSU Magelang	155,50%	113,30%	110,40%	118,30%	77,70%
8	RSU Tarakan	-	-	68,70%	82,90%	79,90%
9	Large Private Hospital	26,60%	25,00%	29,00%	24,00%	24,00%
10	Small Private Hospital	132,90%	119,60%	113,80%	134,10%	142,30%

increased to 18.1 million rupiahs in 1992/1993 and 30.6 million rupiahs in 1995/1996. Tangerang District Hospital, despite of their relatively sophisticated equipment, had low expenditure per bed compared to others. The lowest figure was showed by Magelang District Hospital (non autonomous) and the highest figure was found at large private hospital.

Increased own source revenues received by hospitals after became autonomous, has enabled hospitals to rely more on revenues. All autonomous hospitals in the sample showed significant steady increase of the ratio revenues to expenditures over the years (Table 4).

The ratio at Persahabatan Hospital was 47.5 % in 1991/1992 (before autonomy) and in 1995/1996 was 48.3%. At Kariadi Hospital the ratio was 41.2% before autonomy and increased to 47.1%. Pasar Rebo Hospital, despite of providing only 3rd Class Beds and few 2nd Class Beds, the ratio of revenues to expenditures increased from 49.8% in 1991/1992 (before autonomy) to 89.2% in 1995/1996. This means that the own source revenues could cover about 89% of the routine expenditure. The ratio at Tangerang Hospital before autonomy was 104% and at present it reached 117.8%.

Most autonomous hospitals experience surplus even before autonomy. In the study, we define the surplus as a difference between hospital income (including subsidy) and expenditures. According to current regulation, autonomous hospital as a unit swadana facility could reuse the surplus at the end of a fiscal year for the new fiscal year in accordance with the agreed plan.

Surplus at Persahabatan Hospital decreased from 1,463 million rupiahs in 1992/1993 to 1,009 million rupiahs in 1993/1994; and went up again to 2,219 million rupiahs and 3,648 million rupiahs in 1994/1995 and 1995/1996 respectively.

Pasar Rebo Hospital experienced deficit of 28 million rupiahs before autonomy, but it produces surplus after implementation of autonomy policy. Length of Stay (LOS) in

autonomous hospitals did not change much with implementation of autonomy policy. LOS at Persahabatan Hospital and Kariadi Hospital were higher than the provincial or district hospitals, these might be due to their function as referral hospitals.

Bed Occupancy Rate (BOR) decreased at Persahabatan Hospital, Kariadi Hospital and Tegalyoso Hospital. However, BOR at Pasar Rebo, Tangerang, Abdul Moeloek, Magelang, Tarakan Hospitals and at both of the private hospitals increased over the years.

The ratio of out-patient per bed ranged between 200-500 to 1, except at Pasar Rebo Hospital that reached 1,200 to 1; probably due to the low tariff of out-patient services. Analysis of BOR by class showed that the lower the class, the BOR becomes higher. At Persahabatan Hospital the BOR of VIP Class before autonomy was 58.6%, then it increased to 64.7% in 1992/1993, 67% in 1993/1994 in 1994/1995 and in 1995/1996 it decreased to 55% and 59% respectively.

The Tangerang Hospital showed an increase of BOR from 56% in 1991/1992 to 70% in 1995/1996. BOR of the 3rd Class was also high, ranged around 70%. Surprisingly the BOR of the large private hospital was around 90% for the last five years.

Bed composition by class before and after implementation of the policy, changed in autonomous as well as non autonomous hospitals. The percentage as well as the absolute number of the lowest class beds decreased over the years. At Persahabatan Hospital, the percentage remained the same for VIP Beds that is between 4 to 5% and decreased from 65.5% to 53% for the 3rd Class Beds; however Pasar Rebo Hospital keep dedicating majority of its beds (86%) for the 3rd Class.

The ratio of hospital personnel: physicians, paramedics and non medical personnel to number of beds remained the same, before and after implementation of autonomy. The new recruitment were limited only for accountant, medical record specialist, clerical jobs and or other non permanent employee (security guards).

Recruitment of physicians and paramedics are still arranged through higher authorities in the Ministry of Health and Ministry of internal Affairs.

CONCLUSIONS.

The hospital autonomy policy as directed by the Presidential Decree No 39/1991 brings reform in hospital care in Indonesia. The success of the policy encourages other non autonomous public hospitals to become autonomous.

Own source revenues of autonomous hospitals increased significantly after implementation of autonomy, due to the increase in tariff; especially the in-patient charges.

Despite of significant increase of revenues,

government is still an important component of hospital income and in real term it is increasing every year. However the ratio of subsidy to total income is decreasing after implementation of the autonomy policy.

Hospital expenditures tend to increase over the years, especially after implementation of the autonomy policy, and mainly due to increased incentives of hospital staff.

On the other hand the new system of incentives motivates the hospital staff to perform better. The significant increase in own source revenues did not enable hospitals to gain better cost-recovery.

Unfortunately, VIP beds in certain autonomous hospital are still subsidized. The preliminary observation concludes that the cross subsidy from the "have" to the "have not" does not happen at autonomous hospitals; however it is clearly showed at private hospitals (large and small).

Length of Stay at sampled hospitals remain the same before and after implementation of the autonomy policy.

Bed Occupancy Rate in autonomous central (referral) hospitals tend to decrease; but it increases in autonomous local hospitals.

RECOMMENDATIONS

Although the recent regulation changed the implementation procedures of hospital autonomy policy, the Ministry of Health, based on previous experiences should better prepare the newly convened "autonomous like" hospitals to implement the policy more efficiently and effectively without sacrificing accessibility and equity.

The preparation should include at least the improvement of quality of services, financial management including the calculation of unit cost of services, hospital performance and staff motivations.

The main efforts should be targeted toward the achievement of public hospitals that are efficient, effective and having high quality of services, while maintaining the access of the services by the poor.

REFERENCES:

Rukmono, Soedibjo Swardadi and Budihartono. "Hospital Diagnosis Study". *Health Sector Financing Project.* Monograph Series No 5. Jakarta. 1990

Departemen Keuangan RI. *Pedoman Unit Swadana* (Guidelines of Autonomous Unit). Direktorat Jendral Anggaran Departemen Keuangan RI. Jakarta. 1993

Chawla, Mukesh and Peter Berman. *"Improving Hospital Performance Through Policies to increase Hospital Autonomy: Methodological Guidelines. Data for Decision Making Project.* Harvard School of Public Health. Boston. 1995