STRATEGIC RESPONSES OF AN INDONESIAN PUBLIC HOSPITAL TO HEALTH POLICY AND CRISIS: AN INSTITUTIONALIST STUDY

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by

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ABC	Activity Based Costing
Bappeda	Indonesian acronym for *Badan Perencanaan Pembangunan Daerah* or the Sub-National or Local Development Planning Board
Bappenas	Indonesian acronym for *Badan Perencanaan Pembangunan Nasional* or the National Development Planning Board
BLU	Indonesian acronym for *Badan Layanan Umum* (BLU) or Public Service Agency
BLUD	Indonesian acronym for *Badan Layanan Umum Daerah* (BLUD) or Regional Public Service Agency
CAH	Commission on Accreditation of Hospitals
CBGs	Case-Based Groups
COVID-19	Corona Virus Disease 2019
CPs	Clinical Pathways
DHOs	District Health Offices
DPR	Indonesian acronym for *Dewan Perwakilan Rakyat* or the national parliament
DPRD	Indonesian acronym for *Dewan Perwakilan Rakyat Daerah* or the local parliament
DRGs	Diagnosis Related Groups
GDP	Gross Domestic Product
HCWs	Health Care Workers
HR	Human Resource
ICU	Intensive Care Unit
IKM	Indonesian acronym for *Indeks Kepuasan Masyarakat* or Community Satisfaction Index
IKPK	Indonesian acronym for *Instalasi Kerjasama Pembiayaan Kesehatan* or the Health Financing Collaboration Division
INA-CBGs	Indonesian Case-Based Groups
ISQua	International Society for Quality in Health Care
KFT	Indonesian acronym for *Komite farmasi dan Terapi* or the Pharmacy and Therapeutic Committee
KMKB	Indonesian acronym for *Kendali Mutu dan Kendali Biaya* or Quality and Cost Control
LAKIP	Indonesian acronym for *Laporan Akuntabilitas Kinerja Institusi Pemerintah* or Government Institution Performance Accountability Report

MDGs	Millennium Development Goals
MNDP	Ministry of National Development Planning/National Development Planning Agency of Republic of Indonesia
MOF	Ministry of Finance
MOH	Ministry of Health
MOHA	Misnistry of Home Affairs
MSAE & BR	Ministry of State Apparatus Empowerment and Bureaucratic Reform
Non-PBI	Indonesian acronym for *Non-Penerima Bantuan Iuran* or non-Premium Assistance Beneficiaries
NPM	New Public Management
OECD	Organisation for Economic Co-operation and Development
PBI	Indonesian acronym for *Penerima Bantuan Iuran* or Premium Assistance Beneficiaries (for poor people)
PCR	Polymerase Chain Reaction
PHOs	Provincial Health Offices
PPE	Personal Protection Equipment
PPS	Prospective Payment System
Puskesmas	Indonesian acronym for *Pusat Kesehatan Masyarakat* or primary health centres
RBA	Indonesian acronym for *Rencana Bisnis dan Anggaran* or Budget Document
Renstra	Indonesian acronym for *Rencana Strategis* or Strategic Plan
RQ	Research Question
SAKIP	Indonesian acronym for *Sistem Akuntabilitas Kinerja Institusi Pemerintah* or the Government Institution Performance Accountability System
SDGs	Sustainable Development Goals
SOP	Standard Operating Procedure
SSAH	Social Security Agency for Health
UHC	Universal Heath Coverage
UN	United Nations
UOBK	Indonesian acronym for *Unit Organisasi Bersifat Khusus* or Special Organisational Unit
WHO	World Health Organisation

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TINDAK BALAS STRATEGIK SEBUAH HOSPITAL AWAM DI INDONESIA TERHADAP DASAR KESIHATAN DAN KRISIS: SATU KAJIAN INSTITUSIONALIS

ABSTRAK

Tujuan kajian ini adalah untuk meneroka tindakbalas sebuah hospital awam terhadap perubahan persekitaran yang berpunca daripada perubahan dasar nasional yang dipengaruhi oleh peristiwa global. Fokusnya adalah bagaimana pelaksanaan Insuran Kesihatan Nasional atau National Health Insurance (NHI) dan pandemik COVID-19 telah memberi kesan kepada keutamaan hospital, keputusan pengurusan, dan tindak balas strategik. Kajian ini menggunakan pendekatan kajian kes kualitatif yang tertumpu kepada sebuah hospital milik kerajaan wilayah di Indonesia. Pengumpulan data telah dilaksanakan daripada bulan Jun 2022 sehingga bulan Januari 2024, melalui temu bual bersama informan utama di peringkat kerajaan wilayah dan di hospital kajian, serta analisis dokumen. Teori Logik Institusi dan kerangka kerja Oliver mengenai tindak balas strategik terhadap tekanan institusi digunakan untuk menganalisis tindak balas dan keutamaan hospital. Dapatan kajian menunjukkan bahawa hospital kajian beroperasi di bawah tiga logik institusi yang wujud secara serentak: profesional, negara, dan pengurusan-pasaran. Pada peringkat awal, logik profesional dan negara adalah lebih dominan kerana hospital memberi tumpuan kepada perkhidmatan awam. Namun, pelaksanaan NHI telah mengubah penekanan kepada logik pengurusan-pasaran dengan keutamaan diberikan kepada kecekapan dan kawalan kos. Semasa pandemik, logik profesional dan negara kembali menjadi keutamaan kerana hospital lebih mengutamakan nyawa manusia. Dalam tempoh pasca pandemik, ketiga-tiga logik ini menjadi seimbang. Perubahan logik institusi sepanjang

tempoh masa yang berbeza menunjukkan keupayaan hospital untuk menyesuaikan diri secara dinamik mengikut keadaan semasa. Tindak balas strategik hospital berbeza-beza daripada kompromi kepada pematuhan, bergantung kepada tahap penjajaran antara nilai dan matlamat hospital dengan tekanan luaran. Kajian ini menunjukkan bahawa keupayaan hospital untuk beroperasi dengan pelbagai logik serta menyesuaikan strategi secara berkesan menekankan kepentingan fleksibiliti dan penjajaran nilai dalam pengurusan hospital ketika berdepan dengan perubahan pesat. Kajian ini menyumbang kepada pemahaman tentang pluralisme institusi dalam persekitaran penjagaan kesihatan dengan menunjukkan bagaimana pelbagai logik boleh wujud bersama, diseimbangkan, dan secara kolektif menyediakan pelbagai penyelesaian bagi menyokong daya tindak organisasi dalam tempoh perubahan. Kajian ini turut menekankan kepentingan penjajaran nilai dan kerjasama antara pihak berkepentingan dalam membentuk tindak balas hospital terhadap perubahan dasar. Dari sudut praktikal, kajian ini memberikan panduan tentang kepentingan fleksibiliti strategik dan penglibatan pihak berkepentingan dalam memastikan kejayaan pelaksanaan dasar kesihatan. Pengalaman Indonesia menawarkan pengajaran yang bernilai kepada negara lain yang sedang berusaha untuk melaksanakan transformasi sistem kesihatan secara lestari melalui pendekatan seimbang antara penguatkuasaan peraturan dan penglibatan pihak berkepentingan.

STRATEGIC RESPONSES OF AN INDONESIAN PUBLIC HOSPITAL TO HEALTH POLICY AND CRISIS: AN INSTITUTIONALIST STUDY

ABSTRACT

This study aims to explore how a public hospital responds to environmental changes driven by national policy shifts influenced by global events. It focuses on how the National Health Insurance (NHI) implementation and COVID-19 pandemic have impacted hospital priorities, management decisions, and strategic responses. A qualitative case study was employed in this study, focusing on a provincial government hospital in Indonesia. Data were collected through interviews with key informants at provincial government and case hospital from June 2022 to January 2024 and through document analysis. Institutional Logics Theory and Oliver's framework on strategic responses to institutional pressures were used to analyse the hospital's responses and priorities. The findings reveal that the case hospital operated under three coexisting logics: professional, state, and managerial-market. Initially, professional and state logics were dominant as the hospital focused on public service. The introduction of NHI shifted the emphasis to managerial-market logic, prioritising on efficiency and cost control. During the pandemic, professional and state logics regained prominence as the hospital prioritised human life. In the post-pandemic period, the three logics balanced out. The changes in institutional logics across different periods demonstrate the hospital's dynamic adaptability to prevailing conditions. The hospital's strategic response varied from compliance to compromise, influenced by the alignment between its values and goals with external pressures. The study shows that the hospital's ability to operate with multiple logics and adapt its strategies effectively highlights the importance of flexibility and value alignment in hospital management during times of

rapid change. This study contributes to the understanding of institutional pluralism in healthcare settings by showing how multiple logics can coexist, be balanced, and collectively offer a broader range of solutions to support organisational adaptability during periods of change. This study emphasises the importance of value alignment and stakeholder collaboration in shaping hospital responses to policy shifts. Practically, the study offers insights into the importance of both strategic flexibility and stakeholder involvement for the successful implementation of healthcare policies. The Indonesian experience provides valuable lessons for other countries seeking sustainable health system transformation through a balanced approach between regulatory enforcement and stakeholder engagement.

CHAPTER 1

INTRODUCTION

1.1 Introduction

This chapter explains the objectives and background of this study. The chapter starts with a brief discussion about how hospitals adapted to a changing environment due to New Public Management (NPM) reform. The discussion then continues on how the reform ultimately impacts the health sector in Indonesia through a policy of *Badan Layanan Umum* (BLU) or Public Service Agency and the implementation of National Health Insurance (NHI). This chapter further explains that besides NHI, the Coronavirus Disease 2019 (hereafter COVID-19) pandemic also creates significant pressure on the hospital, which increases the need for a more accurate allocation of hospital resources to achieve the expected quality in responding to the health and economic crisis. The chapter then discusses the problem statement, followed by research questions, research objectives, and research contribution. Finally, this chapter provides a brief outline of the thesis.

1.2 Background of the Study

Public hospitals operate within a dynamic environment shaped by continuous public demands for better management. These changes often stem from global events that lead to significant reforms. For instance, the introduction of the Prospective Payment System[1] (PPS) in the US and UK hospitals in the 1980s was a response to New Public Management (NPM) reforms (Malmmose, 2012). Initiated in the 1960s in the US and the 1970s in the UK, NPM has emerged as a global movement triggered

[1] In prospective payment systems, hospitals or healthcare providers are paid a predetermined amount based on standardised service tariffs, regardless of the intensity of the actual service provided, and payments are facilitated through a reimbursement process (Fainman & Kucukyazici, 2020).

by persistent concerns over the management of public sector organisations, which fostered substantial demands for reform (Malmmose, 2019). NPM has proven influential in enhancing management practices across the public sector worldwide by adopting private business-like management styles and focusing on accounting principles such as efficiency, cost control, and performance measurements (Malmmose, 2019). The success of NPM in various public sectors has led policymakers in public healthcare to increasingly embrace NPM principles to promote managerial efficiency (Malmmose, 2012, 2019; Simonet, 2013).

NPM appears to be the starting point for a global movement to improve the management of public sector organisations, including public hospitals. In reality, the implementation of NPM requires a huge effort and can yield varying results, or even, in some cases, it brings unintended effects (Malmmose, 2019). Thus, it is believed that the result of NPM implementation is influenced by the different settings of political, economic, social, and cultural contexts, including stakeholder views along with institutionalised changes among countries adopting NPM (Malmmose, 2019). Improvements in public sector organisations are initiated at different times and for various reasons, using different strategies or initiatives, and resulting in different impacts in each country. For example, the impact of NPM reforms in Europe, which began in the 1980s, was only manifested in the public healthcare sector after the 1990s in Italy (Macinati, 2010) and Portugal (Conceicao et al., 2024).

Although the NPM movement inspired the reforms, these changes were initiated and triggered at different times and reasons. Indonesia, in particular, is among NPM late adopters. Public sector reform in Indonesia was triggered by a financial crisis that severely hit the country in 1997 (Harun et al., 2012). In 2003, the Government issued a law on State Finance, which is widely regarded as the catalyst for the reform.

Public hospitals experienced the impacts of NPM reform after the introduction of the *Badan Layanan Umum* (BLU) or Public Service Agency policy, which aimed to improve public services by providing broader autonomy in financial management based on economic principles and productivity and implementing business-like management (Government Regulation of the Republic of Indonesia No. 23 Year of 2005 about Financial Management of Public Service Agencies, 2005; Law of Republic of Indonesia No. 25 Year of 2009 about Public Service, 2009).

Public hospitals with BLU status have been encouraged to manage their finances more autonomously to foster business-like management practices (Fahlevi, 2016). The Prospective Payment System (PPS) was first launched in 2008 by implementing Indonesian Diagnostic-Related Groups (INA-DRGs)[2], initially applied to specific-group insurance through Jamkesmas and Jampersal[3] starting in 2009 and then replaced by Indonesian Case-Based Groups (INA-CBGs) in 2010 (Fahlevi & Farber, 2014). However, the impact of PPS was not significantly witnessed as Jamkesmas and Jampersal patients accounted for only about 16% of the total patients in Indonesia (Fahlevi & Farber, 2014). This meant that most patients continued using the fee-for-service or retrospective payment system. As a result, while public hospitals had gained financial management flexibility, the efficient operation expected from cost control through PPS had yet to be realised. This situation was one of the driving factors for the Indonesian government to implement National Health Insurance (NHI), with the goal of providing health insurance coverage for the entire population (MoH

[2] The Diagnosis-Related Group (DRG) system classifies patients into groups based on similar clinical diagnoses and assigns each group a cost-weight index reflecting the average cost of treatment. Hospitals receive a predetermined lump-sum payment for treating a patient in a specific group, regardless of the actual expenses incurred (Fahlevi & Farber, 2014; Fainman & Kucukyazici, 2020; Mboi, 2015)

[3] Jamkesmas (Jaminan Kesehatan Masyarakat or Community Health Insurance) and Jampersal (Jaminan Persalinan or Maternity Insurance) are subsidised health insurance programmes for people living in poverty and vulnerable groups (Fahlevi & Farber, 2014; Mboi, 2015).

Regulation No. 28 Year of 2014 about the Implementation of NHI, 2014). The widespread adoption of PPS became feasible only after 2014, when the NHI, mandatory for the entire population, was introduced.

The implementation of NHI was also encouraged by the global agenda of the Sustainable Development Goals (SDGs), which include Universal Health Coverage (UHC) as one of its goals. The aim of NHI is in line with the objective of UHC, which aims to combat barriers to accessing quality essential healthcare services and to protect against financial risks from health issues (Pratiwi et al., 2021; UN General Assembly, 2015). Thus, the national insurance implementation is part of the Indonesian government's efforts to achieve the SDGs through UHC. The NHI implementation is considered an ambitious project as the government targets 100% coverage within five years (Pratiwi et al., 2021).

In the early years of NHI implementation, both the Social Security Agency for Health (SSAH), which administers the national insurance, and hospitals as its front liners encountered many problems. While national insurance coverage increased to more than 80% in less than five years (Pratiwi et al., 2021), this growth was not supported by financial sustainability, as evidenced by SSAH's huge deficits. The number of participants utilising NHI for healthcare services increased drastically (Pratiwi et al., 2021), while, on the contrary, premium payments from members remained problematic (Deloitte Indonesia, 2019), and reimbursement claims from hospitals continued to accumulate. Broader national insurance coverage without efforts to strengthen financial sustainability and efficient operation resulted in a significant deficit for SSAH. The deficit in SSAH disrupted hospital operations and, in some cases, threatened the continuity of hospital services (Nana, 2019; Ridlo, 2018; Wicaksono & Widyastuti, 2018). As a response, SSAH subsequently implemented

stricter claim reimbursement procedures and emphasised quality control and cost control measures in hospitals.

Amid the ongoing challenges with the implementation of national insurance, Indonesia faced a health crisis due to the COVID-19 outbreak that began in March 2020 (Djalante et al., 2020). COVID-19, initially detected in China around November 2019, infected millions of people worldwide and killed more than half a million[4], including around 3000 health workers[5]. The pandemic then forced every affected country to exploit its resources in preventing the larger transmissions and, at the same time, overcome the effects. Various measures, including social distancing, movement control orders, and even a complete lockdown of the entire country were implemented. Those efforts are time-consuming and costly[6] as they are carried out by blockades between regions and countries that affect people, production, government, as well as economic activities[7]. Consequently, some parties predicted a world economic recession would follow this pandemic (Tandon et al., 2020).

The COVID-19 pandemic highlights the importance of global collaboration and universal health coverage. The pandemic has demonstrated the potential for outbreaks to occur globally and affect countries worldwide. The crisis further stresses the significance of maintaining hygienic and healthy living habits (Arai et al., 2021; González-Olmo et al., 2020) and proves that prevention is far better and cheaper than curative action (Kapinos et al., 2024; Ohsfeldt et al., 2021). This situation is in line

[4] WHO Coronavirus Disease (COVID-19) Dashboard -Retrieved from https://covid19.who.int on 19 July 2020
[5] Global: Health workers silenced, exposed and attacked – Retrieved from https://www.amnesty.org/en/latest/news/2020/07/health-workers-rights-covid-report/ on 19 July 2020
[6] While the world spends on coronavirus bailouts, China holds back – retrieved from https://economictimes.indiatimes.com/news/international/world-news/while-the-world-spends-on-coronavirus-bailouts-china-holds-back/articleshow/75087711.cms on 15 April 2020
[7] COVID-19 to Plunge Global Economy into Worst Recession since World War II retrieved from https://www.worldbank.org/en/news/press-release/2020/06/08/covid-19-to-plunge-global-economy-into-worst-recession-since-world-war-ii on 17 July 2020

with the principles of UHC and SDGs, which emphasise the importance of global collaboration to ensure access to quality healthcare services for everyone (UN General Assembly, 2015). Thus, the goal to achieve UHC must be sustained. This places the national insurance program and hospitals as its frontline in a vital position.

At the operational level, hospitals may significantly contribute to the success of national insurance, which is key to achieving UHC and SDGs. From the overall SDG targets in the health sector, two targets are particularly interrelated, which are achieving UHC, including financial risk protection and access to quality essential healthcare services (Target 3.8), and maintaining proper health financing and Human Resource management (Target 3.C) (UN General Assembly, 2015). These targets indicate that achieving UHC should be supported by adequate health financing and appropriate human resource management. Hospitals can play their role by making "better HR" while the central government strives to produce "more HR" (Campbell et al., 2013). Further, qualified HR will result in higher-quality services (Campbell et al., 2013). Providing quality treatments and medications may prevent unplanned patient readmission and prolonged care, which are believed to be the major drivers of high health financing (Burgess et al., 2015; Mahendradhata et al., 2017). Consequently, the provision of quality services may lower both curative care expenditures and out-of-pocket costs for patients. Therefore, properly managing their HR may lead to better hospital performance and help to strengthen financial sustainability, thus providing positive support for the achievement of UHC.

However, providing quality healthcare services has become more challenging due to the impact of the pandemic and the shift in the national insurance payment system. When the country is under these pressures, SSAH must continue its serious efforts to sustain financial resources by emphasising prevention and urging the hospital

to comply with regulations, avoid fraud, and manage cost and quality (Oxford Business Group, 2018). Meanwhile, hospitals, particularly government hospitals, need to efficiently manage their resources to survive while maintaining their quality service and making progress to achieve UHC.

1.3 Problem Statement

Government hospitals in Indonesia have undergone rapid changes within a relatively short period forced by several policy shifts that fundamentally altered the structure and practices within the healthcare system. These changes have intensified the challenges faced by hospitals, due to increasing financial and operational pressures and the growing tensions between economic demands and prevailing professional or social values (Fainman & Kucukyazici, 2020). Integrating economic considerations into hospital management is widely acknowledged as challenging (Andersson, 2022), as it often creates conflicting institutional logics within the organisation (Andersson, 2022; Naamati-Schneider, 2022; Pettersen, 2004).

Following the introduction of the BLU policy in 2005, hospitals encountered further significant events in 2014 with the implementation of the NHI, and again in 2020 when the COVID-19 pandemic caused both a health and economic crisis. Several studies indicate that these changes can be linked to global events (Figure 1.1). The government's policy to grant BLU status to certain government organisations was triggered by a global reform of NPM (Fahlevi, 2016; Harun et al., 2012). Similarly, the adoption of NHI was driven by the global movement towards achieving UHC, one of the SDGs (MoH Regulation No. 28 Year of 2014 about the Implementation of NHI, 2014). Lastly, COVID-19 emerged globally in late 2019 and reached Indonesia by early 2020. In response, the government introduced strict health protocols that

triggered substantial changes within the national health system throughout the pandemic (Setiati & Azwar, 2020).

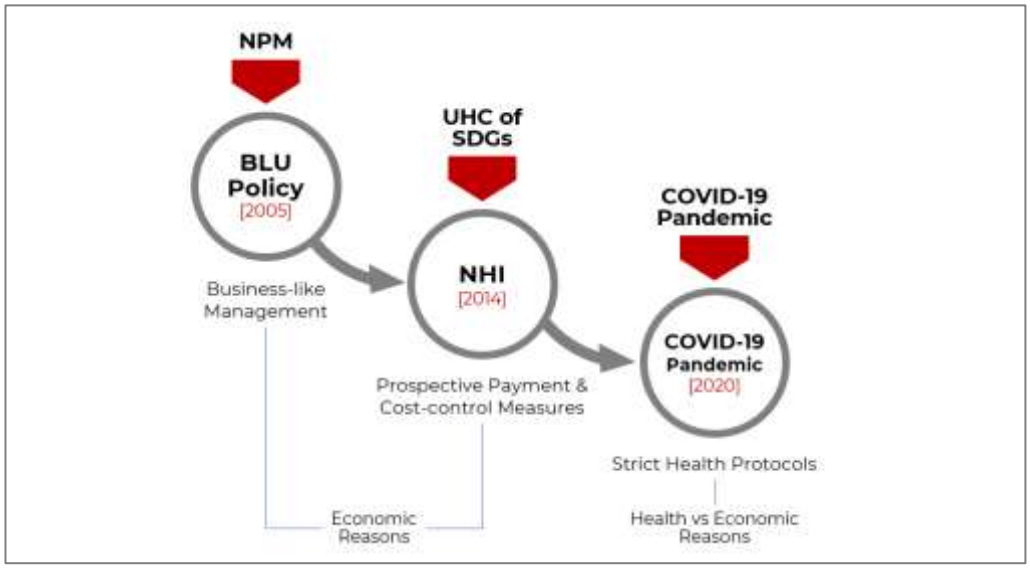

Figure 1.1 Global Events and Changes in the Health System and Policy in Indonesia (Source: Author's Illustration)

The rapid and drastic changes have presented challenges for hospitals. After adopting the BLU system, which required a more business-like management approach, hospital management faced substantial changes with the introduction of NHI. Furthermore, hospitals encountered another significant event, the COVID-19 pandemic, within six years. These events brought about significant changes, some of which might even be contradictory. Following the national insurance system, hospitals have struggled to control costs and operate efficiently while adhering to the quality and pricing standards set by the SSAH. In contrast, the response to the COVID-19 pandemic demanded the implementation of strict health protocols, prioritising human life over cost control. The pandemic placed an excessive strain on the country's resources and threatened the survival of government organisations.

Furthermore, the changes have resulted in a conflict between the new values and objectives and the prevailing ones within the hospital framework. Traditionally, hospitals have often been viewed as organisations deeply embedded with social values

and missions, primarily focused on addressing community health needs (Bode et al., 2017; Fahlevi, 2016). The implementation of NHI, however, is primarily seen as driven by economic factors, as evidenced by the adoption of business-like management practices, the prospective payment system, and the implementation of strict quality and cost-control measures. These conflicts between economic considerations and hospitals' social values and goals make it difficult to integrate these factors into hospital management (Carr & Beck, 2020; Djamhuri & Amirya, 2015; Pettersen, 1995), especially within government hospitals. Subsequently, the COVID-19 pandemic induced a health crisis. Applying strict health protocols in managing this pandemic posed a dilemma as it created a conflict between the objectives of saving human lives and preserving the national economy (Setiati & Azwar, 2020). In hospitals, the conflict was apparent, as efforts to save lives during the COVID-19 crisis often sidelined economic considerations (Malmmose & Dahl Pedersen, 2023). This was particularly challenging as hospitals were, just before the pandemic, transitioning towards more business-like management and cost-control measures in response to NHI.

Integrating economic considerations in managing government hospitals is a challenging task. The hospitals are widely recognised for their deeply embedded social function, with a clear obligation to meet community healthcare needs (Bode et al., 2017; Fahlevi, 2016). Additionally, hospitals operate within a highly institutionalised environment where professional norms and values dominate (Carr & Beck, 2020; Conceicao et al., 2024; Pettersen, 1995). Physicians often prioritise medical standards and the best interests of their patients, mostly neglecting cost-consciousness (Carr & Beck, 2020; Djamhuri & Amirya, 2015; Pettersen, 1995). Some believe that valuing money in providing care is considered unethical as the demand for healthcare services

is basically unlimited for the patient's life (Fritze, 2001), even during financial crises (Carr & Beck, 2020). Therefore, hospitals traditionally separate administrative tasks managed by managers from clinical tasks handled by medical staff (Carr & Beck, 2020; Djamhuri & Amirya, 2015; Pettersen, 1995). In many cases, clinicians dominate hospital decision-making, with managers acting as subordinates (Carr & Beck, 2020). This situation undoubtedly complicates the management of hospitals.

The national insurance implementation and the pandemic may significantly shift the prevailing logic within hospitals. This logic, known as institutional logic, refers to the shared beliefs, practices, and rules that guide how people think, behave, and organise their lives within a society or organisation (Thornton et al., 2012). Institutional logics shape what is considered normative or acceptable and influences how individuals make decisions and interpret their social reality. Under the BLU policy and the insurance system, hospitals were required to adopt business-like management practices and operate efficiently, which are characteristics of managerial-market logic. Thus, after those policies, hospitals in Indonesia are moving towards managerial-market logic from professional logic, characterised by growing concern on some management accounting practices (Astutiningrum et al., 2017; Djamhuri & Amirya, 2015; Fahlevi, 2016). However, the pandemic suddenly hit and caused economic shock and resource scarcity, so hospitals had to respond to it by encouraging even more efficient operations. On the other hand, the pandemic also caused a health crisis that resulted in a massive loss of patients and health professionals[8], and it potentially triggered professional logic. Understanding the institutional logics in this situation is essential, as institutional logics shape organisational decisions (Thornton

[8] Calls for govt action after 14 doctors die of COVID-19 in a week - Retrieved from https://www.thejakartapost.com/news/2020/07/14/calls-for-govt-action-after-14-doctors-die-of-covid-19-in-a-week.html on 19 July 2020

et al., 2012). A decisive response was highly needed in this critical moment to secure hospital survival and, at the same time, to keep the hospital on track in providing access to quality services to the nations.

To understand how hospitals manage the environmental changes and the shift in institutional logics, it is essential to examine their strategic responses to external pressures. Oliver's (1991) framework provide a useful lens to analyse these responses, particularly in institutional environments characterised by complexity and change. The framework identifies various strategic responses, from acquiescence to manipulation, based on the degree of institutional pressure and the alignment with organisational goals (Oliver, 1991). In the healthcare sector, recent studies have referred this framework to examine organisational responses to various institutional demands, such as clinical audit implementation (McVey et al., 2021), accreditation requirements (Silva & Rossoni, 2024), and health IT adoption (Bunduchi et al., 2020). As hospitals in Indonesia encountered pressures from the NHI implementation and the COVID-19 pandemic, which carried different institutional demands, Oliver's framework provides a relevant approach to understand how the hospital responds strategically while balancing competing logics.

Studies on how hospitals adapt to change have been conducted, but the situations faced by government hospitals in Indonesia are particularly unique. First, these hospitals faced drastic changes within a relatively short time, triggered by a series of global events. Secondly, the transition to NHI was generally driven by economic reasons. This transition involved the adoption of business-like management including the use of cost control and efficiency measures as management accounting tools in hospitals. However, integrating these practices have been challenging due to the traditional lack of emphasis on economic considerations in government hospitals.

Lastly, the changes during the pandemic were primarily driven by health and safety concerns. This created conflicts between prioritising human life and economic considerations, where safeguarding human life had to take priority over economic factors. Therefore, it is crucial to investigate further how a hospital responds to these complex situations by examining its adaptations to health policy shifts and crises in Indonesia. This study explores hospital responses across four different phases, namely before and after the implementation of NHI, during the COVID-19 pandemic, and in the post-pandemic period as the crisis began to ease.

1.4 Research Question

The main research question for this study is: how does a public hospital in Indonesia, at the organisational level, responds to complex and rapidly changing environmental conditions resulting from shifts in national health policy and crisis that were both triggered by global events?

The specific research questions are as follows:

1. How do the implementation of the NHI and the management of the COVID-19 pandemic, both significant events triggered by global occurrences, influence environmental changes and priority-setting in the public hospital?

2. How and why does the public hospital set its priorities in response to the environmental changes caused by the NHI implementation and the COVID-19 pandemic?

3. What strategic responses does the public hospital employ to address the pressures arising from environmental changes caused by NHI implementation and the COVID-19 pandemic?

1.5 Objectives of the Study

This study aims to explore how a public hospital, at the organisational level, responds to complex and rapid environmental changes triggered by national policy shifts and global events. This research offers in-depth insights into the hospital's strategic responses by analysing how it addresses challenges stemming from organisational environmental changes. The specific objectives of this study are as follows:

1. To explain how the NHI implementation and the COVID-19 pandemic, as significant events triggered by global occurrences, influence environmental changes and priority-setting in a public hospital.

2. To explain how and why the government hospital set its priorities in responding to environmental changes caused by the implementation of NHI and the COVID-19 pandemic.

3. To explain the strategic responses employed by the public hospital in addressing pressures arising from environmental changes due to NHI implementation and the COVID-19 pandemic.

A case study was conducted at a provincial government hospital to investigate the hospital's response to the environmental changes brought about by the implementation of the NHI and the management of the COVID-19 pandemic. Institutional logics theory was employed to analyse the hospital's response and comprehend the underlying reasons. Also, Oliver's framework on strategic responses was utilised to gain insights into how public hospitals address the pressures arising from these environmental changes.

1.6 Contribution of the Study

This study investigates how hospitals, as highly institutionalised organisations, respond to two significant events: the NHI implementation and the COVID-19 pandemic. The introduction of NHI exerts economic pressures on hospitals, demanding a business-like management approach that frequently employs management accounting tools, such as strict cost-control measures. Concurrently, pandemic control imposes demands on health and safety aspects by implementing stringent protocols, which often conflict with the hospital cost-control efforts. This study, conducted in a real-world setting, reveals how a hospital adapts their initiatives and priorities in response to such changes, providing a clearer understanding of how management accounting practices are executed in organisations characterised by institutional complexity within dynamic environments. Thus, this research aims to contribute to the contextual, theoretical, and practical aspects of hospital management and policy implementation in Indonesia.

This study offers contextual contribution as it explores the unique circumstances faced by the case hospital, which differ from those examined in existing studies due to a distinct combination of regulatory changes and health crises. The study analyses the hospital's responses during both normal conditions, driven by economic pressures from NHI implementation, and during extreme situations that require balancing health and economic priorities, such as a pandemic response. This study explores how economic factors were considered in hospital management while balancing the importance of safety and service. This contextual contribution offers new insights into how hospitals address competing demands while ensuring the continuity of services.

Meanwhile, this study also provides contribution to the theoretical domain. Utilising Institutional Logics Theory (Thornton et al., 2012) and the Strategic Response to Institutional Pressures framework (Oliver, 1991) as analytic lens, this study provides insights into the dynamics of institutional logics and organisational behaviour of the case hospital in responding to changes and facing diverse situations. While many studies have examined changes in the institutional logics of hospitals triggered by critical situations for economic reasons, the analysis in this study focuses on the hospital's responses to changes driven both by economic considerations alone and by health crises and economic considerations simultaneously. Changes and pressures from economic considerations are examined from the hospital's situation before and after the implementation of NHI, while the concurrent health and economic crisis conditions are studied during the hospital's response to the pandemic.

More specifically, this study addresses the complexities of institutional pluralism within the hospital in responding to pressures from multiple constituents, especially during both normal operations and crises. This study gains increased relevance as it examines organisational changes in a government hospital, an entity influenced by numerous constituents from multiple levels, both within and outside the organisation. Therefore, the specific events contextualised in this study are valuable as they provide new insights into institutional logics theory and the strategic response framework.

The findings of this study offer practical contributions by providing insights into how the case hospital responds to significant changes triggered by two key events. In both situations, this study examines how the case hospital overcomes substantial pressures arising from conflicting demands between health or human life considerations and economic concerns, and how it balances regulatory compliance

with the needs of hospital management and clinicians. This study, in particular, sheds light on how the case hospital implements cost control practices, a crucial management accounting tool emphasised in implementing NHI, to ensure their acceptance and effective execution within the hospital. Thus, this study emphasises the need for an effective approach between government, hospital management, and clinicians in addressing the complexities of policy reform, which offers guidance for policymakers in harmonising policy formulation with the professional values underlying healthcare delivery.

1.7 The Outline of the Thesis

This thesis is organised into eight chapters. Chapter One provides the introduction to this study. This chapter describes the changing environment of the government hospitals in Indonesia that leads to the changing behaviour of the organisation in management accounting practices. Those problems are then formulated into research questions for this study, which in turn become the basis for determining research objectives as well as the research design. This chapter also explains the contribution of this study. The outline of this study is then presented at the end of this chapter.

Chapter Two discusses the Indonesian context. This chapter provides essential sections about the two sequencing events, national health insurance implementation and the COVID-19 pandemic, that significantly affect Indonesian hospitals. To provide a big picture of the Indonesian situation, this chapter begins with a more detailed description of the implementation of the national insurance programme in Indonesia. Then, the following section explains the current situation of the COVID-19

pandemic. The chapter ends with a discussion of how those two events affect hospital operations and survival in Indonesia.

Chapter Three provides a literature review on hospitals, particularly government hospitals, in changing environments and their effort in managing operations due to the change. The first part of the chapter describes the changing environment of government hospitals. The following sections explain the factors that shape hospital behaviour, the challenges in implementing a new system in government hospitals, and the enhanced role of management accounting. The final section includes a mini-review of the extant literature to understand the current research on budgeting and other management accounting in the hospital, as well as the research gap based on this review.

Chapter Four discusses issues related to theories used as the theoretical framework of this study. This chapter is opened with a brief overview of the emergence of Institutional Logics Theory as part of institutional research. The following section then discusses the existence of institutional pluralism in an organisation and its related problems in more detail, followed by an explanation of institutional complexity as a result of the existence of multiple logics. The chapter continues with a discussion on strategic organisational response typologies during the process of institutionalisation. This chapter concludes by illustrating how the theories mentioned above are suitable to become analytic lenses in viewing phenomena in the study context.

Chapter Five is provided to describe the research methodology. The chapter starts with a discussion about the philosophical background of this study. The discussion is then followed by a description of the interpretive approach and case study used in this study. The last section of this chapter provides more detailed research

stages and methods and the case analysis that will be performed to understand the phenomena in this study.

Chapter Six presents the research findings from the case study. It begins with an overview of the transformative shift in Indonesia's healthcare system following the implementation of National Health Insurance. It examines changes in actor influence on government hospitals, focusing on the case hospital. The chapter discusses the effectiveness of management initiatives in meeting demands under the NHI system and outlines the hospital's response priorities. It then analyses the impact of the COVID-19 pandemic on the hospital during its NHI adaptation, including its responses and support received. The chapter concludes with exploring the hospital's priorities and initiatives during and after the pandemic.

Chapter Seven presents a discussion based on theoretical analysis, employing institutional logics theory and the strategic response to institutional pressures framework as analytical lenses. These frameworks are utilised to generate the theoretical analysis and provide an explanation of the case findings.

Lastly, Chapter Eight concludes this study by discussing the contributions, acknowledging the limitations, and offering recommendations for future research.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Indonesia has been implementing a National Health Insurance (NHI) programme since 2014, for five years prior to the emergence of the COVID-19 pandemic. These two major events have had significant impacts on the country's health sector, particularly on hospitals. The sequence and nature of these events have created a distinct set of challenges for Indonesian hospitals. To deepen understanding of these conditions, this chapter presents a literature review structured into three main sections. The first section discusses the Indonesian context by providing an overview of the NHI implementation and the COVID-19 pandemic, along with their impacts. The second section reviews extant literature on how hospitals respond to complex environmental changes and examines the implications for hospital management, particularly the role of management accounting. The final section identifies research gaps in the existing literature, in relation to the specific context faced by Indonesian hospitals.

2.2 Indonesian Context

To give a bigger picture of the Indonesian context, this section starts with a detailed description of the implementation of the national insurance programme in Indonesia and its effects on hospital operations and survival. This section then explores the COVID-19 pandemic and its impact on hospitals in Indonesia. Lastly, this section concludes with a section discussing the pressures faced by hospitals after the National Health Insurance Implementation and the COVID-19 pandemic in Indonesia.

2.2.1 National Health Insurance in Indonesia: Towards Universal Health Coverage of SDGs

During the United Nations General Assembly in 2015, 193 world leaders committed to eliminating poverty and other deprivations. The resulting document, entitled 'Transforming Our World: the 2030 Agenda for Sustainable Development,' presents a universal development plan to be carried out from 2016 to 2030. This plan includes the Sustainable Development Goals (SDGs) and targets formulated to achieve improvements in health and education, reduce inequality, encourage economic growth, ensure environmental preservation, and combat climate change (UN, 2015). The SDGs are a continuation of the Millennium Development Goals (MDGs) conducted from 2000 to 2015, with health as a key target and focus. Specifically, SDG 3 aims to address Good Health and Wellbeing and solve wide-ranging health challenges, including achieving UHC, reducing illness and pollution-caused deaths, and increasing human resources for health (UN General Assembly, 2015). UHC combats barriers to accessing the quality of essential healthcare services and protects the financial risk associated with health issues.

Indonesia, a signatory of MDGs and SDGs, introduced national insurance in 2014. However, the programme encountered inequalities due to the country's huge and unevenly distributed population, diverse geographical locations, and decentralisation reform in 1999 that shifted the responsibility for health service planning and management from the central to local governments. Consequently, the quality of health services and access to the population are heavily dependent on local government. As the achievement of UHC requires effective policy translation from global and regional levels to the national level (UN General Assembly, 2015), the commitment of the

central government is important. Besides embedding the SDGs in the national development agenda, Indonesia needs to ensure that SDGs are implementable based on holistic approaches and strategies, and environmental sustainability (UN General Assembly, 2015). Therefore, national policies need to be effectively executed at every administrative level and translated into concrete actions at operational levels, such as within hospitals.

2.2.1(a) Implementation of National Health Insurance in Indonesia.

The target of UHC under SDG 3 aligns with the Indonesian government's policy in implementing national insurance. However, several aspects still need to be addressed in the health sector, such as the quality of health services and the competency of health workers (MNDP RI, 2018). These challenges arise from Indonesia's huge population and diverse geographical conditions. As a growing middle-income country and the world's fourth most populous nation of around 265 million people (Agustina et al., 2019; Deloitte Indonesia, 2019; Mahendradhata et al., 2017; Mboi, 2015), the country spans around 5,200 km east to west, with 5,000 of its 17,000 islands being inhabited (Deloitte Indonesia, 2019; Mahendradhata et al., 2017; Mboi, 2015). These conditions create significant challenges in addressing inequities across the nation.

Decentralisation further worsens the inequities, which leads to different policies and resources in each province or district (Agustina et al., 2019; Mahendradhata et al., 2017). Following decentralisation reform, the responsibility for managing health services shifts from the central government under the Ministry of Health (MOH) to local governments under the Ministry of Home Affairs (Mahendradhata et al., 2017). Local governments must provide the resources needed to meet minimum health service standards (Minister of Health Decree No. 129 Year

of 2008 about Minimum Standard of Service, 2008). The decentralisation is like a double-edged sword. While decentralisation allows local governments to initiate policies and solve local problems by developing healthcare resources based on local priorities (Paramita et al., 2018), it also leads to differences in the healthcare services provided due to the different financial capabilities among local and provincial governments (Mahendradhata et al., 2017). Despite the limited resources problem, capacity has been given priority to the allocation of the Special Allocation Fund from MOH, with a focus on promotive and preventive efforts (MOH Regulation No. 4 Year of 2019 about Technical Standards for Basic Services in Minimum Service Standards in the Health Sector, 2019), rather than on curative care, which is the hospital's core business.

2.2.1.1(a)(i) The Mechanics of Indonesian National Health Insurance

National health insurance in Indonesia is administered by a single-carrier health insurance provider, the Social Security Agency for Health (SSAH). National insurance membership is compulsory for all residents in Indonesia, including foreigners living in the country for a minimum of six months (Law of Republic of Indonesia No. 24 Year of 2011 about Social Security Agency for Health, 2011). Thus, SSAH serves more than 220 million members and become one of the largest health insurance providers in the world (Agustina et al., 2019). Members are classified into two groups: *Penerima Bantuan Iuran* (PBI) or Premium Assistance Beneficiaries (for low-income individuals) and non- Premium Assistance Beneficiaries (non-PBI) health insurance. All members are required to pay a premium, except for the PBI, whose premiums are paid by the government (SSAH, 2019a). For those who work in the formal sector, premium payments are shared between employers and employees, while informal sector workers must register and pay the fee themselves (SSAH, 2019a).

The national insurance employs a Prospective Payment System (PPS) for partner hospitals, with payment based on a claim categorised under Indonesian Case-Based Groups (INA CBGs) . These tariffs accommodate diagnoses and procedures with similar clinical characteristics, resources, and treatment costs (Mahendradhata et al., 2017). Set by MOH, INA CBG tariffs vary depending on the hospital's region, ownership, type, and class of care (MOH Regulation No. 64 Year of 2016 about Standard of Health Services Tariff for the National Health Insurance, 2016). Tariffs for private hospitals are slightly higher than those of public hospitals, with a 3% increase for inpatient services and a 5% increase for outpatient services (Agustina et al., 2019; MOH Regulation No. 64 Year of 2016 about Standard of Health Services Tariff for the National Health Insurance, 2016). Since both government and private hospitals participate in the national insurance, an accreditation system is implemented to ensure quality.

2.2.1.1(a)(ii) Hospital Quality Assurance in the National Health Insurance System

SSAH requires partner hospitals to maintain an accreditation status, which must be renewed every three years (MOH, 2017; President of the Republic of Indonesia, 2019). This accreditation is conducted by the Commission on Accreditation of Hospitals (CAH), an independent national accreditation institution accredited by the International Society for Quality in Health Care (ISQua) (MOH Regulation No. 34 Year of 2017 about Hospital Accreditation, 2017). The CAH adopts the Joint Commission International standards, which assesses 16 standards aimed at improving patient care and addressing essential healthcare functions (CAH, 2019). Since the national insurance implementation, hospital accreditation has taken a more significant role. Previously, accreditation focused on ensuring quality services, patient safety, and meeting legal requirements (MOH Regulation No. 34 Year of 2017 about Hospital

Accreditation, 2017); however, hospital accreditation now serves as a prerequisite for providing services to national insurance members, thus it meets three important purposes: ensuring quality and safety, fulfilling legal obligations, and supporting business operations. As a result, hospitals in Indonesia are strongly encouraged to maintain their accreditation certificates.

2.2.1(b) Achievements of Universal Health Coverage indicators.

In translating the SDGs' strategy, the targets and objectives of the SDGs were set globally but remained aspirational, which allowed each government to match the targets according to its circumstances and link them to national planning (Addis Ababa Action Agenda of the Third International Conference on Financing for Development, 2015). In the health sector, two SDGs targets are relevant to the role of hospitals: the implementation of UHC (SDGs Target 3.8) and health financing and management of human resources (SDGs Target 3.C). Indicators for both targets indicate that UHC must ensure access to quality healthcare services, supported by proper health financing and good human resource management. The linkage between SDG Targets 3.8 and 3.C is presented in Figure 2.1.