

# Understanding the Dynamics Interaction within Indonesia Healthcare Competition

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## Abstract

This paper is intended to comprehend the dynamics interaction within Indonesia healthcare competition that might lead to the unhealthy conducts resulting in harming society and business harmony. It was analyzed by describing market structure using Porter's five forces competition based on descriptive analysis approach to determine whether the structure was conducive for unhealthy competition or not. The intensity of competition within industry is low as a result of the weakness of consumer bargaining power, the strong bargaining power of providers, the malfunction of substitution availability, and the barriers of market entry. The pertinent findings include the existing of consumer service and price discrimination due to asymmetry information, the tendency of providers to integrate vertically and horizontally, as well as the dependency of society to public insurance. The result would be relevant to develop Indonesia healthcare policy to minimize unhealthy competition and to maximize the benefit for society. The findings also imply the necessity of further studies to reevaluate and realign the business practices in Indonesia health care industry.

**Key words:** market structure, healthy business practices, bargain power, entry barriers, substitution, health care industries

## 1. Introduction

There has been a fundamental difference between the Law of Antimonopoly and Unhealthy Competition and the practices of business competition in healthcare industry in Indonesia. Indeed, this issue has also been prolonged concerned by many researchers regulators, and medical community, among others are collusion among healthcare providers, the impact of competition to healthcare quality, and market domination of healthcare providers (Briefing Paper CUTS, 2008; Barlo M., 2006; Pauly M.V., 2004; and Bates L.J. and Santere R.E., 2008).

Similar tones are also found in Indonesia including a substantial amount of people's complaints regarding the consumer discrimination, low community accessibility to the quality of health services, and market domination by only a few pharmaceutical companies (Sparrow et al, 2010; Thabrany et al, 2003; Tempo, April 8<sup>th</sup> 2001). Another fact indicating the practices of unhealthy business competition in the health care industry was the finding of many transfer notes from one of the largest pharmaceutical company in Indonesia into hundred accounts of physicians, pharmacists, and hospital administrators scattered in various cities in Indonesia (Tempo, April 8<sup>th</sup> 2001).

Since the health development in Indonesia is one of the most important pillars of the national development achievement, the government has issued various policies to stimulate the growth of the industries as an important player in supporting the achievement of health development goal. At one hand such growth is expected to increase the affordability of quality, equity, and accessibility of health services for societies. On the other hand, such growth is vulnerable to the proliferation of unhealthy competition. Therefore, it is very important to prevent the competition from unhealthy business practices to assure the achievement of the national health development goal as well as to maintain the business harmony.

## 2. Background

Market-oriented reforms in the health sector continue to dominate health policy agendas in many developing countries including Indonesia despite growing evidence of their negative impacts. Health care competition has taken various forms where different players such as hospitals, insurances and physicians struggle to reach a niche market position (Griffin, 1992; Wagstaff, 2007).

The concept of industrial organization developed by Mason (1939, 1949) and Bain (1959) in Carlton and Perloff (1994) has been well proven in analyzing the strategic choices of firms within industries including market structure and competition in the healthcare sector. This concept has also given a great contribution in breaking down many different perspectives and strategies, which leads to contribute to policy development field in a quite different perspective from its pure concept (Mason, 1939, 1949; Bain, 1959 in Carlton and Perloff, 1994).

Based on that concept, the structure of an industry will influence the behavior or conduct of firms, and subsequently firm's conduct will determine the performance of the industry (Bain, 1968; Mason, 1953). In addition, Porter (1980) introduced the Five Forces of Competition model as a basis for a competition analysis consisting of the bargaining power of supplier, the bargaining power of consumer, the barrier of entry, the availability of substitutes, and the intensity of rivalry within industry.

Unfortunately, perfectly competitive markets exist only in economic theory. In reality, industries and markets have varying constraints on competition. Evans, R.G. (1984) stated that the healthcare industry has often been characterized as unique in its many significant barriers to free market competition. Most of the inhibition from healthcare market controls on price and quality result coming from various factors as follows: (1) The Asymmetry of Information between Providers and Consumers/Patients. Most consumers have limited information about their illness and their treatment options. Consumers with chronic illnesses are supposed to have more opportunity and incentive to gather such information, but there is still a fundamental informational asymmetry between providers and patients; (2) Consumer Uncertainty about Reliability of Health Care Information. Uncertainty increases transaction costs, fraud, and deception dramatically; (3) The nature of health creates an unpredictable, urgent, and infinite level of demand; (4) The intensive involvement of insurance, private and governmental, as an intermediary in the purchase of healthcare interferes with consumer motivations and consequently their choice of providers and services; and (5) The difficulties in measuring healthcare quality and beneficial outcomes (both of quantifying and qualifying) and the lack of information on the relative costs of healthcare providers and services also inhibits consumer selection (Evans, R.G., 1984; Cimasi, R.J., 2000; and Gaynor, M. and Vogt, W. B., 2000).

Gaynor, M. & Vogt, W. B. (2000) and Harbage & Davenport, (2009) also added the unique characteristics of health care industry i.e., uncertainty, unpredictable, complex, asymmetry information between consumers and health care providers, customization, consumer ignorance, non profit motive, health as human right, and externality.

The important issues related to health care competition are clinical integration and collusion in health services. Gilfillan, M.D., J. Richard, et. al, (2010) stated that despite a clinical integration provides the ability to improve health care quality and more effective business strategy, but may also lead to higher costs through increased market leverage with payers. The cost of integration, which include practice acquisition, administration, information technology, operating infrastructure development, and ongoing practice support, can also be a barrier (Hayford, Tamara B., 2008).

In a separate article, Gupta S, Davoodi HR, Tiongson ER, (2002) and Kassirer J., (2006), stated that collusion in health care is a universal phenomenon noticed amongst both Western and non-Western societies that subsequently may lead to harm the patients. In a broad term, collusion is defined as a secret agreement or cooperation between two or more people who are trying to deceive. In healthcare, collusion implies any information (about the diagnosis, prognosis, and medical details about the person who is ill) being withheld or not shared among individuals involved. Collusion also means that relevant and complete medical information is selectively or not disclosed at all to patients and/or relatives. The ultimate burden of such collusion falls on the consumer – inappropriate, excessive or costly medication; unnecessary and expensive diagnostic tests; prolonged and expensive hospitalisation etc (Giedion U, Morales LG, Acosta OL., 2001).

In health care markets, the antitrust laws have played an integral role; among others are protecting consumers from higher prices resulting from efforts to reduce or eliminate price competition, preventing providers from boycotting innovative health care delivery systems, preventing consumers from providers who form joint agreement to increase their fees above competitive levels and pass those unjustified increases benefits to consumers, and preventing from anticompetitive mergers that would result in diminished services, decreased quality and increased prices (Baker, J.B., 1988; Blackstone, E.A. and Fuhr J.P., 1984).

In the case of health care markets, however, the antitrust laws are enforced not only to take into account on the indications of possible competitive harm, but also the potential for procompetitive increases in efficiency, lowered administrative and other costs, improvements in quality, enhanced innovation, and other factors that are important to the cost-effective delivery of quality health care services. Bingaman A.K, (1994) found that many joint activities and types of procompetitive activity could lead to lower costs and improved quality in the health care industry without raising any antitrust issues.

In parallel with the development of economy, the government of the Republic of Indonesia has introduced the antitrust law in the year of 1999, entitled "Law of Antimonopoly and Unhealthy Competition". Meanwhile at the beginning of the year of 2010, The Ministry of Health (MoH) of the Republic of Indonesia launched a National Health Strategic Plan for 2010–2014. The plan outlines the importance of increasing access to and quality healthcare services for middle-income and low-income families, at an affordable price. In recent years, the cost, quality, and accessibility of Indonesian health care have become major legislative and policy issues. Therefore, it is necessary to analyze the profile of healthcare market in Indonesia to assure that the national health strategic goals can be achieved effectively.

### 3. Methods

This study was carried out using a qualitative descriptive approach. Various data were obtained from individual and group interviews through purposive selection. The units of analysis in this study were the dynamics of interactions among hospital, patients, pharmaceutical companies, health insurances, and physicians.

The study was conducted in three major cities in Indonesia i.e. Jakarta, Makassar, Surabaya. Selection of the three cities were selected purposively because these three cities reflect the portrait of health services in Indonesia due to the heterogeneity of economic, social, political, cultural, or religious.

The study was conducted at two private hospitals and two government hospitals in each city. Respondents in this study were (1) patients, (2) top hospital management, (3) middle and lower hospital management related to the procurement of drugs, physician recruitment, legal cooperation, administration, and finance, (4) physicians, (5) pharmacy staff, (6) big pharmaceutical companies staff, and 7) health insurance staff.

The methods of data collection were as follows: (1) in depth interview using laddering technique, (2) focus group discussion, (3) survey, (4) participatory observation, (5) mystery shoppers, and (6) document review.

### 4. Results and Discussions

The competition profile of Indonesia healthcare industry is described in the following sections:

#### 4.1 Bargaining power of the consumers.

Bargaining power of consumer is described by the following variables: concentration ratio of payment type, tariff pattern, utilization value of health services, information exposure, choice of medical diagnostic services, the availability of substitutes, health services differentiation, drug price comparison, and the cost structure.

The concentration ratio of payment type showed the increasing number of public insurance patients as well as declining number of out of pocket patients from year to year. Most of the patients are concentrated in different group health insurance whether public or private insurance, but most of them are covered by public insurance.

For the tariff pattern, there are found that for the same treatment has different tariff for each type of treatment class, types of payment, and type of installations even in the same hospital. So, with the same input, the patients have to pay different tariff. The higher type of class treatment the more expensive the tariff of treatment, physician's visit, and medical diagnostic examination. Similarly, each insurance company assigned a different tariff. In some hospitals, even the tariff for public insurance patients such as JAMKESMAS (society health insurance) is much more expensive than the out of pocket patients. Similar pattern also found at different installations in the same hospital. For example different tariff are applied among Emergency Unit, inpatient, and outpatient tariff for similar services and actions. Some of hospitals observed even set different prices for the same drug at different installation. There are also different tariff between corporate patients and insurance patients, due to tied in sales occurred. Such differences obviously indicate the presence of price discrimination.

Attention has to be paid since the largest utilization value come from insurance patients including public insurances, private insurances, and corporate patients. This indicates the big magnitude of the bargaining power of insurance especially in determining the type and the cost of health services as well as the way it is delivered. Therefore, moral integrity of the institution is very important to protect the communities from disadvantages in terms of cost and receiving the most appropriate and valuable services according to their needs.

Due to information exposure, most patients did not receive complete information regarding the estimation of overall cost and treatment length, the choices of alternative treatments and its possible consequences. The lack of knowledge make patients tend to just follow what the hospital or physician recommended regardless of the services or drugs are the most suitable or valuable for them or not. Besides ignorance, the patient also has the feeling of obligation to buy medicine and to do medical diagnostic examination as appointed by hospital or physician.

There are also horizontal and vertical integration between health care providers which weaken the bargaining power of consumers, which will described at the following sessions.

#### 4.2. The availability of health care substitutions

Although the substitutions of health services are widely available, but the market mechanism does not apply since the price is not determined by supply and demand due to asymmetry information. As a matter of fact the drug's price remains high even though there is sufficient drug's brand available in the market as well as many suppliers. Currently, there are more than 200 pharmaceutical companies in the industry but the real market structure is still far from perfect competition as reflected by only about 7 pharmaceutical companies dominated the market. Indonesia Health Statistics shows that more than 50% of drug trades occur in the hospital, while the price is fully determined by hospital or pharmacies.

Drug's brand is fully determined by the physician unless there are patients who have medical knowledge that ask to substitute the brand, then their request will be considered. Some drug's brands that are written by physician sold only at certain pharmacies limiting patient's choice to seek other preferable pharmacies. Some of the physicians already have integration with the pharmacy and medical diagnostic services for referral.

At some hospitals, patients also steer to reimburse prescription in hospital pharmacies as well as doing medical diagnostic examination in the same hospital. Even some hospitals do not allow patients to buy drugs outside of the hospital with the argument of assuring drug authenticity.

Moreover, public insurance patient could only obtain particular medicines that have been specified in the agreement between the hospital and the public insurance. But this is not in the case of the patients who can afford the more expensive services.

The consumer ignorance leads to their inability to know the availability of such substitution. This condition is worsened by the conduct of hospital or physician who tends to steer patients to utilize certain medical diagnostic services, choose particular brand of drug, or buying drugs in certain appointed pharmacies. Actually there is big price dispersion in health services substitution as well as drugs.

The limitation is much bigger for public insurance patients. The patients who covered by public insurance are regulated in a hierarchical referral system. Firstly, they have to examine their health at primary care services in their domiciled. If the patients require more intensive care and more complete facilities that cannot be provided, then they will be referred to a referral hospital in the same administrative region. This process is done in stages until the center of referral hospital. In practice however, the referral hospital is often farther than the other referral hospitals located outside the administrative territory adjacent. As a result, sometimes patients do not received prompt services. This is due to the consequence of the district autonomy policy.

The ceiling of health insurance costs vary between different hospitals and different districts or regions. Consequently, it has caused the limitation to selecting the preferred medical diagnostic services such as radiology and laboratory in fulfilling their healthcare needs.

The different type of insurance also applies different tariff for the same services in the same hospital. For example the tariff for class III determined by local government is 20,000 in IDR whereas the tariff prescribed class III determined by ASKES (Public Health Insurance) is 80.000 in IDR including routine laboratory examination. The difference in that tariff can still be claimed by the hospital even though laboratory tests are not carried out. Attention should be given to assure that patients will obtain maximum health services.

#### **4.3 Bargaining power of providers of health care services**

There are some agreements among public hospital in the same region in determining the same tariff, which may use different inputs. These agreements are strengthened by the regional or district regulation. This may potentially lead to the discrimination of services since the patients must pay the same tariffs for different health care facilities and equipment of different types of hospitals.

Some hospitals determine a multi pricing tariff. There have been different tariff for the same input in the different class of treatments, in the different installations, and in the different payment type within the same hospital. The tariff differences include medical treatments, physician visits, medical diagnostic services, and drug prices. These clearly indicate the occurrence of price discrimination. Some hospitals integrate the services of both outpatient and inpatient to a certain pharmaceutical and medical diagnostic services. Although such integration may eventually increase the efficiency and comfort of patients, but attention must be paid when the integration is intentionally directed to patients to utilize the services they do not need or burdened higher price. Implicitly, it seems that there has been a tariff agreement between the specialists. This is indicated by the prevalence rates of certain medical specialists in certain areas.

#### **4.4. Barriers to entering the health care industry for new entrants**

The new entrants are relatively difficult to enter the market since the alliance between incumbent and other business actors in the health care industry has been well established. Such difficulties are a form unhealthy competition.

Based on the interview, unhealthy competition has been found in various forms among pharmaceutical companies by giving souvenirs, conducting or sponsoring a symposium arranged by hospitals or physicians, conducting direct approach to the physicians by offering discounts or assistance for continuing medical education, providing a free seminar invitations and transportation costs, prioritizing many physicians who recommend products. These practices are vulnerable to actions that violate the Indonesia Anti Monopoly and Unhealthy Competition Law.

In the Article 13 paragraph (2) Law of Consumer Protection stated that the business actors shall be prohibited from offering, promoting, or advertises drugs, traditional medicines, food supplements, medical devices, and health care services by promising rewards in the form of goods or other services. Prohibition as mentioned above is certainly intended to protect consumers from selecting the goods or services that are not for the sake of the benefit of the goods or services, but because of the influence of reward. Perhaps the question arises, whether the consumer can be equated with the physicians, since the law governing prohibition is the Consumer Protection Act.

In addition, The Indonesia Anti Monopoly and Unhealthy Competition Law stated that the action taken by business actors to provide discounted prices or give certain gifts to other business actors is prohibited since it may also block the new entrants. In article 13 of the Law also stated that business actors shall be prohibited from engaging in one or more activities, either alone or together with other business actors, which may result in monopolistic practices and or unfair business competition.

Therefore, giving particular gifts to offer products that are related to health as prohibited by the Consumer Protection Act should be avoided since it has a potential to the occurrence of violations of the Act and the Consumer Protection Act and the Anti Monopoly and Unhealthy Competition Law.

Basically, healthcare providers can establish cooperation each others as long as such cooperation follow the Law of Antimonopoly and Unhealthy Competition.

#### **4.5. The intensity of competition within health care industry**

The intensity of competition within health care industry is relatively low. This is indicated by unknown differentiations among different drugs, different specialists, different equipment, and different facilities despite the fact the price dispersion is high. Sometimes the drug's price and the tariff of specialists, hospital facilities and equipment, and medical diagnostic examination are different even though the input are the same or vice versa due to dominant power of healthcare providers in the market.

There are also large differences in drug prices among health care providers since hospitals fully determine the drugs price. In one of participatory observations, the drug was sold nearly 1000% over the HET (Highest Price Level). The prices of drugs may also be different for different payment types and different installations in the hospital. Meanwhile, once patients being treated in a certain hospital, they have no choice to find other affordable pharmacies. The patients treated at VIP class generally are given branded medicine which is more expensive than the patients of class III who usually are given generic drugs. Such phenomenon indicates the weak of consumer bargaining power.

As a result, the cost structure also varies in tariffs of health services and drug's prices for different class of treatment, different payment types and different installations. This indicates the occurrence of price discrimination that may need further considerations to protect the rights of the consumers.

### **5. Conclusions and Recommendations**

#### **5.1 Conclusions**

5.1.1. Bargaining power of consumers in health care industry is weak; on the other hand the bargaining of healthcare providers is strong, due to several factors as follows;

- a. The asymmetry of information and consumer ignorance causes inability of consumers to determine the products and services which are mostly suitable and valuable for them.
- b. In most cases businesses in the healthcare industry tend to integrate vertically and horizontally.
- c. Recently market structure tends to form a powerful force to public insurance. Policies and mechanisms in public insurance is relatively open the possibility of discrimination in price and service. On the other hand, the dependency level of societies and hospitals to public insurance is very high.
- d. The availability of health service provider is smaller than the demand for health services.

5.1.2. The availability of health care substitution is relatively high but restricted to be utilized due to asymmetry information.

5.1.3. There are barriers to enter the health care industry in Indonesia due to the vertical and horizontal integration as well as the resistance of the incumbent. Such barriers are also caused by the existing big pharmaceutical and health equipment companies that have been dominating the market.

5.1.5. The intensity of the health care industry competition is relatively low although the number of hospitals, insurance companies, and pharmaceutical companies are quite large. Low competition is primarily because of asymmetry of information, vertical and horizontal integration between providers who have dominant power.

## 5.2. Recommendations

- 5.2.1. Required regulation and supervision regarding the vertical and horizontal integration in order to avoid price and service discrimination.
- 5.2.2. Required regulation and supervision to govern the referral system to assure societies could receive prompt service.

## 6. Implications and Limitations

Some findings indicated a conduct against The Law of Anti Monopoly and Unhealthy Competition in Indonesia. However, health care industry has unique characteristics; therefore it might be inappropriate to apply the law in such industry. This phenomenon needs further studies regarding antitrust and healthy competition in health care industry.

The research has some limitations; among others are the secondary data for integration between pharmaceutical companies, hospitals, health insurances, medical diagnostic services, and physician. The research was also conducted among a relatively small sample, and there is a lack of previous literature evidence to make significant comparisons.

## References

- Baker, J.B. (1988), "The antitrust analysis of hospital mergers and the transformation of the hospital industry," *Law and Contemporary Problems*, 51(2):96-164.
- Barlo M., (2006), "Collusion in Hidden-Action Model", *Journal of Economic Literature*, C61; C71; D82
- Bates L.J and Santere R.E (2008), "Do health insurers possess monopsony power in the hospital service industry?", *International Journal of Healthcare Finance and Economics*, 8: 1-11, 2008
- Berenson, Robert A., Paul B. Ginsburg, and Nicole Kemper. April 2010. "Unchecked Provider Clout in California Foreshadows Challenges to Health Reform." *Health Affairs* 29 (4); 699 – 705.
- Bingaman A.K., "Competition and Antitrust Issues in Health Care Reform", United State Department of Justice, 1994.
- Blackstone, E.A. and J.P. Fuhr (1984), "Antitrust and exclusive agreements: the case of hospital based physicians," *The Antitrust Bulletin*, 29: 739-758.
- Briefing Paper 25<sup>th</sup> CUTS International (2008), "Collusion Among Health Service Providers in India: Need for Effective Regulatory Enforcement", 2008
- Cantlupe, J. "Physician Alignment in an Era of Change." *Health Leaders*, September 2010; 7.
- Carlton, D.W. and Perloff, J.M (1994), "Industrial Organization.", Harper College Collins Publishers, USA
- Cimasi, R.J., (2000), "Lesson from Market Competition in Healthcare" in the "2000 Congress on Healthcare Management", Chicago, Illinois, 2000, online publication at <http://www.healthcapital.com>
- Evans, R.G. (1984), "*Market Failure and the Evolution of Health Care Institutions: A Historical Parable*" in *The Economics of Canadian Health Care*, online publication at <http://www.chspr.ubc.ca>
- Gaynor, M. and Vogt, W. B. (2000). Antitrust and competition in health care markets. In Culyer, A. and Newhouse, J., editors, *Handbook of Health Economics*, chapter 27, pages 1405–1487. Elsevier Science, North-Holland, New York and Oxford
- Giedion U, Morales LG, Acosta OL. 2001. The impact of health reforms on irregularities in Bogota hospitals. In: Di Tella R, Savedoff WD, (eds). *Diagnosis corruption: fraud in Latin America's public hospitals*. Washington, DC: Inter-American Development Bank.
- Gilfillan, M.D., J. Richard, et. al. "Value and the Medical Home: Effects of Transformed Primary Care." *The American Journal of Managed Care* 1(8); 607 – 14; 2010.
- Griffin, C.C. (1992) *Health Care in Asia: A Comparative Study of Cost and Financing*. Washington, DC: The World Bank.
- Gupta S, Davoodi HR, Tiongson ER. 2002. Corruption and the provision of health care and education services. In: Abed GT, Gupta S, (eds). *Governance, corruption, and economic performance*. Washington, DC: International Monetary Fund, pp. 245–72.
- Harbage and Davenport, 2009. "A Public Health Insurance Plan that Delivers Market Discipline", *Competitive Health Care*, March 2009.
- Hayford, Tamara B. 2008. "The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes" ([www.econweb.umd.edu](http://www.econweb.umd.edu)).

- Kassirer J. 2006. The corrupting influence of money in medicine. In: Transparency International. Global Corruption Report 2006: Special focus on corruption and health. London: Pluto Press.
- Mary Witt, M.S.W. and Laura Jacobs, M.P.H., "Physician-Hospital Integration in the Era of Health Reform", Report to The California Health Care Foundation, December 2010
- Pauly V.P. (2004), "Competition in Medical Services and the Quality of Care: Concepts and History", International Journal of Healthcare Finance and Economics, 4: 113-130, 2004
- Porter, M.E. (1980), "Competitive Strategy", Free Press, 1980.
- Sparrow R., Suryahadi A., and Widyanti W., (2010), "Social Health Insurance for the Poor: Targeting and Impacts of Indonesia Askeskin Program", Working Paper, 2010.
- Tempo, (April 8<sup>th</sup> 2001) in [m.klikdokter.com/detail/read/4/188/kesehatan-sebagai-komoditas](http://m.klikdokter.com/detail/read/4/188/kesehatan-sebagai-komoditas), "Kesehatan sebagai komoditas".
- Thabrany H., Gani A, Pujianto, Mayanda L., Mahlil, Budi B.S. (2003), "Social Health Insurance in Indonesia: Current Status and the Plan for National Health Insurance", presented in Social Health Insurance Workshop, WHO SEARO, New Dehli, 102, 2003
- Wagstaff, A. (2007) "Health Systems in East Asia: What Can Developing Countries Learn from Japan and the Asian Tigers?", *Health Economics* 16(5): 441–56.

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