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Collaborative Governance Framework in Health Care: A Qualitative Exploration of Hospital Pharmacy Management Reform at Hospital Setting in Indonesia

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ABSTRACT

Since January 2014, the Indonesian government has implemented national health insurance (NHI) policy which aims to achieve universal health coverage by 2019. Through the new insurance scheme, hospitals are obliged to reform its pharmacy management practices by following national formulary and implementing e-catalogue. However, researches on pharmacy management under the NHI suggests that hospitals as the forefront of health services have limited resources to manage competing interests that hamper the reform. In this paper we examine local hospitals' governing strategies and adaptations to implement the reform. Through extensive in-depth interviews with hospital managers, doctors and staffs at the hospitals pharmacy units in government hospitals in Central Java, we demonstrate the importance of collaborative governance in health care reform including pharmacy management. From the cases, we argue that the national's policy

reform is only effective when hospitals' leaderships are able to create collaboration among stakeholders. Trust to leadership plays a crucial role in establishing organizational change including mitigating negative responses from actors that losing financial benefits due to the reform.

Keywords: collaborative governance, pharmacy management, public sector innovation

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INTRODUCTION

Pharmaceutical administration is an important field of health care. Various studies have shown that virtually all hospital visiting patients need medication and, thus, pharmacy management affects health delivery effectiveness. Nevertheless, pharmaceutical management is a sensitive area of corruption. Report from WHO and Transparency International for example shows that medicines is a leading source of inefficiency in health care (Kohler et al., 2016). In Indonesia, corruption in drugs procurement and pharmaceutical management in general are also alarming. Indonesian Corruption Watch in 2018 issued report which shows that corruption in health sector is the fifth biggest corruption in public sector. From these cases, pharmaceutical corruption is the most significant case. Furthermore, the main cases of pharmaceutical corruptions occur in hospital and health care facilities that offer patients medication. This practice has direct ties with quality of treatment and imposes additional pressures on access to health care.

Since 2014, The Indonesian government implement the national health insurance known as Jaminan Kesehatan Nasional (JKN) policy which aims to achieve universal health coverage by 2019. As of 29 February 2020, JKN covers 223,009,215 people across Indonesia. Through the new insurance scheme, hospitals are obliged to reform its pharmacy management practices by following national formulary and implementing e-catalogue. The Ministry of Health establishes a national formulary (NF) and introduces a electronic database of drugs as an integral part of the government insurance program. The national government decides the classification of drugs and the price range of such medicines in the national formulary and medicine e-catalog. The new program implements three approaches in pharmacy management strategies (Wasir et al., 2019). Firstly, the e-Catalog is a pricing framework for medical procurement and

has been around since 2013. The Ministry of Health proposes medicine at the substance level (eg paracetamol), with specification (dosage and types eg tablets, liquids, capsules) to the National Public Procurement Agency. The Procurement Agency then writes a tender for suppliers at a national scale and selects the preferred suppliers. As a result, the e-Catalog provides a list of medical with specifications, prices, as well as suppliers. All healthcare facilities are expected to purchase medicines through the e-catalogue. Nevertheless, healthcare facilities are allowed to conduct their own medicines supply aside from the specified medicine the e-Catalogue.

Second, the national formulary (NF) is a medicine reimbursement policy. It provides a list of medicines covered by the JKN management agency known as BPJS Kesehatan. The Ministry of Health established committee in charge of regulating and compiling the list of medicines in the NF. These medicines are selected by the NF committee using several criteria which are efficacy, safety, marketing authorization, and benefit-risk ratio.

Third, the use of Health Technology Assessment (HTA) to examine new medicines which might have the potential to be included in the e-Catalog and the National Formulary. The examination is conducted by the HTA committee which was formed by the MOH in April 2014, then renewed in 2016. The current HTA committee consists of eight HTA senior health scientists and one employee of the MOH. They are supported by a technical staff (thirteen clinicians, two MOH employees, one engineer, and four secretaries). Currently, the main task of the committee HTA is to develop and review their program. The guidelines of the JKN-KIS committee is responsible for providing recommendations to the MOH regarding the NF.

The national formulary system was first introduced in 2013 referring to use in the previous formularies in Indonesia and the last edition of the Indonesian essential medicines list. The

list of the NF medicines are revised at least every two years. The last revision was in 2017. All medicines listed in the NF should be available in the healthcare facilities.

Rather contradictive however, the national formulary and E-catalog also still open opportunities for hospital to create their own medicines supply list outside from the national formulary list. Under the JKN, the practice of supplying medical supply outside the formulary list creates additional burden for local hospitals. The first problem from the fact that medicines acquired outside from the National Formulary list will be not reimbursed by the JKN insurance system. Secondly, in many cases, doctors still play an important role in prescribing medicines out of medicines catalog. Consequently, patients still need to buy medicines from pharmacists outside the hospital and create additional cost for patients. Thirdly, as hospitals are still able to acquire medicines outside of the national formulary system, medicines supply remains to be the hotbed of corruption in the hospital. Process of negotiation between hospitals and drug companies has been the source of corruption and gratification between hospital management and drug suppliers. In conclusion, E-catalogue system is only partially solves the problem of drug pricing (Yuniarti et al., 2019). Based on the problem, we examine local hospitals' governing strategies and adaptations to implement the reform. We conducted extensive in-depth interviews with hospital managers, doctors and staffs at the hospitals pharmacy units in government hospitals in Central Java.

Theoretical Framework

In this article we examine how local hospitals implement pharmacy management reform by utilising the collaborative governance framework. Collaborative governance is defined as a governing structure that includes a wide variety of public, private and non-profit actors in collaborative and jointly driven decision-making processes based on common interests and mutual trust (Ansell & Gash, 2004; Emerson et al., 2012; Emerson & Nabatchi, 2015). Collaborative governance is introduced as a means of coping with complex governance issues which mostly lack of clear problem definitions, due to their inherent complexity. Expanding from Ansell and Gash definition of collaborative governance, Emerson tries to cover a broader suite of agents, structures, processes and actions that enable collaboration across organisations, jurisdictions and sectors. Specifically, Emerson et al define collaborative governance as 'the processes and structures of public policy decision making and management that engage people across the boundaries of public agencies, levels of government and/or the public, private and civic spheres to carry out a public purpose that could not otherwise be accomplished'.

According to Batory and Svenson (2019) there are at least five dimensions along which the term can be conceptualised, ranging from narrower (restrictive) to broader, more diffused notions of collaboration. The first of these taps into the public-private divide and essentially interrogates whether collaboration is primarily seen as bringing together governmental and non-governmental actors or, alternatively, this bridging function is not seen as essential or left unspecified. This dimension is also identified in scholarship

on the roles public actors can play with respect to collaborative arrangements, as leaders, encouragers and followers or network brokers. The second dimension concerns agency, that is, whether collaborative processes are seen to be initiated and/or controlled by public actors (typically government agencies). The third, closely related dimension is whether collaborative governance is conceptualised as a multi-organisational process, that is, whether it is restricted to organized interests (stakeholders that take an organizational form) and public bodies, or whether the notion also allows for broad public involvement of citizens. The fourth dimension concerns the scope of collaboration with respect to durability (permanent versus task-oriented) and within the policy process, with some definitions assuming collaboration throughout a program or project, while others anticipate collaborative arrangements that are specific to for instance policy design, decision-making or service delivery. Finally, the last dimension taps into the normative assumptions (or their absence) behind collaborative governance. Thus, a narrow definition of collaborative governance implies processes and actions driven by government (agencies) that involve non-governmental organisations in a specific stage of the policy-process with the aim of achieving a pre-determined public policy objective – where each of these categories are filled with substantive content. In contrast, more diffuse notions of collaborative governance leave open one or more of the following: the range of actors, the driver/initiator of the process, the type of the participants and/or the precise aim of the exercise, and amount to little more than a general sense that multiple actors come together for some sort of common action.

DISCUSSION

Before reform

There are various actors in drugs procurement at hospital level. These actors range from doctors, nurses, pharmacists, as well as hospital's manager. Before the implementation of e-catalogue, there were various disputes especially between doctors with pharmacists. Each actors have their diverse perception about the pharmaceutical procurement. This condition led to severe inefficiency in the pharmaceutical department where medicines over stock and lack of supply for certain drugs exist. The pharmaceutical inefficiency puts too much strain in the hospital's budget.

In terms of medicine procurement, there were many actors involve in the department: Doctors, Nurses, Pharmacists, Pharmacy Unit, and Hospital Management/Administrative body. The disputes among actors was mostly based on different perceptions of how to procure medicines. The result of the dispute is inefficiency in drug procurement, over stock, unused drugs, which eventually resulted in waste of the budget. This condition is exacerbated by hospital management that does not have valid data regarding the budget used to procure drugs. Before innovations and regulations were formed, all procurement activities were carried out by the Pharmacy unit, and there was a lack of transparency regarding drug procurement budgets which resulted in prolonged conflict.

At the same time, doctors also involve in the inefficient drug procurement by doing little provocations in the form of suggestions to patients. Doctors also complaint when their suggested medicines are not available. In the previous regulation, doctors were also required to provide evidence if they want to suggest certain kind of drugs available at the hospital through hospital formulary. But this requirement was considered as hassle by doctors so they were often lazy to submit the drug for hospital formulary.

Prior to reform, drug procurement was a hotbed of corruption and collusion from a number of interested parties. The phenomenon of criminal cooperation called in Bahasa Indonesia as kongkalikong (gratification) in drug procurement. The practices involves doctors, nurses, pharmacists, pharmacist analyst, procurement officials and officers pharmaceutical warehouse and it involves personal gain. This condition resulted in the incompatibility of the proposed planning and procurement of drugs by hospital standards. The main result for example is the fact that stock taking is 3 times more the monthly drug expenses and availability of certain drugs were lacking. The other problem was inefficient operational costs of drug supply. The budget for drugs and equipment/ consumables has a proportion of 35% of the total revenue and expenditure budget of the hospital.

This chaotic condition indirectly results in low customer satisfaction. Patient complaints about the availability of drugs increased. In the consumer satisfaction report in 2013, There was 53 hospital complaints, 7 complaints (13%) about pharmacy and 5 complaints (9%) of them about drug availability. Low patient satisfaction index only reached score of 61 in 2013 which was consider as very low satisfaction. In terms of drugs management, the direct result of corruption and collusion were the high number of expired drugs. Until 2013 medicines that reached the expiry date were still high, reaching at Rp 96,090,255.14 (0.15 % of the drug budget). Another result were overstock and losses. As the drugs recording system was still manual, it could not capture big difference between recording and physical medicine. It created overstock (excess inventory for certain drugs) and losses (physical loss).

In term of following the national program, the condition prior reform led to lack of commitment among medical personnel to use a formulary set by the Ministry of Health especially to use generic medicine. The level of compliance of medical personnel to use formulary set from MOH and to use generic drugs only reached 80%.

The reform process

Due to unclear data in the drugs procurement, there was a thought about how to make an inventory system by using digital drugs stock application system. The application system aims to record all the medicines supplies at the hospital correctly. The idea of IT intervention was to create transparent use of budget related to medicines procurement and to create efficiency. With this application system, supervision can be carried out in depth, because all procurement data is required to enter the system and can be accounted. In the new system, planning and procurement are

carried out separately so that it is easier to control drug procurement.

The application system also changes the medicines pricing system. The medicines stock system in the hospital is usually held twice a year in July and December. The procurement agency known as LPTK monitors and evaluates the implementation of medicine procurement. They monitors and evaluates the procurement plans made by the pharmacy unit, name of the medicines and its suppliers to comply with the national formulary or hospital formulary. As the monitoring by LPTK becomes more intensive, it provides opportunity for the hospital management to change the pricing system from pricelist price provided by drugs companies into the basic price stipulated in the e-catalogue and the National Formulary system. For example, prior to reform, the hospital purchased drugs based on price list given by drugs companies. After thorough investigation, it was revealed that the price purchased by the hospital was different from the original price. The price difference between the original price and the purchase price list went to individual personal pockets. With the new system, drugs payment is carried out based on basic price which excludes discount and bonuses. Thus, the parties who previously benefited from the price difference in the price list, they can now get cheaper price through basic price system.

Furthermore, in the new system, doctors and all interested parties can open e-catalogue so that they are more transparent. When bonus has not been recorded in the register, the parties will be notified later. This bonus and discounts given by pharmaceutical industries which previously was not transparent and now can be monitored by all parties. These bonuses and price discounts emerge as a result of more market competition between pharmacy suppliers. In terms of efficiency between income and the number of patients and medical stock, the new system has resulted in drop of overstock percentage from 35% until now a 28-27%. After using the medicines application system, the hospital also banned purchase of prescription outside of the hospital. Prices of medicines in the hospital is already cheaper compared to prices of medicines in drugstore outside of the hospital. In the old system, the drugstore outside of hospital often sold medicines in cheaper price than the hospital. After investigation, it was revealed that the drugstores were belong to hospital employees.

Hospital Strategies

After realising the severity of the problem, the hospital management carried out holistic problem analysis, especially through meetings. Through a full meeting, the forum discussed issues such as of shortage of drug budgets, over stock especially unneeded drugs and the lack of certain drug stocks. The meetings facilitated different units to meet and to discuss openly. From the meeting, the hospital management found that each parties involved in drugs procurement never held coordination meeting and they did not have mutual interest in drugs procurement. Perception and activities among these parties were carried out based on their individual needs. The consequence is that planning, procurement and drugs prescription were not synchronized with each unit was trapped in its own egoism.

The innovation was implemented by creating a common platform for all units. The platform was intended to reduce egoism of each party such as planner, procurement, doctors, and pharmacists. They have different perceptions regarding drug procurement. This common platform triggers a system that can overcome differences in perceptions such as drugs planning. And yet the main point of the platform was also to not to bring together planners, procurement /purchasing departments, users and other parties directly. Control is carried out together through the on line application. An application that can be used by all parties to check the condition of drugs, starting from the needs of planning, procurement and availability of drugs.

Under the new electronic application system, the hospital slowly implements the National Formulary which contains a list of drugs that should be used at the hospital regardless of the patients' status. In emergency situation where patient has certain drugs resistance the drugs may be replaced with another drug. The formulary already has the basic prescription based on diseases and hospital class. In the formulary there are approximately 900 items but not necessarily suitable to be applied in every hospital. The hospital decided to use 100% of drugs from the national formulary plus 24 types of drugs based upon doctor's recommendation. Out of 900 items, not all of them entered the new system, around 600 drugs were displayed and another 300 were not yet available. To mitigate doctors' discretion, hospital purchase of drugs is not influenced by the planning or doctors.

The implementation of new system received rejection and psychological barriers from personnel such as doctors. In order to mitigate the negative perception, it requires a long time intervention and needed debate among employees and between employees with management. In order to enforce the reform, the hospital management created a little coercive scheme. If the drug is not procured or bought through the electronic system, the doctor cannot prescribe the drugs to patients. This condition makes doctors who initially refused to follow the system to finally believe and follow the mechanism.

Trust is also important factor to get the doctors joining the cause. The hospital management including the hospital director was also committed to strengthen the law enforcement. The director threatens doctors and hospital personnel who do not conform to the news system by stating that those who do not follow the system will be subject to criminal sanctions. From the evaluation it was also found that the efficiency generated through the implementation of this new drug procurement system, the hospital could finance the activities of doctors such as seminars, study assignments and workshops and from the rest of the drug budget could also fund the accommodation of aircraft, hotels, and training. This added benefit further strengthens doctors' support for the implementation of a new and transparent drug procurement system that is put in place.

In conducting socialization to revamp the system, the hospital does not have additional forum outside the ordinary forums or routine meetings. In these meetings, the hospital management did socialization and pointed out transparently the number of drugs requests, the most purchases, also

identified the parties who are not taking medications that have been proposed. In the implementation of the system, planning unit and procurement unit often received threats from doctors for example doctors exposed the risk of patients' death when not using a particular drug. The doctors threatened the planning and procurement units that if the case occurred it will be the responsibility of the procurement. All these problems can be resolved with the system implementation. It is imperative to create trust and enforcement to make all parties agreed to follow the system. In addition, the hospital also created system audit and surveillance conducted by Satuan Pengawas Internal (SPI). SPI members come from hospital employees such as finance unit and nurses. They report directly to the Hospital Board every year.

CONCLUSION

Through extensive in-depth interviews with policy makers and policy implementor, we argue that technological intervention through e-catalogue is not sufficient. In practice, technological intervention is only effective when institution provides new incentive for good (non-corruptive) behaviour and at the same time, enforce reform through the establishment of trust network inside the institution.

Through the case we also demonstrate the importance of collaborative governance in health care reform including pharmacy management. From the cases, we argue that the national's policy reform is only effective when hospitals' leaderships are able to create collaboration among stakeholders. Trust to leadership plays a crucial role in establishing organizational change including mitigating negative responses from actors that losing financial benefits due to the reform.

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