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# Service Quality Management in Public and Private Hospitals in Indonesia: Comparative Analysis Based on Law Number 17 of 2023 concerning Health

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**Abstract**

**Background:** Despite the enactment of a unified regulatory framework under Law Number 17 of 2023, service management quality in Indonesian hospitals remains markedly unequal between public and private providers. This study empirically evaluates the administrative performance differential between the two sectors following the law's implementation, with particular attention to governance constraints inherent in the Regional Public Service Agency (BLUD) model.

**Methods:** A mixed-method design used a 50-item Likert survey (n=684) of administrators, staff, and patients across 30 public and 30 private hospitals in Java and Sumatra, alongside 24 semi-structured interviews and analysis of SPM, KARS, and CMKP documents. Quantitative data were integrated into the Service Management Quality Index (SAQI) using TOPSIS entropy, and comparisons were performed using t-tests and Mann-Whitney U tests.

**Results:** Private hospitals rated public hospitals higher on six SAQI aspects (responsiveness, regulatory compliance, accountability, patient-centricity, human resource management, operational autonomy) and on the composite indices (public M=0.58, private M=0.74; d=1.95; p<.001). Documents show private hospitals improved SPM achievement, increased plenary KAS certification, and had fewer patient safety incidents. Law No. 17/2023 and Govt Regulation No. 28/2024 promote some convergence between mediation and complaint procedures but reveal ongoing structural constraints in BLUD governance within public hospitals.

**Conclusion:** While legislative changes improved hospital service management, the public-private quality gap in Indonesia's dual hospital system remains. Without reforms to boost BLUD's autonomy, regulations under the Health Law 2023 could worsen management inequalities.

## INTRODUCTION

The management of hospital services in middle-income countries faces governance challenges as efforts to expand universal health coverage and maintain efficiency align with SDGs 3 and 10 of the United Nations 2030 Agenda (WHO, 2023). Globally, the gap between public and private health systems creates inequalities in services, accountability, and performance, impacting socioeconomically vulnerable groups (Bossert & Mitchell, 2011; Papanicolas et al., 2019). This problem is exacerbated in developing countries due to institutional fragmentation, weak regulation, and a lack of funding for public facilities (Barasa et al., 2018). Indonesia has a large population, and the National Health Insurance (JKN) system, which covers more than 267 million people by 2024, is an important example for examining how the quality of public administration is formed in a fragmented hospital system (Agustina et al., 2019)

The hospital system in Indonesia is mainly divided into two types. It is a public hospital managed under the BLUD framework and a private hospital run by corporations and non-profit organizations (Republic of Indonesia, Law No. 44/2009; Law No. 17/2023). In 2024, more than 3,100 hospitals, of which about 62% has private facilities. Public hospitals mainly serve patients insured by JKN, all within a common regulatory system. However, there are notable differences between the two departments in service quality, including minimum service standards, patient responsiveness, and certification (Basabih & Kesmas, 2025). Equity analyses of JKN financing further demonstrate that health-care benefits remain unevenly distributed across income groups, with lower-income populations disproportionately relying on public facilities that face the greatest governance constraints (Asante et al., 2023). These differences highlight structural inequalities that challenge constitutional obligations and threaten the social contract of universal insurance.

Law Number 17 of 2023 concerning Health is the most comprehensive health reform in more than 10 years, replacing the previous law and reshaping governance across six pillars: primary health care, referral, resilience, financing, human resources, and technology. Redefining hospital activities, establishing a professional disciplinary board, overhauling personnel governance, and moving from a mandatory healthcare spending base to a performance-based budgeting system. The shift toward performance-based governance reflects a broader global trajectory in hospital management, wherein planning and control systems are increasingly expected to deliver public value rather than mere procedural compliance (Nuti et al., 2021). In particular, given the problems stemming from the BLUD governance model, there remains the question of whether this law can reduce the service gap between public and private hospitals (Barasa et al., 2018).

Although the focus on healthcare quality in Indonesia is increasing, there is no empirical evidence comparing service management across public and private hospitals. Most of the research focuses on subsystems such as patient satisfaction, hospital information systems, and JKN billing, and is often conducted before Law No. 17/2023 (Halona, 2024; Nurwito, 2024). The reform period was a natural experiment, but its administrative impact has not been systematically studied. Comparative evidence from other countries consistently shows that public hospital managers underperform relative to private counterparts across monitoring, target-setting, and incentivisation dimensions (Lucifora, 2023), yet whether this pattern holds in Indonesia's post-reform dual system remains untested. There is no study that combines NPM and institutional theory to explain how legal reform, governance, and market pressures affect the quality of services in the dual hospital system in Indonesia. More specifically, no prior study has (i) simultaneously measured six dimensions of service management quality across a nationally representative sample of both hospital types, (ii) assessed these dimensions against the provisions of Law No. 17/2023 and its implementing regulation (Government Regulation No. 28/2024), or (iii) integrated quantitative index construction (TOPSIS entropy-based SAQI) with qualitative institutional analysis to explain sector-level divergence. This constitutes the primary research gap that the present study addresses.

This study uses New Public Management to analyze how to implement efficiency, performance, and autonomy in hospitals. Institutional theory examines how legislation, such as comprehensive health legislation, creates pressures that lead to real reform or sheer compliance. Combining the two frameworks may explain why the quality of service differs despite a unified legal system. The novelty of this study lies in its design as the first mixed-method, multi-hospital empirical investigation to construct a validated composite Service Administration Quality Index

(SAQI) for Indonesia's dual hospital system, benchmarked against the post-reform legal framework of Law No. 17/2023. By integrating NPM efficiency imperatives with institutional theory's explanatory lens on compliance and decoupling (DiMaggio & Powell, 1983; Meyer & Rowan, 1977), the study moves beyond descriptive performance gaps to provide mechanistic explanations for persistent public-private divergence under regulatory convergence. Accountability structures in hospital governance have been identified as central to the quality of care, yet empirical evidence on how such structures interact with legal reform remains underdeveloped Jalilvand et al., (2024) an analytical contribution not previously offered in the Indonesian health governance literature.

This study explores three questions: how public and private hospitals in Indonesia compare in terms of service quality, such as responsiveness, compliance, accountability, patient centricity, human resources, and autonomy; the impact of Law No. 17/2023 and Regulation No. 28/2024 on these aspects; and also, the organizational factors behind the continuation or convergence of the public-private gap after reform.

## METHOD

### Study design

This study used a mixed-method design that integrates quantitative research (QUAN) with qualitative methods, including interviews and document analysis. At the same time, we used a triangulation approach to achieve statistical comparability across hospital types and to explain the mechanisms behind differences in service management quality.

### Setting and participants

The research was conducted in 60 hospitals across five provinces in Java and Sumatra, Indonesia, from January to June 2024. Through goal-based multi-level sampling, 30 public hospitals (RSUD/RSUP) and 30 private hospitals were selected and stratified by hospital class (types A, B, C according to Government Regulation No. 28/2024) and region to ensure functional comparability across departments. The inclusion criteria for hospitals are at least 5 years of operation, active or continuous KARS accreditation, and participation in the JKN program for at least 3 years. At each hospital, we surveyed three groups of respondents: administrators, frontline staff, and patients, and collected a total of 684 useful responses.

### Instrument

The quality ofservice management was measured using a 50-item (1–5) Likert questionnaire designed to cover six dimensions: responsiveness, regulatory compliance, accountability, patient centricity, human resource management, and operational autonomy. This document was developed based on the Indonesian Minimum Service Standard (SPM) SERVQUAL and governance provisions in Law Number 17 of 2023 and Government Regulation Number 28 of 2024 and refined through expert review. Content validity was confirmed by a content validity index ≥ 0.80; an exploratory factor analysis (n=30) in the pilot sample showed factor loadings≥ 0.50; and a six-dimensional internal consistency ranged from Cronbach's α of 0.81 to 0.93. Questionnaires in Indonesian and semantic equivalence are ensured using forward and backward translation methods.

### Qualitative data collection

In the qualitative survey, 24 semi-structured interviews were conducted with six groups of informants: general hospital directors, heads of public administrations, private hospital managers, heads of private administrations, regional officials of the Ministry of Health, and KARS-accredited personnel. The interviews were conducted in accordance with protocols that discuss administrative reform since Law Number 17 of 2023, institutional obstacles and supporting factors, BLUD autonomy, JKN financial constraints, and organizational responses to regulatory pressures. The interview averaged 58 minutes and was recorded audio with consent. In addition, secondary materials such as SPM achievement reports (2023-2024), KARS accreditation records, and CMKP patient safety reports were also obtained from the national SIRS database from all 60 hospitals.

**Data Analysis**

Quantitative data is analyzed in several stages. First, the psychometric properties of the survey instruments are confirmed as described above. Then, the combined service management quality index (SAQI, range 0-1) of each hospital was constructed using entropy-TOPSIS, and the weight of the objective dimension was derived from the information entropy between hospitals. Third, the difference between public and private hospitals in SAQI scores and average dimensional levels was verified using an independent samples t-test or Mann-Whitney U test, after assessing normality with the Shapiro-Wilk test. The effect size was reported as Cohen, (2013), a statistically significant value set at $p < 0.05$. In the confirmation factor analysis using AMOS v.26, a six-factor measurement model was evaluated, and acceptable fit was defined as $CFI > 0.95$ and $RMSEA < 0.08$.

Qualitative interview recordings were analyzed using a hybrid deductive and inductive coding strategy in NVivo 14, reflective thematic analysis. The encoding reliability was supported by a 0.82 kappa intercoder agreement, which was judged to have reached data saturation if no new codes emerged in three consecutive interviews in the informant group. Documentation metrics (SPM achievement rate, certification rate, number of patient safety incidents, and claim complaints) were extracted and matched with survey-based scores to triangulate results and reduce general methodological bias. In the final integration of QUAN and QUAL, we generate meta-inference for each dimension of service management quality using a shared-view matrix that links SAQI scores and dimension statistics to appropriate qualitative themes.

The triangulation procedure followed a concurrent nested mixed-methods design (Creswell & Creswell, 2017; Fetters et al., 2013). In the first strand, quantitative SAQI scores and dimensional means were computed and statistically tested as described above. In the second strand, qualitative themes derived from NVivo 14 coding of interview transcripts were developed independently of the quantitative analysis. In the third strand, documentary performance metrics (SPM achievement rates, KARS certification levels, CMKP patient safety incident counts, and JKN claim complaint resolution rates) were extracted from national SIRS records for all 60 hospitals. Integration was achieved through a joint display matrix in which the SAQI composite and dimensional scores for each hospital were juxtaposed with the corresponding qualitative theme codes and documentary indicator values. Convergent findings across all three strands strengthened inferential confidence, while divergences were examined as candidates for alternative or contextual explanations. This explicit triangulation procedure enables the study to move beyond statistical description and toward mechanistic interpretation of the public-private service management gap.

## RESULT AND DISCUSSION

## Results

### Characteristics of hospitals and respondents

The analysis covers 60 hospitals: 30 public hospitals (RSUD/RSUP) in Java and Sumatra, and 30 private hospitals. The average number of beds in public hospitals was higher than in private hospitals (312 vs. 198), and the proportion of KARS-accredited facilities was lower (22/30 [73%] vs. 27/30 [90%]). JKN patients accounted for ≥80% of cases in all public hospitals (30/30, 100%) and 20/30 (67%) in private hospitals (Table 1).

The survey yielded 684 valid responses from administrators (n = 120), Field Ssage, (2024) staff (n = 240), and patients (n = 360), for an overall response rate of 95%. This configuration ensures that all analytics integrate organizational and user perspectives on service management quality.

### Quality Integrated Service Management (SAQI)

Private hospitals consistently show a higher quality of service management than public hospitals in all six dimensions and in the comprehensive SAQI. The mean composite SAQI score was 0.58 (standard deviation 0.09) in a general hospital and 0.74 (standard deviation 0.07) in a private hospital, corresponding to a large effect measure (Cohen's d = 1.95; $p < 0.001$). The largest absolute gap was observed in operational autonomy (mean difference of 1.06 on a scale of 1-5) and human resource management (0.87), with the smallest but still large gap being accountability (0.46) (Table 2).

Overall, 26 hospitals (86.7%) out of 30 had scores above the average composite SAQI across the sample, compared to 4% (13.3%) in general hospitals. This trend is consistent across all six dimensions, suggesting systemic performance gaps rather than isolated ones.

### Secondary performance indicators

Secondary document analysis supports differences in SAQI across surveys. The average SPM achievement rate in public hospitals was 68.3% (standard deviation of 11.2%), which was higher than that of private hospitals (84.7% (standard deviation of 7.6%). This 16.4 percentage-point difference was statistically significant ($P < 0.001$). Only 7 out of 30 public hospitals (23.3%) obtained the highest level of KARS (plenary) accreditation, surpassing private hospitals of 19/30 (63.3%).

Patient safety metrics also vary across industries. Public hospitals reported an average of 4.81 safety incidents of CMKP-registered patients per 1,000 (standard deviation 1.94), while private hospitals reported 2.37 cases per 1,000 (standard deviation 1.12) ($p = 0.002$). The claim complaint resolution rate was 61.4% (standard deviation, 14.3%) in public hospitals and 82.9% (standard deviation, 9.8%) ($p < 0.001$) in private hospitals (Table 3).

### The Impact of Law Number 17 of 2023 and the Ratification of PBBS

The implementation of Law Number 17/2023 and the Performance-Based Budget System (PBBS) shows that the adoption rate is asymmetrical. By mid-2024, 11 out of 30 hospitals (36.7%) have implemented PBBS, outperforming private hospitals by 30/30 (100%). In general hospitals, early adopters of PBBS (n=11) recorded an increase of 5.2 points in the average SPM achievement rate between 2022 and 2024, while non-adopters (n=19) showed no significant change over the same period.

Pre-litigation mediation obligations by the Professional Disciplinary Assembly were

adopted in both sectors, and although the escalation of patient complaints decreased by about 18% in each group, the increasing number of cases remained higher in public hospitals than in private hospitals. Diversification into new hospital businesses due to reforms was mainly reported by private hospitals, with non-JKN revenues increasing by an average of 12 percent during the survey period. Public hospitals are reported to have minimal diversity (Table 4).

**Analysis based on the patient's gender and age**

The patient respondents (n = 360), 211 (58.6%) were female, 149 (41.4%) were male, 142 (39.4%) were aged 40 < years or younger, 156 (43.3%) were aged 40-59 years, and 62 (17.2%) were aged ≥60 years. Patients' reported average SAQI dimension scores were higher in private hospitals than in public hospitals across all age groups and sexes, but no statistically significant interactions were observed between sex or age group and hospital ownership (all interaction p values >0.05). This suggests that public-private gaps in responsiveness and patient-centricity are consistent across male and female patients and across younger and older populations. The absence of significant demographic interaction effects carries two important implications. First, from an external validity standpoint, the uniformity of the public-private gap across sexes and age cohorts increases confidence that the observed differences reflect structural features of hospital ownership and governance rather than sample-specific demographic composition.

Second, from a health equity perspective, the consistently lower patient experience scores in public hospitals—which disproportionately serve lower-income, JKN-insured populations (Agustina et al., 2019)—suggest that service quality deficits in the public sector are not mitigated for any particular demographic subgroup. Older patients (≥60 years), who typically have greater healthcare utilization needs and clinical vulnerability, reported service management scores in public hospitals no higher than those of younger cohorts, reinforcing the concern that structural governance constraints in public hospitals may translate into undifferentiated service disadvantages for the populations they predominantly serve.

**Discussion**

The difference in the quality of service management between public and private hospitals is large and consistent. The study shows that regulatory uniformity in accordance with Law No. 17/2023 has not been associated with the convergence of organizational performance. General hospitals have low ratings across all six SAQI aspects and the composite indices, with particularly large gaps in operational autonomy and human resource management, supporting the initial hypothesis that structural governance constraints in the public sector limit the quality of administration even under a common legal framework. This pattern is consistent with multi-country evidence demonstrating that public sector hospital managers systematically underperform private counterparts across monitoring, target-setting, and incentivisation dimensions (Lucifora, 2023). The findings also confirm that private hospitals can better utilize the new regulatory environment to improve their management systems and practices, despite serving a smaller percentage of highly-insured JKN patients.

The results support criticism of the new public management (NPM) in the middle-income healthcare system. NPM reform focuses on performance objectives, measurement, and management policies to improve quality. However, the BLUD governance model limits managers' decision-making in procurement, staffing, and budgeting. This creates a "compliance capacity gap", where performance-based budgets increase accountability pressures but do not increase autonomy. The transition from NPM toward Public Value Management requires not

only performance targets but substantive governance redesign that grants hospital managers meaningful operational discretion (Nuti et al., 2021). According to institutional theory DiMaggio & Powell, (1983), public hospitals respond primarily with ceremonial compliance and adopt formal structures without substantive changes in routine, while private hospitals adhere to market and reputation goals, leading to the implementation of more meaningful standards.

The study combines survey data with documentary and qualitative insights from administrators, regulators, and accreditation bodies to improve our understanding of hospital performance in Indonesia and similar middle-income countries. Unlike previous research that focused on patient satisfaction and specific subsystems, this study reveals that gaps in responsiveness, regulatory compliance, accountability, patient-centricity, human resources, and autonomy are rooted in deeper institutional structures rather than technical issues. Accountability structures—encompassing inclusive governance, commitment to accountability, and independent oversight—are foundational to sustainable quality improvement, yet they remain underdeveloped in many public hospital settings (Jalilvand et al., 2024). Convergence in areas such as MDP-related mediation units suggests that clear, enforceable regulation of legal risks enables rapid coordination across sectors, but its effectiveness varies.

As a strength, the study benefited from a balanced sample of public and private hospitals across the two main island regions, the delivery of multiple respondent groups (administrators, staff, patients), and triangulation using objective performance indicators. It provides a transparent and reproducible framework for assessing the quality of service management using the Service Management Quality Index (QQ), which is explicitly based on TOPSIS entropy and employs robust psychometric tests and confirmatory factor analysis. By identifying mechanisms such as BLUD-related constraints, different incentives, and different compliance motivations, the qualitative strand helps us not only record but also interpret the observed quantitative gaps.

There are some limitations. First, the cross-sectional design precludes causal conclusions regarding Law No. 17/2023 and Government Regulation No. 28/2024. Sectoral differences may reflect big structural differences that preceded reform. Second, the sample includes only hospitals in Java and Sumatra that meet certain JKN accreditation and participation criteria, and the scope of application may be limited to small or remote facilities. Third, while the survey combined administrators, staff, and patient input, implications remained regarding self-reported and social-desire bias, and the documented metrics for triangulation could vary in completeness and accuracy across hospitals. Fourth, while mixed methods allow for nuanced interpretations, they may not account for all contextual factors affecting service quality, such as local politics or informal culture.

The impact of such policies varies. For national policymakers, legal reform alone cannot bridge the public-private gap without structural changes in the BLUD model that maintain accountability while increasing financial and operational autonomy. This includes reviewing procurement approval criteria, allowing flexible staffing, and streamlining oversight to reduce bureaucratic delays. Hospital leaders should incorporate patient-centeredness and accountability into performance management by linking staff incentives and evaluations to patient experience and complaint-resolution metrics, not just accreditation checklists. For regulators, the relevance of the Plenary KAS status to better management operations suggests that accreditation standards are effective when hospitals receive the necessary technical and organizational support that goes beyond mere compliance.

The findings of this study also provide implications for health equity and the long-term

direction of universal health coverage in Indonesia. If private hospitals continue to improve the quality of services faster than public hospitals, and public facilities disproportionately prioritize JKN patients and low-income communities, there is a risk that administrative inequality will exacerbate clinical and financial disparities. Over time, trust in public hospitals and the social contract that underpins JKN can be eroded, impacting access, continuity of care, and health outcomes of the population. At the same time, the observation that early PBBS implementation in general hospitals is associated with a modest increase in SPM achievement suggests that targeted support for implementation, such as technical assistance, capacity building, and efficiency in the approval process, can deliver tangible results amid existing structural constraints.

Future research should use a longitudinal design to track the causal impact of Law No. 17/2023 and related regulations on management performance, and also consider whether initial convergence will lead to substantial quality improvements. Comparative studies between states and states with similar NPM-based health care reforms can help distinguish between context-specific mechanisms and generalizable ones. Micro-level case studies can reveal how general hospitals address or adapt to BLUD constraints and identify policy models. Clinical research can also investigate how improved service management affects clinical outcomes, patient safety, and resource utilization.

## CONCLUSION

The study shows that, despite uniform laws, private hospitals in Indonesia have quality of service that surpasses that of public hospitals across all areas evaluated. This gap is mainly due to structural issues in the BLUD governance model, particularly autonomy and staffing. However, some convergence in complaint mediation suggests that enforceable rules and strong legal support work across industries. Future research should use long-term quasi-experimental methods to explore the impact of governance reform, high-performing public hospitals, and the relationship between administrative improvements and clinical outcomes, safety, and equity.

These limitations notwithstanding, the study establishes a robust empirical baseline against which future reforms can be evaluated. Future research should prioritize: longitudinal or quasi-experimental studies tracking SAQI trajectories two to five years post-Law No. 17/2023 implementation to establish causal impact, cross-national comparative analyses involving countries with structurally analogous NPM-based hospital dual systems (e.g., the Philippines, Vietnam) to disentangle Indonesia-specific from generalizable governance mechanisms and micro-level embedded case studies within high-performing public hospitals that have successfully navigated BLUD constraints, with the aim of identifying transferable institutional practices and policy design principles that could inform BLUD reform proposals.

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