INDONESIAN HOSPITAL UNDER "BPJS" SCHEME: A WAR IN A NARROWER BATTLEFIELD

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Abstract: Indonesian Hospitals under the "BPJS" Scheme: a War in a Narrower Battlefield. *This qualitative study tries to answer the implication of the cost and quality pressures originating from the introduction of National Social Security System (SJKN), particularly in the health care area or what is known as BPJS. This study obtained the data through observation and a series of interviews to key persons in the financial division of five hospitals in Malang, Blitar and Tulung Agung. Following interpretive tradition, institutional theory is employed. It is found that more transformational organizational change may happen when BPJS representing market power in health care start to implement more stringent measures either through cost or quality.*

Abstrak: Rumah Sakit Indonesia di Bawah Skema "BPJS": Sebuah Peperangan di Medan Sempit. Studi kualitatif ini mencoba menjawab implikasi tekanan biaya dan kualitas yang disebabkan adanya skema BPJS di rumah sakit. Studi ini menggunakan observasi serta wawancara pada personel kunci di bagian keuangan dari lima rumah sakit yang berlokasi di Malang, Blitar, dan Tulung Agung. Dengan mengikuti tradisi interpretivisme, teori institusionalisasi digunakan untuk analisis data. Ditemukan bahwa perubahan transformasional akan terjadi saat BPJS merepresentasikan kuasa pasar oleh rumah sakit saat mereka mulai mengimplementasikan ukuran-ukuran yang lebih ketat dalam hal biaya maupun kualitas.

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Organizational change has long been the concern of academic reserach interest, not exclusively in in the context of health. In this context, Lonial, Tarim, Tatoglu, Zaim & Zaim (2008) believed that there are two forcing factors behind such phenomena, namely quality improvement and the strong movement among health care organizations internationally to be more pro-market institutions. In the Indonesian context, those two factors have been also clearly apparent. First, to improve hospital's service in general, Indonesian Law No. 44 of 2009 concerning hospital, specifically article 40 verse 1, 2 and 3 as well as article 76 verse 1 and 2 of the Minister of Health Care Regulation No. 56 of 2014, put hospitals accreditation as a compulsory organization procedure. Furthermore, to assure higher quality of this accreditation process, Indonesian Hospital Accreditation Committee (IKARS) becomes a member of International Hospital Accreditation Committee (IHAC), and both committees are now cross endorsing their own accreditation standards.

Data in the Ministry of Health of the Republic of Indonesia shows the that annual growth of Indonesian health care industry indicated by incresing number of hospitals in the last 10 years reached 5% – 10%. From 2,355 hospitals at the end of 2014, 1434 (61%) are private hospitals while 921 (39%) are government owned hospitals. Interestingly, there is increased growth within private hospitals to be profit seeking ones, that is from 463 units to be 701 units in 2014 or accounted for around 51%. More over, the enactment of both Indonesian Law No. 40 of 2004 concerning National Social Security System as well as Indonesian Law No.24

of 2011 concerning Executing Board of National Social Security comes so close to not merely social and political areas, but also economic one.

The laws will become effective tools for making health care providers more market oriented. The laws, in one side, provide BPJS with a wider space to be the most dominant and the most influenting health insurance company in Indonesia, while at the same time, in order to remain competitive in the market, making hospitals to be more sensitive with cost of service. Consequently, it may be the single health care service price setter where the whole Indonesian health care service providers should relying on that price to set their own service provision cost coost. In accounting as well as in management, cost which is physically in form of resource is critical since organization's operation basically depends largely to its availability. Organizations usually employ both cost and management accounting (here are interchangeable) altogether to provide relevant cost information, thus it is so sensitive to changing organization environment.

In an era when global health care industry in general is in flux (Cutler, 2000) and Indonesian health care industry, by operation of BPJS, is starting to change into what is known as medicare system, it is reasonable to suppose that the change may lead to organizational change within hospital due to change in its management accounting. In fact, the flux of contemporary Indonesian health care environment relates directly to cost, whereas the success of individual hospital to sustain in this more competitive environment is – basically – so dependent to the success of managing its cost. In the language of institutional theory, cost or management accounting takes it role as "organization logics" (Meyer & Hammerschmid, 2006) where hospital managers will heavily rely on it in making economic decisions.

This qualitative study will explore the roles of management accounting in the changing Indonesian health care market following the implementation of National Social Security System scheme (or in Indonesian acronym: BPJS). Therefore, this study will explore the process of hospital organizational change resulted from the implementation of BPJS, the mode of the organizational change, and relevant factors behind such change as well as to know whether the hospital management's response to this new problematic situation relied (or not) on management accounting.

METHOD

Though accounting change has been an accounting research issue since 1990s, but there were still limited studies exploring such issue. Researchers conducted study about accounting change in that era generally directed their attention to explore change in accounting systems, accounting techniques, the accountancy profession, and the role of an accountant (Burns, 2000). Two of them are Hopwood(1990) and also Robson (1991). It seemed also that the flourish of organizational change issues in management and organization studies journals during 1990s started to have its impact in accounting research in 2000s to bewhat so called as accounting change issue. Among others, several works on that issue during this era are mentioned here such as the work of Burns (2000), Burns and Scapens (2000), Briers and Chua (2001), Burns and Vaivio (2001), Larrinaga-Gonzales and Bebington (2001)Kasurinen (2002), Arunachalam and Beck (2002), Baines and Langfield-Smith (2003), Potter (2005), Siti Nabiha and Scapens (2005), Webster and Hoque (2005). Relatively different with the research works on accounting change issue in 1990s that not only they were limited in number, but also quantitative in nature and generally applying contingency theory as their back ground theoretical analysis, the works on accounting change issue in 2000s started to be different, they entered to case study in their methodology and commenced to rely on qualitative with various perspectives such as post-positive, interpretive and even critical.

This interpretive qualitative case study is a descriptiveand a bit post-positive in nature where reliance to theoretical framework remains important. The theory, however, is employed more to inform relevant investigated phenomena rather than to be tested using the phenomena themselves. Furthermore, what is meant by theory here, is rather different with what Llewellyn (2003) mentioned it as "grand theory" resulted from "context free theorizing", but closer to one she described it as the result of a combination from metaphor, differentiation, conceptualization and context-bound theorizing offsetting. This means that theory could be in narrative form (DiMaggio, 1995) and does not automatically deliver causal relationship among variables.

Unlike positive research, the interpretive research provides a wider room for subjectivity and does not follow nomothetic principles strictly to get generalizable conclusions. In other words, it appreciates more to contextual situation where the study is performed. Thus, the case study takes its role more as research strategy than – like in positivist or purely post positivist – as a research method.

This study employs several data gathering from case hospitals that includes two private hospitals located in the city of Malang, another one located in Blitar and one local government owned hospital located in Tulung Agung Regency.Several interviews were conducted with financial managers from each case hospital. In average, each financial manager was interviewed twice up to three times for about 4 hours per interview. Other data were gathered from hospital observation in those hospitals. This study also got benefits from one of researcher's membership in hospital controlling board (or *Dewan Pengawas*) of a local government owned hospital in the city of Malang as well as his capacity of as a lecturer at the Master Program of Hospital Management. In such capacities, various relevant data or information are gathered such as from formal meetings in the hospital and also from less formal communications with students who are doctors or hospital management members.

As an interpretive work, the data analysis in this study is performed by employing institutional theories (institutionalism or institutional perspective), specifically concerning the institutional logics and organization change, as the basis for informing the relevant organizational phenomena in case hospitals. In so doing, the theoretical concepts are eclectically used when they connect to their own relevancies. Following Abbott's (1992) recommendations, the use of New Institutional Sociology (NIS) is due the fact that it is closer to process perspective theory than to variance perspective theory. In this context, micro social process, if any, in the case hospitals, therefore, is important to be given attention.

National Social Security System Scheme in health care (SJSN-Kesehatan or BPJS). The implementation of the National Social Security System Scheme in health care (SJSN-Kesehatan or BPJS) marked a new era for Indonesia when health care issues seemed to be moved from family or domestic realm to – in large extent – governmental realm. Under the scheme that its origin is the enactment of both Indonesian Law No. 40 of 2004 concerning National Social Security System and Indonesian Law No. 24 of 2011 concerning Executing Board of Social Security, Indonesian government applied what in so called as managed care system. In this system, all Indonesian citizens health care are basically insured by BPJS, a specific designed board for executing social security in health care. The citizens are grouped into two main categories, those who pay for their own health services provided by hospitals or Health Maintenance Organizations (HMOs) in general through health care insurance premium and those who do not pay the premium for the service but government bears it for their benefit. There are nine principles that govern BPJS operation, those are (1) mutual cooperation, (2) non-profit, (3) openness, (4) prudential, (5) accountability, (6) portability, (7) compulsory participation, (8) mandated fund, and (9) fund management outcome.

As the number of eligible beneficiaries increased significantly since the first operation of BPJS (according to SindoNews.com 18 Agustus 2014, the number of beneficiaries has reached 123.4 million at the end of 2014), simultaneously it reduced substantially the number of hospital patients who pay directly to hospitals. Financially, therefore, the liquidity of hospitals in general drop though they get new benefit in form of more certain (guaranteed) payment. Such as an insurance company, BPJS strongly attempts to operate as efficiently as possible in order to sustain and provide benefits to wider scope of beneficiaries. In this respects, BPJS apply what so known as INA-CBGs (Indonesian Case Based Groups), an Indonesian grouping system of medical service based on case or diagnosis. Following DRG (Diagnosis Related Group), the INA-CBGs categorizes medical services into diagnosis case and each diagnosis case is coded according to a designated coding system following level of complexity as the result of case severity.A case, by definition, is a combination of diagnosis (such as laboratory services and radiology), medical treatments including surgeries, medications (through medicines usages), and others like stay in hospital needed to cure patient. In other words, it includes all kinds of services needed to cure a patient committed to a certain type of illness (as coded case in Ina

CBGs) from very beginning when the patient registered in hospital up to the end when he/she has been permitted by the authorized doctor to discharge from hospital. Based on an in depth study, BPJS set the quality as well as the price of each coded medical service. The quality is represented in the normal standard of medical service provision as well as maximum length of stay (LOS) if inpatient treatment is required. BPJS sets equal national wide price per each coded case for a similar level hospital. Thus the higher level the hospital is, the higher level of price applied by BPJS for a similar code. This is to support the implementation of the existing national referral system in health care as well as following the fact that more complicated cases are subject to be referred to higher level hospitals supported by more competent human resources and also equipped by better medical facilities. By implementing this strategy, BPJS is able to minimize variability in medical service quality and - at the same time - decrease excessive but unnecessary resource outlays.

From the hospital management point of view, this payment system may terminate the practice of fee for service payment system or might also be per day payment system. Under fee for service, for instance, hospital receives fees through price or charges based on unit of activity within patient caring process. Meanwhile, under per day payment system, hospital receives fee based on daily accumulation of services provided multiplied by each own charge or price. When it is connected to the possibility of gaining profit or surpluses for hospital, the BPJS system will give profit or surpluses for the hospital only when two requirements could be fulfilled. First, when the hospital has its own charge relatively lower than price set by BPJS. This is like a positive price variance in the language of management accounting.Second, when the hospital can perform relatively efficient, that is able to provide relevant medical services in compliant to agreed standard but by using less inputs. This is like a positive quantity variance in the management accounting terminology. Both for hospital and also for medical doctors in general, however, this can be interpreted as an alarm. The dominant position of doctor within a hospital might be no longer sustained as cost efficiency now is imperative and should be put in the first consideration in every medical treatment.

Four of the five case hospitals in this study have been the implementing BPJS hospitals and only one which is located in Malang that has not been the implementer yet. From three case hospitals located in Malang, one is A level (third or fourth level in health care referral system) hospital, whereas the other two are B level (second or third level). Meanwhile, the case hospital located in Blitar is C level (first to second level) and one which is located in Tulung Agung is B level. The hospital levelling system in Indonesia is based on the number of core medical services provided by the hospital as well as on the number of bed availability in the hospital. The higher the level of hospital, the more number of core medical services provided and the more beds available for patient in the hospital. Under the BPJS payment scheme, the lowest level of hospital or HMO is D level hospital or either medical clinical centre or community medical centre (PUSKESMAS). Thus, under normal condition (excluding emergency situation), any BPJS beneficiary should visit the lowest level HMO designated for him/her to consult every medical case he/she has committed prior to be referred (if required based on medical reasons) to higher level HMOs.

RESULTS AND DISCUSSION

From institutional perspective, organizational change could be viewed as conversion of existing "institutional logics" or "organization rationality" (DiMaggio & Powell, 1991) to the new ones. Each organization, according to this perspective, is basically anchored deeply in its own institutional logics. This makes organization always tries to represents its uniqueness. Due to the fact that the institutional logics may compete each other in the organization, thus organizational change story as well as institutionalization story is a story of institutional logics competition and diffusion (Green, Babb, & Alpaslan, 2008; Meyer & Hammerschmid, 2006; Orlitzky, 2011; Purdy & Gray, 2009). According to institutional perspective (DiMaggio, 1991). When it occurs at the organization field level, it brings isomorphic situation into existence in the relevant industry.

Currently, conflicting or diffusing logics are emerging in the health care industry, more specifically hospital. This due to the fact that hospital that has been long representing its self more as social institution should take its new role more as economic entity. As a result of healing technological progressions, specifically in the area of

medical diagnosis, treatment, pharmacies as well as the professionalization of doctors, nurses, and other parties involving in health care service provision, hospitals even have become an inseparable part of modern society's institution. Thus, physical doctors started to dominate daily hospital affairs. Easily, their own professional logics had become hospital's institutional logics. However, since there are so many professional groups in the daily life of hospital such as nurses, pharmacologists, psychologists, bio chemical analysts and so on, there may be more than one institutional logics competing each other in a hospital. Organization participants may against, resist, diffuse, or fully accept to those group's logics. The medical doctors, for instance, a group that in general are characterized by strong professional culture, always emphasize quality of care (due care), and this gives the distinctive organizational character of hospital life. This very specific culture, in fact, tends to neglect cost consciousness and prefer more on achievement of only medical professional standards. Consequently, the emergence of new dominant institutional logic, the market economic logic, within organization, as mentioned by Purdy and Gray (2009) will produce internal conflicts. The dynamics of the conflict will be characterized by the existing comparative strength of each conflicting logics. When the new institutional logics representing new institution is so strong compared to the existing one, the diffusion mode may happen. In this mode, there is none of conflict between institutional logics, or – if any - is less apparent. The new institutional logics diffuses and slowly but certaintly colours the new life of the organization.

In another situation, the infiltrating market system into the field of health care organizations may produce a different story. In the case of U.S.A. in 1980s, the competition of logics involved what Light (2002) termed it as "buyer revolt" as the payers of medical services strongly opposed to doctors' main logic in the era known as professional dominance but failed to provide inexpensive and high quality medical services. Michel, Sakhed and Daley (1985 p. 235) observed that, even in the. U.S., the introduction of pro-market system in the area of health care had dramatically changed the profile of the industry as well as individual health care organization. First, the industry flourished as a result of payment guarantees originating from medicare and medicaid schemes. Subsequently, however, the efficiency pressure continously pushed by insurers (such as BPJS in Indonesia) to this industry eroded accumulated economic surpluses from prior periods. This set the medical doctors in a rather hard situation since they had to give high attention about cost of treatment, something that has not been beyond their own logics. This made the industry stagnant and hospitals should start to use their belt more stringent, the hospital profitability rate tended to decilne, and the investment growth started to slow (Michel et al., 1985 p. 235).

Hospitals seemed to be in the center of turbulence due to the fact that, unlike others, it is one where its management only has minimum level of grip over couples of performing professional groups. Thus, hospital management can only use management accounting as a defence over the pressures from professionals. In the context of for-profit private hospitals, the situation might be worse since the management was not merely facing with professionals, but also investors whose investment commenced to experience of lowering rate of return. Both threats of firing and also divestment had become real. The dynamics of institutionalization of the new logics, more economic dominant logics, may even be complicated by the fact that health care industry, where ever, is one that can not be separated from government regulations.

Using an event history analysis, Nancy Thorley Hill (2000) investigated about the adoption of cost accounting by American hospitals between 1980 and 1990. She found that the use of accounting and information systems within organizations is always influenced by organizational characteristics. Its intensity positively associates with organization's degree of uncertainty. This means, in a situation when an organization should face relatively uncertain environment, the organization will rely more to accounting and information systems. In relation to the issue of Medicare and Medicaid in U.S. as governmental attempts to control more strictly the health care government budget, she showed that both Medicare and Medicaid contributed more to the adoption of American hospital's cost accounting systems during the period of 1980-1990. Other organizational characteristics such as its size, ownership status as well as its status in relation to hospital network also contributed to adoption of cost accounting system by hospitals. It can

be concluded, therefore, that environmental uncertainty as well as organization characteristics are two important factors affecting organizational adoption of accounting and information systems in general.

The issue of BPJS implementation is really a hot issue among hospitals regardless of their own status (private or public owned), and even regardless of their own participation in BPJS service provision scheme. This is evident from data collected through series of interviews conducted to key persons in the case hospitals. Basically, as recognized by all interviewees from all case hospitals, what is now implemented by BPJS is not actually new. All of them – to certain extent - had experienced in doing business with certain private health insurance companies, specifically for customers from corporate employees or selected individuals who have higher level income. The case hospitals that are public hospitals such as one from Tulung Agung and the other one from the City of Malang even have been familiar with what has been known as the scheme of *Jamkesmas* (*Jaminan Kesehatan Masyarakat* – Community Based Medical Security Scheme) funded by the central government, and also *Jamkesda*, the similar scheme funded by local government. The new practice under BPJS is nearly similar with them. The only difference is in the level of charge or price set by those two different institutions. Under private health insurance scheme, the price per case or diagnosis is negotiated individually between the hospital and corresponding health care insurance company. A better negotiation may lead a hospital to achieve a profitable price. A similar situation may not happen in the case of participation in BPJS scheme. BPJS applies an equal price for similar code (case) performed by similar level of hospitals. Thus, as could be imagined previously, most of the organizational changes commenced from the change in the level of cost consciousness among hospital management. The change in the core of consciousness about cost could trigger further changes within or outside of the management accounting area.

The statement stated by all informants emphasized about the importance of cost management. The informant from Tulung Agung public hospital, for instance, clearly stated that the strategy implemented to cope the challenge of BPJS is performing a better cost management, specifically which associated with the use of medicines (pharmacies). Realizing that the contribution of medicine cost in each total case cost is relatively substantial, and the fact that the final decision of selecting medicine (branded or generic) at the hand of caring doctors, the management of this hospital decided to increase the doctor's fee for service provided to be in the highest level compared to any hospital in the region. This strategy evidently attracted doctor's loyalty to the hospital. Concurrently, however, the hospital management applied what is known as the single formulae for medication prescription that only permit non-branded (generic) medicines usage. Since the price difference between branded and non-branded (generic) medicines is so significant, even - in average - exceeding the increase in doctor's fee for medical treatment, this hospital can transform the threat to be opportunity. In the language of strategic management, this is what is known as cost leadership

Moreover, the implementation of BPJS scheme may also be interpreted as positive thing. At least two informants originating from different case hospitals, those are from Blitar and Tulung Agung, indicate such phenomena. They believed that BPJS beneficiaries are financially guaranteed patients, so that they have higher level of willingness to pay as well as higher level of ability to pay. In so doing, these two hospitals started to reclassify the existing classification of inpatient wards. BPJS, in principle, does not differentiate the price for medical case wherever the patient is treated except when he/she is treated in higher level hospital based on eligible medical reasons. Consequently, current classification of ward classifying them into class 1, class 2 and class 3 began to be no longer relevant. Realizing this situation, both hospitals renovate class 3 rooms to be class 2 rooms. In the long run they even planned to convert them further to be only class 1 rooms. This strategy, again, is implemented – in one side - to attract more consumers as they will be served by better facilities. On the other side, however, this is also to attract doctor loyalty as they will receive treatment fees higher since in the old practice doctor's fee is also differentiated by patient's class. This strategy is apparently effective to boost the number of patients in the whole non-splendid classes (class 1 and class 2) and even the splendid class as well. Distinctively with non-splendid class patients, a patient in the splendid class could be charged by additional medical expenses due to the difference

in medical service prices. In the heart of this strategy is the idea about level of capacity utilization. The higher the level of utilization, the lower the cost charged to service provided, specifically those from overhead cost. Since the modern hospitals are generally equipped by more expensive and advanced technological equipment, increasing level of equipment utilization becomes critical.

When we try to link the implementation of BPJS scheme and the structural change in the case hospitals, it is clear that the whole case hospitals except Persada Hospital assign specific person to handle the work of coding, normally this person is from medical record section. This assignment is now very important since most of the hospital potential revenue depends on the performance ofthis person. Thus, in the very light organizational change, the whole case hospitals seem to be alike. However, in more conceptual thing such as cost consciousness believed to be the most potential changing element of institutional logics, private for profit hospitals seem to be more ready than their counterparts coming from public hospitals. In this concern, the Tulung Agung public hospital might be the exception. Looking at the background of the then hospital director as well as its financial manager, it is clear that both of them have been pioneering persons who have not only relevant competencies (one is senior medical doctor whom is known as humble and honest) and the other one is management background person whom is frequently appointed as hospital management consultant, so that they have visionary mindset in the era when most of Indonesian public hospitals now are entrapped in their attempts to implant what so called as accrual accounting.

The implementation of BPJS scheme clearly lead hospitals to accept new institutional logics. The logics that emphasizes the importance of cost consideration in every managerial and operational activity within hospital. In reality, however, compared to public or government owned hospitals, private hospitals seem to be more prepared to face the problem of decreasing service price in health care industry as caused by market pressure. In average, private hospitals have been freed from the problem of implanting accrual accounting. Though only two from five informants interviewed showing their preparedness in installing hospital cost accounting, in general they, except one from the public hospital in the city of Malang, realize the increasing importance of cost calculation in medical care. It seems that the change in institutional logics will take a part faster in the private hospitals than in government owned hospitals. Following Purdy and Gray(2009), it might be due to the fact that government owned hospitals have been longeras twisted by old stronger institutional logics.Management grip over conservative professional groups might be weaker compared to what can be found in private hospitals in general. Additionally, by relying to a rather imperfect accrual accounting information systems, the government owned hospitalsin general have no relevant cost information.

So far, by observing the general phenomena occurred in the whole case hospitals, it seems that new institutional logics characterized by higher level of cost consciousness within hospitals has started to diffuse with the old institutional logics characterized mainly by their strong commitment to safety and standard by ignoring the importance of cost. Cost or management accounting in the case hospitals, though not entirely in the state of a complete information system, take important roles in the process of new institutional logics diffusion. It may be assumed that when BPJS starts to control more strictly its future value of claim for the benefit of its beneficiaries, hospitals in general would be in a more inflexible situation. They, again, should press various kinds of expenses in serving their consumers. Increasing reliance to cost or management accounting will happen. And due to the fact that market always run by its own logics, that is the logics of economic rationality, the success of BPJS in making cost pressure to Indonesian hospitals, for instance, will attract private health care insurers to do the same thing. They start to raise some questions concerning different price set by hospitals for their policy holders compared what is applied for BPJS beneficiaries. When, in reality there is no difference in service quality delivered both to BPJS beneficiaries and to private insurer policy holders, the difference will be seen as unnecessary economic surpluses. Marketization, such as now is happening in the hospital industry will eventually get rid of such surpluses.

In front of the hospitals participants, the coming of BPJS as the main health care service purchaser is interpreted differently. At the beginning, it was around one or two years ago, hospitals in general were in strong

reluctantto participate in BPJS scheme. The main issue raised then was the issue about health care service price set by BPJS. The hospitals Industry were questioning about the fairness of that prices including questioning about what basis used by BPJS in setting those prices. Series of negotiations involving the Ministry of Health Care lead to adjustments in that prices and produced mutual accepted prices contemporarily applied by BPJS to its current participating hospitals. Another important issues negotiated was payment due date or duration of BPJS payable. Again, after negotiation and adjustments, this issue could be resolved, and now BPJS normally pays its payable to participating hospitals within around 1 – 2 months. On the time being, hospital industry is viewing BPJS rather in mix as between bounty and problem. They realize that the battlefield has been not as wide as before, and the choice for them is now even very limited. This kind of understanding appears to be spread evenly among the case hospital's informants, but there seem to have differences in the level of awareness. Those who come from the government owned hospitals feel that they have been in harder situation compared to their counterparts from private hospitals due to bureaucratic twisting characteristic they have. This is what Purdy and Gray (2009) considered as new driver for governmental bodies like government owned hospital to convert into what is known as hybrid organization, an organization believed to be able to rely more on (quasi) market imperatives. In the Indonesian context, *BLU* or *Badan Layanan Umum* (Public Service Agency) is one designed to fully follows the concept of hybrid organization.

CONCLUSION

Based on previous delineations of the introduction of BPJS in the case hospitals, it is possible to conclude that BPJS had constituted its self as the main and powerful purchaser of contemporary Indonesian hospital medical services. The BPJS policies, specifically affecting its price offered to participating hospitals as well as quality standards applied to the hospitals will directly influence the demand for or supply of the medical service provided by hospitals in general. Through implementation of an unvarying price system and quality standardization following INACBGs, the introduction of BPJS viewed by case hospitals in a mix of as bounty and problem. In one side it had provided abundant patients with higher certainty in payment, but it can be realized to be actual hospital revenue if, and only if, hospital perform more effectively and more efficiently. Metaphorically, it has made the battlefield for producers narrower and the availability of choices more limited. While relatively comprehensive cost or management accounting systems still non-existent in most of case hospitals, the management of case hospitals realize the importance of cost information to cope the problem of participating in BPJS scheme.

This study implicates to the issue of future organizational change, specifically within hospital industry. The introduction of BPJS has evidently showed that a bit incremental organizational change has been brought by such introduction. The new institutional logics seems to diffuse into the existing and dominating one, but this study also showed that it is rather slowly. The transformational organization change might be occurred in the next wave when BPJS (and may be followed by private health care insurers) start to implement more stringent measures either through cost path or quality path.When this happens, hospital industry may change rather dramatically such as the emergence of increasing number of mergers and acquisitions, particularly among private hospitals. Thus what can be observed now is remained a shallow organizational change.

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