IMPROVING PUBLIC SERVICE QUALITY THROUGH CITIZENS' PARTICIPATION

(A Case Study of Project Evaluation in Abdul Wahab Sjahranie General Hospital, Samarinda)

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CERTIFICATION

I, Veronika Hanna Naibaho hereby declare that the contents of this Final Report contain only my own original work. Any contributions by others have been cited or acknowledged appropriately.

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LIST OF ABBREVIATIONS

ASKES	Asuransi Kesehatan (Health Insurance)
ASKESKIN	Asuransi Masyarakat Miskin (Insurance for the Poor)
ASMARA	Asuransi Kesehatan Masyarakat Samarinda (Health Insurance for Samarinda Citizens)
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
IGD	Emergency Installation
ISO	International Standard Organization
KemPAN & RB	Kementrian Negara Pendayagunaan Aparatur Negara & Reformasi Birokrasi (State Ministry of Administrative Reform)
NGO	Non-Governmental Organization
NPM	New Public Management
NPS	New Public Service
PDCA	Plan Do Check Act
QI	Quality Improvement
SfGG	Support for Good Governance (GTZ Program)
TQM	Total Quality Management
Tupoksi	Tugas Pokok dan Fungsi (Main duty and functions or Job Description)

ABSTRACT

According to Law Number 25 Year 2009, public service is activities or series of activities in the context of meeting the need for services in accordance with the law for each citizen and resident for goods, services, and/or administrative services that are provided by public service providers. In Indonesia, most public services are provided by the government. Problems arise when public sectors are considered monopoly in delivering service.

As the capacity of government is being questioned for not delivering public services effectively and efficiently, the government nowadays are pursuing for accountability and democracy. They want to create good governance. Public service is one way to represent government's performance. In public sectors, service providers through the street-level civil servants interact with citizens as service users. Consequently, implementing State Minister of Administrative Reform Regulation Number 13 Year 2009, as a tool to improve public service quality through citizens' participation, remains a very important aspect in government organizations like Abdul Wahab Sjahranie hospital.

Utilizing qualitative method, this research identifies, describes, and analyzes the improvements of public service quality in Abdul Wahab Sjahranie hospital by evaluating the implementation of the regulation. Based on the result of achievements, outputs of the project are achieved and a number of positive changes have been identified in the hospital. The implementation of the method is also relevant with the government's policy. Impact from the implementation of the method is not only experienced by the service users by having a more transparent service, but also by the service providers as their capacity enhanced through training and education. The hospital commitment in improving public service quality is represented through the vision and mission of the hospital in pursuing excellence in service provision. Consequently, the implementation of the project remains sustainable.

Keywords: *Improving Public Service Quality, Abdul Wahab Sjahranie Hospital, Evaluation.*

CHAPTER I INTRODUCTION

1.1 Research Problem

According to Law Number 25 Year 2009, public services are activities or series of activities in the context of meeting the need for services in accordance with the law for each citizen and resident for goods, services, and/or administrative services that are provided by public service providers (Article 1). In Indonesia, most public services are provided by the government. These services can be found through various sectors like medical care, education, village administration, permits and licenses, citizen's registration, agricultural extension or other economic services, and transportation among others. However, public service implementation still does not meet the needs of and the changes in the various sectors of life in society, nation and state (elucidation of Law of the Republic of Indonesia Number 25/2009, p.41).

Unlike the private sectors, public sectors can deliberately provide service without competitors because they are not required to be profitable to survive. In Indonesia, building licence, for instance, can only be issued by a licensing office, however the procedures are considered ineffective which consume longer time and of course cost more money than it should be (Ministry of Administrative Reform and GTZ – SfGG, 2008, p.41).

Reformation movement in 1998 has widely opened opportunity for public rooms to monitor and evaluate the performance of the government in Indonesia.

Starting from mass media (newspaper, television, radio, magazines, etc.), internet, non-governmental organization (NGO), even civil society can always broadcast, publish and express their complaint, criticism, protest, objection or grievance against government's performance. As a result, plenty of cases were revealed ranging from low performance, vague procedures, extending processing time, high or illegal fees, unequal treatment especially of the lower class (poor) population, to incorrect planning, irregular procurement, and corruption (Ministry of Administrative Reform and GTZ – SfGG, 2008, p.11), which indeed still exist nowadays. These facts indicate that there are many things that the government should improve particularly in giving their service. The changing paradigm in the public management has challenged the government to turn complaints from the citizens into satisfaction.

Despite the changes made by the government, rules and regulations do not give impact to the quality of public service. It can be noticed especially when dealing with health services. When people go to the hospital, they have to wait for long hours to get treatment and not to mention the complicated administrative procedures they have to deal with in the first place. The doctors are still unwilling to listen to patients' complaints and give information about the patients' condition and the consequences of medical treatment (Kompas, 2009). They do not put a lot of attention toward rules, regulation and vows they have agreed upon.

Another similar situation also occured in Abdul Wahab Sjahranie General Hospital Samarinda where the hospital was claimed for not delivering equal treatments to the people (Kaltim Post, 2011). A poor patient cannot get treatment

only because of incomplete administration requirements. This situation contradicts to the fact that hospitals are obliged to serve poor/the have not patients (Law 44 Year 2009, Article 29f) and that the patients are entitled fair treatment (Law 44 Year 2009, Article 32c).

All this time, public service improvement has always emphasized on the provider-based point of view instead of user-based. Thus, the solutions offered cannot meet the service – users' expectation. Consequently, complaints keeps rising inspite of decreasing. Dissatisfaction is everywhere. This has become the central idea in the changing perspectives in private which is later applied public sectors in delivering their services from provider-based into user-based ones, by turning complaints into satisfaction. By hearing complaints from the service users, a service unit can improve quality exactly like what the service users' expectation. As a result, the government of Indonesia through the State Ministry of Administrative Reform supported with technical assistance from the Government of the Federal Republic of Germany (channeled through the German Technical Cooperation (*Deutsche Gesellschaft für Technische Zusammenarbeit* (GTZ) – GmbH) within the Support for Good Governance (SfGG) joined in a cooperation. One of the results of this cooperation is the development of a GuideBOOK which is used as a reference in the effort to improve the delivery of public services, which complements the various policies of the State Ministry of Administrative Reform aimed at the end in achieving Good Governance.

In 2001, this methodology was first tested in several pilot locations, such as the District of Solok, where the focus was on public service delivery improvement

through civil society participation within village administrations (Nagari) in West Sumatra, as well as the Municipality and District of Bima, where services in several health centers (Puskesmas) were being improved.

Based on service users complaints, Penajam Paser Utara General Hospital, for example, has improved its service by offering basic health service for free (Kaltim Post, 2010). Another good practice comes from Malinau General Hospital by giving 24 hours health service (Kaltim Post, 2010).

Improvements in public health services have also started in Padang Panjang where the practice hours are more transparent nowadays, in addition to the fact that the hospital management introduced a policy requiring all doctors to give patients an estimate of the cost of the medicines they prescribe, doctors have to offer equivalent, lower cost alternatives, and pharmacy staff must calculate the price of the medicines before the patients or their families decide to purchase them (GTZ – SfGG & KemPAN, 2008, p.52). These practical experiences can serve as good exemplifications in successful applications of the project in improving public services by turning complaints into satisfaction. The service units identify complaints from the users then find out what they can do to overcome complaints.

In 2004, the method has been spread to all local governments in Indonesia by the State Ministry of Administrative Reform through Circulation Letter Number SE/20/M.PAN/6/2004. Until June 2008, 15 regions in 199 service units (with participation of 152.262 respondents) have applied this method in improving their public service deliveries. The number keeps increasing that in

2009, 75 regions in 485 service units (with participation of 400,000 respondents) apply the method including 14 regions in 24 service units in Kalimantan. This increasing number of application of this method and success stories from the regions that have been implementing this method has enhanced the legal status of the Circulation Letter Number SE/20/M.PAN/6/2004 into Ministry of Administrative Reform Regulation Number 13 Year 2009 on the Method of Improving Public Service Quality through Citizens' Participation. Some improvements have also been made to perfect the method.In Samarinda, the implementation was conducted in April 2010 in Abdul Wahab Sjahranie General Hospital Samarinda.

Many service units claim that they have made many progresses regarding the services upon implementing this project. Nevertheless, it requires evaluation in order to recognize the improvements which have been performed by the public service unit. In this case, evaluation has a very important and strategic role as a means to establish whether or not the implementation of social policies, programs and projects actually had any effect on society (Miyoshi, 2008, p.2). Despite being able to implement the method, it is difficult to say that the goal of the project has been achieved without evaluation.

1.2 Research Questions

1. How is the implementation of the method of improving public service quality through citizens' participation in Abdul Wahab Sjahranie Hospital? (Chapter V)

2. What are the changes that have been performed by Abdul Wahab Sjahranie Hospital by implementing the method? (Chapter VI)
3. What are the supporting and constraining factors in improving public service quality in Abdul Wahab Sjahranie Hospital? (Chapter VII)

1.3 Research Objectives

Generally, this research will be to evaluate the implementation of the method as the means of improving public service quality in the hospital as service unit in public sector. Specifically, objectives of the research are as follows:

1. To examine the achievements of the project implementation in the hospital.
2. To identify the supporting and constraining factors in implementing the project.
3. To evaluate the project in terms of relevance, impact, and sustainability.
4. To make recommendations for further improvements which are applicable to other similar ongoing and future projects.

1.4 Significance of Research

Hospitals deliver public health services whether they are public or private ones. The different lies when dealing with the users of the hospital. For private hospitals, users are customers because they pay for the service. On the other hand, in public hospitals, users are all citizens whose rights are protected to get service that most patients can get the service for free. Thus, improving public service quality in public hospitals is more challenging than those in private hospitals since

the users of the service will come even when the hospital does nothing about their service quality.

This research will evaluate the implementation of the method which applies citizens' as service-users' centered to improve public service quality in the hospital. The approach of the method is interesting since it represents the changing perspectives in public sector like government's hospital. Situated in the heart of East Kalimantan, Samarinda, AW Sjahranie hospital has become referral hospital throughout the province of East Kalimantan. With a more complete infrastrucutures combined with high medical technology, the hospital is striving for better service quality improvements.

1.5 Structure of Research

This research will be divided into seven chapters. The introductory chapter 1 highlights the problem, questions, objectives, and significance of the research. Chapter 2 presents a literature review of the changing paradigm in public management, and public service quality. Chapter 3 describes the social setting of Abdul Wahab Sjahranie hospital in Samarinda. Chapter 4 describes the design of the research, data collection process, sources of data, fieldwork, and data analysis. Chapter 5 presents the implementation processes which are evaluated in the following Chapter 6. Finally, the last chapter 7 provides the conclusion of the research and recommendation about the importance of a follow-up action for the project.

CHAPTER II THEORETICAL REVIEW

2.1 Public Management

Over the years, the government is always associated with the mental image of slow, inefficient and impersonal in delivering public service (Osborne and Gaebler, 1992, p.14). This has become a central theme in the transformation of study in Public Management. Government is seen by the citizens, the media, and sometimes by public servants and political leaders themselves, as plodding, inefficient, bureaucratic, change-interest, incompetent, unresponsive or corrupt (Rondinelli, 2001, p.1). This is the implication from the fact that normal government budgets encourage managers to waste money. If they do not spend their entire budget by the end of the fiscal year, three things happen: they lose the money they have saved; they get less next year; and the budget director scolds them for requesting too much last year. Hence the time-honored government rush to spend all funds by the end of the fiscal year (Osborne and Gaebler, 1992, p.3). This has been the fundamental reason for juxtaposing government (public sector) from business (private sector) where responsiveness, quality, efficiency and productivity become the central image of how to run the business.

For businesses, service quality has become important because of increasing national and global competition which has forced them to differentiate themselves from their competitors through competition at the margins by use of quality (e.g. speedy service delivery). The private sector has been forced to manage customer

satisfaction with the ultimate goal of increasing customer loyalty and hence profits (Black *et al.*, 2001, p.400). On the other hand, public sector can deliberately provide service without competitors because they are not required to be profitable to survive. In Indonesia, for instance, building licence can only be issued by licensing office, however the procedures are considered ineffective which consume longer time and of course cost more money than it should be (GTZ – SfGG & KemPAN, 2008, p.41). The service users are forced to take all the consequences for granted and follow inappropriate procedures. This is monopoly, take it or leave it.

Monopoly does not need competition, because it does not have motivation to reform, renew and improve. Competition is an effective means for efficiency and monopoly is its enemy (Tiihonen, 2004, p.265 - 268). Monopoly has also raised the issue about equity. Public services that offer their users little or no choice can create substantial inequities whereas extending user choice within those services can create greater equity (Le Grand, 2006). The competitive atmosphere, habit or culture to drive public administration to become more and more efficient is less developed in public organizations. No wonder if inefficiency, laziness and bad service quality characterized almost all public service delivery in Indonesia (Dwiyanto *et al.*, 2006:6). This situation has to become the central idea for the government to change and reform its service to better accelerate with its neighbors in the private sectors.

Black *et al.* (2001) argue that there are two main "drivers" for change in the attention given to the issue of service quality; "competitive advantage" in the private sector in the private and public sector and "the new public management" in the public sector. Indeed, it is the New Public Management (NPM), or sometimes refer to as the "new managerialism" (Frederickson and Smith, 2003, p.214), which has become an important phenomenon in the changing paradigm in the public sectors' performance which incorporates the business values into the public sectors.

The term of NPM come into use at the beginning of the 1990s to describe public sector reform in the UK and New Zealand, as a conceptual device invented for the purpose of structuring discussion of changes in the organization and management of government. The New Public Management refers to a cluster of contemporary ideas and practices that seek, at their core, to use private sector and business approaches in the public sector (Denhardt & Denhardt, 2003, p.12). Markets are simply *better* at learning, experimenting, and innovating than public sectors organizations. Markets are simply better at dealing with rapid change and complexity than government (Parsons *et al.*, p. 4). Success stories from the British government as well as the application entrepreneurial government in the reinventing government movement in the United States have proved that NPM remains successfull in making efficiency in public sectors. Nevertheless, the emergence of democratization has provided the NPM movement with new challenges as well as critics.

Table 2.1 Comparing Perspectives: New Public Management and New Public Service

Comparing Perspectives	New Public Management	New Public Service
Primary theoretical and epistemological foundations	Economic theory, more sophisticated dialogue based on positivist social science	Democratic theory, varied approaches to knowledge including positive, interpretive, critical, and postmodern
Prevailing rationality and associated models of human behavior	Technical and economic rationality, economic man,"or the self-interested decision maker	Strategic rationality, multiple tests of rationality (political, economic, organizational)
Conception of the public interest	Represents the aggregation of individual interests	Result of a dialogue about shared values
To whom are public servants responsive	Customers	Citizens
Role of government	Steering (acting as a catalyst to unleash market forces)	Serving (negotiating and brokering interests among citizens and community groups, creating shared values)
Mechanisms for achieving policy objectives	Creating mechanisms and incentive structures to achieve policy objectives through private and nonprofit agencies	Building coalitions of public, nonprofit, and private agencies to meet mutually agreed upon needs)
Approach to accountability	Market-driven – the accumulation of self-interests will result in outcomes desired by broad groups of citizens (or customers)	Multifaceted – public servants must attend to law, community values, political norms, professional standards, and citizen interests
Administrative discretion	Wide latitude to meet entrepreneurial goals	Discretion needed but constrained and accountable
Assumed organizational structure	Decentralized public organizations with primary control remaining within the agency	Collaborative structures with leadership shared internally and externally
Assumed motivational basis of public servants and administrators	Entrepreneurial spirit, ideological desire to reduce size of government.	Public service, desire to contribute to society

(Source: Denhardt & Denhardt, 2000, p.554)

Vigoda argues that expanding orientation of government and public administration systems towards responsiveness, as prescribed by New Public Managerialism, is frequently accompanied by lower willingness to share, participate, collaborate, and partner with citizens. The role of "customer" or "client" refers to a passive orientation of citizens toward government (2002, p.528). When someone is defined as client, he or she is not actively engaged in social initiatives, but is merely a passive service (or product) consumer, dependent on the goodwill and interest of the owner. On the other hand, direct democracy suggests that citizens themselves "own" the state and run their lives through representatives because they also need a "board of directors" that is professional and capable of making wise decisions for huge communities (Vigoda, 2002, p. 534). This changing attitude creates what Vigoda identifies as an evolutionary continuum interaction from responsiveness to citizens as clients into collaboration with citizens as partners. This transformation is represented by the New Public Service movement.

The New Public Service (NPS) is a set of ideas about the role of public administration in the governance system that places citizens at the center. This approach assumed society as citizens who have rights and duties, not as customer. Based on the NPS approach, the efforts to improve service quality begins with recognition of the differences between customers and citizens. Citizens are described as bearers of rights and duties within the context of a wider community. Customers are different in that they do not share common purposes but rather seek to optimize their own individual benefits (Denhardt & Denhardt, 2003, p.60). The

ideas such as serve rather than steer, the public interest is the aim, not by the product, think strategically act democratically, serve citizens not customers, and accountability is not simple are primarily role of the public servant to help citizens articulate and meet their shared interests rather than to attempt to control or steer society (Denhardt & Denhardt, 2003, p.42). The New Public Service seeks to encourage more people to fulfill their responsibilities as citizens and for government to be especially sensitive to the voices of citizens. This has become the primary distinction between New Public Management and New Public Service (see table 2.1).

To conclude, in a democratic society, a concern for democratic values should be paramount in thinking about systems of governance. Values such as efficiency and productivity should not be lost, but should be placed in the larger context of democracy, community, and the public interest. This has become one major challenge in the public management in performing their task to deliver service and democracy.

2.2 Defining Public Service

Public service refers to government employment especially within the civil service. Public service can also be defined to the provision of essential services: the business or activity of providing the public with essential goods or services such as electric power and service benefiting general public or a service that is run for the benefit of the general public, e.g. the utilities, the emergency services, and public transportation (encarta dictionary tools, 2006). In this research, public service refers to the second definition.

In Indonesia, public service is defined as activities or series of activities in the context of meeting the need for services in accordance with the law for each citizen and resident for goods, services, and/or administrative services that are provided by public service providers (Law of Republic of Indonesia Number 25 Year 2009; Minister of Administrative Reform Decree Number 63 Year 2003). Public service in Indonesia is generally provided by the government. Consequently, the standards and principles are set by the government through laws and regulations.

2.3 Quality Improvement in Public Service

For business sectors, the major reason for applying these quality improvement (QI) strategies was an effort to *respond to the needs of customers* and manage the complex interrelationships between costs, competition, market share, productivity, and profit (Milakovich, 1995, p.2).

Quality in public service emerges as the people grow and the needs for more housing, more education and more health services are increasing. The rapid change in globalization together with democratization has put into effect that the drive for economy and efficiency had its limitations. Quality seemed to offer a way to improve public services from the perspective of service user rather than the provider.

According to Doherty and Horne (2002, p.145), there are external and internal reasons for concern about quality in public services. The external reasons for concerns include:

1) Legislative changes, such as Compulsory Competitive Tendering

2) Financial constraints, forcing a rethink about how best to use resources
3) Complaints about declining standards in areas such as transports, education, and health
4) Increasing concern with effectiveness as opposed to economy and efficiency

Whereas the internal reasons for concerns are:

1) The need for benefits analysis as well as a cost analysis
2) The rise of internal audit and the concern for quality as well as value for money
3) 'Big ideas' such as 'Excellence' and "Total Quality Management"
4) Demotivation of employees by performance management

The definition of quality includes references to conformance, specification, fitness for purpose, or responsiveness to customers or clients. If public services aim to provide what users expect, this implies that managers of public services should concern themselves with managing user expectations as well as designing service provision. Service users are also entitled to expect that services have been designed thoughtfully. Quality also implies that there must be a reasonable match between the intent of the design and the actual service delivered. Quality in public service is about meeting or exceeding stakeholder expectations (in Doherty & Horne, 2002:146).

Jager, Plooy, and Ayadi (2010, p.133) argue that in public sectors like government-controlled hospitals, it is critical for public service provider to determine the patients' as service users' point of view about the service in order to

understand what is valued by patients, how the quality of care is perceived by the patients and to know where, when and how service changes and improvements could be made.

Some scholars indentify strategies for developing and maintaining service quality. Milakovich identifies 7 (seven) key elements to develop a total quality service.

1) Integrating cross-functional management through teamwork and flattening the hierarchy
2) Strengthening customer-supplier relationships
3) Increasing employee empowerment and participation
4) Monitoring results and customer feedback
5) Understanding systemic relationships
6) Implementing continuous quality improvement or 'kaizen'
7) Reducing poor quality cost practices

Doherty and Horne (2002, p.146-150) offer approaches to managing quality as follows:

1) Quality Control: Detecting Poor Quality
2) Quality Assurance: Building in Quality
3) Building in Bureaucracy
4) Total Quality Management (TQM)
5) Beyond TQM

Whereas International Standard Organization (ISO) sets the standard for managing quality into eight principles (www.iso.org) as follow:

1) Principle 1 : Customer focus
2) Principle 2: Leadership
3) Principle 3: Involvement of people
4) Principle 4: Process approach
5) Principle 5: System approach to management
6) Principle 6: Continual Improvement
7) Principle 7: Factual approach to decision making
8) Principle 8: Mutually beneficial supplier relationship

Considerations in applying these approaches should be in line with the needs as well as the ability of an organization.

2.4 Barriers and Strategies to Achieving Service Quality Improvements

The success ofaservice unit in providing a quality service can be done through implementing various strategies and innovation in service delivery. Various concepts of service improvements which are successfully practiced inthe private sectors are adopted and developed in the public sector such as the concept of TQM, Citizens' Charterand ISO. Other factors that support the success in providing quality services, among others are the leadership's commitment toproviding services with good quality, giving focus to the customer, complaint management, employee empowerment, use of information and technology and satisfaction index measurement (LAN, 2006, p.147-246).

Another action strategy to achieve service quality improvements is proposed by Milakovich (1995, p.214 – 216).

1) Consistent with the mission of the organization, flatten hierarchies that discourage teamwork and create barriers between departments.
2) Formulate a mission statement that reflects the shared values and operationally defines the vision of organization.
3) Empower employees instead of threatening them.
4) Pay more attention to your customers and suppliers.
5) Begin slowly and do not create unrealistic expectations.
6) Anticipate and continually adapt change.

2.5 Concluding Remarks

It can be drawn that pursuing efficiency and productivity have always been the major issue both in private and public sectors. Although earlier development of quality improvement was introduced in the private sector, the public sectors

also taste the success of its application in government organizations. The various approaches to maintain quality in delivering service in private sectors have become inspiring models and methods for government to be adapted in their public service policies.

The fundamental goal between private and public sectors is to fulfill the expectation of their users. Indeed, there are differences arise when comparing the goals for both sectors. First is fact that private sector serves customers while public sector serves citizens. Private sector delivers products while public sector delivers democracy. For private sectors, the final goal in pursuing effectivity and productivity is profit or value for money whereas in public sectors, the aim is accountability to gain the heart of *the owner of the boat* (citizens). For public sectors, accountability remain an important aspect as it is the pillar of democracy and good governance that compels the state, the private sectors, and civil society to focus on results, seek clear objectives, develop effective strategies, and monitor and report on performance. It implies holding individuals and organizations responsible for performance measures as objectively as possible (Cheema, 2003, p. 99). Thus, for government controlled organization like hospitals, delivering efficient and effective public service delivery together with good quality like those in private sectors for the citizens has always become a challenge.

Using the theories mentioned above, this research will explains, describe, analyze, and evaluate the quality of public service in AW Sjahranie General Hospital, the methods together with the processes of the hospital in increasing public service along with the problems they face as well as the supporting factors

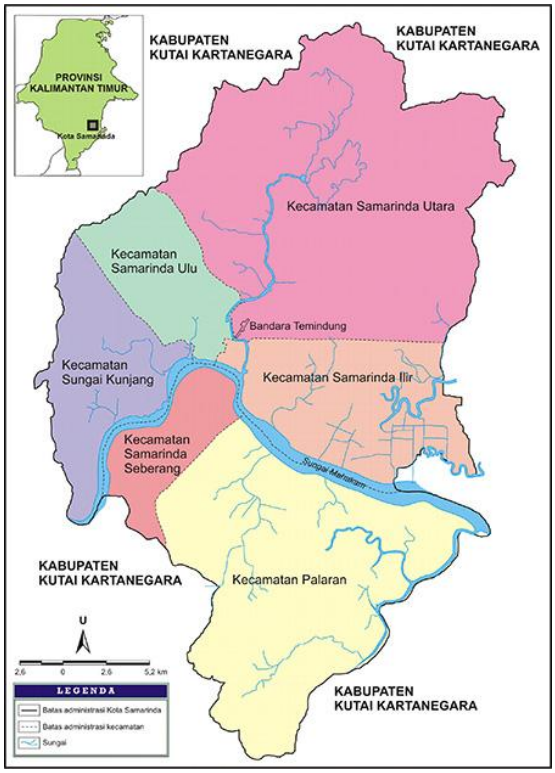
that will enable them to overcome the problems. Consequently, evaluation becomes an important aspect during the analysis as it can give organized assessment of the implementation and effects of various policies, programs, and projects (Weiss & Miyoshi in Miyoshi, 2008, p. 2).

CHAPTER III SOCIAL SETTING

3.1 General Description

Public services which can be found in education, health, and administrative sectors are public service units that directly serve the people. The performance and quality of their services are highly attached with the social condition of where that public service exists. Therefore, it is important to describe the social setting in order to evaluate the service improvement identified in a service unit.

Figure 3.1
Map of Samarinda City



This research is conducted in AW Sjahranie Hospital which is located in Samarinda, the capital city of East Kalimantan Province, Indonesia. The area of Samarinda City is 718,00 km² and divided in 6 (six) subdistricts (i.e. Palaran subdistrict, Samarinda Ilir subdistrict, Samarinda Seberang subdistrict, Sungai Kunjang subdistrict, Samarinda Ulusubdistrict and Samarinda Utarasubdistrict) with 53 villages. Samarinda city is adjacent with Kutai Kartanegara Regency and has become the gateway for other rural Regencies/Cities in East Kalimantan.

The population of Samarinda City keeps increasing per annum. Based on BPS-Statistic of Samarinda City (2010), until 2009 the population of Samarinda is 607.675 people, and the number keeps growing in the following year.

Table 3.1
Population Census by Regency/City between 2000 and 2010

No.	Regency/City	Census 2000	Census 2010
1.	Paser	159,022	230,316
2.	Kutai Barat	135,960	165,091
3.	Kutai Kartanegara	427,791	626,680
4.	Kutai Timur	146,510	255,637
5.	Berau	117,769	179,079
6.	Malinau	36,632	62,580
7.	Bulungan	76,445	112,663
8.	Nunukan	79,620	140,841
9.	Penajam Paser Utara	109,739	142,922
10.	Tana Tidung	6,592	15,202
11.	Balikpapan	409,023	557,579
12.	**Samarinda**	**521,619**	**727,500**
13.	Tarakan	116,995	193,370
14.	Bontang	99,617	143,683
	Total	*2,443,334*	*3,553,143*

Source: BPS-Statistics of East Kalimantan 2011, p.73

As indicated in table 3.1, among the cities and regencies in East Kalimantan, Samarinda becomes the city with the largest amount of population. This can be indicated from the number of population in the regencies and cities in East

Kalimantan. Indeed, the increasing population affects the public service delivery in Samarinda.

Table 3.2
Number of Patients between 2005 and 2010

No.	Kind of Visit	2005	2006	2007	2008	2009	2010
1.	Number of beds	421	435	465	505	604	612
2.	Emergency	20.151	25.172	29.139	25.882	26.561	38.286
3.	Outpatient	135.926	137.865	114.088	132.939	141.788	144.846
4.	Inpatient	21.791	24.187	26.591	27.513	30.193	36.814
5.	Laboratories	495.342	674.680	698.810	879.548	805.965	896,793
6.	Radiology	20.162	21.343	21.383	24.002	29.679	31,241
7.	Delivery (Baby)	1.377	1.366	1.571	1.630	2.509	2,576
8.	Sectio Caesar	545	464	642	714	938	989
9.	MCU	-	1.342	833	4.585	4.988	5,246

Source: AW Sjahranie Hospital, 2011

Based on table 3.2, it can be noticed that in health sectors, for example, the number of the patients in AW Sjahranie hospital since 2005 keeps increasing. The increasing number of patients compared to the resources owned the hospital (as indicated by the number of beds in table 3.2) indeed has generated gap related to the public service delivery at the hospital. The project implementation was one way for the hospital to built communication between them as service providers and their users.

3.2 Profile

AW Sjahranie hospital was builtin1933and located around Selili area, Samarinda Ulu Subdistrict. During the earlier establishment, there were only several beds in the hospital until 1960, there were 50 beds and became 75 beds in 1970. The hospital area was 2 hectares and it was difficult development since the location was in the mountainside.

Figure 3.2
AWSjahranie Hospital Location

Source: AW Sjahranie Hospital Profile 2010

Along with the rapid increase of the population (reaching 6% per year), the hospital could not afford to fulfill the need for health service. As a result, in 1973, a more representative hospital was built in the center of Samarinda City. The transfer process of the hospital from Selili area to dr. Soetomo area started on November 12, 1977. The whole transfer of the hospital services was conducted 7 years later on July 21, 1984. On February 22, 1986, the hospital was inaugurated as Abdul Wahab Sjahranie General Hospital (to commemorate the late Mr. AW

Sjahranie, the head of the hospital in the periodfrom 1968 to 1975). Since 1993, AW Sjahranie hospital becomes referral hospital Class Bon thebasis ofHealth Ministry Decision Letter Number 116/Menkes/SK/XIII/1993 enacted inJakartaonDecember 15, 1993, which was renewed by the Health Minister Decision Letter Number Ym.01.06/III/580/2010 dated February 1, 2010.

Based on the chronological history of the establishment of AWSjahranie (AWS) General Hospital, it can be concluded that the hospital is trying to be accessible for the people of East Kalimantan in general and Samarinda people specially. It is indicated by the movement of the hospital into a strategic location where the public transportation can access the location. In addition, Samarinda is the capital city of East Kalimantan Province and becomes the gateway for other cities/regencies especially those located in the rural areas in East Kalimantan.

3.3 Main Duty and Function

According to the East Kalimantan Governor Regulation Number 47 Year 2008 concerning the main duty, function, and working procedure, Regional Hospital in East Kalimantan has the fundamental duty to make health effort through healing, recovery as well as referral attempts with health service quality according to hospital service standard.Accordingly, to carry out its main duty, AW Sjahranie General Hospital has the following functions:

a. Conducting Medical Service
b. Conducting Medical and Non Medical Support Services
c. Conducting Nursing Services
d. Conducting Referral Services

e. Conducting Education and Training

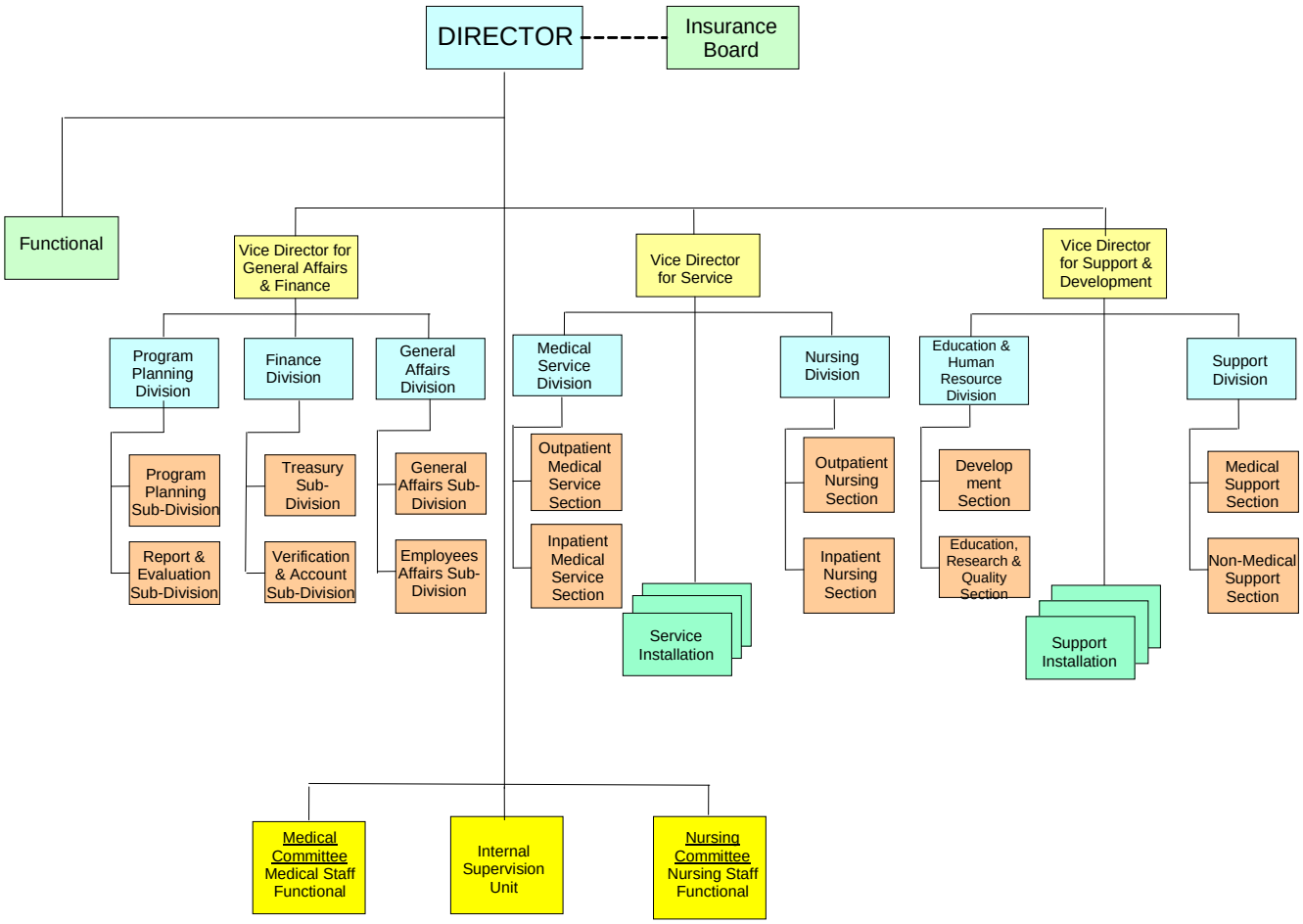
f. Conducting Research and Development

g. Conducting General Services and Finance

3.4 Organizational Structure

The organizational structure of AW Sjahranie General Hospital is based on East Kalimantan Government Regulation Number 10 Year 2008 concerning the Organization and Working Administration of East Kalimantan Regional Hospital which consists of a director, 3 vice directors, 7 head of divisions, 14 head of sections and installations, and a number of functional groups as described below:

Figure 3.3
Organizational Structure



3.5 Human Resource

As per January 31, 2010, AW Sjahranie General Hospital has 1,260 personnel with 25 people in the structural positions and 845 people belong to functional positions and administrators (civil servants) with 390 honor employees.

Tabel 3.3
Employee Data from 2006 - 2010

No.	Kind of Employment	2006	2007	2008	2009	2010
1	Specialist	56	59	52	64	61
2	General Practitioner	38	41	44	42	40
3	Dentist Specialist	5	4	4	5	4
4	Dentist	4	4	4	6	6
5	Pharmacist	8	8	7	9	9
6	Pharmacist Assistant	36	16	22	25	36
7	Nursing Staff	401	425	430	437	440
8	Medical Support	60	71	86	93	86
9	Non Medical Staff	290	290	314	316	314
10	Cleaning Service	85	90	90	101	114

Source: Accountability & Performance Report of AW Sjahranie Hospital, 2011

Although the number of employees rises (see table 3.3) and the quality of the employees are considered to be adequate to fulfill their main duty and functions, still they require more employees to meet their service users' needs.

3.6 Facilities and Infrastructure

To fulfill their main duty and function, the hospital is equipped with facilities and infrastructures including buildings, medical equipments, nursing equipments, laundry equipments, nutrition equipments, office supplies, on-duty vehicles among others. The rapid changes in science and technology have enforced the hospital to renew their health service facilities. However, some of the facilities remain in good condition and some are not. Nevertheless, it is expected that all facilities can be optimally utilized.

3.7 Types of Services

Types of services available in AW Sjahranie General Hospital cover:

a. Emergency Service
b. Outpatient Service
c. Inpatient Service
d. Central Surgery Service
e. Midwife Service
f. Intensive Care Service
g. Radiology Service
h. Pathology Clinic Service
i. Anatomical Pathology Clinic Service
j. Medical Rehabilitation Service
k. Pharmacy Service
l. Nutrition Service
m. Blood Transfusion Service
n. Poor Family Service
o. Medical Record Service
p. Waste Management
q. Ambulance/Hearse Service
r. Corpse Handling Service
s. Laundry Service
t. Facility Maintenance Service

3.8 Vision and Mission

Considering current condition as well as for future anticipation, the hospital sets its vision "to become the best center referral hospital for medication, education, and research service" which can be interpreted as follow:

a. Center means that the hospital is surrounded by other hospitals that need AW Sjahranie Hospital's aid and support such as service, human resource, health equipments, laboratory, radiology, etc for reference, source of study, benchmark, and exemplification;
b. Referral means that other nearby hospitals and patients can always count on AW Sjahranie Hospital in case they need follow-up treatment.
c. Service means that the hospital provides everybody in need of medication or treatment related to prevention, diagnosis, and cure.
d. Education means to make the transformation of attitude and behavior through education and training.
e. Research implies collecting, processing, analyzing and presenting data systematically and objectively when solving problems or testing hypothesis in order to develop new principles with continuous assessment in quality management as in PDCA (Plan, Do, Check, Act).
f. Health means to make people healthy, or to give 'health', complete, qualified, adequate, and affordable services.
g. Medication emphaizes on the "process of service" whether it is treatment, diagnosis, whereas paramedic refers to the person (doctor, nurse).

h. The best as the superlative form of the word good, which essentially means good in ethic, value and culture and good in the system and procedure. By utilizing the superlative form ‘the best’, the hospital is attempting to act and perform beyond average or standard.

Referring to the above description, the vision embodies the future expectation of the hospital. The vision is expected to be a noble aspiration which comprises moral value and motivation for the hospital’s administrators. Consequently, to bring the vision into reality, the hospital set the mission of the hospital such as:

a. to prepare and develop human resources, which have been conducted through education and training. With qualified human resource, it is expected that the hospital can offer optimum health service.
b. to completethe facilities and infrastructure; considering the rapid changes in of science and technology, the hospital keeps improving the facilities and infrastructure covering the masterplan of design, landscape, safety, security, building, etc., in order to fulfill the service needed by the society.
c. to provide excellent service; the hospital is offering quality, which can be identified through exploration from the patients who have experienced the service provided by the hospital. Thus, the hospital can conduct quality control through PDCA (Plan Do Check Act) cycle to maintain excellent service.
d. to improve the welfare ofemployees by giving renumeration based on minister of domestic affair regulation number 61 concerning the competency, performance, and main duty of an employee.

3.9 Concluding Remarks

Every citizen is entitled to get equal treatment and access to health services as it has been stipulated in the Law and Regulation. Hospitals are built and established to serve the people. AW Sjahranie Hospital has the ability, competency, capacity, and resources to realize it. Strategic issues and the gap as well as complaints along the process of services have made the hospital worth of research. Another reason is because AW Sjahranie has a strategic position as referral hospital throught East Kalimantan. Whether the citizens see this as improvement toward better service quality will be analyzed in the discussion.

CHAPTER IV RESEARCH METHOD

4.1 Type of Research

The research applied qualitative approach. According to Cresswell (2009, p.4), qualitative research is a mean for exploring and understanding the meaning of individuals or groups ascribe to a social or human problem. The process of research involves emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data. This research will perform a projectevaluation study ofimproving public service quality based on citizens' participation by using qualitative approach.

The strategies of inquiry in qualitative approach can be conducted through ethnography, grounded theory, case studies, phenomenal research, and narrative research. In this study, the writer will conduct case studies strategy. Stake defines case studies as a strategy of inquiry in which the researcher explores in depth a program, event, activity, process, or one or more individuals. Cases are bounded by time and activity, and researchers collect detailed information using a variety of data collection procedures over a sustained period of time (in Creswell, 2009:13). This research will be conducted through a case study at AW Sjahranie General Hospital in Samarinda, East Kalimantan.

4.2 Research Focus

The research is focusing on the method applied in the hospital to improve the service quality. The research will evaluate the project implementation according to the Minister of Administrative Reform Regulation Number 13 Year 2009 on improving public service quality through citizens' participation in AW Sjahranie General Hospital which consists of the following steps:

a. Preparatory Stage
b. Complaint Mechanism
c. Survey
d. Complaint Analysis and Action Plan
e. Monitoring and Evaluation

This research uses report, documents and documentations related to the application of the method. Therefore, the research can recognize whether the hospital has gradually fulfilled its mission to improve public service quality for the citizens.

4.3 Source of Data

This research utilized both primary and secondary data. The primary data will be obtained by getting information from informants whereas secondary data were acquired through facts from field or direct observation, and documents especially during the implementation of the project.

4.4 Data Collection Procedures

Evaluation is carried out on the basis of information gathered and analysed. There aremany methods used for these activities. Individual methods have their advantages anddisadvantages and it is important to combine several methods in order to enhance the accuracy of the data gathering and analysis (ODA Evaluation Guidelines, 2009:5).The data collection steps will be conducted through several techniques (Creswell, 2009:181-182):

a. Observation by which a researcher can have a first-hand experience with participant, record information as it occurs, notice unusual aspects during observation and explore topics that may be uncomfortable for participants to discuss.

b. Interviews which can be can be organized through 1) face-to-face – in-person interview, 2) telephone – researcher interviews by phone, 3) focus group – researcher interviews participants in a group, and 4) e-mail internet interview. In this research, the interviewees are the citizens related to the hospital like patients and their accompanies as service users and service officials as service providers.

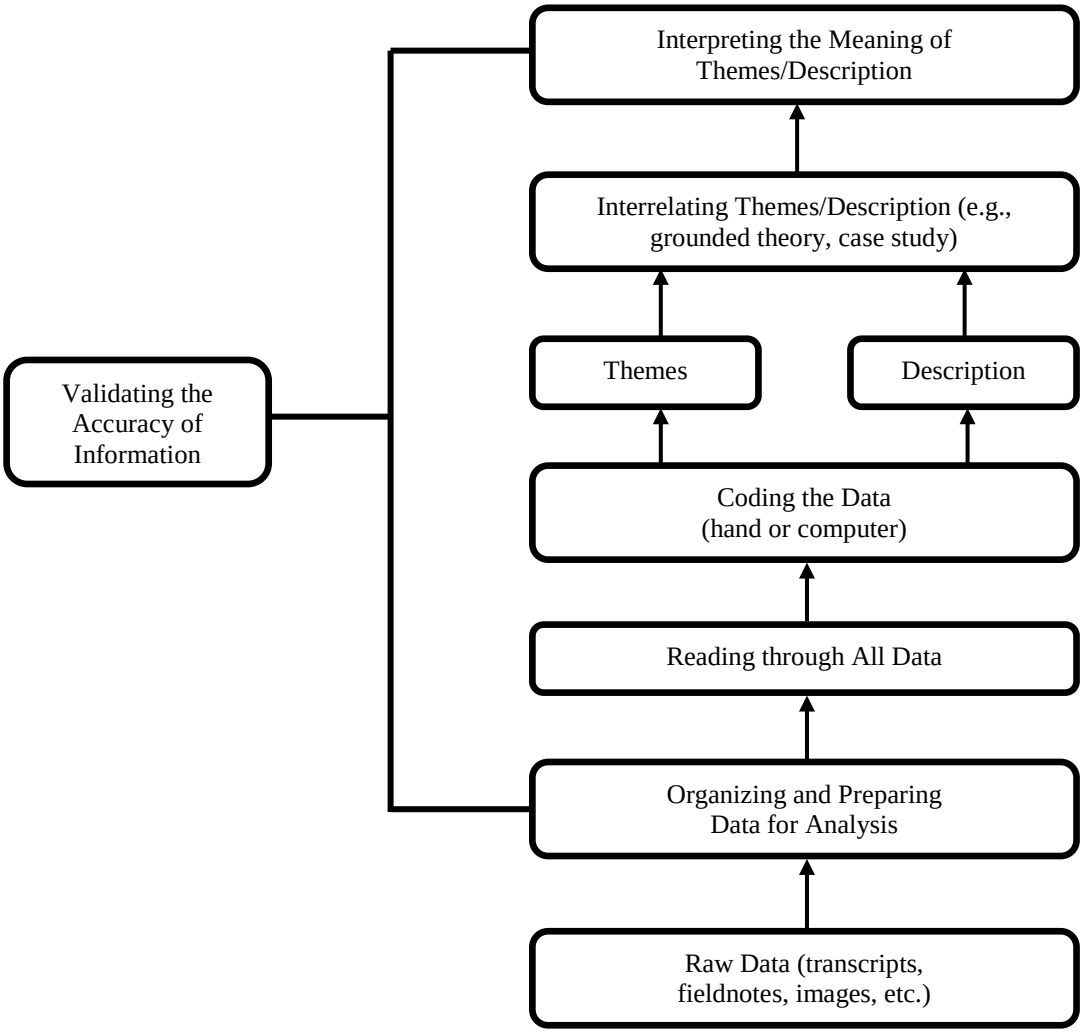
c. Documents which will enable a researcher to obtain information in the form of minutes of meetings, newspapers, letters, strategic plans of the research object, websites, reports, laws, regulations, complaint index.

d. Audio-Visual Material which can serve as an unobtrusive method of collecting data, provides an opportunity for participants to directly share their reality and creative as it captures attention visually like photographs.

4.5 Data Analysis and Interpretation

The process of data analysis involves making sense out of text and image data. It involves preparing the data for analysis, conducting different analysis, moving deeper and deeper into understanding the data, representing the data, and making an interpretation of the larger meaning of the data (Creswell, 2009:183).

Figure 4.1
Data Analysis in Qualitative Research



(Source: Cresswell, 2009:185)

Qualitative inquirers often use a general procedure and convey in the proposal the steps in data analysis. An ideal situation is to blend the general steps

with the specific research strategy steps as illustrated in Figure 4.1. The figure suggests a linear, hierarchical approach building from the bottom to the top, but in practice, it is more interactive; the various stages are interrelated and not always visited in the order presented. These levels are emphasized in the following steps:

Step 1. Organize and prepare the data for analysis. This involves transcribing interviews, optically scanning material, typing up field notes, or sorting and arranging the data into different types depending on the source of information.

Step 2. Read through all data. A first step is to obtain a general sense of the information and to reflect on its overall meaning. What general ideas are participants saying? What is the tone of ideas? What are the impression of the overall depth, credibility, and the use of information? Sometimes qualitative researchers write notes in margins or start recording general thoughts about the data at this stage.

Step 3. Begin detailed analysis process. According to Rossman and Rallis coding is the process of organizing the material into chunks or segments of text before bringing meaning to information. It involves taking text data or pictures gathered during data collection, segmenting sentences (or paragraphs) or images into categories, and labeling those categories into a term, often a term based in the actual language of the participant (called an in vivo term).

Step 4. Use the coding process to generate a description of setting or people as well as categories or themes for analysis. Description involves a detailed rendering of information about people, places, or events in a setting.

Step 5. Advance how the description and themes will be represented in the qualitative narrative.

Step 6. A final step in data analysis involves making an interpretation or meaning of the data.

4.6 Validity

Qualitative validity means that the researcher checks for the accuracy of the findings by employing certain procedures, while qualitative reliability indicates that the researcher's approach is consistent across different researchers and different projects (Gibbs in Creswell, 2009:190). Gibbs also suggests several reliability procedures:

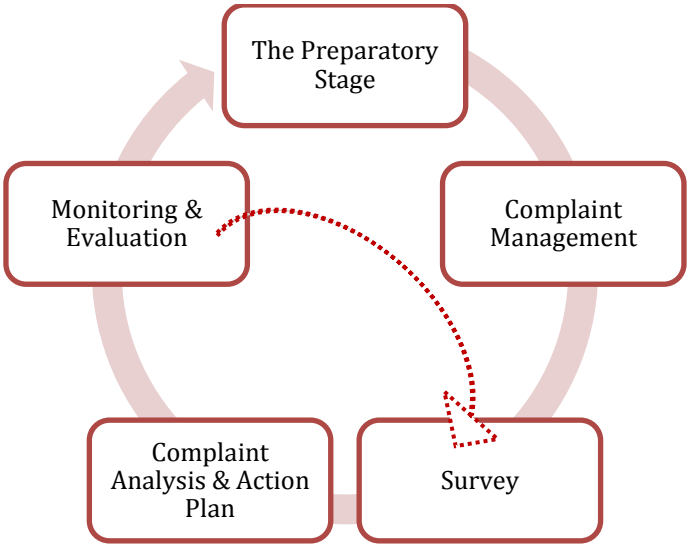
a. Check transcripts to make sure that they do not contain obvious mistakes during transcription.
b. Make sure that there is not a drift in the definition of codes, a shift in the meaning of the codes, a shift in the meaning of the codes during the process of coding.
c. Triangulate different data sources of information by examining evidence from the sources and using it to build a coherent justification for themes.
d. Use member checking to determine accuracy of the qualitative findings through taking the final report or specific descriptions or themes back to participants and determining whether these participants feel that they are accurate. This procedure can involve conducting a follow-up interview with participants in the study and providing an opportunity for them to comment on findings.

CHAPTER V THE IMPLEMENTATION OF THE MINISTRY OF ADMINISTRATIVE REFORM REGULATION NUMBER 13 YEAR 2009

This chapter will describe and analyze the implementation process. Examination of implementation process is for the purpose of investigating the whole activities and what happening during project implementation (JICA, 2004, p.17). The Ministry of Administrative Reform Regulation Number 13 Year 2009 concerning the method of improving public service quality through citizens' participation, which has been implemented in AW Sjahranie hospital, encompassed five consecutive stages starting with: 1) The preparatory stage, 2) Complaint Management, 3) Survey, 4) Complaint Analysis & Action Plan, and 5) Monitoring and Evaluation (see figure 5.1).

Figure 5.1

Simple Steps to Improve Public Service Delivery



Source: Ministry of Administrative Reform Regulation Number 13 Year 2009

Generally, the preparatory stage involves mostly people from the service provider and trained - facilitators whereas the following stages will involve various actors outside the service provider (such as Non-Governmental Organizations and the media) in order to guarantee objectivity during the application of the method. However, the application of the method is commonly marked by 4 (four) ceremonial events involving all parties in the service, beginning with 1) Complaint Mechanism Workshop, 2) Survey, 3) Complaint Analysis Workshop, and 4) Signing of Service Pledge.

In AW Sjahranie General Hospital, the Complaint Management Workshop was held from 10 to 11 April 2010, continued with the survey which was conducted from 12 to 21 April 2010. Finally Complaint Analysis Workshop and the signing of service pledge were executed in 8-9 May 2010. Based on the findings, the implementation of the method will be explained below.

5.1 Preparatory Stage

The success of the application of this process depends very much on its preparation. This means creating awareness to improve service delivery, confidence, and support by all stakeholders, as well as forming a common understanding of the objectives and consequences. Getting ready also means providing the tools and the skills needed to carry out the process. It also means to get institutionally prepared by forming a small team of local facilitators and to get the service units physically ready to run the process. So although this method has proved tobe successfully applied to improve the quality of public services in

different service units in Indonesia, the decision to apply this method depends entirely by the service unit.

The characteristics of public services in Indonesia that still remain monopoly is one factor why the public service units in Indonesia do not think criticism is an attempt to improve the quality of public services. Public service units tend to be resistant and as they have no competitors they do not need efforts to improve their services to the citizens.

The initiative to apply this method in AW Sjahranie hospital initially is a manifestation of the vision and mission of hospital to become the health center that provide public service. With the increasing number of services, patients, and infrastructure along with complaints from the citizens consequently the hospital require a direct method that can be perceived by the citizens (message from the Director of the Hospital at the opening of the Complaint Mechanism Workshop, 10 April 2010). Considering the success stories from the previous application of the method, the hospital thus decided to replicate this method as well.

Preparation is an important aspect of this method because at this stage the hospital should socialize about this method to elements of human resource in the hospital both structural and functional. In this case, the AW Sjahranie using regular management meetings held every Monday with heads of the rooms and nursing care to socialize this method so that they can continue communicating about this to all hospital employees. Socialization is also implemented in the form of circulation letter. In addition to socialization activities, preparatory stage is also a stage where the hospital underwent mental preparation to receive complaints

from the citizens. Commitment from the director of hospital supported with the management has made preparatory stage in AW Sjahranie general hospital run smoothly. After all has been decided, then the next step is complaint mechanism workshop.

5.2 Complaint Mechanism Workshop

This workshop is the event where the service providers (government administrators of the service units) are assembled with the service users (citizens) for the first time. The purpose of the complaint mechanism workshop are:

1) To identify the complaints from the service users;
2) To create awareness of the service providers about the positive aspects of complaints;
3) To create awareness among the service users on the positive aspects of delivering complaints for the sake of service quality improvements;
4) To build service users trust toward the service providers commitment in their effort to improve the service quality;
5) To ensure that all workshop participants agree with the workshop’s result and action plan.

The results expected from this workshop are:

1) The draft of the questionnaire collected from the service users' complaints and has been approved by all the workshop's participants;
2) To make action plan;
3) To recruit additional volunteers to conduct the survey;

Since the purpose of this workshop is to invite public complaints thus the precentage of the participants of this stage consist of 20% - 30% from the service providers and 70% - 80% from the service users. Not only service providers and the service users are joined together in this workshop, but various parties such as the mass media, community leaders, NGOs, etc are also invited to ensure the objectivity. In this case, in addition to inviting representatives from local government, AW Sjahranie Hospital invites community leaders (religion leaders), Local NGOs (LSM Laras, LSM Pokja 30, LSM PKT, KNPI, and Persadia), the media (local newspaper and television such as Tribun Kaltim, Kaltim Post, Samarinda Post, Tepian TV, and TVRI) to monitor this activity.

In complaint mechanism workshop, all participants write complaints they know or have heard of one by one on cards and put them on the pin board. The facilitator reads each card and groups similar cards or eliminates cards, which do not contain customer complaints, after discussing it with the participants. At this stage, important aspects of service delivery might still be missing. In order to complete and to cluster the cards, the facilitator can help providing information on the tasks of the service unit (based on the respective law or regulation, TUPOKSIs – main task and duty) and on the principles of Good Governance.

The complaint questionnaires developed jointly by local stakeholders based on the Decision Letter of Ministry of Administrative Reform Number 63/KEP/M.PAN/7/2003 concerning the general guidelines of public service execution. Basicly, complaints related to public service consist of the following categories namely:

1) Service delivery procedures;
2) Requirements for the service;
3) Clarity of information of service delivery;
4) Discipline of service officials;
5) Responsibility of service officials;
6) Qualification of service officials;
7) Promptness of delivery;
8) Fair, impartial, and non-discriminative service provision;
9) Courtesy of service officials;
10) Proper service fees;
11) Guarantee of service fees;
12) Guarantee of processing time;
13) Appropriate office space and facilities;
14) Reliability of service.

For the sake of objectivity and correctness, the "complaint management" should be carried out by an independent group, or at least in cooperation with such a group. However, at the beginning of such a complex process, it is important to develop confidence, especially on the side of the service providers to overcome the anxiety, which is naturally prevailing if one addresses complaints. Upon identifying complaints from the service users, the draft of the questionnaire is approved by all workshop participants. Since the participants are randomly selected, it is assumed that all complaints may not represent the complaints of all

service users then a space will be available in case the respondents have other relevant complaints.

After passing through preparation stage, AW Sjahranie hospital in collaboration with some facilitators from the National Institute of Public Administration (NIPA) in Samarinda set up a workshop for citizens' complaint mechanism. Due to the many services provided by since the number of service types in the hospitals, the participants selected in this stage in addition to having experience of receiving hospital services must also represent at least 3 (three) major services in AW Sjahranie hospital namely outpatient, inpatient, and emergency instalallation. Characteristics of the workshop participants also have a wide range of social backgrounds and this is seen from this type of insurance they are using when having treatment such as ASKES, ASKESKIN, ASMARA, etc. As a result, the type of complaint can be diverse.

Based on the experiences of the method’s application, in general the number of complaints that is discussed mostly ranging from 20 to 25 complaints. However, in AW Sjahranie hospital, the complaint consists of 35 types of complaints. This indicated the complex challenges faced by hospital. This fact is also revealed by the facilitator of this workshop who argued that during workshop, it is very difficult to avoid the complaints about the service at AW Sjahranie hospital because at this workshop service providers party should be open and not resistant toward criticism or complaints from the citizens (Mr. Akhmad Sirodz, interviewed on June 12, 2011). In the end of this stage, all

complaints were compiled in a questionnaire and then confirmed to the service users through a survey (see table 5.1).

Table 5.1 Questionnaire for Survey

No.	Statement of Complaint *When you go to AW Sjahranie Hospital or accompany members of your family to this hospital, have you ever experienced the circumstance as mentioned below?*	Yes*)
1.	The doctor is mistaken in diagnosing the patient.	
2.	There is a "naughty" doctor in maternity care unit.	
3.	There is service deficiency from doctors in the evening.	
4.	General practitioners are slow in serving patients.	
5.	Specialists are less conscientious when examining patients in hospital but more thoroughly when doing it at their private practice because the cost is expensive.	
6.	Physicians often come late to the polyclinic.	
7.	The doctor comes late to examine the patient in the inpatient service.	
8.	Doctors frequently recommend patients to other hospitals (private).	
9.	In the operating room, it is not the doctor who performs the operation controls the patient's condition, but only a physician assistant.	
10.	Doctors are less capable to take advantage of sophisticated equipment and less experienced so that patients seek treatment in another city/region.	
11.	The nurse visits the patients when the doctor is around.	
12.	Nurses often fall asleep during the night shift.	
13.	Nurses are not responsive to patient complaints.	
14.	Nurses give wrong medicine.	
15.	The nurses are mostly still junior and have less skilled.	
16.	Officers and midwives are less friendly in maternity services.	
17.	Service for ASKES member is complicated.	
18.	Security officers let or do not reprimand noisy visitors.	
19.	Hospital prioritizes money/profit.	
20.	Complicated service procedure; administration goes first before service.	
21.	Referral for patients from poor families (gakin) is convoluted.	
22.	Letter of Disadvantaged (SKTM) is not valid if one does not have "Asmara"card.	
23.	There is a difference of service delivery (discrimination) between the have and the have not citizens.	
24.	Only the pavilion class employs specialists.	
25.	Drug provision for health insurance members (civil servants & poor families) is incomplete.	

Source: AW Sjahranie, Compalint Management Workshop Report, 2010

From the questionnaire, it can be noticed that complaints from the citizens toward public service quality in AW Sjahranie hospital can be categorized as follows:

1) Service delivery procedures;
    a) Service for ASKES member is complicated.
    b) Complicated service procedure; administration goes first before service.
    c) Referral for patients from poor families (gakin) is convoluted.
2) Requirements for the service
    a) Letter for Disadvantaged people (SKTM) is not valid if one does not have "Asmara"card.
3) Clarity of information of service delivery;
    a) The medicine is not prescribed at once that people need to go back and forth to the pharmacy.
4) Discipline of service officials;
    a) There is a "naughty" doctor in maternity care unit.
    b) Physicians often come late to the polyclinic.
    c) The doctor comes late to examine the patient in the inpatient service.
    d) Nurses often fall asleep during the night shift.
    e) Security officers let or do not reprimand noisy visitors.
5) Responsibility of service officials;
    a) There is service deficiency from doctors in the evening.
    b) Doctors frequently recommend patients to other hospitals (private).

c) In the operating room, it is not the doctor who performs the operation controls the patient's condition, but only a physician assistant.

d) The nurse visits the patients when the doctor is around.

e) Patients who are ill take their own medicine from hospital's pharmacies.

f) Patients are rejected to IGD.

6) Qualification of service officials;

a) Doctors are less capable to take advantage of sophisticated equipment and less experienced so that patients seek treatment outside of the region.

b) The nurses are mostly still junior and have less skilled.

7) Promptness of delivery;

a) Nurses are not responsive to patient complaints.

b) The waiting list (queue) for ultrasound exams is too long.

c) General practitioners are slow in serving patients.

8) Fair, impartial, and non-discriminative service provision;

a) Only the pavilion class employs specialists.

b) Drug provision for health insurance members (civil servants & poor families) is incomplete.

c) There is a difference of service delivery (discrimination) between the have and the have not citizens.

9) Courtesy of service officials;

a) Officers and midwives are less friendly in maternity services.

10) Proper service fees;

a) Hospital prioritizes money/profit.

11) Guarantee of processing time;

a) It takes too long waiting for the medicine at the clinic.

12) Appropriate office space and facilities;

a) Lack of hygiene.

b) Supply of certain blood types are often unavailable in the hospital.

c) The road to the hospital is full of merchants.

d) Mushola is not available in every unit.

13) Reliability of the service

a) The doctor is mistaken in diagnosing the patient.

b) Placement of patients is inappropriate (for example: a patient with broken leg shares the same room with a stroke patient).

c) Nurses give wrong medicine.

d) Specialists are less conscientious when examining patients in hospital but more thoroughly when doing it at home because the cost is expensive.

By categorizing the complaints, it can be identified that most complaints drawn from complaint management workshop are ranging from the responsibility of service officials, discipline of service officials, reliability of the service, and fair, impartial, and non-discriminative service provision as well as promptness of delivery which involve officials in the front liners. However, to ensure the objectivity and fairness, a survey was conducted in order to verify these complaints.

5.3 Survey

The survey consist of three stages; the setting-up of the survey, its field implementation and the recapitulation and publications of the results. The survey will carried out on working days or in service offices, or through group meetings during a fixed period (e.g. 2 weeks). Target is to interview as many respondents as possible. The number of questionnaires depends on the usual number of customers. All service units have records on the yearly number of customers. Based on this number the ratio of customers for a two-week period can be calculated. The survey should at least represent 80% of the number of service users for the days calculated. Example of a simple calculation of the minimum number of respondents (questionnaires) will be if it is assumed that the yearly number of customers is 12,000, this corresponds to 1,000 per month or 500 during a survey period of 2 weeks which implies that 80% are 400 respondents (SfGG Guide Book, p. 57). The initial surveys are mainly managed by the service providers themselves. However, they should be assisted (rather than controlled) by independent organizations.

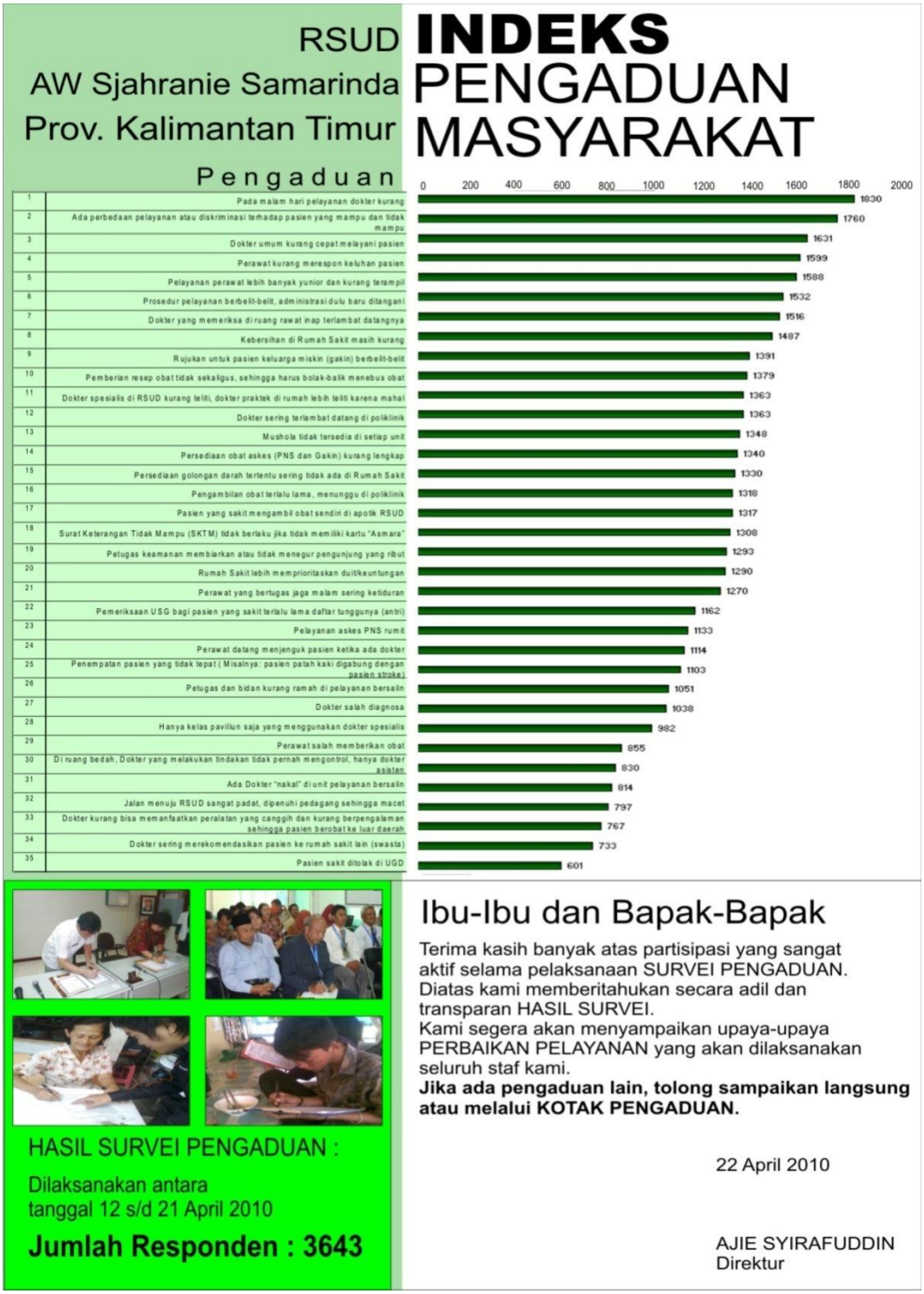
The survey method utilized depends on how the service itself provided (in an office, in the field, or both). In the offices of the service unit, an “interviewer” will receive all service users on the “Complaint Desk”, hand over the questionnaire and ask them to fill it out. The “interviewer” will explain the “why and what for” of the survey and that the results will be publicly displayed in the service unit. In case the customer is afraid or not able to do it (e.g. illiterate, only

speaks local language, to old, etc.), the “interviewer” will assist the customer in an adequate way.

The questionnaire is anonymous; thus, the name of the respondent will not be recorded. At the end of the working day or after the “field event”, all filled-out questionnaires will be properly filed and the results will be transferred to the “calculation sheet”. The calculation sheet will be updated daily or after a field survey. At the end of the survey period, the updated “calculation sheets” from all survey sites will be compiled into one “survey result’s form”. The final results will be sorted according to the number of complaints. The complaint with the highest number of answers will be rank 1. This sorted table or Customer Complaint Index is part of the survey report. If necessary, this sorting can be done for the service office and each service branch separately. The detailed results should also be included in the survey report. This report will have the following chapters:

1) Name of the service unit, members of the Process Management Group and of other facilitators;
2) Period of survey, list of daily respondents and field interviews carried out;
3) Result of the survey distinguishing results in the service unit and in the different field interviews;
4) Overall (compiled) survey results (sorted survey results form and block chart).

Figure 5.2 Poster of Citizens' Complaint Index



(Source: AW Sjahranie Documentation, 2010)

As soon after the survey, citizens are informed on the findings (complaint feedback). Prepare the Citizens' Complaint Index in form of a block chart in poster-size (120x60cm) and display it on the information board in the service unit, and if necessary in its branch offices (see figure 5.2). Additionally, inform the public through local media by providing a press release on facts and findings of the survey.

The survey in AW Sjahranie hospital was conducted from 12 to 21 April 2010. Prior to the survey execution, the public service team for AW Sjahranie hospital assemble for coaching on 11 April 2010 with surveyor team. From this coaching, it was informed that the target of respondents is 3,200 respondents since the average number of the visitors in the hospital is 400 people per day. The team was divided in several groups because the survey was conducted inside and outside the hospital's location. There were 5 (five) strategic locations in the hospital such as:

1) Teratai Room/Pavilion (Inpatient Care)
2) Emergency Installation
3) Outpatient Room (New Poly)
4) Anggrek Room (Inpatient Care)
5) Flamboyan Room (Inpatient Care)

Whereas the prospect locations outside the hospital were:

1) Samarinda Ulu Subdistrict
2) North Samarinda Subdistrict

3) Sei Kunjang Subdistrict
4) Samarinda Ilir Subdistrict
5) Places of Worship
6) Places of entertainment, restaurant
7) Public places, terminals, markets, malls, stadiums, ATM
8) Campus, school, courses, boarding houses
9) Government offices, private banks, training institutions

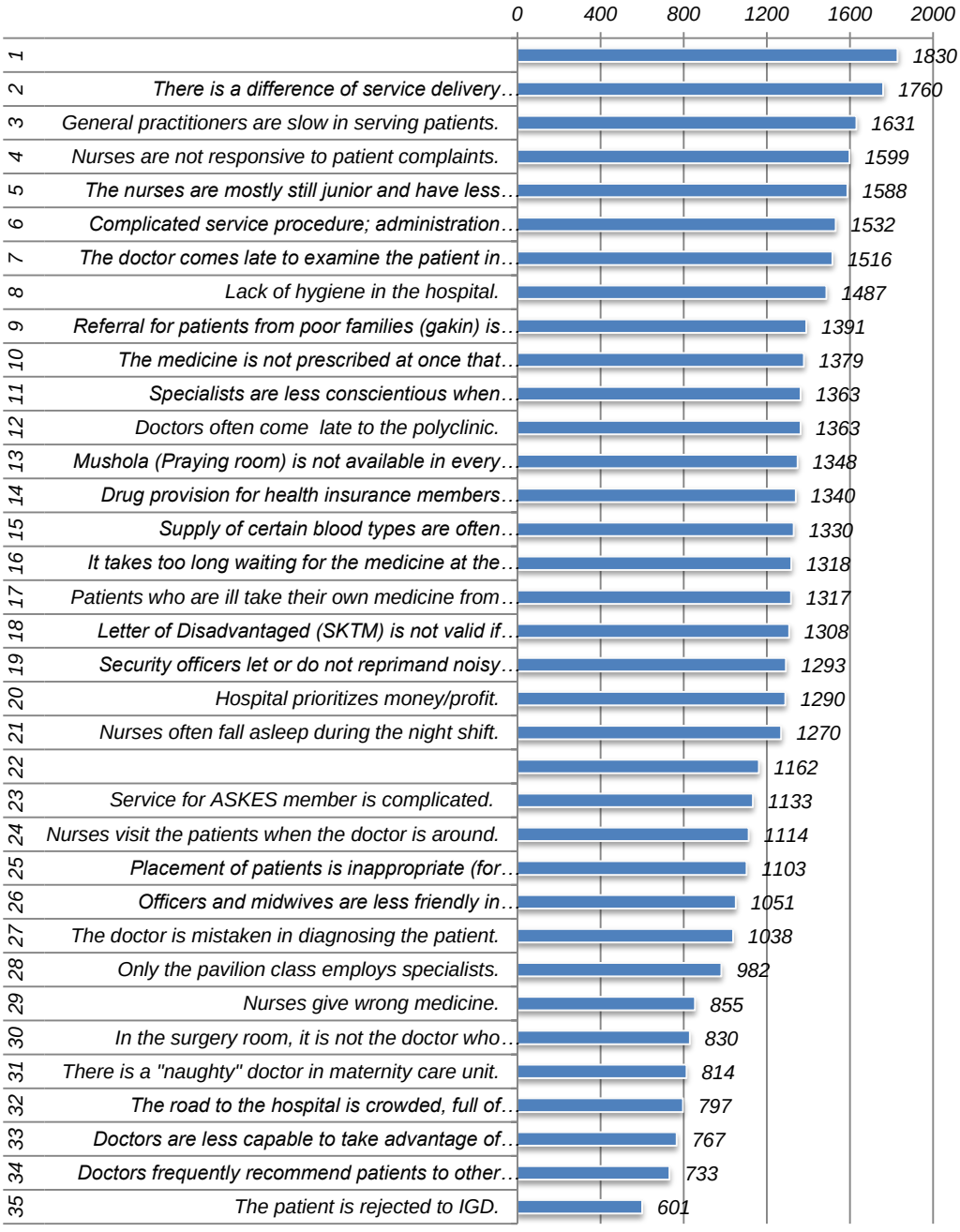
However, for some public services like schools and hospitals, usually the survey stage can be easily conducted inside the service unit since the service users frequently come to the these places so that the target of minimum respondents can be achieved. Besides, the hospital provide complaint corner, a place completed with *complaint box* along with table, chairs, questionnaires, pens, and one or two officers attending the to make complaints easily communicated between users and providers. Furthermore, for places like emergency installation and inpatient care where visitors keeps coming or stay in the hospital, the survey can be executed for 24 hours. But on the other hand, for the other 3 (three) survey locations in the hospital, the survey can only be done from 8 a.m to 2 p.m according to the service hours. The surveyors consisted of people from different backgrounds such as local NGO (represented by KNPI), university students (Mulawarman University), and others.

Tabel 5.2 Daily Recapitulation of the Survey

No.	Complaint Statements	Days of Survey										Total	Rank
		1	2	3	4	5	6	7	8	9	10		
1.	The doctor is mistaken in diagnosing the patient.	93	22	36	77	38	167	218	153	82	152	**1038**	27
2.	There is a "naughty" doctor in maternity care unit.	93	14	7	58	10	129	206	138	62	97	**814**	31
3.	There is service deficiency from doctors in the evening.	197	87	71	98	124	204	349	252	165	283	**1830**	1
4.	General practitioners are slow in serving patients.	167	77	69	94	116	176	319	225	146	242	**1631**	3
5.	Specialists are less conscientious when examining patients in hospital but more thoroughly when doing it at private practice since the cost is expensive.	162	43	54	72	96	179	255	190	118	194	**1363**	11
6.	Doctors often come late to the polyclinic.	144	59	54	69	74	163	275	189	135	201	**1363**	12
7.	Doctor comes late to examine patients in the inpatient service.	139	63	51	100	122	177	297	198	142	227	**1516**	7
8.	Doctors frequently recommend patients to other hospitals (private).	43	24	18	38	22	106	170	133	76	103	**733**	34
9.	In the surgery room, it is not the doctor who performs the surgery controls the patient's condition, but only a doctor assistant.	85	27	24	54	38	133	180	107	76	106	**830**	30
10.	Doctors are less capable to take advantage of sophisticated equipment and less experienced so that patients seek treatment outside of the region.	51	39	25	59	56	104	126	119	87	101	**767**	33
11.	Nurses visit the patients when the doctor is around.	94	49	25	53	76	139	286	162	83	147	**1114**	24
12.	Nurses often fall asleep during the night shift.	152	44	33	96	80	162	273	173	99	158	**1270**	21
13.	Nurses are not responsive toward patient complaints.	179	88	71	97	122	187	318	201	136	200	**1599**	4
14.	Nurses give wrong medicine.	88	18	22	58	47	123	191	144	84	80	**855**	29
15.	The nurses are mostly still junior and have less skilled.	190	90	73	104	139	162	304	185	130	211	**1588**	5
16.	Officers and midwives are less friendly in maternity services.	100	35	25	60	41	127	245	158	104	156	**1051**	26
17.	Service for ASKES member is complicated.	95	48	37	93	35	131	264	162	105	163	**1133**	23
18.	Security officers let or do not reprimand noisy visitors.	151	49	45	76	90	156	261	164	121	180	**1293**	19
19.	Hospital prioritizes money/profit.	130	64	49	81	87	137	286	169	108	179	**1290**	20
20.	Complicated service procedure; administration goes first before service.	156	78	68	107	116	147	317	184	139	220	**1532**	6
21.	Referral for patients from poor families (gakin) is complicated.	135	75	58	101	72	146	302	169	129	204	**1391**	9
22.	Letter of Disadvantaged (SKTM) is not valid if the patient does not have "Asmara"card.	148	44	29	79	42	176	294	219	107	170	**1308**	18
23.	There is a difference of service delivery (discrimination) between the have and the have not citizens.	190	80	58	108	108	208	367	232	147	262	**1760**	2
24.	Only the pavilion class employs specialists.	80	42	29	51	30	119	227	149	109	146	**982**	28
25.	Drug provision for health insurance members (civil servants & poor families) is incomplete.	113	46	51	98	123	137	277	163	116	216	**1340**	14
26.	The medicine is not prescribed at once that people need to go back and forth to the pharmacy.	160	49	55	94	68	173	323	169	105	183	**1379**	10
27.	Patients who are ill take their own medicine from hospital's pharmacies.	134	56	75	93	145	126	250	150	111	177	**1317**	17
28.	It takes too long waiting for the medicine at the clinic.	155	61	64	61	85	137	287	157	135	176	**1318**	16
29.	Supply of certain blood types is often unavailable in the hospital.	143	59	50	98	59	188	310	154	96	173	**1330**	15
30.	The hospital is still lack of hygiene.	144	75	61	105	101	140	304	203	125	229	**1487**	8
31.	The road to the hospital is crowded, full of merchants.	77	43	30	42	25	113	159	114	71	123	**797**	32
32.	The patient is rejected to IGD.	37	20	18	30	35	67	121	104	83	86	**601**	35
33.	The waiting list (queue) for ultrasound exams is too long.	147	40	51	69	89	88	212	150	114	202	**1162**	22
34.	Placement of patients is inappropriate (for example: a patient with broken leg shares the same room with a stroke patient).	100	49	36	84	85	60	239	170	109	171	**1103**	25
35.	Mushola (Praying room) is not available in every unit.	89	50	39	94	116	65	295	226	132	242	**1348**	13
	Total Respondent	**403**	**155**	**153**	**368**	**399**	**338**	**541**	**486**	**332**	**468**	**3643**	

(*Source: AW Sjahranie Survey Recapitulation, 2010)*

Figure 5.3 Citizens' Complaint Index Toward The Public Service In AW. Sjahranie General Hospital Survey Period : 12 - 21 April 2010 N = 3643



Source: AW Sjahranie Hospital, Survey Report, 2010

The team recapitulate daily survey results in a table (see table 5.2). Upon completing the surveyfor the ten days which have been determined,then the team can make the rankof complaints ranging from the highest to the lowest one. Results of the recapitulation is then transferred inachart which is called the citizens complaint index. The index is then published in the hospital area.These complaints are then analyzedby the hospital as the provider of services who is responsible for the services in order to improve the quality of public service in the hospital.

Based on the survey (see table 5.2), it can be noticed that from 3,643 respondents, it turns out that five major complaints in the hospital are closely related to the service officials which directly deal with the citizens in delivering services. These complaints cover from complaint concerning service deficiency from doctors in the evening with 1,830 respondents, the service discrimination between the have and the have not citizens with 1,760 respondents, lengthy service from general practitioners with 1,631 respondents, unresponsive nurses towards patients' complaints with 1,599 respondents, and less-skilled nurses with 1,588 respondents. By obtaining the data from the survey, hospital can begin their improvements starting from the highest complaint then followed by the next ones based on the complaint satisfaction index (see figure 5.3).

5.4 Complaint Analysis and Action Plan

The analysis of the findings was carried out in form of a workshop with the staff of service units, sector agencies, facilitators, representatives of customers, and civil organizations. Unlike the previous workshop in first step, the

composition of the participants is 20% - 30% from the service users and 70% - 80% from the service providers. This workshop is a key event for successful problem solving, especially for the service providers since they are generally considered as being the main responsible party for the complaints or poor service delivery. However, this analytical step will prove that there are others, which might have an even higher influence toward the service quality.

This fact will put the service units in double position; partly as the cause of bad services or as victims of poor support from higher level. With this view, a 'feeling' of solidarity with the service users will emerge, and the citizens are becoming an empowering force for the service providers in their struggle for more support. Even if earlier requests might not have been listened to when they were made only by one head of a service unit, the fact that hundreds or thousands of people have complained about that same fact will lead to a change of attitude among the superiors and decision-makers in Government and Parliament. The factor "empowerment by the citizens" can be increased through strategic media reports on the survey and analysis results in addition to reporting through official channels. The main workshop results are:

1) Analysis of the causes of the complaints.
2) Formulation of alternative solutions and determination of solution priorities.
3) Formulation of service pledge.
4) Formulation of response recommendations to superior.

The analysis method starts with the most important complaint. After collecting causes of complaints, possible solutions (response) for improvement then classified. The solutions are categorized according to the responsibilities (internal responsibilities for service unit and external responsibilities for the government, possibly civil society). The responses to be implemented by the service unit itself are compiled in a document called Service Pledge or Letter of Commitment of service unit to the service users. Action to improve will have to start from the moment on when the Service Pledge is displayed, and the service users should be invited to monitor the implementation.

In AW Sjahranie hospital, complaint analysis workshop started with analyzing the complaints with highest response. Based on surveys, the highest complaint is about service deficiency from doctors in the evening. After being discussed, the analysis of cause is because the number of doctors are insufficient. To overcome the problem then the hospital offer an internal solution that the hospital can make rescheduling in order to add another doctor at night. However, for the external solution the hospital will ask for new doctors (general practitioners and specialists) to work for the hospital. Likewise, the next complaint will be analyzed in order to find both the causes and then the solution that can be done immediately by the hospital (internal solution) and/or solutions that can be submitted to the local government because the hospital did not have the authority to decide (external solution) like what has been done for the highest complaint.

Tabel 5.3 Result of Analysis Workshop

No.	Complaint Statement	Causes	Solution	
			Internal	External
1.	There is service deficiency from doctors in the evening.	The number of general practitioner is still inadequate in the hospital. Doctors are lack of discipline.	Rescheduling. Increase the number of attending doctor for night duty. Improve the quality of the doctor Improve oversight. Apply sanctions.	Propose for additional new doctors, both general practitioners and specialists to the local government.
2.	There is a difference of service delivery (discrimination) between the have and the have not citizens.	Wrong perception. The procedures are not understood by the citizens clearly. The number of the have-not patients are higher than the have patient. Lack of communication. There are various kinds of services in the hospital. (Different service means different treatment)	Making a more detail information board. Put the knowledge from the customer service training into practice.	
3.	General practitioners are slow in serving the patients.	Patients have not comprehend the SOP in handling patients. Doctors are not communicative to the patients & their families. The ratio of doctors and patients is imbalance. The doctors are saturated and exhausted because of too many patients. The doctor is still new. Sometimes a general practitioner consult to a specialist.	Creating a chart/flow diagram of handling patients and delivering services in the ER. To educate the public about the service in the ER. Making triage line. Increase the number of attending doctors in the ER.	Proposing Health Center to open 24 hours in order to reduce the workload of the hospital.
4.	Nurses are not responsive to patients' complaints.	The number of nurses and patients are imbalance. Many nurses work beyond their main duty. Not all complaints from patients are under the responsibility and the authority nurse that it needs coordination in order to take action. Lack of training from the seniors. The nurses are jaded.	Increase the quality of the nurses through training and formal education. Making comparative study (benchmark) or outbond to refreshen their minds. Improving supervision. Rotating nurses Improving nurse-patient communication.	Propose additional number of new nurses for each unit so that on-duty nurse could facilitate patient complaints.
5.	The nurses are mostly still junior and have less skill.	Many institutions/students appoint the hospital as practice place. The number of nurses are insufficient that the hospital need to make use of new nurses and practice students. Lack of training from the seniors.	Limiting/controlling the amount of students who practice in the hospital. Continuous training for nurses in order to improve their knowledge and skills. Supervision by the seniors when on-duty (juniors shall be accompanied the seniors). Training for all nurses (PNS & honorarium).	
6.	Complicated procedure; administration goes first before service.	Lack of communication Computerized payment system is not optimal. Separate payment system.	The service is based on the level of emergency. Improve communication with patients and patients' families Optimizing billing system	
7.	Doctor comes late to examine patients in the inpatient service.	Immediate surgery/CITO. Sometimes, doctors go to the clinic first then to the inpatient. No written information about the service hours.	Making a written information/information board about service hours, doctors' visit and schedule.	
8.	The hospital is still lack of hygiene.	Lack of supervision toward cleaning service workers. Insufficient cleaning service workers; Large hospital areas require many RS cleaning service workers. Security guards are less strict selecting visitors. Overload patient, exceeding the capacity. To many companions for only one patients which produce tremendous waste Families who accompany the patients are not aware of hygiene	Shift and working hours arrangements of cleaning service workers. Making information about "keep cleaning" or "throw the garbage in the garbage can". Limitating on the number of families who accompany patients. Optimizing patient visitors card. Ask the Janitor to standby at his workplace.	Propose making public building for patients' families.

No.	Complaint Statement	Causes	Solution	
			Internal	External
9.	Referral for patients from poor families (gakin) is complicated.	Poor citizens do not carry the complete letter. Lack of information about how to obtain Askin. The public does not understand the procedure about insurance for poor families.	Toleration for completing the requirement within 2x24 hours Giving information/dissemination to the regions, districts and villages on the urgency of referring process. Socialization about complete documents throughout subdistrict and village. Coordination with the health department within city/regency when doing dissemination.	
10.	The medicine is not prescribed at once that the people need to go back and forth to the pharmacy.	Sometimes the patients are suffering of more than one disease so complaints of patients can vary in a day.	Coordination with the guarantor: askes & Jamkesmas team. Providing information to patients	
11.	Specialists are less conscientious when examining patients in hospital but more thoroughly when doing it at their private practice since the cost is expensive.	The number of patients are too many.	Referral system of health centers to hospitals to be revised. Improving doctors-patients communication.	
12.	Doctors often come late to the policlinic.	Same as number 7		
13.	Mushola (praying room) is not available in every unit.	Lack of information/instruction signs leading to the mosque.	Providing signs/clues that lead to the mosque	
14.	Drug provision for insurance members (civil servants & poor families) is incomplete.	Availability of drugs from distributors are often empty, and mostly caused by scarcity of raw materials for making medicines.	Informing the patient health insurance and civil servants about the unavailability of drugs.	
15.	Supply of certain blood types are often unavailable in the hospital.	Lack of blood donor groups (no blood stock)	Coordinate with PMI (Indonesia Red Cross) Informing the public about the emptiness and the need for specific blood groups.	
16.	It takes too long waiting for medicine at the clinic.	The admission recipes from the polyclinic arrive about simultaneously. There is a concoction of drugs that takes longer time. The number of patients are too many. Pharmacies need accuracy in dispensing medications.	Provide entry number. Informing about the time consumed if making medicinal concoction which need accuracy.	
17.	Patients who are ill take their own medicine at the clinic.	Patient come without companion/family.	Enabling/optimizing the existing postal workers (servants of the sick).	
18.	Letter of disadvantaged (SKTM) is not valid if the patient does not have “Asmara” card. Correction: Asmara Card does not valid if there is no SKTM.	SKTM is only valid for 1 month and only issued by the district. Citizens do not understand or are not well-informed about the procedure of using SKTM.	Inform patients / families of patients about the use of SKTM. Recommend to the district/city to disseminate the procedure of how to make and use SKTM.	

(Source: AW Sjahranie Workshop Analysis Matrix, 2010)

Refer to the matrix of complaint analysis in table 5.3, it can be noticed that for complaint number 1, the hospital decided to add a doctor for evening shift because the hospital have the authority and ability to do so. However, this solution will solve the problem temporarily since the main cause of this problem is because the hospital is still need more doctors to fulfill the gap number between paramedics and patients. As a consequence, the hospital needs doctors procurement. Nevertheless, this is not the authority of hospital's management. As a result, the hospital can only make a kind of proposal to the local government for doctors' procurement. Fortunately, this kind of method application can become the basis for such requirement.

In general, after analyzing the complaints, problems related to hospital and patients relation mostly occur because of misunderstanding between them. It can be identified in most of the analysis such as the discrimination in delivering services between the have and the have not citizens, the lengthy service from doctors, procedures and requirements in obtaining free medication, unavailability of medicines. These problems are mostly caused by the fact that procedures are not understood properly by the citizens and the hospital does not have the chance to communicate or inform this to the citizens. When going to the hospital to get free treatments, there are terms and conditions applied. Some requirements such as documents or referrence letters are required by the hospital. Besides, the fact that the increase number of patients from time to time has become a challenge for the hospital in providing service for all citizens.

Figure 5.4 Service Pledge

Dear Samarinda Citizens and Family of AW Sjahranie Hospital Service Users,

During "Public Complaints Survey" which has been conducted from November 12 to 21 April 2010, a number of 3643 citizens participate to fill out and return the questionnaires. We have sorted out the responds ranging from the highest to the lowest complaints as the result of the survey recapitulation of the complaint as presented on CITIZENS COMPLAINT INDEX mentioned below.

We are currently trying to respond almost all the complaints and we promise to improve the services related with each complaint, with the efforts as mentioned there. We sincerely wish to make changes gradually. Since there are complaints beyond the authority of AW Sjahranie hospitals, we have submitted recommendations to the municipality in order to obtain responses. We promise to announce this to the public, so that we can get feedbacks.

We openly invite the citizens' participation to continue monitoring our services performance and immediately submit complaint into the available complaint box, or directly to the staff at the table of complaints, especially if service improvements that we have mentioned cannot be fulfilled.

We thank you for your kind participation.

Samarinda, May 2010
Signed
Ajie SYIRAFUDDIN
Director

1. *In response to complaints that "there is service deficiency from doctors in the evening", starting from August 2010, we promise to:*
   - *1.1 Increase the number of attending doctor for night duty;*
   - *1.2 Improve the quality of the doctor;*
   - *1.3 Reschedule for night duty doctor.*

2. *In response to complaints that "There is a difference of service delivery (discrimination) between the have and the have not citizens", starting from August 2010, we promise to:*
   - *2.1 Make detail information about procedures and requirements of service;*
   - *2.2 Improving the quality of human resources through the implementation of "Excellent Service" Training*

3. *In response to complaints that "General practitioners are slow in serving the patients", starting from August 2010 we promise to:*
   - *3.1 Increase the number of attending doctors in emergency room (ER);*
   - *3.2 Improve the quality of doctors in ER;*
   - *3.3 Improve the systems in ER;*
   - *3.4 Give more information (through communication) for visitors/patients in ER.*

4. *In response to complaints that "Nurses are not responsive to patients' complaints", starting from August 2010 we promise to:*
   - *4.1 Give clear information and improve communication to patients/patients' family;*
   - *4.2 Improve the quality of nurses through formal education and training;*
   - *4.3 Perform rotation to certain nurses based on their competencies;*
   - *4.4 Conduct election of outstanding nurses.*

5. *In response to complaints that "Nurses are mostly still junior and have less skill", starting from August we promise to:*
   - *5.1 Optimize the performance of nurses;*
   - *5.2 Increase the number of nurses;*
   - *5.3 Regulate the practice of students according to their level of activities;*
   - *5.4 Improve the quality of coaching to junior nurses.*

6. *In response to complaints that "Complicated procedure; administration goes first beforeservice", starting from August 2010 we promise to:*
   - *6.1 Enhance the service and administration systems;*
   - *6.2 Intensify communication with patients and patients' family.*

7. *In response to complaints that "Doctor comes late to examine patients in the inpatient service", starting from August 2010 we promise to:*
   - *7.1 Provide written information about doctors' visit;*
   - *7.2 Improve discipline of doctors.*

8. *In response to complaints that "The hospital is still lack of hygiene", starting from August 2010 we promise to:*
   - *8.1 Make an appeal to keep the environment clean;*
   - *8.2 Limit the number of families who accompany patients;*
   - *8.3 Make the janitor to standby at his workplace.*

9. *In response to complaints that "Referral for patients from poor families (gakin) is complicated", starting from August 2010 we promise to:*
   - *9.1 Make clear information about service procedures and administrative requirements for Gakin patients;*
   - *9.2 Tolerate the service users to complete the requirement within 2x24 hours;*

9.3 Coordinate with the health department within city/regency when doing dissemination;

10. In response to complaints that "The medicine is not prescribes at once that the people need to go back and forth to the pharmacy", starting from August we promise to:
- *10.1 Conducting system improvement for pharmacy services;*
- *10.2 Make clear information about the procedure of pharmacy services;*
- *10.3 Coordinate with the guarantors, such as health insurance and Jamkesmas team.*

11. In response to complaints that "Specialists are less sonscientious when examining patients in hospital but more thoroughly when doing it at their private practices since the cost is expensive", starting from August 2010 we promise to:
- *11.1 Optimize the specialists performance in giving services;*
- *11.2 Develop and add specialistic services.*

12. In response to complaints that "Doctors often come late to the policlinic", starting from August 2010 we promise to:
- *12.1 Provide written information about doctors' visit;*
- *12.2 Improve discipline of doctors.*

13. In response to complaints that "Mushola (praying room) is not available in every unit, starting from August 2010 we promise to:
- *13.1 Provide signs/clues that lead to the mosque;*
- *13.2 Establish a prayer room in the middle of hospital area.*

14. In response to complaints that "Drug provision for insurance members (civil servants and poor families) is incomplete", starting from August 2010 we promise to:
- *14.1 Intensify coordination with PT ASKES;*
- *14.2 Intensify communication to patients about health insurance drug services.*

15. In response to complaints that "Supply of certain blood types is often unavailable in the hospital", starting from August 2010 we promise to:
- *15.1 Intensify coordination with PMI (Indonesia Red Cross).*

16. In response to complaints that "It takes too long waiting for medicine at the clinic", starting from August 2010 we promise to:
- *16.1 Enhance pharmaceutical care system;*
- *16.2 Intensify communication to patients about the pharmaceutical service for insuranced users.*

17. In response to complaints that "Patients who are ill take their own medicine at the clinic", starting from August 2010 we promise to:
17.1 Repair the system/procedure of obtaining medicines.

18. In response to complaints that "Letter of disadvantaged is not valid if the patient does not have Asmara card", starting from August 2010 we promise to:
18.1 Coordinate with Health Department of Samarinda

(Source: AW Sjahranie Service Pledge Document, 2010)

Nevertheless, the hospital tries make solutions according to their capability as identified (see table 5.3). It is expected that by offering these solutions, the hospital-patient can have good communication and relation.

Having obtained the causes and solutions to citizen complaints which have been agreed by all participants, the solutions are then transferred into a document called "service pledge. The essence of the service pledge is to make people aware about the efforts made by the hospital in meeting the citizens' satisfaction. Since all complaints come from the citizens and exposed by the media then the realization can be monitored and evaluated directly by the public. In AW Sjahranie hospital, this service pledge is printed in a 1x2 meter(s) poster-sized which are displayed on strategic places like places where people receive direct services from the officers such as registration counters and waiting rooms.

5.5 Concluding Remarks

The implementation of the method of Improving Public Service Quality through Citizens' Participation in AW Sjahranie Hospital has encompassed 4 (four) consecutive steps which involved various stakeholders, mainly citizens as service

users and at the same time as the target group. Based on the examination of implementation process, the logic framework of the implementation process can be summarized as follows:

Table 5.4 Logic Framework of the Implementation of PerMenPAN Regulation Number 13 Year 2009 in AW Sjahranie Hospital

End Outcome	*Intermediate Outcome*	*Project*		
		Outputs	***Activities***	***Inputs***
The service delivery is improved	✓ Citizens as service users are participated during the workshop; ✓ Citizens' complaints are accommodated;	✓ Draft of the questionairre collected from the service users' complaints arranged; ✓ Questionnaire approved by all the workshop's participants (*35 complaints were identified during the workshop*) ✓ Action plan constructed; ✓ Additional volunteers to conduct the survey appointed	Complaint Mechanism Workshop (10-11 April 2010)	✓ Budget (Local Government/Hospital Budget) ✓ Facilitators (NIPA Facilitators) ✓ Supervisors (Local Government) ✓ Participants (20% - 30% from the service providers and 70% - 80% from the service users), during the implementation the participants were 75 citizens, 25 service providers, Local NGOs. ✓ Media (Local Newspaper – Tribun Kaltim, Kaltim Post, Samarinda Pos, Local Television – Tepian TV & TVRI)
	✓ Citizens are participated during the survey; ✓ Targeted respondents achieved; ✓ Citizens' Complaint Index in form of a block	✓ Daily recapitulation (from 3,643 respondents) is created & calculated; ✓ Citizens' Complaint Index is created.	Survey (12-21 April 2010)	✓ Budget (Local Government/Hospital Budget) ✓ Facilitators (NIPA Facilitators) ✓ Supervisors (Local Government) ✓ Participants/Respondents

End Outcome	*Intermediate Outcome*	*Project*		
		Outputs	*Activities*	*Inputs*
	chart in poster-size (120x60cm) is displayed in the service unit.			✓ Surveyors (consists of the University Students, Hospital Employees & NGO representatives - KNPI) ✓ Publication (through local media by providing a press release on facts and findings of the survey
	✓ The solutions of the complaints are given by the service-providers. ✓ The Action Plan for service improvement is expanded/exposed through the media.	✓ Matrix of complaints analysis is created; ✓ Service Pledge (the things that the hospital do to overcome the complaints from the service users) is created; ✓ Recommendation (as solution to overcome the complaints which are beyond the service unit authority such as civil servants recruitment, budget, etc.) is created;	Complaint Mechanism Workshop & Action Plan (The Signing of Service Pledge) (8-9 May 2010)	✓ Budget (Local Government/Hospital Budget) ✓ Facilitators (NIPA Facilitators) ✓ Supervisors (Local Government) ✓ Participants (20% - 30% from the service users and 70% - 80% from the service providers), during the implementation all service providers enrolled along with citizens & Local NGOs. ✓ Media (Local Newspaper – Tribun Kaltim, Kaltim Post, Samarinda Pos, Local Television – Tepian TV & TVRI)

The logical framework for the project implementation indicates that all activities have achieved the output of the activities. The Complaint Management Workshop was attended by the service users. The complaints that they had were revealed and transferred into a questionnaire as many as 35 complaints. During the

survey, 3,643 respondents participated to take part in the activity. The surveyors who distributed the questionnaires consisted of the people from different backgrounds. Based on the survey, citizens' complaint index is created. The hospital can identify complaints from the highest to the lowest. In this way, the hospital offers solutions toward the complaints. These solutions were then transferred into service pledge which was created together by both hospital and citizens.

However, the end outcome of project is the service improvement of the service delivery in the hospital. It is through the action plan from the service pledge that the service improvement can be identified. In other words, examination of implementation needs to be continued with the results of achievement to find out about the service improvements which have been performed by the hospital as an action plan from the service pledge. This will be discussed in the following chapter VI.

CHAPTER VI EVALUATION RESULTS

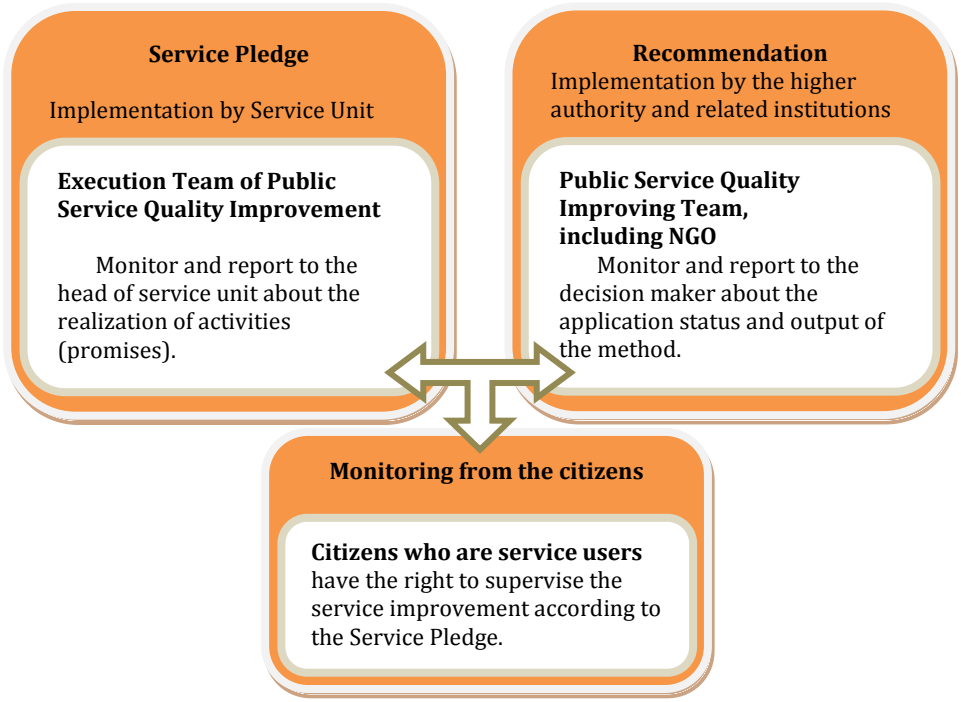
Quality in public services is how to meet citizens' expectation. Improving public service quality can represent the application of good governance in public sectors. Moreover, it can assure the better service provision for the community. The application of the method improving public service quality through citizens' participation in AW Sjahranie hospital can become a tool for the hospital to maintain the quality improvement of the hospital services. Citizens' involvement in every stage of the implementation is one way to identify the citizens' expectation. By identifying the citizens' expectancy toward the public service in AW Sjahranie hospital, it is expected that the hospital can offer solution against the complaints from the citizens as service users. This chapter will highlight a number of achievements that have been performed by the hospital to improve the public service quality in the hospital. Then, based on these achievements, evaluation results can identify whether the application of this method has reached the end outcome of the project.

6.1 Stakeholders

One of the representations of good governance is the improvement of service quality, delivery, and provision in public sectors. Through public service provision, it be seen how the street level public servants as the government representation interact with citizens. Nowadays, improving public service does not merely turn out to be the

responsibility of the government, but also other stakeholders from the planning, implementation, up to the evaluation.

Figure 6.1 Role in Monitoring& Evaluation



(Source: Annex of Ministry of Administrative Reform Regulation Number 13 Year 2009, p.65)

Based on the figure 6.1 above, there are some elements of stakeholders, which take part during the planning, implementation, and evaluation of the activities.

1) Service Unit

The hospital as the service unit has a very important role because the improvements should begin from the inside organization. Improving Public Service Quality Team which consists of the personnel from the service unit and has been established from the beginning of the application should continue working even after the service pledge is enacted. However, the

agenda will alter as in this stage they will conduct periodic monitoring and evaluation to ensure that the purposes of pledge can be achieved.

2) Decision-Making in the Department/Institution/Local Government

   During the application, there are things that are beyond the authority of the hospital and therefore should be coordinated with other department, institution, and local government. As a result, Public Services Quality Improvement Team at Department/Institution/Local Governmentlevel should continue their activities as well in order to give facilitation so that Public Services Quality Improvement Team at the service unit is capable of doing monitoring and evaluation well, and also to monitor and evaluate the extent to which the recommendations submitted by the service unit has been considered by the Minister/Chairman/Governor/Regent/Mayor.

3) Citizens (service users)

   Citizens have a very significant role during the application from the planning, implementation, as well as evaluation. Public service users are entitled to oversee the service performance and the realization of service pledge through the service they receive in the hospital. (service unit level). Input can be submitted in the form of written or oral complaint.

6.2 Result of Achievements

As has been stated in the previous chapter, the qualification of citizens' complaints in Indonesia is based on the General Guidance on Customer Satisfaction

Index in Public Services (Decree of the Minister of Administrative Reform Number KEP/25/PAN/2/2004). Thus, the realization of service pledge that has been done by the hospital as the result of achievements can be categorized as follows:

1) **Service Delivery Procedure**

Related to the realization of the promise of service improvements to service delivery-related complaints procedure which revealed *that (6) complicated procedure, administration goes first before service and (9) referral for patients from poor families (gakin) is complicated*, then the hospital has made the information board about the flow of services to poor families to get free medical treatment following requirements that must be fulfilled. In addition, emergency patients can immediately receive treatment first before taking care of administrative affairs.

Figure 6.2 Information concerning the flow of services to get medical treatment

2) **Requirements for the service**

In response to complaints concerning *(18) the validity of the letter of disadvantaged* then the hospital has coordinated the local government which issued the policy in order to socialize the terms and conditions to use such insurance.

3) **Discipline of service officials**

In response to complaints concerning *doctors comes late* (7 & 12) then the hospital has set a punishment by cutting incentives for undisciplined officers including physicians and perform rescheduling to add the doctors in charge. The hospital has also made information about the service hours as can be seen in the following documentation.

Figure 6.3 Information concerning Service Hours

4) **Responsibility of service officials**

In response to complaints concerning *(1)service deficiency in the evening, (17) patients who are ill take their own medicine at the clinic, (14) drug provision for insurance members (civil servants and poor families) in incomplete, and(15) the supply of certain blood type is often unavailable* then the hospital has coordinated this problem to the insurance company in addition to provide pharmacy services in every unit.

5) **Promptness of delivery**

In response to complaints concerning *(3)general practitioners are slow in serving the patients, (16) it takes too long waiting for medicine at the clinic, (10) the medicine is not prescribed at once, and (4)nurses are not responsive to patients' complaints* then the hospital has performed in house trainings for customer service for front liners employees like doctors, nurses, and security guards.

6) **Fair, impartial, and non-discriminative service provision**

In response to complaints concerning *(2) the difference of service delivery between the have and the have not citizens* the hospital has provided written information (posters) to make sure that citizens find out the flows to get services for every visitors are likely the same.

7) **Ability of service officials**

In response to complaints concerning *(5) junior and less skilled nurses and (11) less conscientious specialists* then the hospital has conducted peer-teaching and had the employees attend formal education and trainings.

8) Appropriate office space and facilities

In response to complaints concerning *(8) hospital hygiene and (13) praying room* then the hospital has made notification for CV Karta Utama as the supplier of hygiene in the hospital through the letter number 205/Bang-Diklt/VII/2010 on July 16, 2010 and made some written directions/information to invite visitors to "keep clean" by throwing their garbage in the trash bins and the sign boards that lead people to the praying room.

Other aspect that can indicate the service improvement in the hospital is the fact that despite being a class B education hospital, AW Sjahranie hospital offers more than the standards that have been set by the government. This can be noticed through the increasing and improving services found in the medical services, medical support services, and nursing services. According to the regulation, a class B hospital requires medical facilities andservice capabilitiesof 4 (four) basic specialists, 4 (four) medical support specialists, 8 (eight) otherspecialistsand 2 (two) basis subspecialists (Explanation of Law44Year 2009Article24 Clause2). However, AW Sjahranie

hospital provides 24 kinds of specializations, 7 medical support specialists, and 4 basic subspecialists. By providing services that exceed thestandardshave been established then AW Sjahranie public hospital showed improvement in terms of services.

As public hospital, AW Sjahranie hospital provides services for the have not people. Poor citizens can obtain services by bringing their insurance card which usually diverse for every region but usually known as Askeskin (Asuransi Kesehatan Masyarakat or Insurance for Poor Citizens) or Asmara (Asuransi Masyarakat Samarinda). The idea of free medication is an initiative from the local government cooperation with the hospital. In this way, every citizen is entitled of health services in every public health center. The hospital also provides special counter for the insurance so that the citizens do not have to wait long hours to deal with administration or registration, as experienced by Mrs. Nola, a patient from Tanah Hulu, East Kalimantan, who is using 'free medication' for a dental surgery stating that

> It was not difficult to follow the procedure to obtain the insurance card. All you have to do is go to the Head of neighborhood association and bring our family and identity cards. In one day, I get my insurance card ready and I can get free medication here. Since the first time I got a check up on my dental and mouth, they did not ask for money. Last month I had my blood checked since I will have a dental surgery and it was free of charge. They also gave me medicine for free. It's just that I have to wait for a month to have my surgery executed because the nurses said that there are many patients waiting for the same surgery like I do (interviewed on June 9th, 2011).

Other opinion is stated by Mrs. Humairah who used to have a surgery using government's health insurance (ASKES) saying that:

> It is quite difficult to get a room according to our insurance class, except if we want to enter first class or paviliun. You have to queue to get a room. Thank God, when I got to the hospital for my surgery, I did not have to wait a long time that when a patient just went out of the hospital, I could stay in her room which is suitable with my insurance class. I get free medication which covered my surgery and medicines expense (Interviewed 14 June 2010).

Free medication means that the government supports the values of humanity and equality as well as the social function of the hospital as stated in Law Number 44 Year 2009 concerning Hospital. In the perspectives of New Public service, this means that the government tries to serve the citizens instead of customers in obtaining public health services. The hospital do not merely respond to the demands of "customers", but responsible for assuring and facilitating the public interests consistently that the citizens can get justice, fairness, equity in accessing public health service. Mrs. Nola's experience is an exemplification that every citizen is entitled to have access to the public hospital. Even when the people have to pay, they do not put higher price in public hospital as experienced by Mrs. Titis, a patient in Maternity Poly.

> As a matter of fact, I am used to getting medication in private hospital because of "trauma" of getting medication here (AW Sjahranie hospital)- the service is not good here and many people in my family say so. But after having consultation with my family doctor, I have to here because only this hospital which has the equipment to detect and cure my disease in Samarinda so I come. It turns out that many things have changed here, from the administration up to this comfort waiting room and I think the cost is reasonable (Interviewed on June 7, 2011).

Experiences of these patients from different backgrounds of service users indicate that the hospital is giving equal treatments to all service users, whether they are insurance users or not. It is in compliance with hospital's commitment as stated by the director of the hospital to perform all service activities based on the regualtion and Law in order to satisfy their service users by fulfilling the hopes and expectations.

6.3 Supporting and Constraining Factors in Improving Public Service in the Hospital

The realization of the service improvements that have been performed in the hospital cannot be separated from the supporting factors that support the action plan. However, challenges in improving services in the hospital are not free from the constraining factors that exist in the hospital. Following are the supporting and constraining factors in improving services in the hospital.

6.3.1 Supporting Factors

A. Leadership

Leaders establish unity of purpose and direction of the organization. They should create and maintain the internal environment in which people can become fully involved in achieving the organization's objectives (www.iso.org). Improvement initiative in AW Sjahranie hospital services is the sincere commitment of the leaders (higher level management) in order to realizing the vision and mission of the hospital whose main duty and obligation is to improve the health of citizens in East

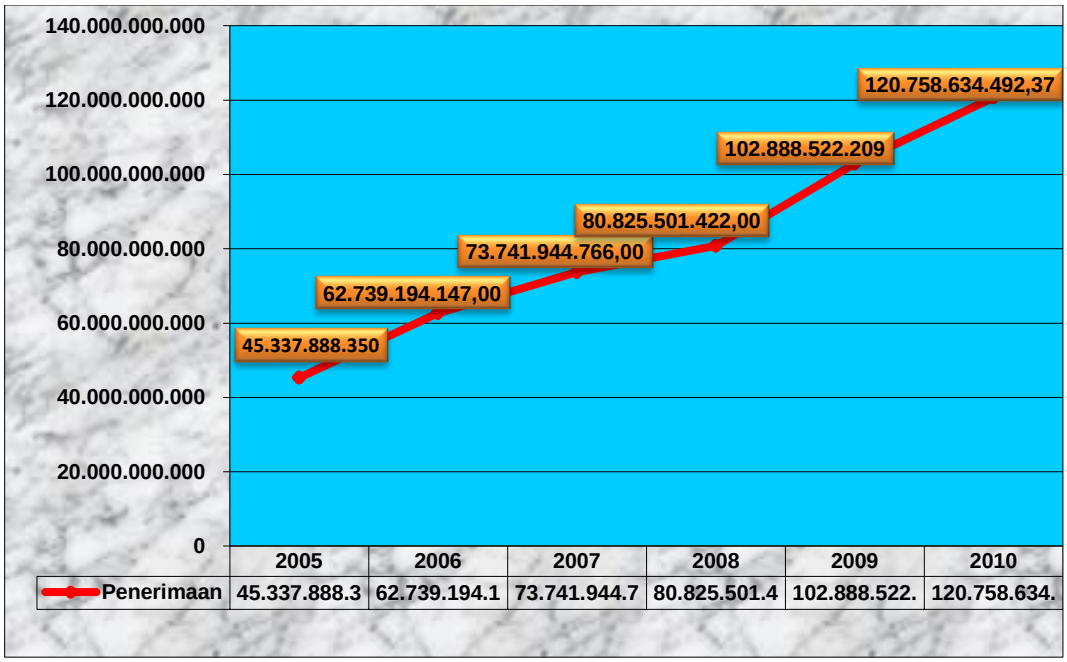
Kalimantan. This commitment is also demonstrated by the coordination with the heads of the room every Monday to evaluate the work of each unit in the hospital and also the internal dissemination of the policies that will and is being developed in the hospital. Additionally, hospital leaders also take advantage of coordination to filter opinions and ideas or suggestions from each room to improve the quality of hospital services. Even the complaints against the hospital by text (short message service or sms) is received directly by the director and should there is a name of an officer mentioned in the text, the director directly forwards the text to the officer concerned. Thus, employees know that the leader directly evaluates the activities carried out by hospital officials.

Leadership strategy that can be noticed in the hospital is implementation of management by walking around. This is effective strategy implemented in the AW Sjahranie hospital because in addition to evaluating and monitoring staff who are doing their job, in this way a higher authority (director, vice directors, the head of the room) can directly find out what should be improved in certain units. Besides, in an emergency situation where all officers are occupied, then the superior (head of the nursing care) may directly give helping hands. This attitude can also establish communication with subordinates. So, instead of sitting in the room, management by walking around is very useful in AW Sjahranie hospital.

B. Budget

Increased budget for hospital services Sjahranie AW is the manifestation of the commitment of local governments to improve public health in East Kalimantan. As a result, the hospital can continue improve its services by continuing to keep up dating current health development and technology. This can be seen through more new medical equipments owned by the hospital, improving hospital facilities (new building) which can be experienced by the citizens. This can be seen through the following figure:

Figure 6.4 Budget of AW Sjahranie Hospital 2005 - 2010



(Source: LAKIP RSUD AW Sjahranie Hospital, 2010)

From the above figure, it can be noticed that the budget for the hospital keeps increasing from year 2005 to 2010. As a result, the hospital has the opportunity to

make more improvements especially for the procurement of the facilities and infrastructure like buildings and medical equipments.

C. Training and Education

Training and education is one important aspect of service because they can add the knowledge of the officers. As a follow-up of the implementation PerMenPAN Number 13 Year 2009 for example, the hospital set up in-house trainings for hospital officers from the guards, nurses as well as doctors. Therefore, they can know-how to better connect to the citizens. Although they have found out how to react toward the service users, such training can become refreshment for them. Commitment to develop officers to the training and education is also shown by the officers sent to attend overseas training as well as continuing education into the higher strata or for general practitioners to take specialization as indicated through the following table:

Table 6.1 Number of Employees Attending Training and Education

No	Kinds of TE	2006	2007	2008	2009	2010
1	TE within East Borneo	253	242	417	713	980
2	TE outside East Borneo	111	83	141	159	106
3	Overseas TE	6	12	14	8	2
4	Post-Graduate (S2)	4	5	1	6	30
5	Doctoral (S3)	-	1	8	8	6

(Source: LAKIP AW Sjahranie Hospital 2010)

The table indicates that the number of employees attending training and education increases from year 2006 to 2010. The number significantly increases especially for the employees attending training and education within East Kalimantan

Region. This is one of the strategy that hospital decides to overcome employees shortage in the hospital as stated by the Head of Training and Development Division in the hospital, Mr. H. I Ketut Suantra, M:

> Performing in house trainings within the hospital are one of the strategies that we are trying to do nowadays and we find out that it is quite effective. We can monitor and evaluate both sides, the trainers and also the employees. Besides, more employees can be trained within the region than by sending them outside the region. However, for some training like training to get specific certification, we are sending them outside the region or overseas (interviewed June 10, 2011)

In other words, despite having enough budget to conduct trainings or sending the employees to attend trainings, the hospital prefer to conduct in house training since they can make direct monitoring and evaluation towards the activity done during trainings. Doing in house training or sending employee to have training within East Kalimantan Region are also useful for the hospital to overcome the shortage of employees working in the hospital. As a result, 713 employees in 2009 followed by 980 employees in the following year are trained within East Kalimantan.

D. Facility

Another important aspect that relate directly to the citizens is a form of facilities and infrastructure facilities. The new building with new equipments with more modern style are can really bring practical benefits considering those who come to the hospital are ill. So, all they want is some comfort when doing registration and waiting for their turn. The improvements of the buidings can be seen though the picures below:

Figure 6.5 The Comparison between the Old & New Policlinic

(Source: AW Sjahranie Documentation, 2008 & 2010)

Figure 6.6 The Comparison between the Old & New Emergency Installation

(Source: AW Sjahranie Documentation, 2008 & 2010)

From the pictures, it can be seen that the buildings that are cited here are policlinic and emergency installation building, some which are mostly visited by the citizens or user of the hospital. This indicates that the hospital puts high priority toward the comfort of their service users.

E. Reward and Punishment

Reward is one kind of reinforcement that is useful to motivate employees to work. But it becomes useless if not accompanied with high discipline. Thus, relating to the discipline in the hospital, the management applies coffee morning every Monday morning that must be attended to all hospital management and the finger attendance for hospital's employees. If the employee does not comply then their incentives will cut as a punishment. This is an effective discipline procedure since it is easy to execute and measurable.

6.3.2 Constraining Factors

A. Increasing Number of Patients

The larger an organization that serves the people, the more complex the problem they face. Obstacles were encountered by the AW Sjahranie hospital. Regulation that prohibit AW Sjahranie hospital to reject patients is a dilemma for the quality improvement in this hospital. When all beds in the hospital are occupied, then the officers inevitably must ask the citizens to bring their own beds and so that they can be treated along the hallway of the building between the treatment rooms. This kind of situation very often occured in the hospital since it is the closest hospital that accept free treatment.

Table 6.2 Number of Visitors from 2005 to 2010

No.	Kind of Visit	2005	2006	2007	2008	2009	2010
1.	Number of beds	421	435	465	505	604	612
2.	Emergency	20.151	25.172	29.139	25.882	26.561	38.286
3.	Outpatient	135.926	137.865	114.088	132.939	141.788	144.846
4.	Inpatient	21.791	24.187	26.591	27.513	30.193	36.814
5.	Laboratories	495.342	674.680	698.810	879.548	805.965	896,793
6.	Radiology	20.162	21.343	21.383	24.002	29.679	31,241
7.	Delivery (Baby)	1.377	1.366	1.571	1.630	2.509	2,576
8.	Sectio Caesar	545	464	642	714	938	989
9.	MCU	-	1.342	833	4.585	4.988	5,246

(Source: LAKIP AW Sjahranie Hospital 2010)

The table indicates that although the number of beds is increasing from year to year, it does not compatible with the number of patients of the hospital. During 2009, for example, the number of inpatient visitors were 30,193 with 604 beds in the whole hospital whereas in 2010, the number of inpatiet visitors were 36,814 with the total beds of 612. The increase number of inpatient visitors from year 2009 to 2010 were more than 6,000 patients whereas the number of beds only increase 8 beds. This has become one major problem that the hospital faces. Besides, more beds mean more rooms, and more rooms mean more buildings.

B. Lack of Human Resource

Increasing the number of service users in AW Sjahranie hospital also have an impact on the quality of the hospital because unequal comparisons between paramedics and patients served. The unequal comparisons between employees and patients and the demand of good service has resulted gap in service delivery. The paramedics claim that they are too tired handling too many patients at once. Based on

the observation, the head of the Emergency Installation that cannot be available in his room in the morning every Monday to Thursdays because he has to do bone surgery on those days.

Table 6.3 Types of Worker

No	Types of Worker	2005	2006	2007	2008	2009	2010
1	Specialist	56	56	59	52	64	68
2	General practitoner	37	38	41	44	42	53
3	Orthodentist	2	5	4	4	5	5
4	Dentist	9	4	4	4	6	10
5	Pharmacist	8	8	8	7	9	9
6	Pharmacist Assistant	12	36	16	22	25	41
7	Nursing	396	401	425	430	457	583
8	Medical Support	64	60	71	86	93	98
9	Non-Medic	282	290	290	314	316	319
10	Cleaning Service	80	85	90	90	101	110

(Source: LAKIP AW Sjahranie Hospital 2010)

Comparing to the number of services the hospital has and the number of specialists they employ and not to mention the number of patient they serve daily have made the hospital faces complicated schedule for service provision. The total number of nurses of the hospital, for example, are 583 nurses in 2010 compared to 144,846 visitors in outpatient service. This has resulted the overwhelming duty for hospital workers.

Technological developments in medical world has a good impact for AW Sjahranie hospital with the procurement of a variety of sophisticated medical equipments, but this has also impacted on the readiness of human resources in order

to use these tools. This is a great investment. According to one of the nurses in the inpatient service, Budi Santoso, sometimes a training for the use of equipment can spend up to 50 million rupiah. Even when the hospital can sent their officer to attend the trainings, the management still have to fulfill the vacant position of the officer since a training for certification can last more than a month (interviewed on March 7, 2012). Sending officers means less officers can serve the citizens. For that strategy, the hospital initiates for a peer teaching or an in-house training. Nevertheless, this will become temporarily solutions for them.

Another problem relating to human resource is the problem of employee rotation. Besides giving the opportunity for employees to broaden their knowledge, rotation can be refreshing for them after such a long dedication in a division. The problems arise when officers who have attended long-term training or certification cannot be replaced into another medical service/room because sometimes a certification is graded as in BTLS to ATLS (to get Advanced Trauma Life Support, an officer should attend and pass Basic Trauma Life Support). As a consequence, some employees stay at the same position by more than ten years. This also experienced by Mr. Agus, the head of nursing care in emergency installation that has spend his 16 years of his entire carreer in the emergency installation (interviewed on June 11, 2011).

6.4 Evaluation Justification

Evaluation is a practical tool to know whether or not a project is producing effects or being properly conducted from the viewpoint of accountability (JICA, p.16). The evaluation will be interpreted based on 3 (three) criteria, i.e. relevance, impact, and sustainability. The examination of the project implementation indicates that the outputs are achieved. However, considering results achievements, there are also factors that promoted and inhibited the process of improving public service quality in the hospital. Based on these identifications, the evaluation result is as follow:

6.4.1 Relevance

The relevance is the measure for determining whether the outputs, the project purpose and the overall goal are still in keeping with the priority needs and concerns at the time of evaluation.

Table 6.4 Evaluation Grid for Relevance

Main Question	Sub-Question	Required Data	Information Source	Data Collection
✓Does public service become one important aspect in government's agenda?		✓Policy of the government concerning Public Service	✓Content of the Policy	✓Review of Material
✓Does improving public service quality relevant with the vision and mission of the hospital?	✓What are the efforts that have been conducted by the hospital to improve the service?	✓Information and activities that support the improvement of service delivery in the hospital	✓Project Documents ✓Hospital's Employee	✓Review of Material ✓Interview

Based on the evaluation, the implementation of the method is considered relevance with national agenda. Problems related to public services have become one major challenge for Indonesia Government to be solved. The government under the Ministry of Administrative Reform then enacted a regulation concerning the method of Improving Public Service Quality through Citizens' Participation. During the pilot projects in several areas, it is claimed that services have been improved and citizens have experienced the positive changes in service delivery. It is from the success stories of many public service units like administrative office, hospitals, and schools the method spread through Indonesia. The implementation of the method in AW Sjahranie hospital has become one way for the hospital to improve the service delivery in the hospital. One of the missions in the hospital is to give excellence service. Among other efforts and activities, this project implementation has achieved output of the method and made some positive changes related to the service delivery in the hospital.

However, this method is only among other methods to improve public service quality in the hospital such as ISO 9001:2008, accreditation system, or annual survey of customer satisfaction index. As a result, the process of improving public service quality in the hospital becomes overlapping and unfocused.

6.4.2 Impact

The impact is intended or unintended, direct or indirect, positive or negative changes that occur as a result of a project.

Table 6.5 Evaluation Grid for the Impact

Main Question	Criteria & Method for Judgment	Required Data	Information Source	Data Collection
✓Does the implementation of the project give influence and benefit both service users and service providers?	✓Before/after comparison	✓Opinions	✓Informants (citizens and hospital employees)	✓Interview
✓Does the hospital have the initiative to make a re-survey in order to know whether the same complaint exists or not?		✓Content of the Report	✓Accountability & Performance Report	✓Review of Material
✓Does the hospital have other activities that support the idea of improving public service quality in the hospital?	✓Before/after comparison	✓Content of Regulation	✓Accountability & Performance Report ✓Documentation	✓Review of Material ✓Observation

Based on the evaluation, outcomes of the project implementation are achieved and the hospital has made improvements. Benefits of the implementation of the method are not only experienced by the citizens as service procedures are becoming easier and more transparent, but also hospital employees as they can get training and education about 'Excellence Service'.

Still complaints from the service users and solutions offered by the hospital may not represent the citizens' expectation. The hospital provides numerous services and the users keep coming back and go. Thus, in order to give broader impact for the society, upon formulating the service pledge, the hospital must conduct a re-survey in order to find out whether the same complaints exist or whether they have made progress upon implementing the project. The project was implemented in 2010, yet there has not been a plan to conduct a re-survey in the hospital.

6.4.3 Sustainability

The sustainability is the measure for determining whether or not the project benefits are likely to continue after the external aid comes to an end.

Table 6.6 Evaluation Grid for the Sustainability

Main Question	Sub-Question	Required Data	Information Source	Data Collection
✓Does the regulation consistent with Indonesian Law concerning Public Service?	✓Does the implementation become an important agenda in Indonesia?	✓Content of Regulation ✓Number of service units applying the method.	✓Law Number 25 Year 2009 concerning Public Service ✓Ministry of Administrative Reform Regulation Number 13 Year 2009	Review of Material
✓Are there prospects that the overall goal will be achieved?	✓Has a re-survey conducted by the hospital?		✓Report of Strategic Plan	Review of Material
✓Does the project have the potential to continue?	✓Does improving public service become important agenda in the hospital?	✓Vision & Mission statement of the hospital	✓AW Sjahranie Hospital Profile	Review of Material

Minister of Administrative Reform Regulation Number 13 Year 2009 is in line with the purpose of Law Number 25 Year 2009 which is basically related to the public service delivery in government's service units. AW Sjahranie is government's hospital and therefore, improving service delivery has also become one of the visions and missions of the hospital. As implementation of this regulation in the hospital is consistent the government policy and the hospital's vision and mission, implementation of this regulation can always remain a strategic agenda in the future to improve the service quality in the hospital. Thus, this project has the potential to continue in the hospital.

CHAPTER VII CONCLUSION AND RECOMMENDATION

7.1 Conclusion

The hospital is a public sector organization is very vital because it deals directly with the public. Therefore the quality of public services is an important aspect in ensuring excellence service provision to the community. Based on the implementation processes and evaluation results it can be concluded that the changing attitude of hospital-patients has made the hospital become more open to public needs and try to fulfill its obligation as public hospital by giving equal treatments for all service users.

The changing paradigm of public service from provider-centered to user-centered can be noticed from the application of Minister of Administrative Reform Regulation Number 13 Year 2009 concerning the method of improving public service quality through citizens participation. The method encompasses 4 (four) stages of application from the complaint management workshop, survey, complaint analysis, and the signing of service pledge. Based on the process and evaluation, the hospital has achieved some positive changes. For the citizens, public service delivery nowadays is more transparent as they can know the procedures of obtaining services through the flowchart and other sign boards in the hospital. For the employees,

trainings and education about excellence service have enhanced their capacity as the service providers.

The improvements performed by the hospital are due to some supporting factors such as leadership, budget, training and education, facilities, reward and punishment system. Nevertheless, as the number of the people increasing, the need for health services are also increasing. The challenge to provide services towards the increasing number of patients with lack of human resources have become some constraining factors that the hospital faces nowadays.

Furthermore, the idea to improve public service quality is one of important agenda in achieving the visions of administrative reform toward the good governance administration 2025. In PER/15/M.PAN/2008, it is clearly stated that public administrators/government apparatus are obliged to give excellence service, satisfaction that can be felt by the public/citizens as the effect of professional and dedicated bureaucracy performance with high moral standard in executing their duty as public servant, with all their hearts and responsibility. The government desires to create an administration which is serving, meaning that administration is giving excellent service in spite of asking to be served.

Giving excellence service has also become the policy of the hospital as it is revealed in the vision and mission of the hospital. As the implementation has achieved the output of the activities and progresses are accomplished by the hospital, patients and employees can taste the impact of improvement in service delivery.

However, to remain sustainable, a re-survey should be taken by the hospital in order to find out whether the same complaints exist, reduce, or increase in the hospital.

7.2 Recommendation

Improving services quality provision in public hospital in Indonesia has become the responsibility of various elements of the governance. Thus it is recommended that:

1. The hospital revitalizes the hospital-patients relationship by giving more and intense socialization about rules, regulations, and code of conduct of performing medical services in the hospital in order to eliminate misunderstandings between hospital-patients.
2. It takes commitment of the hospital first in order to make quality improvement in public health services. The quality improvement cycle needs to be implemented constantly. It has been two years since the hospital implemented the method and the first cycle of improvements have been conducted. Thus, the hospital needs to continue repeating the improvement cycle to show their commitment for quality improvement.
3. As the hospital has its limitations in serving the increasing number of patients, government should work together with the citizens or NGOs for health promotion in order to teach and educate people of how to live a healthy life.

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