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Research Article

Economic Factors in Professional Commitment

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Abstract

The question that often arises in various seminars and debates is "why should wealthy people and Indonesian officials go abroad for health affairs, including the simplest... check-up". If observed various physical things in hospitals such as medical equipment, buildings, and medicines in Indonesian hospitals are not much different from hospitals in Malacca, Singapore, Bangkok. A striking difference may be with Boston or Houston hospitals. One of the hypotheses presented is the difference in the quality of human resources determines the quality of health services. However, when viewed individually, there are certainly no racial and ethnic differences between Indonesians and Malaysians or Singaporeans. In this case there is another hypothesis that if the HR management system is improved so that the commitment of Indonesian hospital resources increases to the hospital, then there will be an improvement in the quality of services. This paper discusses the relationship between economic factors and professional commitment. The purpose of the commitment here is the amount of attention and relationship between professional doctors and hospitals. This needs to be put in context, why there are many cases of specialists working multiplely in various places which can eventually result in low commitment.

Keywords: economic factor, business, hospital, professional commitment

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1. Introduction

Specialists are not satisfied with the income earned from one hospital. As a result specialists tend to work not only in hospitals. Based on utility theory, working behavior can

be discussed through Life-cycle approach and a minimum fee for specialist [1]. The life-cycle of the cardiothoracic surgeon who had very long in their education process, so that when they graduated they were old and resulted in a narrow time to work before retirement [2]. In general the life-cycle of a specialist can be described as in Figure 1.

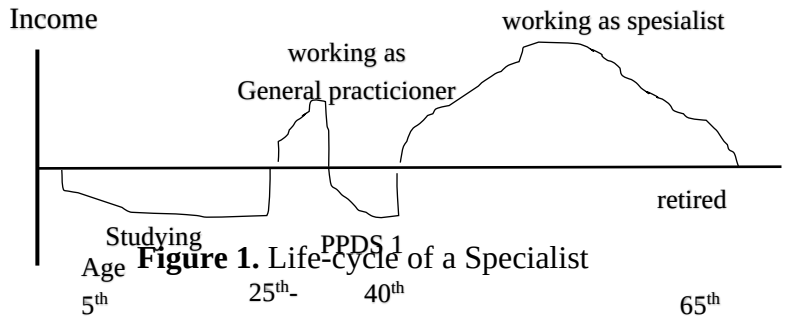


Figure 1. Life-cycle of a Specialist

This life-cycle shows the specialist's working period which starts relatively late, that is, over 35 years of age, based on the passing age of the specialist. This delay is relative to other professions, such as an accountant who can work since the age of 23, while studying MBA for a year. The education and work system of doctors makes the graduate age of specialists be older, for example about 36 years old. At this age, a specialist can be said to be starting a new life for a new job [3]. This can be felt when a specialist is placed in a new place. Meanwhile, at this age the needs of life are already high, including the needs of families [4].

In terms of income, the cases above shows that the salaries of government specialists are relatively small [5]. With a long period of education and a period of starting to work as a specialist in a high age, the element of finding additional income outside the salary becomes important [6]. The cases studied showed that specialists were dissatisfied with government salaries and had to increase their fee-for-service activities [7]. However, this is where the difficulty begins to arise, namely how much income is expected from fee-for-service because there is no information about income standardization [8].

For example, a surgeon who graduated at the age of 35 years. This surgeon can calculate that his active period as a surgeon is 25 years with the calculation of retirement age at the age of 60 years. Another factor taken into account is lifestyle. Globalization of lifestyles has penetrated into Indonesia, including children's education standards, home ownership and car types. The price of a Toyota Corolla car in Indonesia is around Rp225,000,000.00 which is identical to the 200 months salary of a government doctor with the rank of IV A. While in the United States the price of a Toyota Corolla is equivalent to 1 month doctor's salary. The BMW X 5 series jeep 3.0 is equivalent to 3 months of average

doctor's income in the United States. In Indonesia, the jeep is worth around 800 million rupiah. It is possible that the surgeon wished to send the child abroad, having a large house and a luxury car. This condition can lead to the emergence of various phenomena such as supplier-induced-demand or inappropriate relationship between the pharmaceutical industry and doctors.

This is where the main difficulty arises in determining how the surgeon's lifestyle at the time of work in such a short time [9]. The failure of professional associations to create standards can result in a highly varied doctor's lifestyle. This is the trigger for the difficulty of standardizing income so that the surgeon will be like an "artist" who does not have standards. A study by foreign consultants at a government education hospital showed the expectations of young specialists for a monthly income: “A group discussion was implemented with 6 young specialists. They were asked to identify their hopes for X Hospital. All of them want to work mainly in X Hospital. However, their financial income is far below their expectations. Dr. A (female) from the Department of Dermatology asked for the sum of 5-10 million Rp per month. Dr. B (female) from the Dept. of Radiology asked for 5 million Rp per month. Dr. C (female) from the ENT Dept. asked for 10 million Rp per month. Dr. D front the Eye Department asked for 5-10 milion Rp per month. Dr. E Onale) from ObGyn asked for about 40 million Rp per month, and Dr. F (Cardiac surgeon) asked for about 80 million Rp per month”.

When this answer is contrasted with their income from government hospitals, there is a big difference. The Government General Hospital (RSUP) where they work provides very low salaries and medical services. The most extreme is that the cardiothoracic surgeon's income is only about 3% of their expectations. Therefore, young specialists also do double work in various hospitals.

2. Life-Cycle in a Specialist's Career

An important question arises: why do government doctors stay in government hospitals? Job satisfaction is quite high even though low salary. This is due to the pattern of working in government hospitals has a culture as expressed by a senior specialist as follows: working in a government hospital is devotion, while earning money is carry out in a private hospital [10].

With this culture, the government specialist in planning a future career in their life-cycle will try to find a place to work in a private hospital or open a private practice. This is evidenced by the accumulation of specialist in areas which have the economic power of many

private hospitals [11]. Even though income is low in government hospitals, positions in government hospitals, especially those who work as lecturers, tend not to want to leave their jobs as civil servants [12]. This working pattern and culture leads to an Earning at Risk situation, where specialists remain as government employees but have jobs outside the government to get unlimited incentives [13].

a. The Need for Standardization Development in the Doctor's Market

In an effort to improve the quality of hospital services, too many double jobs need to be avoided. One way is to take an approach based on the fairness of a profession. Universally, the medical profession is not an artist whose members' income cannot be adjusted. The doctor profession is a profession such as an accountant or engineer who requires standards. For hospitals in areas where there are many specialists, such as DKI, the standardization of income for specialists can be used to plan the recruitment of young specialists who are expected to work full-time, without duplicating it. With this standard, there will be a more predictable supply and demand mechanism, not a type of mechanism like the unpredictable art sector. For hospitals in Indonesia, the standardization of income for specialists can be a guide for hospital owners, such as local governments, to make recruitments [14]. For example, to recruit a surgeon in Merauke Regency, Papua Provincial Government and Merauke Regency Government will provide incentives that are close to this income standard.

Various concepts indicate a need for a benchmark for the development of a specialist's income standardization. The development objectives are to:

Doctor's career development. By having a standard of income, a doctor can estimate his career path in terms of income. For example, as a young specialist (under 5 years of graduation), the amount of income which expected to earn is an important guideline.

Determination of tariff and incentives by hospitals. Hospitals need information to be able to provide a decent income for working specialists. This is important in DKI Jakarta. It is expected that there will be standards so that a hospital has a benchmark in order to be able to provide standard income for a specialist. In several recruitment advertisements, this income has started to open as shown in Figure 2.

XXX HOSPITAL HIRING :	
Surgeon	Gaji + Rp. 3.000.000,-

Internist Gaji + Rp. 3.000.000,-
Pediatrician Gaji + Rp. 3.000.000,-
Obstetrics and Gynecology Doctor
Otolaryngologist (ENT) Gaji + Rp. 3.000.000,-
Oculist Gaji + Rp. 2.000.000,-
Neurologist Gaji + Rp. 2.000.000,-
Genital Dermatology Doctor Gaji + Rp. 2.000.000,-
Anesthetist Gaji + Rp. 2.000.000,-
Head of Senior Nursing Officer
in a good private hospital Gaji + Rp. 1.500.000,-
The salary is fixed (whether there are patients or not).
The above salary is added by 50% of the salary for outpatient and inpatient doctors.
Polyclinic practice in the hospital morning and evening for the benefit of people in need
Complete application to PO BOX 144 Cimahi Bandung

Figure 2. Example of specialist recruitment advertisement

1. Salary and income determination by local governments who want to have a specialist full-timer in their local hospitals. For example, how the Local Government of Papua will hire Obstetrics and Gynecology Doctor or surgeon. In 1999 the doctors were paid based on civil servant standards + allowances around Rp 1,000,000.00 beside the private practice (Ridhoto, 2000). In total, an Obstetrics and Gynecology Doctor gets around Rp 4.000.000,00. The question is, is it possible for Papua Provincial Government to follow a market demand, for example, to pay based on Rp20,000,000.00 a month?
2. By knowing the doctor's income standard, including in the regions, there will be legal demand and supply in the distribution of doctors. The case in the United States shows that remote areas of the United States are apparently filled with foreign doctors, especially from India. These foreign doctors still want to work in remote areas because the income earned is considered sufficient and the spirit of survival is high. Thus, if there is standardization of this income, then there is value and information which may be able to attract doctors to work in remote areas in Indonesia. It is not closed to the possibility for Specialist of the Philippines or Myanmar to work in remote areas in Indonesia.
3. Educating the public appreciates the profession of specialists. Cases at a regional hospital show that the tariff of specialist polyclinic check is very low, and the medical services per

check up are only Rp 500.000,00. Meanwhile, salaries are very low, well below what specialists expect. The result is that specialists often do not exist in polyclinics at the appointed hours. In the long run, the impression on the specialist will be bad.

This standard is important for fairness to specialists working in Indonesia. For example, a specialist who both graduated from obstetrics and gynecology from a leading state university. An obstetrics and gynecology doctor in Depok after 3 years of work is able to earn Rp 20,000,000.00 a month. Meanwhile, fellow workers working in Abepura, Papua, only earn Rp 3,000,000.00 a month with a much higher risk of working and life difficulties in Abepura.

Based on the compensation theory, the size of the specialist's income must be determined by various factors, namely: type of specialization, type of expertise and the workplace (related to security risks, distance and geographic access, as well as local economic capabilities). In order to obtain a specialist's monthly income standard, it is necessary to do a process of determination based on the income per specialist in one hospital. In order to avoid the double phenomenon, it is expected that a hospital can afford to pay a specialist on a full-timer or perform a clear part-timer contract.

This calculation still needs to be negotiated with various factors outside and inside the hospital. Factors outside the hospital are regarding legislation or labor, as well as the bargaining power of specialists to be taken into account. Meanwhile, one of the factors that must be considered is the big problem of the difference between the income of a specialist and a nurse. If this model is applied, a specialist can receive Rp 50,000,000.00 per month, while the surgical nurse's income is "only" Rp 2,000,000.00 a month. Not to mention the income from administrative staff. These are the things that make it difficult to standardize a specialist's income.

In order to establish a specialist's expectations regarding monthly income, it is best to do it based on a survey. It is expected that this survey will be conducted nationally, on a per-region basis. In the survey, it is necessary to specify income expectations based on specialist groups, length of work, and geographic area. As a first step, the Health Service Management Center of FK-UGM (Faculty of Medicine) Yogyakarta conducted pilot surveys in two regions, namely Yogyakarta and Kedu. Examples of questions and results are in the appendix. In summary, the results show that:

1. There is a difference between Yogyakarta and Kedu regions.
2. Specialists who are not consultant specialists have difficulty answering questions about the income of consultant specialists.

3. The length of working is one of the important considerations for rising incomes.
4. There is a difference between a specialist who uses a knife and one who does not.

The final results of the survey are expected to have information on Minimum and Maximum Regional Income. Practically this can be used for example by the Papua Government which will attract a surgeon to work at Merauke Hospital. As an illustration, the association of surgical professions (for example) states that the regional income for newly graduated surgeons in Papua amounted to Rp 15,000,000.00. These income standards will be used by the Papua Provincial Government to attract specialists and pay them according to demand. If the salary from the center is only Rp 1,000,000.00, and private practice only provides medical services of Rp 2,000,000.00, then the Papua Provincial Government will provide a salary of Rp 12,000,000.00.

From the results of this survey, it is continued by negotiating with related parties, such as the local government or hospital owners. The question is what if the Papua Provincial Government can only afford and willing to pay Rp 7,000,000.00 a month (below the regional income standard)? In this case the demand and supply mechanism will work. It is possible that there are surgeons who are willing to work with such income (below standard). If there were no Indonesian surgeons who wanted to. It is possible that foreign surgeons will want to take it, for example from the Philippines or Myanmar, even from Australia who have non-material motivations. Thus, advertisements such as those carried out by XXX Hospital can be carried out by the local government. If there is no response from doctors in Indonesia, then recruitment advertisements can be posted in Philippine or Australian media, or other countries where the regulations allow. With the existence of regional autonomy, the recruitment of specialists directly by local governments is possible. Thus, it can be imagined that if the Papua Provincial Government and the Merauke Regency Government have difficulty finding indonesian surgeons to work in Merauke, then recruitment may be possible to find a Philippine surgeon or Australian surgeon, as long as they meet their compensation expectations.

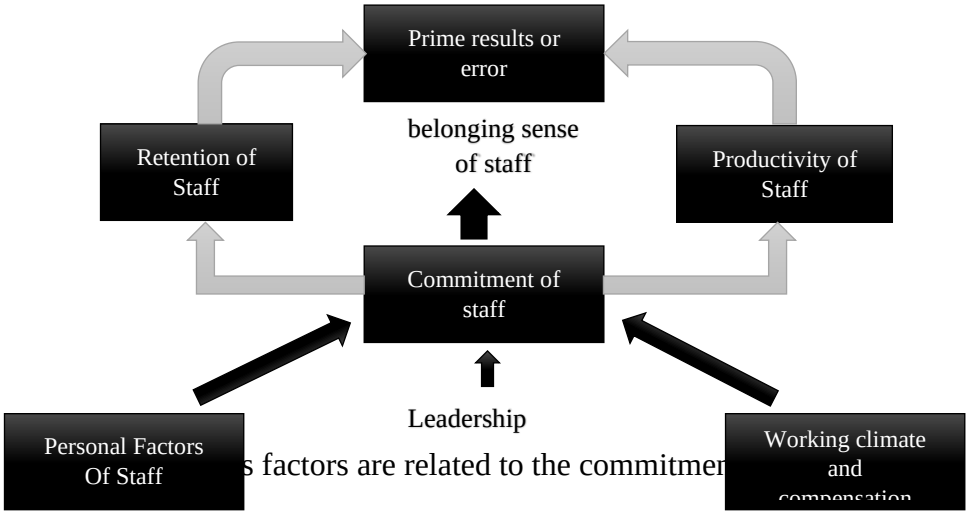
Thus, the important point of this standardization is to determine the ability and willingness of the community to get a specialist with the willingness of specialists to provide their energy. This point has been ignored for decades in Indonesia due to the reluctance or taboo to discuss about this issue. The result of this reluctance is a spread of specialists and variations in the income of specialists between types of specialization and between regions which tend to be uneven.

b. Commitment and Concept of full-timer/part-timer

The concept of full timers and part-timers is interesting to analyze. What percentage of time does a specialist spend working in a government hospital? Looking at the inequality of the number of specialists in the government and private sector, there is a double job position with a very complex time [15]. The specialist tends to be a part-timer at government hospitals, where they officially works.

The various cases studied illustrate several factors that influence the commitment of a specialist in educational hospitals such as incentives, work climate, transparency, security certainty, attention. The impact of poor organizational commitments can also vary from simple to severe. In this case used the definition of commitment according to Luthans (1996), states: “The organization's commitment is defined as a state of strong desire from the members of the organization to bind themselves into an organization voluntarily and strive hard for the benefit of the organization”

Thus, the commitment is nothing but the loyalty of members and leaders of the hospital to the organization. Commitment is an ongoing process with each member of the organization contributing to the progress of the organization. In the hospital, the role of commitment is very important as an adhesive system that has been made as seen in the Figure 3.



s factors are related to the commitmen

High commitment will determine the level of employee retention and good work productivity and sense of belonging to the institution in the hearts of employees. These things will give the result in either excellent or bad performance. The question is, why is there a lack of commitment? Are economic factors important?

The historical aspect may explain why commitment is a problem. In this case, it can be seen from the historical fact that there is a reality in the 1970s or 1980s that a large

medical service is part of illegal fees, (personal communication with Dr. Sudibjo Sardadi, former Director of Dr. Sardjito Hospital (RSUP)). In the early 1980s, Dr. Soedibjo Sardadi risked his position to develop a pattern that will lead of self-funding policy for doctors in the Wijaya Kusuma class (VIP ward) of Dr. Sardjito Hospital. This incentive is determined with an awareness contrary to government regulations which tend to regard hospitals as bureaucratic institutions. In the same period, many specialists work part-time to large private hospitals or if they do not exist then senior lecturers in the Medicine Faculty will establish their own small hospitals. Empirical evidence in Denpasar and Padang shows this. In both cities there is no history of large religious private hospitals. As a result, many private hospitals are owned by specialist education hospitals. There are cases where the hospital was set up within walking distance of the educational hospital. Thus, dissatisfaction in compensation is one of the reasons for the establishment of various private hospitals by specialists. Providing medical services outside of government regulations is one way to increase commitment. In this case it is necessary to realize that there are various commitment factors that need to be studied, namely (1) leadership style; (2) working climate and compensation; and (3) personal factors.

3. Leadership Style, Working Climate and Compesation

The leadership model of top leaders and principle-based supervisors will certainly evoke more commitment than the 'bossy' leadership model. In this case, for example, the directors of educational hospital (RSUP pendidikan) can be exposed in a "bossy" context with bureaucratic management-based on hierarchical management. With the economic behavior of the budget maximizer, it is possible that the hospital directors are considered as bureaucrats who only attach importance to the relationship with superiors in the Ministry of Health related to the central government projects, but do not think of the staff below. This situation can lead to staff dissatisfaction.

The condition of the workplace, the relationship between employees, trust in the system, openness and various other things are part of the working climate which can increase commitment.

“There are two things people want more than sex and money ... recognition and praise”, The quote is as uttered by Mary Kay Ash, Chairman Emeritus, Mary Kay Cosmetics. These words actually aim to state that the compensation provided by an institution for its employees can be in the form of money or non-money compensation. Here there is an interaction between the nature of the employee and the type of compensation. There are

employees who expect money but there are also employees who expect more heaven in return for their hard work in the hospital. This combination of money and non-money compensation can affect commitments. This compensation issue became interesting due to there is a situation that educational hospital (RSUP Pendidikan) is unable to provide sufficient material compensation. Interestingly, although low paid, it turns out that many educational hospital specialists are still satisfied with their working conditions. Despite being paid a low reward, specialists apparently do not want to leave the public servant because this status provides other compensation outside the material.

4. Personal Factors and Commitment Types

A person who is older usually has a different category of needs. At a young age, physiological needs may be needed, while the 35s begin to look for the need for safety and stability, while the 50s begin to look for the need for self-actualization (good name). The rapid acceleration of the transfer of needs is also determined by the educational period of the organization members. The problem which has occurred so far in Indonesian specialists is the age too advanced to become a specialist. A specialist can pass at the age of 35-40 years. In this case the need for money is already very large. If there is not enough income available in the educational hospital, then the specialist will look for it in a private hospital. Emotional feelings and intelligence influence commitment to the organization.

Human nature is a determinant of commitment. Some human beings who are greedy, are never satisfied with what they get. It is likely that a person will never be satisfied with the financial income of a hospital. However, there are doctors who are high in humanity. In the early 2000s, new developments occurred. The doctor's placement policy allows a newly graduated doctor to directly enter a resident education. This policy will affect the personal factors of the doctor.

Each specialist can have different commitments. Specialist commitment can be a commitment to a private hospital or education hospital. It is expected that a specialist in educational hospital (RSUP Pendidikan) will have a commitment to the educational hospital. However, the possibility of such commitments is in private hospitals. Figure 13.4 shows various models of specialist attachment to the hospital.

	Adherence to private hospitals	
	Low	**High**

Adherence to government hospitals	Low	A. Not commitment everywhere	B. commitment to private hospital
	High	C. commitment to Government hospital	D. commitment to both

Figure 4. Various models of specialist commitment to the hospital

Is it possible that a specialist has a commitment to government hospitals and private hospitals equally (box D)? Theoretically it can actually be, but it is practically likely to have difficulties. One practical difficulty is the division of time, given that it is possible for a specialist to work in more than one private hospital. If the specialist works in more than one private hospital, then it may be difficult to divide the time. With the presence of residents in educational hospitals, it is likely that there is a representative to the resident to handle cases in a private hospital. As a result, specialists are difficult to find in educational hospitals, including in specialist polys which are supposed to be class C or private hospital referrals below.

In this case there are many cases that show odd references. A district hospital specialist referred to an educational hospital, instead the patient was handled by a resident. The difficulty of commitment will be greater if the specialist in question has a private hospital and competes in getting patients. In this case there will be conflict of interest. It takes a high level of wisdom to maintain this balance of commitment. The important question here is how is the composition of a specialist educational hospital? Is it in boxes A, B, C, or D? The hope is in box C.

One of the proposed measures is the radical handling of specialist management by finding specialists who really work in the hospital with high commitment, have an attachment to government hospitals. This radical way is essentially to do affirmations, who will work full-timers at RSUP and who will be part-timers. For those who are full-timers are expected to have enough income. This approach seeks to encourage the commitment of some specialists to box C. Given the VIP capacity of RSUP and poly specialists. It is unlikely that all specialists will get a place. Therefore, it is necessary that some specialists become full-timers. In case of division difficulties, it is expected that young specialists become full timers

in educational hospitals. Meanwhile, seniors who already have a place in private hospitals are welcome to continue working without any significant changes. However, it is expected that seniors will approve and encourage young specialists to live out of educational hospitals.

Over time, these young specialists will develop into seniors and live from their government hospitals. Meanwhile, private hospitals will also educate prospective specialists or get from government specialists who apply for early retirement. In essence, there is a separation of government and private specialists.

5. Conclusion

This paper has discussed the behavior of hospitals and hospital staff from an economic point of view. The reality in Indonesia is that there are various types of hospitals such as public non-profit hospitals, private non-profit hospitals such as religious and humanitarian hospitals, and private profit-seeking hospitals. These hospitals can be analyzed behavior with the approach of companies or non-profit institutions. This approach of behavior must look at the context of the environment and the type of hospital ownership.

It is interesting to observe that various economic models of hospitals are influenced by the behavior of specialists. In the discussion of specialist behavior, economics is an important factor for discussion. Various studies have shown that the behavior of specialists is no different from the behavior of other professionals by placing money compensation is important. With a relatively small number of doctors, doctors can act as price-makers in relation to hospitals. With this role then the doctor's income can become unlimited. Therefore, a system is needed to set the specialist's income standard. The use of this standard of income does not apply rigidly, it means that the standard is used as a design for recruitment or provision of services to doctors by private hospital owners or local governments. It is recommended to standardize the doctor's income and make transparent and firm working time arrangements so that the quality of service can be increased.

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