Compassion-Based Charity Care as a Model for Health Equity: A Qualitative Case Study from a Tertiary Hospital in Indonesia

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Article

Compassion-Based Charity Care as a Model for Health Equity: A Qualitative Case Study from a Tertiary Hospital in Indonesia

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Highlights

Public health relevance

- Unequal access to healthcare remains a major public health challenge, particularly for vulnerable populations in resource-constrained health systems.
- This study explores how compassion-based charity care can function as a supportive mechanism to expand healthcare access beyond the limits of national health insurance coverage.

Public health significance

- The study provides empirical evidence that compassion can be institutionalized within healthcare governance and service delivery systems in the tertiary hospitals.
- It proposes a conceptual model linking compassion, charity care, and health equity within a public health framework in developing country settings.

Public health implications

- Embedding compassion within organizational policies and healthcare governance can support equitable service delivery for socially and economically vulnerable patients.
- Charity-based compassionate care may serve as a strategic approach to public health systems, mainly in tertiary hospital management, to improve equity and continuity of care.

Abstract

This study aims to explore the implementation of integrated medical services and social compassion in charity-based patient care at Tzu Chi Hospital Jakarta. The study focuses on healthcare practices that emphasize empathy, humanitarian values, and social support for patients from vulnerable populations. A qualitative approach with a case study design was employed. Data were collected through document analysis involving healthcare professionals and patients, observation, and followed by in-depth interviews with hospital management that provides charity-based care. The findings indicate that the integration of medical services and social compassion is realized through the provision of equal and non-discriminatory clinical care, empathetic communication, social assistance, and administrative as well as spiritual support for charity patients. This integrated approach enhances patients' sense of safety, trust, and adherence to treatment. Moreover, compassion emerges as an institutional value and work culture that strengthens the professionalism and commitment of healthcare workers. This study provides insight that compassion-based healthcare offers a holistic and socially model of care in private hospitals. The integration of medical and social dimensions can improve the quality of healthcare services, improving equity and access to care for vulnerable groups in hospitals.

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1. Introduction

In the past two decades, the global health system has experienced a paradigm shift from a disease-focused biomedical approach to a public health approach that emphasizes justice, sustainability, and humanity. This shift was driven by the realization that health problems are determined not only by clinical conditions but also by interrelated social, economic, psychological, and moral factors. In this context, the concept of compassionate care has evolved as an approach that places active concern for human suffering at the core of healthcare services [1].

Conceptually, compassion is not understood solely as emotional empathy, but rather as a moral drive to take concrete action to reduce suffering and inequities in access to healthcare services [2,3]. Cross-disciplinary research shows that compassion has a strong psychological and neurocognitive basis and is closely linked to prosocial behavior and philanthropic acts. Experimental studies have shown that compassion-based interventions can increase individuals' propensity to contribute to charitable activities and support vulnerable groups [4].

The role of tertiary hospitals is critical as the complexity of medical cases necessitates highly specialized expertise and resource-intensive intervention. While tertiary hospitals offer the pinnacle of clinical care, the high cost of specialized services often creates a gap in equitable access. Consequently, tertiary hospital management often faces a dilemma of maintaining financial sustainability versus the willingness to provide charitable care for indigent patients. Compassion is an important foundation for charitable practices, including in public health care [4]. Therefore, the integration of compassion into healthcare systems is crucial, particularly in efforts to address inequities in access and to strengthen the principles of health equity.

The issue of unequal access to healthcare remains a major challenge in many countries, both developed and developing. Various studies show that public healthcare systems often fall short of meeting the full scope of service needs, particularly for high-cost cases, chronic diseases, or conditions with particular clinical complexity [5,6]. In these situations, charitable and nonprofit healthcare institutions play a crucial role as complements to the public healthcare system. The history of hospital development is inseparable from the practice of charity and concern for the poor and marginalized [7,8].

International literature on charity care demonstrates that nonprofit hospitals and socially responsible healthcare institutions have a moral and social mandate to provide services to vulnerable populations. However, various studies also reveal that charity care practices are often inconsistent and influenced by regulations, tax incentives, and organizational orientation [3,4,8]. In the United States, for example, studies have found that charitable care contributions by nonprofit hospitals are not always commensurate with the fiscal benefits they generate [9,10]. This situation has given rise to criticism that solely administrative charity care is insufficient to ensure equitable healthcare.

Critics of the traditional charity approach emphasize the need for a more normative and equitable framework. Charities that focus solely on financial assistance risk reproducing inequality if they are not accompanied by principles of social justice and respect for human dignity [11]. In this context, compassion serves as a bridge between charitable practices and broader public health goals. Compassion ensures that charitable services are not merely reactive, but integrated into a service system that is oriented towards the needs of patients and vulnerable groups on an ongoing basis [12,13].

Studies on compassion in healthcare demonstrate that compassion is a multidimensional phenomenon encompassing emotional, cognitive, moral, and professional dimensions. Compassion is not only present in direct interactions between healthcare workers and patients but is also reflected in organizational policies, structures, and practices that enable access to services for those who are socially and economically vulnerable [14,15]. Qualitative and systematic studies confirm that the organizational environment and service systems significantly influence the sustainability of compassion practices in healthcare [16,17].

Furthermore, recent literature highlights the close relationship between compassion and spiritual care, particularly in the care of patients with serious and chronic conditions. Spiritual care

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is understood as an integral part of compassionate care because it provides emotional support, helps patients find meaning, and maintains dignity in situations of medical and economic constraints [18,19]. Studies during the COVID-19 pandemic have shown that a compassion-based approach can increase patients' sense of security and reduce psychological distress, even in situations of stressed healthcare systems [20]. These findings reinforce the argument that compassion must be operationalized systemically, rather than relying solely on the attitudes of individual healthcare workers.

In the context of developing countries, the challenges of equity and access become increasingly complex. Public health financing systems often face fiscal and structural limitations, preventing all service needs from being met. In Indonesia, the National Health Insurance (Jaminan Kesehatan Nasional, BPJS Kesehatan) has significantly expanded service coverage, but still faces challenges in ensuring access to certain services, particularly for the poor and patients with complex medical needs. Research shows that in these circumstances, patients tend to seek alternative services through charitable or social-based health institutions [21].

Indonesia has a long tradition of philanthropic and religious-based health care practices. Charitable clinics and hospitals have developed in response to the limitations of the formal system and the needs of the poor [22]. However, academic studies on the role of these institutions are limited and tend to be descriptive. Little research has examined how compassion values can be systemically integrated into charitable care practices to support public health goals, particularly in strengthening equity and access to health services.

Comparative studies in other countries have shown that social-based and philanthropic health institutions can function as strategic actors in national health systems if they have a clear service model oriented toward social justice. Research on waqf-based and social health institutions in Malaysia, for example, shows that integrating moral values, charity, and service systems can improve the sustainability of services for vulnerable groups [23]. These findings are relevant to the Indonesian context, but remain largely unexplored empirically and conceptually.

The literature on charity care also emphasizes the importance of policy and governance frameworks that support the social mission of healthcare institutions. Regulations, eligibility standards, and accountability mechanisms influence the extent to which compassion can be translated into consistent service practices [24–26]. Without systemic support, compassion risks becoming a sporadic practice dependent on individual goodwill or specific circumstances.

In recent years, the scientific literature increasingly emphasized the need to understand compassion not only as an interpersonal virtue but as a systemic and organizational construct within healthcare delivery. A comprehensive scoping review by Malenfant et al. identified compassion as a multidimensional phenomenon encompassing emotional resonance, moral commitment, relational presence, and concrete alleviation of suffering, while also highlighting the importance of institutional culture and structural enablers in sustaining compassionate practice. Their findings suggest that compassion becomes sustainable only when embedded within organizational policies, leadership practices, and governance structures, rather than relying solely on individual goodwill [16].

Qualitative studies conducted in high-pressure clinical contexts further reinforce this argument. For example, research examining compassion-based care during the COVID-19 pandemic demonstrated that nurses perceived compassion as both an ethical responsibility and a systemic necessity in situations of limited resources and institutional strain. Such studies reveal that compassion can directly influence patient trust, psychological safety, and continuity of care, particularly for vulnerable populations. However, these investigations primarily focus on interpersonal and professional dimensions of compassion and rarely extend the analysis to institutional financing mechanisms such as charity-based healthcare programs [20].

Parallel to the compassion literature, policy-oriented and empirical studies on charity care in nonprofit hospitals have examined regulatory compliance, tax benefits, financial eligibility criteria, and governance accountability. Research in charity care provision in the United States demonstrates significant variation in institutional commitment and alignment between fiscal incentives and actual

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charity contributions. While these studies provide important insights into structural and regulatory dimensions of nonprofit healthcare, they are largely quantitative and policy-analytic in orientation. Few adopt an in-depth inductive case study approach that integrates clinical practice, organizational values, financing mechanisms, and patient experiences within a single institutional setting [27,28].

Despite the growing body of indexed research on compassion and charity care separately, an important conceptual and empirical gap remains. There is scarce qualitative evidence that inductively explores how compassion can be operationalized through structured charity-based mechanisms as part of a broader public health equity framework. particularly by tertiary hospitals in developing country contexts where national health financing systems face fiscal and structural limitations. Addressing this concern may be relevant for advancing the discourse on how humanitarian values can be translated into sustainable governance models that strengthen equity and access in healthcare systems.

Based on this phenomenon, there is a limitation in the public health literature, particularly regarding how charity-based compassionate care in hospitals can be developed as a model to strengthen equity and access to healthcare in developing countries. Most research on compassion still focuses on interpersonal relationships, while studies on charity care emphasize financial aspects and regulatory compliance. The relationship between compassion, charity, and public health goals has not been studied integratively.

Therefore, this study aims to gain an empirical understanding of charity-based compassionate care as a systemic approach that connects the value of compassion with charity practices within a public health framework in Indonesia. The focus of this research is not solely on individual case descriptions or internal organizational dynamics, but rather on how compassion functions as a guiding principle in expanding service access, protecting vulnerable groups, and strengthening equity in health care. To that end, this study is expected to provide contributions to the development of compassion-based health care models that are relevant to the context of developing countries and facilitate the international discourse on equity and access in public health.

2. Materials and Methods

2.1. Study Design

This research uses a qualitative approach with a case study design. This design was chosen because the research aims to explore in depth how the value of compassion is operationalized in charity-based healthcare services as part of efforts to strengthen equity and access to public healthcare services. Case studies allow researchers to understand the interconnected processes between clinical practice, social support, and service policy frameworks in the real-life context of healthcare [15,16]. This approach aligns with recommendations for qualitative research in public health, which emphasizes a contextual and systemic understanding of complex phenomena [13].

This research adopted an embedded case study strategy, where each charity patient is treated as a case unit, while the healthcare institution serves as the systemic context. Reporting of research results follows the principles of the CARE Case Report Guidelines to ensure clarity and consistency of case unit descriptions, and the Consolidated Criteria for Reporting Qualitative Research (COREQ) to maintain the methodological rigor of qualitative research.

2.2. Research Paradigm

This research is grounded in a constructivist paradigm, which views social reality as plural, contextual, and shaped through the experiences and interactions of actors within the healthcare system. In this paradigm, compassion is understood as a social construct interpreted differently by healthcare professionals, management, and patients, and influenced by policies and service structures [15].

Ontologically, reality is viewed as plural and dynamic. Epistemologically, knowledge is generated through intensive interaction between researchers and participants. Axiologically, the

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researcher's values and reflections are recognized as part of the data interpretation process. Methodologically, the research design is flexible and evolves based on field findings and the data triangulation process [16].

2.3. Study Setting and Participants

The research was conducted at a philanthropic hospital in Jakarta that offers a charity service program for underprivileged patients. Tzu Chi Hospital Jakarta was selected as the focal case for this study because it represents a unique example of a tertiary care hospital that integrates advanced medical services with a strong humanitarian mission. In addition, Tzu Chi Hospital Jakarta operates within a distinctive charity-oriented service model that prioritizes patient need and compassionate care, particularly for vulnerable populations who face financial barriers to accessing specialized treatment. This setting was chosen because this particular hospital serves as an alternative service provider for community groups facing limited access to formal healthcare, making it relevant in the context of public health and health equity [21,22].

Research participants were recruited using purposive-criterion sampling, with the criterion of direct involvement in charity patient care. The informants included:

1. medical personnel (doctors) treating charity patients,
2. nurses and supporting healthcare workers,
3. managerial or structural personnel involved in the formulation and implementation of charity service policies.

Four patients were also selected as case units, representing the complexity of service needs and care coordination. The purpose of selecting these case units was to illustrate the variation in compassionate care processes within the context of limited access and resources, not to generalize clinically.

2.4. Data Collection

Data collection was conducted in stages and followed the principles of qualitative research in public health [16]. Data collection techniques included:

2.4.1. In-Depth Interviews

In-depth interviews were conducted face-to-face with key informants using a semi-structured interview guide. Interviews lasted 30–50 minutes and focused on experiences with compassion practices, service coordination processes, social support, and interpretations of charity policies in ensuring access to healthcare. This approach allowed for exploration of the subjective meaning and systemic dynamics of compassion in healthcare [13,15]

2.4.2. Non-Participant Observation

Non-participant observation was conducted in outpatient units, inpatient units, and service areas to observe patterns of professional interaction, communication practices, and manifestations of compassion in daily service processes. This observation aimed to complement interview data and reduce narrative bias [20].

2.4.3. Document Review

Document analysis included charity service policy documents, clinical governance, patient data, and internal coordination reports. Documents were used to understand the systemic framework that supports or limits the implementation of compassion in charity-based healthcare services [24,26].

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2.5. Data Analysis

Data analysis was conducted using inductive content analysis. The analysis process included a thorough reading of the data from specific cases and interview and interpreting represented patterns of compassion practice in charity services. Analysis was conducted within-case for each case unit and followed by cross-case analysis to identify cross-case patterns.

To guide the interpretation, data analysis was guided by the Donabedian Model (Structure–Process–Outcome) and the conceptual framework of compassion in healthcare [15,16]. This framework was used to map the relationships between service structures, compassion-based care processes, and their implications for patient access and experience.

2.6. Study Limitations

This study is limited by the number of case units and the specific institutional context, so the findings are not intended to be statistically generalized. However, the qualitative approach allows for an in-depth understanding of charity-based compassionate care practices, which are relevant as a conceptual model for strengthening equity and access to public health services in Indonesia.

3. Results

This study presents real-world cases for analysis of how integrated compassion directly affects the continuity of care, particularly for medical conditions requiring long-term follow-up or cross-unit service coordination. The approach focused on charity care practices based on compassionate values. This enables continuity of care through regulated treatment schedules, guaranteed access to medications and medical procedures, and consistent communication with patients' families. The case in this study follows the previous findings that structured charity care is more effective in maintaining service continuity than approaches based solely on individual generosity [9,26].

The four cases presented in Table 1 illustrate highly complex clinical situations that require multidisciplinary expertise, advanced medical technologies, and intensive resource utilization. The pediatric head trauma case, congenital mandibular defect, high-risk neonatal case in the NICU, and chronic thalassemia management represent severe medical conditions that demand specialized care pathways involving pediatricians, neurosurgeons, maxillofacial surgeons, anesthesiologists, intensivists, and specialized nursing teams. In pediatric trauma and critical care settings, the management of such patients is inherently complex because care processes involve multiple transitions across units such as the emergency department, operating room, intensive care unit, and inpatient wards, often requiring coordination among numerous medical roles and specialties.

Table 1. Data Charity Base Patient Treatment.

Cases	Patient Profile	Medical Therapy/Interventions
1. Pediatric Head Trauma Case – Acute Inpatient Care	Ans, female patient, born in Jakarta on December 8, 2011, child, treated in the General Pediatric Ward	Conservative therapy for EDH, anticonvulsants (phenytoin IV & PO), gradual analgesics (tramadol, oral morphine), antibiotics (ceftriaxone → cefixime), blood pressure control (amlodipine), anti-inflammatory therapy, nebulization, IV fluids
2. Pediatric Charity Case – Congenital Jaw Defect	AA, male, 5 years and 3 months old, weighing 13.7 kg, measuring 111 cm tall, blood type O Rh(+), pediatric patient	Bilateral mandibular distraction, mandibular distractor insertion and removal, right cheek cyst enucleation, postoperative care in the PICU, serial CT scans, antibiotic therapy, analgesics, intravenous fluids, and nasogastric tube feeding

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3. High-Risk Neonatal Case – NICU	BY, neonatal (born on December 10, 2023), birth weight ±3300 g, NICU weight fluctuating ±3420–4015 g, height 51 cm, blood type O Rh(+), insured by BPJS Kesehatan DKI Jakarta	Mechanical ventilation, sedation and anticonvulsants (diazepam drip, midazolam, levetiracetam), broad-spectrum antibiotics (ampicillin, gentamicin, metronidazole, meropenem, ceftazidime), supportive therapy (packet-packet transfusion, albumin, electrolyte correction), gradual enteral nutrition
4. Pediatric Chronic Disease Case – Thalassemia	LL, female patient, ±10 years old, weighing ±20–26 kg, measuring ±122–124 cm tall, blood type O Rh(+), insured by ADMEDIKA–Allianz / Self-Paid	Planned pack-packet transfusion (target Hb), supportive therapy (NaCl infusion), supplementation (acid folate, vitamins), iron chelation (Ferriprox), symptomatic therapy, serial laboratory monitoring

EDH: epidural hematoma, IV: Intra Venous, PO: Per Oral, Rh: Rhesus, PICU: Pediatric Intensive Care Unit, Hb: Haemoglobin.

Previous studies indicate that pediatric trauma care alone may involve dozens of clinical roles and several care transitions throughout hospitalization, reflecting the highly coordinated and multidisciplinary nature of treatment for critically ill children [29]. Furthermore, severe pediatric trauma and congenital anomalies frequently require advanced interventions such as surgical reconstruction, mechanical ventilation, intensive pharmacotherapy, and continuous monitoring, which substantially increase the complexity of clinical decision-making and the risk profile of treatment

Beyond clinical complexity, these cases also represent a significant financial burden due to the high cost of intensive care, advanced surgical procedures, repeated imaging, and long-term treatment requirements. Pediatric trauma and critical illness have been associated with substantial hospital resource utilization and long inpatient stays, contributing to a large economic burden for both health systems and families [30]. In charity-based hospital settings, such as the case examined in this study, these financial demands create a managerial dilemma between maintaining equitable access to life-saving treatment for vulnerable populations and ensuring the financial sustainability of hospital operations. The inclusion of these four cases, therefore, provides a meaningful representation of how charity-oriented tertiary hospitals navigate highly specialized, high-risk, and resource-intensive treatments for patients who often face limited financial coverage. These cases highlight the operational and ethical challenges faced by hospital management when delivering advanced medical care to disadvantaged populations whose treatment costs may exceed standard reimbursement mechanisms.

Cross-case analysis shows that integrating compassion and charity care enables healthcare providers to overcome structural barriers often faced by low-income patients, such as limited funding, administrative uncertainty, and the risk of care interruptions. In this context, compassion serves as an “enabler” of service access, where clinical decisions, service flows, and financing mechanisms are aligned to ensure that patients continue to receive adequate and dignified care.

The four cases in this study illustrate the management of decision-making in hospitals based on charity-based compassionate care that serves as a strategic mechanism to strengthen equity in public healthcare. There were four cases demonstrates that compassion can be operationalized systemically

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through the integration of humanitarian values, service governance, and social financing mechanisms.

The four cases in Table 2 above can provide an illustration of a complex case, which needs to be handled by a specialist, multiple departments, and requires high costs. These cases then went through cross-case analysis, which shows that integrating compassion and charity care enables healthcare providers to overcome structural barriers often faced by low-income patients, such as limited funding, administrative uncertainty, and the risk of care interruptions. In this context, the explanation in Table 2 shows the outcome and managerial approach by the hospital management.

Table 2. Case Outcome and Managerial Approach.

Cases	Clinical Outcomes	Psychosocial Outcomes	Continuity of Care Outcomes	Multidisciplinary Team Involved	Managerial Interventions	Hospital Policy Framework
Case 1	Consciousness improved, neurological condition was stable, no worsening of EDH occurred, and the patient was fit for discharge.	Decreased family anxiety as the patient recovers, increased family understanding of post-traumatic care	Continuity of care is maintained through discharge medication, blood pressure control, and post-discharge education.	Neurosurgeon, Pediatrician, Inpatient Nurse, Clinical Pharmacist, Nursing Team	Determining non-surgical admissions, rationalizing antibiotics, managing IV to oral medication transitions, and planning discharge medications.	Pediatric head trauma clinical pathway policy, pediatric patient safety standards, guidelines for the use of anticonvulsants
Case 2	Postoperative condition was stable, pain was controlled, mandibular callus formation was good, there were no intracranial complications, and vital	Decreased family anxiety, increased sense of security and trust in hospital services, and parental compliance with the follow-up plan	Continuity of care is ensured through follow-up, nutrition, and referral planning; uninterrupted due to cost constraints.	Oral Surgeon, Pediatrician, Anesthesiologist, Radiologist, PICU Nurse, Nutritionist, Pharmacist, Social Service Team	Early charity case determination, managing non-commercial funding channels, scheduling elective surgeries without financial delays, and coordinating	Patients' service policy for low-income patients, Tzu Chi Humanistic Medicine principles, donation-based financing policy and health

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	signs were stable.				across clinical and administrative units.	philanthropy
Case 3	Gradual hemodynamic stability, decreased seizure frequency, improved respiratory function, and even ventilator weaning, and infection was controlled.	Parents' understanding of the disease and the long healing process, and reduced anxiety through intensive communication with the medical team	Continuity of care is ensured through extended hospitalization, follow-up planning, and transition from IV to oral therapy.	Pediatrician Consultant Neonatologist, Pediatric Surgery, Dermatology, Neurology, Medical Rehabilitation, NICU Nursing, Clinical Pharmacy, Physiotherapy	Scheduling periodic evaluations (ABGs, blood/ETT/urine cultures), ventilator management, coordinating multidisciplinary consultations, and controlling NICU infections.	Neonatal intensive care policy, NICU patient safety, neonatal tetanus clinical pathway, JKN-BPJS policy for critical cases
Case 4	Hb levels increased post-transfusion, hemodynamic condition was stable, and there were no acute complications during hospitalization.	Family psychological adaptation to chronic illness, increased understanding and acceptance of the child's condition	Continuity of care is maintained through regular check-ups, long-term therapy, and follow-up evaluation plans.	Pediatrician Consultant Hematologist, Inpatient & Outpatient Nurses, Pharmacist, Laboratory, Transfusion Team	Scheduling transfusion admissions, managing chronic medications, coordinating insurance/self-payment financing, and longitudinal patient documentation.	Pediatric chronic disease management policy, blood transfusion guidelines, patient safety transfusion protocol

EDH: epidural hematoma, IV: Intra Venous, PO: Per Oral, Rh: Rhesus, PICU: Pediatric Intensive Care Unit, NICU: Neonatal Intensive Care Unit, Hb: Hemoglobin, ABG: Arterial Blood Gas.

Table 2 demonstrates that the management of these four cases resulted in clinically meaningful outcomes through coordinated multidisciplinary care and adaptive hospital management strategies. In the pediatric head trauma case, conservative management combined with neurological monitoring

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and pharmacological therapy allowed stabilization without immediate neurosurgical intervention, illustrating the effectiveness of careful clinical observation and staged treatment in selected traumatic brain injury cases. The congenital mandibular defect case was successfully addressed through staged reconstructive procedures and intensive postoperative monitoring in the PICU, highlighting the importance of specialized surgical expertise and advanced perioperative care for complex craniofacial anomalies. In the high-risk neonatal case, comprehensive NICU management, including mechanical ventilation, intensive pharmacotherapy, and nutritional support, enabled physiological stabilization and gradual recovery, reflecting the critical role of technologically advanced neonatal intensive care in improving survival outcomes for critically ill newborns.

Meanwhile, the case of chronic thalassemia demonstrates the importance of long-term disease management strategies, including regular transfusion programs, iron chelation therapy, and continuous laboratory monitoring to prevent complications and maintain functional health status. Taken together, these outcomes suggest that charity-based tertiary hospitals can successfully manage highly complex and resource-intensive cases when supported by multidisciplinary clinical teams, structured care pathways, and adaptive resource management. Such experiences provide transferable insights for other hospitals seeking to balance equitable access to specialized care with organizational sustainability in resource-constrained healthcare systems.

The findings from the cases indicate that the successful management of a complex charity is more than clinical expertise and relates to the targeted managerial interventions designed to ensure coordination, financial feasibility, and continuity of care. This hospital's decision-making is implemented by several managerial mechanisms, including multidisciplinary case work and coordinated referral management. Further, flexible financial assistance schemes for patients with limited insurance coverage. These interventions enabled clinicians to deliver advanced treatments, such as intensive neonatal care, complex craniofacial surgery, and long-term chronic disease management while maintaining operational efficiency and patient safety. Prior research suggests that complex clinical cases, particularly in tertiary hospitals, require integrated management structures that support interdisciplinary collaboration, rapid decision-making, and coordinated care pathways across hospital units [31]. In this context, managerial facilitation functions as an enabling mechanism that allows specialized medical teams to operate effectively despite high clinical uncertainty and resource intensity.

From a policy perspective, the hospital's charity-based service model reflects an institutional framework that integrates social mission with healthcare governance. The policy approach adopted by the hospital includes structured eligibility assessment for charity patients, cross-subsidization mechanisms, and collaboration with philanthropic donors to support high-cost medical interventions that may not be fully reimbursed by national health insurance schemes. Such policy frameworks are increasingly recognized as important instruments for improving healthcare equity, particularly in settings where vulnerable populations face financial barriers to accessing specialized treatment [32,33].

By institutionalizing charity care within a formal governance structure, the hospital can systematically balance ethical obligations to provide care for disadvantaged patients with the financial sustainability of hospital operations. These findings suggest that tertiary hospitals operating in resource-constrained health systems may benefit from developing hybrid policy models that combine clinical excellence, managerial coordination, and socially oriented financing mechanisms to ensure access to high-quality care for complex and underserved patient populations.

The complex cases presented in Table 2 demonstrate that the provision of care in a charity-based tertiary hospital extends beyond purely clinical decision-making and involves broader organizational, ethical, and managerial considerations. To better understand the underlying institutional logic, a qualitative inquiry was conducted through targeted interviews with key informants directly involved in clinical leadership, hospital management, and frontline medical care. This qualitative phase was designed to capture the perspectives that shape decision-making

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regarding charity care in situations where clinical uncertainty, high treatment costs, and operational pressures intersect.

The interview protocol in the qualitative phase was intentionally structured around three core questions representing three complementary organizational perspectives: strategic leadership, institutional governance, and clinical practice. Accordingly, three key informants were selected based on their roles and direct involvement in the management and delivery of the reported cases: the Chief of Medical Services, a member of senior hospital management, and an attending physician responsible for patient treatment. In qualitative case-based research, purposive selection of knowledgeable informants is widely accepted as a valid approach for obtaining rich, context-specific insights from individuals who possess direct experiential knowledge of the phenomenon under study [34].

The use of three focused questions was intended to maintain analytic depth while ensuring conceptual clarity across these organizational levels. The responses presented in this section represent the most salient content emerging from the interviews and were considered sufficient to capture the essential institutional rationale. This response underpins charity-based care within the hospital context. Although the interviews generated a broader range of qualitative insights, only three key responses are presented below as they represent the most salient and conceptually relevant information. The remaining interview materials were documented and retained as part of the study's qualitative records, but are not elaborated here to maintain clarity and analytical focus in reporting the findings.

Question 1 (Chief of Medical)

How does the hospital justify and sustain its decision to provide care for patients with highly complex conditions, even when the clinical outcome is uncertain, and the financial return is not guaranteed?

Answer:

"As a humanitarian hospital, our primary consideration is not financial outcome, but patient need. When a patient comes with a serious condition, our responsibility is to provide the best possible care, regardless of their financial situation or the certainty of clinical outcome. We understand that not every case will have a predictable result, but the value of healthcare is not measured solely by outcome, but by our commitment to care for human life with dignity. Therefore, the hospital provides structural support through charity programs and social funding mechanisms to ensure that care can continue."

Question 2 (Senior Management)

What organizational values or ethical principles motivate the hospital to continue supporting such patients despite operational and financial challenges?

Answer

"Compassion is not just an individual attitude here; it is an institutional value. Our mission is grounded in humanistic medicine, which means we treat patients based on their medical needs, not their financial capacity. The hospital leadership here ensures that systems, policies, and resources align with this mission. Even when cases are complex and require significant resources, we believe that providing care is part of our ethical responsibility as a healthcare institution. This is embedded in our culture, and it guides decision-making at every level. We do not see charity care as a burden, but as part of our mission. Healthcare should not be limited only to those who can afford it. Our role is to reduce suffering where possible, even in situations where outcomes are uncertain."

Question 2 (Physicians who Handle The Case)

What motivates you as the attending physician to devote time and effort to treating charity patients despite the absence of additional financial compensation?

Answer

"As physicians, our primary responsibility is to care for patients, not to prioritize financial compensation. When I see a patient in need, especially those with limited access to healthcare, I feel a professional and moral obligation to help. The hospital's culture also reinforces this perspective, emphasizing compassion and service.

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Even without additional compensation, seeing the patient's condition improve and knowing that we are able to help them gives a strong sense of professional fulfillment. It reminds us of the true purpose of being a doctor."

The interview findings also reinforce that compassion is positioned as an organizational value, not merely an individual attitude of healthcare workers. Management emphasizes that empathy, humane communication, and equal treatment of patients are part of a systematically instilled work culture. This is consistent with studies showing that institutionalized compassion can increase patient trust, reduce family anxiety, and strengthen the continuity of healthcare relationships, particularly for vulnerable groups and patients with complex conditions [4,13,16,20].

Furthermore, the interview results confirm the principle of equal service standards between charity and non-charity patients. Management emphasized that there is no differentiation in the quality of medical services, patient safety, or continuity of care. The only difference lies in the financing support mechanism. These findings strengthen the argument that institutionalized charity-based healthcare can align with medical professionalism and equitable governance, as discussed in studies of nonprofit hospitals and charity care in various country contexts [9,27,28,35].

In the Indonesian context, the integration of these case findings and interviews broadens the understanding that charity-based compassionate care can be a relevant alternative model for strengthening the public healthcare system, particularly in addressing funding constraints and unequal access. This model supports a shift from a charitable approach to a social justice approach in healthcare, as demonstrated by the literature on health philanthropy, humanitarian values, and community preference for charity-based healthcare providers [18,29,34]. Thus, the results of this study contribute to the development of a conceptual framework for healthcare oriented toward equity, compassion, and sustainability of the public healthcare system.

4. Discussion

Based on a synthesis of empirical findings and management interviews, this study confirms that the charity-based compassionate care model is consciously implemented as an institutional strategy to ensure equity and access to healthcare services, rather than as an incidental practice. Interviews indicate that charity-based care is understood as a moral and social mandate of healthcare institutions, where clinical decisions must be fully driven by the patient's medical needs, while financial aspects are handled through structured social mechanisms. This perspective aligns with the literature that positions charity care as an instrument of social justice within the public healthcare system, rather than simply an additional philanthropic activity [6,8,10,36]. These findings align with international literature highlighting the role of nonprofit and philanthropic hospitals in closing access gaps that are not fully addressed by national health insurance systems [6,10,36].

The results of this study indicate that compassion contributes to increased service equity by reducing the gap between patients covered by formal financing systems and those outside the full scope of health insurance. The charity-based compassionate care model identified in this study demonstrates that humanitarian-based services can complement national health insurance systems, particularly in addressing high-cost cases and social groups experiencing structural exclusion. These findings are consistent with studies demonstrating that charity care systems play a crucial role in ensuring equitable access, particularly in developing countries with limited state fiscal capacity [21,22,37].

This study found that the integration of compassion impacted patient and family experiences, particularly in terms of safety, trust in the service system, and adherence to the care process. Compassion, manifested through empathetic communication, openness of information, and recognition of patient dignity, contributed to reduced anxiety and increased family involvement in the care process. This supports the finding that compassion is a key component of quality healthcare and has direct implications for non-clinical outcomes relevant to public health [13,16,20].

The research findings also indicate that sustainable compassionate practice requires consistent policy support and an organizational framework. Social justice-oriented charity care cannot rely solely on the motivations of individual healthcare workers but requires a system that explicitly

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recognizes compassion as part of the healthcare mission. These findings reinforce the argument that an organization's mission and value orientation significantly influence the level and quality of charitable services provided [34,38,39]. In this context, compassion serves as a guiding principle that aligns social goals with daily healthcare practices.

Regarding the spiritual and moral dimension, the research findings indicate that compassion is also interpreted as a form of ethical responsibility for human life and dignity, particularly for patients with serious medical conditions. This dimension strengthens the legitimacy of charity care practices as part of holistic healthcare that focuses not only on biological healing but also on meeting the emotional and spiritual needs of patients. These findings align with literature emphasizing the link between compassion, spiritual care, and the quality of patient experiences in healthcare [14,18,19].

The findings of this study reinforce international literature, which asserts that charity care cannot be understood solely as a financing mechanism, but as an expression of institutional values and social justice-oriented healthcare governance. Several studies have shown that charity care practices in nonprofit hospitals often align with the social mandates and fiscal incentives received by these institutions [10,27,36]. In this context, the research findings point to an alternative model, namely charity-based compassionate care, in which charitable services are positioned as an integral part of clinical practice and the service system, rather than simply an administrative obligation or financial reporting requirement.

Conceptually, the findings indicate that integrating charity care with clinical practice based on medical needs is a key prerequisite for achieving equity in healthcare. The literature confirms that inequities in access often arise when charity care is separated from the primary care system and treated only as an add-on program [5,6,37]. The case identified in this study demonstrates that when charity care is systemically integrated, service quality can be maintained while expanding access for vulnerable groups, consistent with findings from studies in developing countries regarding community preference for charity-based healthcare providers [21].

From a compassion perspective, this study reinforces the view that compassion in healthcare is not simply an individual emotional response, but rather a social and organizational practice that can be institutionalized. Qualitative and conceptual literature define compassion as a combination of empathy, emotional presence, and concrete actions to alleviate patient suffering [3,13,15,16]. The findings of this study are consistent with this view, while also extending it by demonstrating that compassion can serve as a connecting mechanism between clinical decisions, continuity of care, and equity of access.

The interview results demonstrate that compassion is understood as a capacity shaped by organizational values, norms, and practices, rather than solely a personal characteristic of healthcare workers. These findings align with neuropsychological and medical education evidence demonstrating that compassion can be developed, trained, and impact prosocial behavior and clinical decision-making [2,4,14]. Thus, charity-based compassionate care relies not on individual goodwill, but on systems that enable consistent compassionate practice.

Within the framework of public health policy, the findings of this study provide an important contribution to the discourse on the role of nonprofit healthcare institutions in expanding access to services. Previous studies have shown that the distribution of charity care is often uneven and has the potential to reproduce inequality if not integrated with a social justice framework [11,28,37]. The model identified in this study suggests that charity care can serve as a corrective instrument to address the limitations of the public financing system, as long as it is supported by a consistent social mission orientation and governance [8,35,39].

In the Indonesian context, these findings are relevant to the history and development of philanthropic and religious-based healthcare services, which play a role in reaching poor and marginalized groups [22]. In line with social and waqf-based healthcare models in Southeast Asia [23], charity-based compassionate care can be positioned as a strategic complement to the public health system, not as a substitute for the state, but as a partner in realizing more equitable and humane access.

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Overall, this study contributes to the development of a conceptual framework for value-based healthcare by positioning compassion as a structural element in healthcare governance. The integration of charity care, compassion, and needs-based clinical practice demonstrates that equitable healthcare depends not only on financing but also on the institution's values, culture, and mission orientation. This model offers policy implications for strengthening equity and access to public health services in Indonesia, particularly in addressing the needs of vulnerable groups amidst limitations in the formal financing system.

This case study can also be further interpreted through the lens of human dignity and humanistic medicine. Drawing on the philosophy of Bernard Lown, humanistic medicine positions patients as moral subjects whose dignity must be preserved regardless of prognosis, socioeconomic status, or financial capacity. Within this framework, the value of healthcare is not determined solely by measurable clinical outcomes, but by the ethical integrity of the caregiving process itself. The hospital's commitment to treating patients based on medical need rather than financial predictability reflects this dignity-centered orientation. Charity-based care, therefore, becomes not merely a financial assistance mechanism but a manifestation of respect for intrinsic human worth.

At the organizational level, these dignity-based values are operationalized through ethical leadership. Ethical Leadership Theory suggests that leaders shape ethical climates by modeling morally appropriate conduct and embedding ethical principles into governance structures and decision-making processes. In this case, hospital leadership institutionalized compassion through structured charity programs, social funding mechanisms, and non-discriminatory service standards. Such actions demonstrate that compassion is not dependent solely on individual virtue but is sustained by policy alignment, resource allocation, and organizational culture. This integration of humanistic medical values with ethical governance enables compassion to function as a systemic mechanism for advancing health equity.

By linking human dignity with ethical leadership, this study extends existing discussions on charity care beyond administrative compliance or fiscal analysis. It illustrates how nonprofit hospital governance can translate moral commitments into operational systems that protect vulnerable populations. In doing so, compassion becomes both a moral imperative and a managerial strategy, reinforcing equity as an institutional outcome rather than an incidental effect of individual goodwill.

In the context of persistent health inequities and structural limitations in healthcare financing, the issue of compassion-based charity care is both urgent and highly relevant. Strengthening equity requires not only expanded coverage, but also dignity-centered governance and ethical institutional leadership. Developing sustainable models that integrate humanitarian values with organizational systems is, therefore, a timely priority for health systems, particularly in resource-constrained settings.

5. Conclusions

The results of this study indicate that charity-based compassionate care practices in tertiary hospitals operate not solely as a clinical response to patient needs but rather as a systemic mechanism to expand access to healthcare and reduce service inequalities for vulnerable groups. Compassion, in this context, serves as a normative principle that bridges limited public funding with complex clinical needs, thus ensuring continuity of care without discrimination based on economic status. These findings reinforce the view that compassion is not only interpersonal but also serves as a foundation for social justice-based healthcare policy and governance [15,16].

This study demonstrates that the integration of medical services and social care through a charity-based compassionate care model at Tzu Chi Hospital Jakarta extends beyond clinical treatment to encompass a holistic, humanitarian approach to healthcare delivery. Care for charity-based patients is provided through the combination of professional medical services, empathetic communication, social assistance, and moral as well as spiritual values embedded in institutional practices. This integrated approach enhances patient safety, trust in healthcare providers, and adherence to treatment, particularly among vulnerable populations.

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The findings revealed insight that compassion-based care is not merely an individual attitude of healthcare workers but an organizational value that shapes service delivery, clinical decision-making, and interactions with patients. By integrating medical and social dimensions of care, the hospital is able to promote equity and improve access to healthcare services without discrimination. This case study illustrates how charity-based healthcare can function as a supportive mechanism within the public health system to address gaps in access for disadvantaged groups. The study findings broaden understanding of the role of charity care beyond mere social assistance to become a relevant public health policy instrument for developing countries like Indonesia.

Several limitations should also be acknowledged. First, this case study was conducted in a single hospital setting, which limits the generalizability of the findings to other healthcare institutions with different organizational cultures or governance structures. Second, the number of informants was relatively limited and focused on experiences within the charity patient program, which may not capture the perspectives of all stakeholders involved in healthcare delivery. Third, as a qualitative study, the findings rely on informant narratives and researcher interpretation, which may introduce subjectivity despite efforts to ensure credibility and rigor.

Future research is recommended to involve multiple hospitals with diverse institutional characteristics to provide a broader understanding of compassion-based and charity-oriented healthcare models. The use of mixed methods approaches could further strengthen the evidence by integrating qualitative insights with quantitative outcome measures. Additionally, future studies should examine the long-term effects of compassion-based care on patient quality of life, health equity, and the sustainability of healthcare systems.

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Data Availability Statement: We encourage all authors of articles published in MDPI journals to share their research data. In this section, please provide details regarding where data supporting reported results can be found, including links to publicly archived datasets analyzed or generated during the study. Where no new data were created, or where data is unavailable due to privacy or ethical restrictions, a statement is still required. Suggested Data Availability Statements are available in the section "MDPI Research Data Policies" at https://www.mdpi.com/ethics.

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