62

PN-AAW-752

IAN-49340

936 5927

DEVELOPMENT OF HEALTH SECTOR FINANCING PROJECT

INDONESIA

A Report Prepared by PRITECH Consultant:
SUSAN ABRAMSON

During The Period:
OCTOBER 25 - NOVEMBER 16, 1986

TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT
Supported By The:
U.S. Agency for International Development
AID/DPE-5927-C-00-3083-00

AUTHORIZATION:
AID/S&T/HEA: 2/26/87
ASSGN. NO: SS 168

TABLE OF CONTENTS

		Page
I.	INTRODUCTION	1
	A. Scope of Work	1
	B. Methodology	1
II.	STATUS OF HEALTH INSURANCE	2
	A. Background	2
	B. Current Health Insurance Program	2
	C. Stimulus for Health Insurance	4
	D. Pertamina Oil Company	4
III.	GENEVA WORLD HEALTH ORGANIZATION	5
IV.	RECOMMENDATIONS FOR THE PRIVATE SECTOR HEALTH PROJECT	6
V.	PROPOSED CHANGES TO THE HEALTH SECTOR FINANCING PROJECT	10
APPENDIX:	List of Persons Contacted	13

I. INTRODUCTION

A. Scope of Work

On October 24, 1986, the consultant traveled to Indonesia to work with the USAID Mission for a period of 19 days on the development of a health sector financing project. On November 14, the consultant traveled to Geneva to work with WHO staff to revise the proposal for the WHO Recurrent Cost Study and returned to Washington, D.C. on November 16, 1986.

B. Methodology

The first twelve days in Jakarta were spent learning about the health sector, public and private, in Indonesia. Dr. Tom D'Agnes, Advisor to HPN at the USAID Mission, arranged daily meetings with an array of personnel from the MOH, BAPPENAS, the School of Public Health in Jakarta, ASKES, PKTK, etc. (A list of persons contacted is found in the Appendix.)

The objectives of these meetings were threefold: 1) to learn about the political and programmatic agendas of the various agencies involved in the health sector, specifically in areas of financing; 2) to develop ongoing relationships with those persons whom USAID has identified as key players in national health financing issues; and 3) to identify those health financing issues which are appropriate for USAID involvement vis-a-vis the proposed health sector financing project.

In addition, participation in a REACH study, commissioned by USAID, assessed the feasibility of creating an HMO delivery scheme at PERTAMINA, the national oil company. This study is part of an ongoing effort by USAID to work with the private sector as both provider and payer of health care in Indonesia. USAID rationale for engaging the private sector to provide and insure curative health care is based on the idea that public resources previously devoted to curative care could be freed up for preventive and promotive health care and for subsidizing curative care for those unable to pay. In addition, a private sector model for managed health care might serve as a prototype for improving the efficiency with which services are delivered in the public and private sectors.

The final week was devoted to working with USAID Mission and REACH staff to develop the framework for the health sector financing project This entailed a review and synthesis of five major consultant reports contracted by USAID on specific health financing issues; development of an outline for the PID; and development of a workplan for follow-on activities.

II. STATUS OF HEALTH INSURANCE

A. Background

Due to the drop in oil revenues over the last several years, government ministries have been faced with across-the-board cuts in their respective budgets, amounting to as much as 40% in the health budget. As a result, both the public and private health sectors in Indonesia are searching for ways to reduce and recover costs and improve the efficiency with which health care is delivered to a population numbering close to 170 million.

One of the options being considered by the Ministry of Health (MOH) to make up the anticipated budgetary shortfall is a national health insurance scheme, referred to in the National Health Law as DUKM. The MOH believes that the development of a new government-sponsored health insurance plan or an expansion of the existing one would increase the revenues of the public treasury, which would in turn be made available to the MOH to finance its obligations. Furthermore, the development of a private health insurance sector might alleviate some of the strain on government services by shifting demand to private facilities. In theory, this would allow a reallocation of MOH funds from subsidizing curative care at public facilities to more cost-effective, prevention-oriented services.

B. Current Health Insurance Programs

There are several social insurance/health schemes presently in operation in Indonesia. The primary public health insurance program is Husada Bakti, or ASKES which covers all civil servants and their dependents and retired civil servants. All civil servants are required to join Husada Bakti; two percent of their wage and five percent of the retiree's pension are deducted for the free use of MOH health services. Approximately 12.5 million employees, pensioners and dependents (about 8% of the total population) are covered by this program. Very recently, a decree was issued which changed the Husada Bakti program into a government-owned general company called a perum and it is now under the joint supervision of the MOH and the Ministry of Manpower Development (MOMD). This was done in anticipation of the Husada Bakti expanding to cover the private sector. Under this proposed plan, all private employees with a minimum number of employees would have to enroll their employees with this organization in return for free use of government health facilities. A voluntary version of this plan, called PKTK is presently being pilot-tested in Jakarta with the hope of refining it into a national model. A concept paper, written by the Special Advisor to the Minister, contains the specific directives for this program, and will be submitted to the President, along with a request to draft national health insurance legislation.

This plan has created a great deal of commotion in both the public and the private health sectors. In the public domain, the Ministry of Manpower Development (MOMD), which operates a large social insurance program (ASTEK, see below), is very interested in the future of the plan because of the implications for revenue collection and possible competition with its existing program. The MOH is interested because of the potential to increase its resources and increase the demand for its presently underutilized services. The Ministry of Finance and BAPPENAS are leery of the plan due to the fiscal and social policy implications of earmarking tax revenues for health which would unilaterally increase MOH fiscal allocation. The private sector is very concerned about this new plan. Most private companies and parastatals in Indonesia already provide extensive health care to their employees. A required employer contribution to the government fund and the concommitant agreement by the employee to use public facilities rather than the existing private arrangements would both anger the employees by reducing the perceived quality of their benefit package and put the private health sector out of business.

The other major system of social insurance for government workers is ASTEK, sponsored by the Ministry of Manpower Development. It covers about 2 million persons with a range of benefits including disability, workmen's compensation, retirement and death benefits, but does not include major health insurance. ASTEK has developed its own clinics on a pilot basis, but most companies participating in ASTEK have made their own arrangements for health care of their employees and their families.

A third arrangement for the social financing of health care is the Dana Sehat, small village-based health care purchasing cooperatives. The cooperative collects a small amount of money or in-kind contributions each month from each family in the community and holds it for the group. The money may be used to purchase medications, finance a water system, or purchase investment, with the proceeds going to health-related activities. The Dana Sehat differ in success and effectiveness from one community to the next and depend on the strength of the leadership. There is some discussion between USAID and the MOH on linking the Dana Sehat to the proposed scheme of national health insurance, however, these ideas are only in an exploratory phase. Other proposed social financing arrangements for the poor include prepayment schemes for seasonal workers which would ensure access to health care year round; setting up facility-based services and concommitant insurance schemes on plantations and cooperatives for the surrounding populations; and encouraging large corporations to expand their existing network of health services to surrounding indigent populations, especially in remote areas. Mobile Oil Company presently does this at their more remote drilling sites through cross subsidization with their services for regular employees.

C. Stimulus for Health Insurance

A major factor stimulating the interest in health insurance is a recent change in the tax laws for businesses and corporations in Indonesia. Previously, companies allowed their employees to seek medical care wherever they wanted and would either pay the bills or reimburse the employee, which was then deductible as a business expense. With this change in the tax laws, all medical expenses would have to come out of a company's profits. However, the purchase of health insurance for employees would still be considered a normal cost of doing business and thus, would be tax deductible.

A final factor in the consideration of health insurance is the escalation of health care prices, costs and expenditures over the last several years. By law, all employers must provide health care for their employees and their dependents. Most private employers and parastatals provide care either through their own facilities or they contract out. As the cost of health care continues to rise, employers are spending a higher and higher ratio of profits to wages which increases the cost of labor. Health insurance is seen as one way of limiting the employers risk via payment ceilings on the amount of care reimbursable.

D. PERTAMINA OIL Company

PERTAMINA is the largest industrial enterprise in Indonesia and is considered to have the best medical facilities in the country. It spends an exorbitant amount of money on the health care of its 250,000 employees, their dependents and some 15,000 retirees and employs a large medical staff to do so. Faced with rising medical costs, the drop in oil revenues and the new business tax law, PERTAMINA is considering the privatization of employee health benefits through Tugu Mandiri, a life and health insurance subsidiary of PERTAMINA. USAID/Jakarta requested the REACH project to provide technical assistance to Tugu Mandiri to determine the financial, administrative and political feasibility of developing a prepayment scheme for PERTAMINA employees, their dependents and other potential employer groups. MOH personnel are very interested in the development of an HMO system as a model for improving their own internal efficiencies and as an exemplar for the emergence of alternative health delivery schemes as options to the public sector.

III. GENEVA/WORLD HEALTH ORGANIZATION

In September, 1986, a $250,000 grant was made to the WHO to examine the recurrent cost issues in the health sector of three developing countries over a two year period. A study proposal had been submitted to AID/W and reviewed, however, several important issues were left unresolved. The consultant met with Dr. Andrew Creese, Sr. Economist with WHO and Project Manager of the Recurrent Cost Study, to resolve the outstanding issues and refine the proposed study protocol, methodology and agree on the countries of study.

Over the course of two full days of meetings we were able to achieve these objectives and present them to the WHO Steering Committee for final agreement. The study protocol has been refined, countries have been contacted, and teams of national counterparts have been identified. This study promises to fill an important gap in the current state of knowledge about public sector and donor inefficiencies in financing the health sector and the ramifications on service delivery.

IV. RECOMMENDATIONS FOR THE PRIVATE SECTOR HEALTH PROJECT

A. The first recommendations regarding the structure for the health sector financing project concern the title of the project, which should reflect the broader concept of health care financing. Since the project addresses the public and private financing of health services, something like the Health Financing Project would perhaps be more appropriate.

B. The overall goal of USAID involvement in the health sector is to reduce infant, child and maternal morbidity and mortality in Indonesia, particularly among the poor. The purpose of this project is to initiate the process of redirecting scarce public resources away from the financing and delivery of curative health care and towards preventive, promotive public health programs. Concommitant to this diversion of government resources is the necessary engagement of private resources in financing and delivering health care to those who can afford to pay.

C. The project strategy must emanate from a conceptual paradigm which enables this shift of public and private resources to occur. This type of conceptual framework should address the following sectoral objectives:

1. Reduce the government burden of financing and provide curative health services to those who can afford to pay;

2. Reduce government support of the delivery of inefficient hospital services and introduce management incentives which promote cost containment behaviors;

3. Establish policy dialogue and an operational mechanism for shifting resources previously allocated for curative care into preventive, promotive health programs over the long term;

4. Facilitate risk sharing for health care through insurance schemes for the rural poor through subsidy or capital formation;

5. Establish incentives for parastatal and private organizations to create more cost efficient risk sharing arrangements for financing health care;

6. Ensure the viability and expansion of ASKES;

7. Develop an appropriate framework and operating structure for DUKM.

D. The following components would begin to address these objectives inherent in the diversion strategy:

1. Development of a Health Economics Development Institute as a semi-autonomous structure under the budgetary authority of BAPPENAS. The Institute would establish the agenda for health development/economics research in Indonesia, coordinate national and donor studies and analyze policy alternatives. The Institute would serve as an analytical arm supporting the Health Financing Steering Committee (or Health Insurance Board, see below), and establishing the policy, analytical framework and database for policy changes and legislative mandates.

2. Establish the Health Financing Committee/Health Insurance Board as the decision-making body on health financing policy or perhaps limited to health insurance. This board would be interministerial, consisting of representatives from the MOH, MOF, MOMD, MOI, MOHA, BAPPENAS, MOA, etc. The Board would set policy, develop regulations and standards for health insurance and rule on all matters of public health finance.

3. Upon completion of the health sector budgetary review, the Institute would analyze the policy implications and set the tone for improving the efficiency with which public hospitals are managed, services delivered, revenues collected and utilized. A variety of pilot projects could be supported under this component, such as that proposed by Carl Stevens, whereby hospitals are able to retain fee revenues and use them for improving service delivery and management; focusing the locus of accountability within the public sector hospitals at various levels; institute management incentive which alter physician and patient behavior regarding the supply and demand for drugs; and establish a joint venture hospital whereby the government shuts down a public hospital with low occupancy rates and inefficient operations and subsidizes a nearby private/mission hospital which operates with a relatively high occupancy rate and provides quality care.

4. Support for the development of pooled risk financing schemes for health care in rural areas through the MOH. This would include technical assistance and/or capital for:

   - Linking successful Dana Sehat as a federation to the delivery of puskesmas services;

- Pooling risk for health care through existing cooperatives, i.e., the KUD's farmer cooperatives, under the aegis of the Ministry of the Interior;

- Providing incentives (perhaps through taxation or legislative mandate) for parastatals and international joint ventures in isolated rural areas to extend health services to the indigent populations (cross-subsidizing the services with fee revenue from their employees, for example). MOBIL OIL Co. operates two high quality clinics for the indigent populations living near their drilling sites; their incentive is "good will;"

- Pooled risk/social financing arrangements for health care on plantations, especially when there is excess capacity in service structure due to the seasonality of labor;

- Working with the MOH to recognize, license and regulate through standards, the informal sector of paramedics who now provide a substantial portion of the health care for the rural populations at significant cost.

5. Private sector resources should be engaged to finance and deliver health care. This includes the creation and piloting of various risk-sharing schemes to manage, finance and deliver private health care in primary, secondary and tertiary settings. Incentives for private sector involvement should be incorporated into the policy framework for the diversion strategy.

E. Some comments about the proposed components:

1. Tackling the pharmaceutical sector directly is potentially troublesome. There are too many invested interests from the top on down. It would be advised to establish incentives in medical establishments to change prescription practices by doctors and pharmacists and demand behavior through education, and IEC campaigns to change consumer behavior.

2. A focus on financing issues would be preferable as opposed to looking at private sector involvement in the development, production, distribution and delivery of health technologies. This could be part of another effort.

3. Equity objectives and efficiency objectives are directly counter to each other. Ultimately, a compromise between the two should arise.

F. Finally, the outcome of this project should be the development of an institutional capacity to manage public/private financing of health care through various risk sharing arrangements; the development of continued policy dialogue and policy development on improving the ways in which health care is financed and delivered in Indonesia; and the establishment of a variety of research and demonstration projects, based on existing initiatives, which pilot concepts of pooling risk for financing and delivering health care. This embraces issues of efficiency, equity, community organization, resource allocation and institutional viability.

V. PROPOSED CHANGES TO THE HEALTH SECTOR FINANCING PROJECT

The following comments emanate from discussions with several of the REACH consultants regarding the feasibility of project initiatives. They should be viewed as supplementary to the original outline which was left on November 14th, 1986.

A. In the first year of the project, the USAID mission might consider co-sponsoring a conference or a series of workshops with the MOH on a range of social financing issues, including national health insurance, social security-type arrangements, etc. for various key Ministries/Agencies within the government. The workshops would be led by high level persons with expertise in the design and implementation of health financing/management schemes from around the world. The objectives of these workshops would be threefold: to facilitate a formal dialogue between the MOH, MOF, BAPPENAS, MOM, MOI, etc. on national health insurance and its relationship to the broader issues of fiscal policy; to explore a wide range of policy options for social financing schemes, enabling legislation, cost recovery schemes, etc.; and to ensure that AID's interests in securing additional resources for child survival programs and for the rural underserved populations are factored into the policy discussions on resource allocation within the MOH budget. An integral component of these workshops would be the opportunity to examine policy options based on the results of the Health Sector Budgetary Review now underway.

   Rather than providing casual technical assistance to the MOH on the design of such important social and fiscal policies as that embraced by the DUKM legislation, USAID might want to assume the role of facilitator. That is, expediting a discussion of health financing issues at the appropriate levels. The project might support high level experts from US agencies such as the Social Security Administration, HCFA, the National Association of Insurance Commissioners, etc. upon MOH request, to assist in both the policy dialogue and the design of appropriate social financing schemes for health care.

B. Another important link between policy and implementation is the legal framework for health insurance. I know of two pieces of legislation which affect health care delivery and its financing: the first is that all employers, over a certain size, must provide health care benefits to their employees and pregnant spouses; the second and more recent, states that the direct expenses of employer sponsored health plans are no longer deductible as a business expense. However, there exists substantial enabling legislation on the social responsibility of private employers regarding the provision of health care. It would be in USAID's best

interest to ensure that all such legal mandates are known and understood, prior to engaging in policy dialogue with the MOH and other parties. USAID may want to provide some assistance to developing minimum standards of health care for the private sector, particularly for the smaller employers.

C. I am still convinced of the need and desirability of supporting a National Health Economics Development Institute to coordinate health economics/financing studies, collect data and analyze it, and provide regular analytical support to MOH, BAPPENAS, MOF, and the potential health insurance commission. The AID-supported Korean Health Development Institute could serve as a model for developing such an institution. The proposed health insurance commission would have to be born as a product of the interministerial level discussions suggested above.

D. USAID should not provide TA to the MOH to develop the DUKM pilot project as a model for national health insurance. As a pilot project it has not lived up to the expectations of its authors, claiming an estimated 10,000 beneficiaries instead of the projected 2 million. It has been beset by significant managerial and administrative problems, and most importantly, it is not supported by the MOF or BAPPENAS. This may be, in part, due to the policy implications of setting up an earmarked tax specifically for private employee health benefits. On the other hand, USAID support to strengthen ASKES would be appropriate. ASKES is an existing program which finances the health care of 12-13 million civil servants and is facing severe financial and managerial barriers to effective and efficient operation. ASKES must begin to address such issues as its inefficient claims and reporting procedures; the high utilization rates its has created among its beneficiaries; the widening gap between the subsidy it receives from ASTEK and the cost of service delivery to its beneficiaries; etc. Hunter recommends several potential avenues for ASKES support in his paper, such as supporting the effort currently underway by the University of Indonesia Computer Center project to develop a management information system; exploring capitation schemes at the puskesmas level; and exploring private sector arrangements for ASKES beneficiaries. I would recommend that the TA provided by USAID be from institutions either in the US or abroad, which have evolved similar systems.

E. Another important component of the project might include a Fund for the Testing and Development of social financing schemes. This fund would provide a combination of loans and grants to community groups, such as the Dana Sehat, plantation owners, cooperatives, and private entrepreneurs that wanted to establish health financing schemes. USAID

would have to take an active role in soliciting proposals; providing TA to ensure feasibility and viability of the schemes; and collecting data to evaluate the schemes for their applicability to other groups. Several important factors must be addressed in all schemes; financing schemes are tied to some standard of acceptable quality of care; equitable arrangements which acknowledge the varying levels of purchasing power within a community/group; and a plan for the subsidized financing of preventive care, particularly MCH care, ORT and EPI programs.

F. TA to the hospital sector should be included in this project. Pilot projects could be developed which test out prepayment schemes, capitation plans, prospective budgeting and managerial autonomy, particularly as it applies to the use of generated fee revenue and management of the professional staff. Small research projects might be incorporated into this component which address the causes for differential bed utilization rates among the Class B, C and D hospitals; average hospital cost of catastrophic illness; existing insurance coverage for various types of hospital care, etc. Carl Stevens is the most knowledgeable about what this component should include.

APPENDIX: List of Persons Contacted

Mr. Emmanuel Voulgaropoulos, USAID, Chief of HPN, Jakarta

Dr. Tom D'Agnes, USAID, Advisor for Health Sector Financing Project

Mr. David Denman, USAID, HPN

Ms. Joy Riggs-Perla, USAID Health Officer

Dr. I.G.M. Brataranuh, Chief Executive of ASKES (Civil Servants and Pensioners Health Maintenance Fund -- Perum Hasada Bakti)

Dr. Sulastomo, Medical Director, ASKES

Dr. Soekirman, Chief of Bureau of Health, BAPPENAS

Dr. Brotowasisto, Chief of Bureau of Planning, MOH (DEPKES)

Dr. Mohammed Isa, Director of Hospitals, MOH (DEPKES)

Dr. Ascobat Gani, Teaching Staff, Faculty of Public Health, University of Indonesia

Dr. Souomi Saki, Researcher, Faculty of Public Health

Dr. Soekaryo, Secretary General, MOH (DEPKES)

Dr. Rizaldi Noor, Special Advisor to the MOH (Head of DUKM effort)

Mr. Rasnim Djafaar, President, PT Tugu Mandiri

Dr. McClure, Chief of Medical Services, MOBIL OIL Company, Indonesia

Dr. Adib, Municipal Health, Jakarta

Dr. Susilo Surachmad, Head of DUKM, Jakarta