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Indonesia:

The Organization and Financing  
of Health Care Services

USAID/Jakarta  
Summer 1986

Resources for  
Child Health  
Project

REACH



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**INDONESIA:**  
**The Organization and Financing of Health Care Services**

Abstracts of Five Consultant Reports  
Sponsored by The Resources for Child Health Project,  
The Enterprise Program and John Snow, Inc.

USAID/Jakarta

Summer 1986

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## FOREWORD

During the past few years, the United States Agency for International Development (USAID) has devoted increased attention to the ways in which the organization of health services delivery in developing countries affects their capacity to finance those health services. In order to explore innovations in health care financing in developing countries, the Office of Health in AID's Bureau of Science and Technology established the Resources for Child Health (REACH) Project. As part of its technical assistance program, REACH has been assisting the USAID Mission in Jakarta, Indonesia, to prepare the foundation for the development of a private sector/health financing project.

This monograph contains abstracts of five consultant reports submitted to USAID/Jakarta during 1986 in fulfillment of assignments from the Mission to explore some aspect of the health services system. Each of them presents descriptive and analytical insights into the way in which health services are organized and financed in Indonesia. Three of the reports were sponsored by the REACH Project. It is our hope that this summary document will provide the Mission and the Government of Indonesia with a reference to the major findings and recommendations made by the five consultant teams to the Mission and to the Ministry of Health

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March, 1987

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## EXECUTIVE SUMMARY

### I. Introduction

This monograph abstracts reports of five technical assistance consultancies performed on behalf of the USAID Mission in Jakarta, Indonesia, between June and September, 1986. Three of these technical assistance activities were carried out and financed by the Resources for Child Health (REACH) Project [AID contract no. DPE-5927-C-00-5068-00]. Because the findings of each consultant report have a direct bearing on the current status and future progress of the Mission's efforts to design a private sector/health care financing project in Indonesia, results have been collected and summarized in a manner conducive to discussion and planning. Each abstract attempts to summarize the authors' findings in a cogent and succinct manner; but we encourage the reader to refer to the individual reports for details.

### II. Background

The background to the development of this series of consultancies began with discussion of a USAID concept paper entitled, "Private Sector Health and Family Planning Project: Mobilization of Private Sector Resources for Health and Family Planning". As originally conceived, the goal of this proposed project was to reduce fertility, and infant, child and maternal mortality by focusing more resources -- largely through private sector channels -- on the promotive and preventive outreach community services which most directly influence child survival. The proposed project made two assumptions:

1. Greater private sector involvement would free-up government funds which now support hospitals and clinics and allow their use for promotion and prevention.
2. In coordinating the planning and delivery of private sector services, a significant proportion of private sector expenditures could be diverted from curative to preventive care aimed at larger health status goals.

Although the original project design specified expected outputs at the end of five years, USAID/Jakarta believed that significant information on Indonesia's private sector, particularly with reference to health insurance, was lacking. Therefore, in April 1986, USAID identified 14 areas where a dearth of information existed, and developed scopes of work for four two-person teams of experts to investigate these areas. Each two-person team was to consist of one expatriate expert and one Indonesian health professional. The end objective of a series of studies would be a further refinement and focusing of the proposed private sector project.

The specific studies for short-term technical assistance originally called for:

1. A review of the role of PVOs in health care service delivery and financing;
2. A review of the hospital sector, with specific emphasis on management and efficiency issues and on potential information needs of the proposed project;
3. A comprehensive review of current experience in Indonesia with pre-paid health delivery schemes; and
4. A review of current legislation, regulations, and policies governing health care financing.

During the summer of 1986, the REACH Project was contracted to provide three consultants: Dr. Harold Hunter, to review the role of PVOs (#1); Professor Carl Stevens and Dr. Peter Berman to review the hospital sector (#2). In July 1986, The Enterprise Program [AID contract no. DPE-3034-C-00-5072-00] provided a short term consultant, Dr. James Jeffers, to examine the legislative issue (#4). In July-August 1986, John Snow, Inc. through an IQC [contract no. PDC-1406-I-00-4061-00], provided a short-term consultant, Professor Paul Torrens, to examine health insurance and prepayment in Indonesia (#3). Scopes of work for these consultancies are included at the beginning of each of the abstracts.

### III. Overview of the Abstracts

Although each report focused on a distinct area in the health sector, together they provide us with information as to the complexity, flexibility, and rate of change in the Indonesian health sector. In "Health Care Financing Issues in Indonesia", Dr. Harold Hunter described the future roles of ASKES and PTK (DUKM/ASTEK) in private sector financing of health care. Dr. Carl Stevens concluded in his report that many inefficiencies exist in the hospital sector and that it is possible to develop opportunities for diverting funds from curative toward preventive care (see "Increasing the Efficiency of Health Services in Indonesia: A Key Strategy for Child Survival"). Dr. Peter Berman examined the information needs for a private sector hospital-based scheme and identified current and future sources of information for policy formulation and project evaluation. Dr. James Jeffers, in his report entitled, "Indonesia's Health and Family Planning Policies and Laws, and their Relation to Expanding the Private Sector's Role in Service Delivery", described the health legislative process as it relates to the formulation of health policies and laws. Dr. Paul Torrens in his report, "Current Status and Future Prospects for Health Insurance and Pre-paid Delivery Systems in Indonesia", concluded that the private sector project should focus on policy development and on health insurance development.

The REACH Project hopes that this document helps to clarify the purpose and goals of these three REACH short-term consultancies in Indonesia, as well as those of the two related studies.

ABSTRACT I

HEALTH CARE FINANCING ISSUES IN INDONESIA

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The overall goal of this consultancy was to identify management and policy issues, procedures, and potential problems in health care financing in private and public sector programs in Indonesia, and to propose a series of options for the Government of Indonesia and USAID/Jakarta that would test policy issues and improve efficiency in the health sector.

Various markets for health insurance, based upon type of work, income source and current sources of health care exist in Indonesia today. Prepaid health care delivery, incorporating cost-saving incentives and alternative revenue sources (e.g., user fees), may serve to reduce government's financial responsibilities for curative health services in the face of budgetary constraints. Development of prepaid health plans must include proper management systems if they are to promote cost savings in the private, urban, curative segments of the health industry, thereby freeing scarce resources for rural and preventive care.

For example, ASKES (health care insurance program for civil servants) utilizes mandatory wage deductions, public sector resources and third party payments to strengthen community health resources. Although recently reorganized as a perum (government enterprise responsible for revenues and expenditures that reports independently to the Minister of Finance), ASKES personnel as well as its administrative and incentive policies can serve as a starting point for developing an alternative health insurance scheme. In fact, ASKES has served as the foundation for DUKM (general program for social security-financed health insurance for private sector workers). DUKM has begun a pilot project in Jakarta called PKTK. This report will examine health insurance schemes in more detail.

#### A. PREPAID HEALTH INSURANCE

##### ASKES

ASKES was created under a Presidential Decree in 1968 which earmarked funds nationwide for health care of civil servants. This program is funded through a mandatory two percent wage deduction, and services are delivered through public and private resources. In 1975, this system was reorganized and decentralized to the provincial level. Free choice of provider was suspended and civil servants are now required to use the puskesmas and public hospitals. ASKES has recently been further reorganized into a perum. Some problems faced by ASKES, as currently configured, fall under five categories:

#### 1. Demand for services

- a. ASKES experiences excessive use and expenditures for drugs. Approximately half of all ASKES health care costs are for drugs, which are in part due to over-prescribing and over-utilization.
- b. There is increasing demand for expensive tertiary care.
- c. Enrolled patients use care out of proportion to their numbers in the greater population. ASKES patients account for a high percentage of in-patients and contacts for eye examinations.

- d. Higher-ranking civil servants have higher rates of expenditures for drugs, and also seek more specialty, eye and hearing care. This problem will increase as more and more ASKES patients fall into this category.
2. Rate Setting
- a. Participating hospitals set their own rates, resulting in a lack of predictability for cost recovery for ASKES in certain geographic areas over time.
3. Cost recovery
- a. ASKES has a weak claim control system and therefore has difficulty in paying bills to providers.
  - b. The ASKES system does not yet promote price competition among various providers (hospitals) to help reduce the costs of delivering health services.
  - c. Surcharges for second class (40%) and first class (60%) hospital rooms are discounted compared to other patients. If hospitals were to shift full costs to all patients instead of shifting costs to first and second class patients, decisions for bed allocations could be made on the basis of real costs.
4. Cost Information
- a. Accrual accounting is not fully implemented and accounts payable and receivable are not accurately known.
  - b. Information systems do not contain information on personnel, inventory, or accounting on a timely basis.
  - c. Little or no cost or revenue data are available from participating hospitals.
  - d. Audit and inspection procedures are not well developed.
5. Quality of Care
- a. ASKES patients do not feel they are treated well by the puskesmas.
  - b. Services offered through ASKES do not reflect the actual epidemiologic needs of the population.
  - c. Quality checks performed by ASKES are in an early stage and require further development.

## DUKM

DUKM was established in 1984 as a program for developing health insurance schemes for wage-earning workers and their families. A pilot program testing one scheme (PKJK) is funded through a seven percent mandatory employer contribution to ASTEK (social security and disability insurance scheme administered by the Ministry of Manpower). Most care is delivered through the puskesmas by choice of the patient. PKTK is administered jointly by the Ministries of Health and Manpower.

PKTK has begun a pilot project in Jakarta. Original forecasts for the pilot project predicted 1,000,000 enrollees based on 300,000 workers covered by ASTEK and 100% market penetration. Currently, only 35 employers are participating (1% of forecast) and 8,300 persons or 0.5% of predicted are enrolled. Low enrollment levels are due in part to the following:

1. ASTEK is responsible for marketing yet lacks experience in this area.
2. The price for employers was either 7% of payroll or 2,500 Rupiah per month per person. The 7% arrangement creates an incentive to enroll lower paid workers, who are found to have greater demand for health services, thus placing the project in financial risk.
3. Most employees do not want to use the puskesmas as first site of contact for care.
4. Many employers have their own employee health arrangements.

Several other factors contribute to the initial slow growth of the PKTK pilot project and are potential obstacles for future expansion. The next paragraphs discuss these factors and possible solutions.

Pricing Policy: Because of the incentives created by current pricing policies to enroll higher risk individuals, compromise between per person charges and percentage of payroll is necessary. One alternative is the step rating system used by insurance companies to spread risk, improve competitiveness, and provide equity to subscribers.

Management: A major management issue is the lack of information about accrued costs and costs incurred but not repleted through the accounting system. Management information, while adequate now, would not suffice if enrollment increased. Known "out-of-plan" use of services and prescriptions is high. In addition, only 8 of the 118 puskesmas in Jakarta account for most care. Numerous quality of care concerns were raised on site visits. Therefore, the next phase of the project should focus on collecting management information.

Implementation: Mandatory contributions through ASKES raise numerous issues:

1. Will it discourage contribution to ASKES for other social insurance?
2. Would a voluntary system lead to adverse selection?

3. Would a mandatory system cause the reduction of wages, other benefits or lay offs?
4. Can the pilot project be sustained under a voluntary system?
5. Would the costs of collection and administration substantially increase premiums?
6. Would a voluntary system create different levels of care among employers and within firms?
7. Can the pilot project develop a system based on indemnity payments rather than for service?

The consultants recommended the following activities as means to improve the overall functioning of PKTK and ASKES.

1. Increase enrollment by:
  - o concentrating marketing of PKTK to blue collar employees.
  - o permitting companies to enroll their employees but have a minimum group size.
  - o requiring firms not joining PKTK to offer a minimum health insurance package.
  - o funding a study on how government department clinics effect utilization patterns.
2. Strengthen management and financing by:
  - o continuing to implement PKTK financing through ASTEK.
  - o allowing companies to maintain their own system of care, but pay a tax of 1-2% into ASTEK for puskesmas and PKTK management improvement.
  - o considering whether the functions of PKTK might better be assumed by ASKES, which has more experience. The plan should be phased in to allow smaller employers more time to obtain sufficient revenues.

## B. PREPAID HEALTH CARE IN THE WAGE-BASED SECTOR

The wage-based sector has been estimated to comprise 15 million workers. Only 30% of workers in the formal sector have enough income to be taxed and therefore participate in health insurance. Many pre-paid schemes exist in Jakarta. However, no systematic research on the capacity, utilization costs, and potential of company-owned facilities has been performed. An ASKES survey of Jakarta companies found that most companies post-pay or self-insure. The cost per worker was 11,000 Rupiahs per month; and was higher in small companies. Lowest costs were found in companies of 500-1,000 employees. Several hospitals currently contract with factories in exclusive arrangements.

Managed health care implies an enrolled population, a controlled number of providers, and participation of the financers in management. Potential problems in development of such systems are detailed in the main report. Major constraints during start-up include: 1) the availability of capital; 2) management capacity; and 3) willing provider groups.

Potential research and pilot projects in the wage-based sector include: 1) creating a health system in a trade zone near Singapore to capture local industry workers, (this idea has received attention from the Batyam Island Development Authority); 2) development of a US-Indonesia Fund to fill capital needs through grants and loans; 3) research on incentives, reimbursement and organizational models; and 4) assistance to PERTAMINA to develop a managed-care, HMO-type organization.

## C. RURAL PREPAYMENT SCHEMES

Although approximately 600 subvillage level health funds (dana sehat) have been identified, little rigor has been applied in evaluating their performance. While the dana sehats promote outreach for puskesmas, their viability as a base for prepayment is uncertain. Experimentation with subcenters, often underused and understaffed, is called for.

In addition, parastatal organizations in oil and mining are located in remote areas and could be induced to provide community health services. Currently 21 million persons belong to 13,000 cooperatives and these cooperatives may form the basis for strong health and economic development activities. Cooperatives could be funded to purchase or deliver health services.

Interventions to consider include: 1) strengthening cooperatives and linking them to child survival activities through LKMD; 2) promotion of cooperative pharmacies; 3) hiring professionals for "special clinics"; 4) developing a confederation of dana sehat to pool funds; and 5) improving private-public sector cooperation, including involvement of the private sector.

#### D. DEVELOPMENT AND REGULATION OF MANAGED HEALTH PLANS THROUGH A GOVERNMENT COMMISSION

Those private sector organizations which can purchase health services will be able to render the best services to the greatest number. At the present time, purchasers of care include: 1) companies; 2) small village-based funds (dana sehat); 3) individuals; and 4) a few labor organizations through state enterprises and through ASKES which purchase health care for civil servants.

Ideally, consumers should have a choice of health plans in order to promote efficiency through competition between delivery systems. While possible for some sectors, the availability of beds, physicians, paramedical personnel, managerial capacity, and adequate funds to purchase care do not make consumer choice a practical possibility in Indonesia at this time. However, consumers can still be given a choice of providers within a delivery system whenever possible.

The agency that would regulate private sector arrangements would incorporate the functions of a state insurance commission in the U.S. along with planning, quality assurance on behalf of purchasers, and technical assistance, loan guarantee, and ombudsman function.

These functions require the collaboration of several Ministries: namely, the Ministry of Health (health planning and quality monitoring), Ministry of Finance (insurance regulation tax aspects, and control of revenues), Ministry of Manpower (monitoring employment based fringe benefits, employer supplied health care), BAPPENAS (long range planning for health resource and expenditures), and Ministry of Home Affairs (to determine a review role of local governments in regulation and changes in provision of care through public facilities). In addition, representatives of consumers (individuals, employees and cooperatives) and employers (private, parastatal and public) would be involved. This unit would be designated as the 'Health Care Financing Commission'.

#### E. PILOT PROJECTS FOR CONSIDERATION

USAID/Jakarta could assist in strengthening the PKTK Jakarta pilot project and could contribute to the development of other private sector schemes at different levels of the health system through subprojects. These pilot projects could include:

1. Research on health financing, credit expansion, income generation or agricultural service activities.
2. Extension of health care by PTP XXI-XXIV in East Java to seasonal workers living in proximity to the sugar refinery which employs them for six months per year.
3. Develop a Federation of dana sehat in a defined geographic area to both increase purchasing power and enhance outreach.

4. Continue support of the Jakarta PKTK pilot project in the absence of mandatory contributions. This would include technical assistance in marketing, enrollment, filing and billing, staff organization, and rate setting. Assistance could be found in both the U.S. and within Indonesia.
5. Incorporation of existing ASTEK clinics in Surabaya into PKTK as a model public-private system in the blue collar wage-based population.
6. Continuation of an ASKES - University of Indonesia Computer Center project to improve management-incorporating medical care, inventory, finance and personnel modules already in the implementation phase. Budget cuts will stop this project unless part of the costs of \$2-3 million hardware and \$700,000 software and training are funded. Benefits will spill over to the MOH. This project should be a high priority.
7. Institution of a "Development Fund For Health Care Financing Commission" with technical, start-up assistance from U.S. government agencies with parallel responsibilities.
9. Organization and implementation of training activities for high level policy makers as well as for program managers in the principles and implications of appropriate health financing mechanisms.

ABSTRACT II

INCREASING THE EFFICIENCY OF HEALTH SERVICES IN INDONESIA:  
A KEY STRATEGY FOR CHILD SURVIVAL

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This report provides an in-depth analysis of the health sector in Indonesia and the potential for improved efficiency through the proposed private sector project. The overall strategy of the private sector project is to "direct" public funds from public hospital budgets to PHC activities, a strategy to be facilitated by increasing cost recovery in the government hospital sector.

In the context of the proposed project, privatization can be seen as a means to increasing the efficiency of the health services sector, such that there will be a more adequate commitment (a "diversion") of resources to those preventive and promotive activities which are important for child survival. The report provides three examples of what is meant by privatization for this project.

- o On the demand side of the market, the project will seek to promote private social financing (insurance, prepaid schemes) of the demand for services provided by both the public and private sectors. This may encourage the growth of the private hospital sector such that some pressure is taken off resource allocation to the public hospital sector, thereby enhancing the prospects for the "diversion" strategy. This will also make for greater equity in the way in which the burden for supporting the nation's health care system is distributed among the people.
- o The project will encourage organizational formats for public hospitals so that the management of these facilities will be at risk for both their success and failure, and in this way will motivate and facilitate greater performance efficiency. This may be regarded as a type of privatization in that it seeks to map private sector-type incentives into public organizations.
- o In addition, privatization may also mean that the nation's health services system is comprised of interdependent, complementary private and public sectors, with appropriate roles assigned to each. This concept is part of the MOH's long-term plans for health, in which it is envisaged that the private sector should be responsible for acute/curative illnesses while the public sector should have responsibility for preventive and chronic illnesses. Related to this, in this project, a distinction is made between what economists term "public goods" and "private goods." The case is made that, generally speaking, public financing will be more appropriate for the former and private financing for the latter. This is, in turn, related to the "diversion" strategy, for if we are to have more public financing of such public goods as preventive/promotive activities, the funds must be found somewhere in the public budget.

The report analyzes the Indonesian hospital services sector in terms of structure, performance, and financing. Some of the most salient findings are summarized below:

1. The bed to population ratio is quite lean at about 0.65 beds/1000 population. This ratio can be compared to the US HMO ratio of 2.0 beds/1000 population, which in the US is regarded as lean.
2. Private hospitals provide 31% of total hospital beds and 25% of general hospital beds; thus, the government hospitals are a major factor on the supply side of the market for hospital services.
3. The distribution of hospital capacity relative to the population is uneven, ranging from 187 beds/1000 in Jakarta to 26 beds/1000 in Nusa Tenggara Barat.
4. Hospitals in the government health sector are operated not only by the Ministry of Health and by provincial and local government health departments, but also by other Ministries (i.e., Defense).
5. The governmental hospital beds are classified in descending order (e.g., Class A, B, C, and D) by the number and sophistication of services they provide.
6. The most striking feature of the hospital services sector is the very low bed occupancy rates for virtually all classes of facilities. It would appear that the general hospital services sector is "over-bedded" relative to demand, despite the modest bed-to-population ratio.
7. The higher class hospitals (A and B) have the greatest proportion (80%) of specialist physicians. As compared with standard physician staffing ratios, the Class A and B hospitals are above standard whereas the Class C and D hospitals are very much below standard.
8. Out of a total 1980/1981 national health budget of Rp. 52 billion, 53%, or Rp. 27.4 billion is provided for hospital services. For the routine budget, if one could recover an additional quarter of the MOH hospital budget and transfer a like amount to those directorates carrying out public-health, preventive, promotive services, one could increase those budgets 300 percent.
9. Estimates of the 1983/1984 development budget allocates 57.4% to health services development as opposed to 20% for communicable disease control.
10. In the aggregate, the "vertical" hospitals (those operated directly by the MOH) recovered about 25% of total routine costs, ranging between 11% and 33% in 1985/1986. However, fees in hospitals are not collected in a standardized way.
11. It appears that local government pays out less in allocations to health programs than it gets back from them in fee revenue. Local hospitals recover between 42% and 81% of routine costs and these hospitals appear to be more seriously in the cost recovery business than are "vertical" hospitals.

In the development of a strategy to improve efficiency in the health sector, the authors recommend a focus on the central government (MOH) budget, rather than the local government budgets. However, financing events at the local level may help to release additional central government funds for PHC activities.

The authors also recommend a hospital budgeting scheme (prospective budgeting) which would put the hospitals at risk for both success and failure. This organization format not only provides an incentive structure to motivate more efficient performance by management and staff but also some of the discretionary resources necessary to accomplish this. The MOH might be interested in this scheme because of its potential to reduce the need for subsidies by the MOH.

The report contains a detailed section on issues and problems for efficiency in government hospitals services. Some of these include:

1. The issue of low bed-occupancy rates. Since unused bed capacity represents a waste of resources, the reasons for low occupancy should be determined;
2. The financial burden of fees for the consumer. It is possible that low occupancy in hospitals reflects the consequences of price rationing of demand if many people are excluded from the market because of the inability to pay. However, social financing through insurance alleviates this household burden. Social financing would tend to lower rates and increase utilization, so the low occupancy rates may be, to some extent, an artifact of out-of-pocket financing; and
3. Treatment of the medically indigent. If hospitals are expected to be self sufficient in all aspects of routine operations, they cannot afford to handle significant numbers of free patients.

The private hospital services sector was also examined during this consultancy. The private sector consists of three major subsectors: the deluxe private hospitals; employer or company-owned facilities; and church-related hospitals. It is noted that, with the exception of mission hospitals, preventive and promotive services are rarely offered in the private sector. Further, the mission hospitals appear to be somewhat economically unstable; the employer based schemes appear to be in a state of transition because of new laws; and the deluxe hospitals are highly unlikely to provide substantial services to the mainstream of health care. For these reasons, the authors suggest that focusing on improving financial viability of mission hospitals may be an appropriate early agenda item for the private sector project.

In conclusion, the authors recommend that the private sector project initiate a pilot project based on the prospective budgeting scheme described in the report. This pilot study would be a test as to the most appropriate way of increasing efficiency and diverting funds from curative to promotive services. In addition, the project might provide:

- o front-end money for initial planning of programs, including funds for technical assistance (where this is desired by the proposing party); and
- o technical assistance for implementation of pilot projects.

The project's institutionalization will have to include an appropriately designed decision-making process to respond to initiators and promoters in the field and decide which proposals are to get how much of what kinds of funding.

The project might attract as a major client the MOH and a vertical hospital proposing to implement a trial run with the prospective-budgeting format. A large amount of initial planning would be called for, e.g., what criteria and data the MOH and the hospital are to use in reaching agreement on the prospective budget and the rate of prospective income from fees. The hospital might want to think about designing schemes to market the product in innovative ways, e.g., to groups on a prepaid basis. And the project might assist with stimulation of the state of affairs which would be obtained if the hospitals were to retain income from fees.

More modestly, a government hospital or a private hospital might want to seriously consider marketing services on a prepaid basis to groups of consumers. This might require a good bit of assistance with initial planning, operational planning and ultimately, risk underwriting. Or, a government hospital might want to give serious consideration to and ultimately implement more innovative schemes aimed to enhance cost recovery. One such scheme currently being implemented is to make special provision for private patients in public hospitals.

In its relationship with some private hospitals, ASKES is having some cost-containment problems. Perhaps ASKES and the hospital could negotiate a capitation arrangement for these patients. ASKES and the hospital might propose to the project some assistance in the design of such a scheme and maybe some risk underwriting once it was launched.

The MOH (or other government ministries who may regard themselves as being "at risk" in the situation) might propose to the project and seek assistance for a serious inquiry into the low-occupancy problem in the Class D sector -- with an eye to more rational planning of the (now diminished) development budget in this domain.

Employers (firms) seeking to adapt their employee benefit plans for health to changes in the tax law might come to the project for some technical assistance in exploring alternatives (e.g., contracting with providers on a prepaid basis).

The prospects that the proposed private sector project will do important business seem promising; and, it seems clear that the government health services sector stands to gain as much or more from the project as does the private health services sector. Although, both will gain and may be able in the process to improve the complementarity between the two sectors.

ABSTRACT III

AN INFORMATION COMPONENT FOR THE PROPOSED USAID  
PRIVATE SECTOR HEALTH AND FAMILY PLANNING PROJECT:

WHAT IS NEEDED,  
WHAT IS AVAILABLE,  
HOW MIGHT IT BE ORGANIZED

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This consultancy focused on the information requirements for the proposed private sector project in Indonesia. This report identifies essential health economics data needed to plan, monitor, and evaluate the project; identifies the source of information; and recommends how routine data collection can be implemented and institutionalized.

There are three major applications for the information component of the private sector project:

1. policy and planning;
2. development of projects and programs to test and disseminate interventions to improve health sector finance and management; and,
3. monitoring and evaluation.

The first component, analysis for policy and planning, is concerned with broad assessments of current status, goal-setting, and identification of the medium and long-term requirements for achieving project goals. The second, project and program development, relates to the development of specific methods to meet the objectives identified by policy-makers and planners. Information needs are at the "micro-level" in order to identify and solve problems and to expand financing mechanisms. The last component, monitoring and evaluation requires intervention at both the macro and micro levels.

For each application, specific-types of data are needed. These applications serve the two primary goals of the proposed private sector project: to increase real resources for health programs and to improve allocation of resources to both the public and private sector.

The following figure illustrates the range in information requirements of the project. This figure shows that more global data on resources and outputs have their primary application at the policy and planning level and for longer term evaluation. Operational data on service costs and productivity have their main application in the design of interventions and their immediate monitoring and evaluation.

The figure lists several types of information that should be collected, including information on public sector resources, private sector resources, information service providers and organizational capacity, and information on households. The report describes each of these categories in detail.

THE LINK BETWEEN CATEGORIES OF DATA NEEDED  
AND THEIR MAIN APPLICATION IN THE PROJECT

Categories of Data	Data Application		
	Policy/ Planning	Project/Program Development	Monitoring/Evaluation
Public Resources and Outputs Physical Resources Budgets, Expenditures, Revenues Outputs	X		Needed for longer term
Private Resources and Outputs Physical Resources Income Outputs	X		Needed for longer term
Service Providers Costs Utilization Efficacy Institutional Factors		X	Needed for shorter term
Households Use and Expenditure Behavior Determinants Health Needs and Impact		X	Needed for shorter term

Data for public sector resources represent the physical and financial inputs available from government for the health sector. Physical resources include facilities and manpower. Financial resources refer to budgets (the planned availability and use of resources), expenditures (the actual use), and revenues (the "income" to health facilities from fees and reimbursement). These data are needed to assess the capacity and potential of the public sector to provide services. They also are used to describe the existing allocation of resources and trends in resource levels. Monitoring of specific indicators from this category will provide one of the main components of tracking project-related improvements in the public health sector.

Data on private sector resources provide the non-government analog to the first category. Again, physical resources refer primarily to an inventory of facilities and manpower. While this may be straightforward for registered practitioners, there is also a large non-formal medical sector that may be quite significant in terms of both practitioners and finances. On the financial side, private sector "income" is a data category. The earnings of private health practitioners are the analog to expenditures in the public sector.

While the preceding two categories deal with resources and outputs on a general or sector-wide level, the service provider category relates more to the operational aspects of health services, mainly on a micro level. Data are needed on the total costs of different types of services (curative care, maternal and child health, hospital care, for example) as well as on the cost per service provided (clinic outpatient contacts, inpatient days, and immunization). The latter unit or average cost measures combine service costs with utilization or output. These indicators are needed for planning the financing of service delivery programs. They are also important for identifying low productivity or inefficiency in existing service programs and assessing interventions to improve operating efficiency. Cost comparisons of different types of health care organizations providing similar services (primary curative care visits to hospital outpatient departments, health centers, and subcenters, for example) can be used to identify potential efficiency gains from changes in health care organization or utilization patterns.

The fourth category contains data on households and, of course, the individuals who make up households. Data from households are crucial sources of information on the levels and patterns of use of all kinds of health services. Another dimension to service use is household expenditures on health care. Data on patterns and trends in use and expenditures are needed to develop interventions in health care organization and financing as well as to evaluate the coverage and equity results of such interventions. There has yet not been a careful attempt to estimate the potential market for certain services in order to develop fee schedules or estimates of potential enrollment for prepayment schemes. At a later stage in the proposed project, experiments with fees, prepayment, or other innovations need to be evaluated in terms of their impact on service use and spending in the population in general and for specific target groups.

Much of the information needed to initiate the proposed private sector project is already available in Indonesia, although not always adequately analyzed and accessible. Several important sources of information were identified in the report, including the "health sector work" which is an exercise being undertaken by the Bureau of Planning, Department of Health and BAPPENAS, and funded largely by the World Bank and USAID. The results of the work are expected to be available by late 1986. These data should permit a comprehensive review of health needs, resources, and programs.

A second important source of data is the national household surveys routinely carried out by the Central Bureau of Statistics (BPS) and the Health Research and Development Board (Basdan LitBangkes). Other sources of information include ASKES, the curative health insurance scheme, major universities and service organizations, hospitals, and the Indonesia medical association. The report contains a complete list.

In addition, the report extensively identifies where data exist for each of the four important information categories and how deficits in information can be rectified.

The author recommends a two-pronged strategy for an information component: support for policy analysis and a flexible focus on project funding and applied research. The major tasks to be accomplished in these two areas might include:

1. establishing a repository for up-to-date data and analysis;
2. compiling and publishing a periodic status report on the health sector structure and finance;
3. providing technical support for the development, monitoring, and evaluation of pilot projects and field experiments in health care organization and management;
4. improving the capacity to design, carry-out, and analyze household surveys on health status and utilization;
5. improving the capacity for organizing and analyzing large health service record data bases; and
6. opening a center for exchange of ideas and experiences related to health sector organization, management, and finance.

The report identifies four areas for USAID involvement during the next 12 months: financial and technical assistance for the private sector provider survey; analysis of levels, patterns, and trends in health care utilization and expenditures at national and regional levels; financial and technical support for computerization of health service records; and support for a national forum on health policy, finance, and management.

ABSTRACT IV

INDONESIA'S HEALTH AND FAMILY PLANNING POLICIES  
AND LAWS AND THEIR RELATION TO EXPANDING THE  
PRIVATE SECTOR'S ROLE IN  
SERVICE DELIVERY

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The purpose of this consultancy was to explore existing Indonesian laws and policies in relation to the possible expansion of private sector involvement in the delivery of health and family planning services. The report explores the private sector's role in meeting social and economic development objectives, the attitudes toward expanded private sector activity in these areas, and the legal and policy-making processes that must exist or be developed to promote expanded private sector involvement. Therefore, this document serves as a background for discussion of the role of USAID in developing options for private sector health services. Although the report is mostly descriptive, it provides us with a general overview of important aspects of health and population policy in Indonesia.

### PRIVATIZATION

Privatization is defined differently, depending on the particular context of discussion. In general, the term implies a reduction in the government's traditional role in providing and financing health services. Privatization also means the private sector bears a greater share of the responsibility in providing health services in order to achieve national social and economic development objectives.

In general, the trend toward privatization has been spurred by mounting domestic and external deficits that many governments are facing today. It also is fueled by a growing recognition that in the past, governments promised more than was feasible given their current and prospective resources, and that governments were often less efficient in the production of health services than portions of the private sector.

However, not all services can be produced more efficiently in the private sector. The private sector may not be interested in providing preventive services which are considered public goods because their private production would not be profitable relative to alternative investment and production opportunities.

On the other hand, many government officials tend to view the private sector in general with suspicion, and many feel strongly that because the private sector's primary motive is profit, it cannot or will not be willing to assume social responsibility in the same fashion as the public sector. Thus, it is possible that governments will only be committed to privatizing a portion of the delivery of health and family planning services even when significant budget pressures exist.

If governments are not completely sold on the philosophy and concepts of privatization, they may again assert their traditional interests and usurp the role and activities temporarily conducted by elements of the private sector when budgetary circumstances improve. The prospect that government may eventually reverse itself would be sufficient to discourage the private sector from taking a very active role in service delivery, particularly when it involves large capital investment. Thus, it is extremely important that government make a clear-cut and permanent commitment toward privatization and reinforce this commitment with both law and policy. The author recommends that privatization take place in an incremental manner.

## CONSIDERATIONS FOR PRIVATIZATION

There are three issues that exist in Indonesia which will determine the relative role of the private sector in the future. First, the role of government in the direct provision of family planning services is not clear. Based on simplifying assumptions, government's role may be projected to decline from 80% in 1986 to 40% in 2010. Consequently, the private sector's provision of these services would increase from 20% in 1986 to 60% in 2010. Second, the relative roles of various levels of government can be assumed to change, with local governments assuming relatively greater responsibility, and central and provincial governments reducing their roles appreciably. Also, within the private sector, greater expansion logically must be projected for NGOs, and industry and local communities, than for the commercial sector and universities. Third, the greatest relative growth logically projected for the private sector would be in the direct delivery of family planning services by industry and communities relative to other components of the private sector.

The report also describes several social and economic objectives which can be applied to national level planning for increasing the role of the private sector in health in Indonesia. These criteria include the following:

1. Operational efficiency describes the relationship between the quantities and prices of inputs to achieve the most health outputs at minimum cost. Goods and services should be produced privately if it results in lower costs.
2. Allocative efficiency is a term which describes the "mixture" of services. An example of allocative efficiency in the health sector is the combination of preventive and curative health services which are produced.
3. Equity issues can help determine the relative role of the public and the private sectors. In the case of health and family planning services, access, coverage, and ability-to-pay are common equity issues.
4. Administrative feasibility refers to the government's ability to change its role from one of being predominantly involved in the operational management and direct delivery of health and family planning services, to one that is more involved in monitoring, administering, and enforcing regulations and supervising the maintenance of the quality of services delivered by the private sector.
5. Political acceptability refers to the philosophy of the government with regard to the private sector in general. If the government's dominant attitude toward the private sector is one of mistrust, it is not likely to create a regulatory environment that is sufficiently unrestricted to allow the private sector to realize its full potential share of responsibility in providing services.

6. Demand and consumer acceptability include society's view of the legitimate role of the private sector and society's willingness to accept services from this sector which were previously provided by the government. It is also extremely important to determine the level of demand that exists for health services prior to privatization.
7. Professional acceptability is the degree to which providers are willing to accept new roles and responsibilities. Professional satisfaction, rates of remuneration, professional opportunities for continuing education, and opportunities to acquire new skills and knowledge are all important factors in decisions that providers make about their styles and sites of practices. In Indonesia, many public physicians operate small, private practices after their government hours, which may indicate their acceptability of private sector medicine.
8. Absorbitive capacity of the private sector refers to the ability of the private sector to provide services in a commensurate level to demand. Expanding the output of goods and services requires capital, labor, and land. Capital is accumulated in the public sector through taxation, internal deficits (internal debt financing) or through borrowing or receiving gifts from external agencies (external debt financing). However, the private sector generally must rely on equity or debt financing.
9. Maintenance of quality and competition should be a priority during privatization. Standards of quality, particularly when contemplating the reimbursement of privately-produced health and family planning services, should be established and maintained. One of the central issues in privatization decisions is the maintenance of quality control, which is a significant administrative burden if done properly. Assurance of the maintenance of competition will have a favorable impact on holding down prices in the absence of collusion. However, competition also stimulates producers to cut quality to meet the competitive pressures of the market. Thus, quality assurance programs and cost containment programs must be developed jointly.

#### INDONESIAN HEALTH POLICY AND LAW

The Government of Indonesia has mixed feelings about the private sector. While the private sector is expected to contribute to the nation's social and economic progress, there is a strong feeling in the MOH that this sector should not profit from illness. However, the Ministry has also expressed interest in having 50% of the nation's hospital beds eventually located in the private sector.

ABSTRACT V

CURRENT STATUS AND FUTURE PROSPECTS FOR HEALTH  
INSURANCE AND PRE-PAID DELIVERY SYSTEMS IN  
INDONESIA

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In general, Indonesia has several levels of law, regulation, and policy which constitute the regulatory environment for the private sector's involvement in health and family planning. The process by which existing laws are modified and new laws are introduced and passed is often lengthy and time consuming. New legislation or modifications are initiated by the Ministry of Health, reviewed and endorsed by the Cabinet, and registered by the Secretary General of the Cabinet. After consultation with the leaders and chairman of the General Assembly, the Secretary General of the Assembly places the legislation on the docket for consideration by the General Assembly. Legislative decisions can also take place at the Cabinet, joint-Ministry, and Ministerial levels as well.

The report states three factors which affect the legislative process.

- o letters of decision may substitute for the introduction of new laws;
- o letters of decision require substantial consultation and consensus; and
- o various channels are available to formulate and approve policy.

The Health Law of 1960 states both the government's and the private sector's health care responsibilities. The former is responsible for improving health status through such activities as preventing and controlling diseases, health education, and research. The private sector is regulated and guided by the government and can provide these same services. However, the government is responsible for providing health care for all people of Indonesia.

In recent years, several health laws have been written. The National Health System (SKM) published in 1982 states that every citizen is entitled to optimal health status and encourages people's potential in solving the problem of health financing. The National Health Development Law of 1982 states eight major health goals for Indonesia. The Major Programme Plan for Long Term Health Development of 1983 states that a 4% allocation of the national budget to health is sufficient. Out of this legislation developed civil servants' insurance schemes.

The report identifies key policy-making and coordinating bodies, as well as potential problem areas and opportunities for USAID in the privatization of health services. The authors recommend that USAID be involved in:

- o policy coordination and formulation;
- o policy-relevant research coordination;
- o discussions on policy options; and
- o implementation of privatization policy decisions.

The report points out potential problem areas in the categories of potential efforts listed above. In particular, it is pointed out that significant obstacles are likely to be encountered in any effort to negotiate establishment of an ad hoc policy coordination and formulation body at this time, even though the need is great. It is argued that the Ministry of Finance will be the lynchpin in the outcome of the whole policy decision process, and its role is not now a visible or predictable one. Nevertheless, the report strongly urges USAID to continue to pursue policy dialogue with key decision makers in order to help forge the critically needed consensus on policy. However, this dialogue must be based on a foundation of solid analytical studies which assemble facts and access options.

In September 1986, USAID/Jakarta requested the assistance of a short-term consultant to conduct a comprehensive review of the various pre-paid health delivery systems in Indonesia and to provide recommendations on the most appropriate configurations of health insurance and pre-paid provider schemes for Indonesia. A large part of the report describes factors influencing the development of health insurance schemes in Indonesia and the current characteristics and status of major government-sponsored, government-related, and private health insurance schemes currently in operation. In addition, this consultant and an Indonesian counterpart suggested operations research and other analytical studies which could be conducted on this subject matter.

It is clear that USAID can play two important roles in the development of health insurance and prepaid delivery systems in Indonesia. One is related to policy development and the other to policy implementation.

Although important policy development decisions are being discussed and perhaps made, a well-organized body of data upon which policy assumptions can be based is lacking. Thus, policy options are not being fully discussed in a way that tests their usefulness and validity. Although some consideration seems to be given to major new governmental endeavors in health insurance, a careful analysis of the impacts of fiscal and patient care policies has not been performed to the degree that would be appropriate for an undertaking of this magnitude and importance.

USAID should assist in the development of a process to help the government ensure that the appropriate degree of planning and preparation has been carried out before the policy is implemented. This process would include:

1. identification of all parties, governmental and non-governmental, that will play a major role in the outcome;
2. development of a coordinated, cooperative process of discussion and deliberation among interested ministries and groups, with a clear understanding of the process by which major national policy will be settled;
3. accumulation of appropriate background data to develop an approach to the policy decision in question;
4. identification of all the major policy options and alternatives that need to be considered;
5. careful costing and estimating of the finances necessary to carry out each policy option or alternative; and
6. selection of the most appropriate policy options for the country and development of a long-range plan for their implementation.

The report states that USAID could provide financial support for the studies that will be needed to evaluate the alternative policy options that are developed. USAID should not attempt to steer the ultimate policy decisions towards one option or another. Rather, its active support should include technical assistance and research funding for studies sponsored by

important parties, particularly those studies which cannot be carried out at the present time using local funds. USAID might also take the lead in bringing together the various external donor organizations and agencies (many of whom are individually talking about funding one major health economics study or another) so that their efforts can be better coordinated and integrated into a more clearly delineated public policy process. Because many of the ministries and planning bodies that must be involved in a decision of this magnitude are already overloaded and are utilizing already-strained resources, USAID might provide funding for additional staff to work on the project, either domestic, foreign, or both.

#### PROPOSED HEALTH INSURANCE SCHEMES

Once this important phase of policy development is completed, the authors recommend a focus on the following three areas for national health insurance development.

1. The development of a central health insurance organization to operate the government health insurance plan and to supervise/regulate private plans.

Considerable on-site working experience with these various organizations will have to be obtained by key managers both through short-term training "crash courses" and through longer-range training programs to develop future management skills. Also, numerous short-term technical experts will have to be brought to Indonesia to help solve specific problems that may arise in the early phases of the expanded plan's operations.

With regard to its regulatory functions, the government health insurance agency will have to establish standards for private insurance plans and a means of certifying and registering them, as well as a means of monitoring their performance. Each of these regulatory sub-functions can be extremely complex in its own right and would require a great deal of sophisticated technical assistance from USAID if the function is to be done well.

With regard to the maintenance of an accurate data-base (in cooperation with a national institute for health economics to be described below), the central health insurance body will be required to develop standards for information for all insurance plans in the country; to gather and integrate the required data; to monitor and analyze trends of expenses, utilization, and outcomes; and to report in a timely fashion to policy-makers. In addition, assistance will probably be required for the purchase of computer equipment and support systems.

2. The development of multiple "model" plans throughout the country in order to learn which type of plan (or which mixture of plans) will best serve the goals of the previously-agreed upon public policy.

The most urgent need for assistance rests with the DUKM pilot project in Jakarta. Originally planned to cover almost a million people, it now has fewer than 10,000 people enrolled and by all accounts is doing rather poorly. The failure of this pilot project would harm the credibility of the government's plan for expanded health insurance for many years to come. Therefore, there is a need for powerful short-term assistance in marketing, financial flow management, and quality of patient care - the three areas of major concern for the DUKM pilot project at the present time.

More important for the longer term is the development of a pilot project in one of the provinces involving the dana sehat. Here the emphasis should be on learning how to develop the dana sehat themselves as contributory schemes for national health insurance and how to link these dana sehat with the posyandu and the puskesmas. Considerable effort should be devoted to community development and marketing, dues collection and financing, and developing a system of primary care services that is equal to or better than what now exists.

A simpler, but equally important pilot project, could involve two or more large farms or plantations. One plantation or farm might serve as a control, with a full-time, completely-salaried health service providing services in plantation-owned facilities using plantation-provided drugs. In another setting, the plantation or farm managers might be interested in contracting out the responsibility for health services to private providers in the surrounding area. In this case, plantation management might be encouraged to contract with an outside health maintenance organization (such as PERTAMINA) to provide a complete package of services, on a per-capita reimbursement basis.

PERTAMINA has not contracted with an outside insurance agency for managing the reimbursement of health care services within its own facilities. Thus PERTAMINA's physicians are now under a pre-paid, managed care system similar to U.S. HMOs. The opportunity to work with developing the PERTAMINA HMO could involve technical assistance in converting the present facilities and personnel into a real HMO, or more important, to document the population's actual experience under the HMO system. PERTAMINA represents an excellent opportunity to observe the development and operation of a nationwide system and to learn about costs, utilization, and outcomes in a long-term enrolled population. In the same fashion, USAID should try to seek out one or two other large employers to study their experiences in social financing as compared to PERTAMINA and other private insurance plans.

If possible, two final groups should be assisted in their interest in developing health insurance plans. The first group is IDA, the Indonesia Doctors' Association, which would like to sponsor and operate a Blue Shield type of fee-for-service health insurance plan for physician services. St. Carolus Hospital, on the other hand, represents the major private hospital provider in the country, and would like to set up a private, non-profit hospital-operated HMO.

3. The development of an accurate, current health economics data base and analytical capacity, so that current events can be effectively monitored and future development can be effectively planned.

At present, many government agencies and international and donor groups are studying various components of health financing and resource allocation in Indonesia, but there is no one central coordinating body where all this diverse information is brought together. Further, there is not yet a clear way to feed existing health economics information into the country's policy development process.

Three kinds of information are necessary for an adequate health economics and monitoring system: inputs (revenues), throughputs (expenditures), and outputs (outcomes). With regard to health insurance specifically, this center should attempt to aggregate data on financial flows -- about their inputs, throughputs, and outputs from all insurers in the country. An additional source of input and output data would be some type of household survey carried out from time to time throughout the country, probably on a small, but select sample of the population. The creation of this type of center would call for a tremendous amount of assistance and support from USAID and others.