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HEALTH SECTOR FINANCING PROJECT

Ministry of Health
Republic of Indonesia

CONSULTANT REPORT SERIES

REPORT 21:

REPORT REGARDING THE
CONTINUING DEVELOPMENT OF
HEALTH INSURANCE PROGRAMS IN
INDONESIA



A USAID-Sponsored Project in Collaboration with
The International Science and Technology Institute, Inc.

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INDONESIA

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ACRONYMS

ASKES	Parastatal organization that administers the government employees health benefits program.
ASTEK	Asuransi Kesehatan
CB	Coordinating Body
DepKes	District Health Officer
DS	Dana Sehat
DUKM	Dana Upaya Kesehatan Masyarakat (principles of Managed Health Care adopted by the Department of Health)
PHB	Perum Husoda Bahakti
PKTK	Pemeliharaan Kesehatan Tenaga Kerja (health insurance for wage-based employees)
PMU	Project Management Unit
PPD	Pengumpul dan Pengelola Dana (Collection and management of premiums)
PPK	Penyelenggara Pelayanan Kesehatan (service providers)
SPSS	Statistical Analysis and Data Management software
PusKesMas	Pusat Kesehatan Masyarakat (sub district Public Health Center)
TPA	Third Party Administrators

I. INTRODUCTION

This report reviews the consultancy activities of Robert G. Shouldice, D.B.A., provided to USAID/Jakarta June 5 through June 23, 1989 regarding the continuing development of health insurance programs in the public and private sectors. This work was a part of the Social Financing studies under Contract No. ANE-0354-C-00-8030-00. Principal activities were conducted at the Jakarta offices of Perum Husada Bahakti, (PHB) the parastatal organization that administers the government employees health benefits program known as ASKES, and at the Ministry of Health's offices in the province of Bali.

The consultant was requested to perform four activities during his visit; these included the following:

- Assist with the conceptualization of the integrated program of health insurance which includes PHB, PKTK, Dana Sehat, private health insurance, and employers' self insured programs.
- Design and arrange training experiences and apprenticeships for persons interested in learning the internal operations of an HMO.
- Finalize the design of an actuarial study to assess premium rates for the PHB program, and oversee the initial phases of implementation.
- Assist the project with further development of private sector health insurance initiatives.

The following sections of the report review the Consultant's activities in these four areas and his findings, conclusions and recommendations.

II. THE INTEGRATED PROGRAM OF HEALTH INSURANCE IN BALI

One of the most important activities of the Social Financing Project is the pilot and experimental program in Tabanan Regency, Bali. The objective of this program is an attempt to establish a coordinated and integrated program of health insurance that would include PHB (ASKES), PKTK (ASTEK), Dana Sehat, private insurance plans, and self-insurance programs. In effect this is to attempt to carry out the principles of DUKM in one province by bringing together under one umbrella organizational structure all the available forms of health insurance. It is an experiment to see whether all health insurance programs in a geographic region can be integrated and coordinated so as to assure health insurance coverage for the entire population.

Initial discussions were held with members of the PMU to inform the Consultant of the progress to date regarding the pilot. The consultant met with representatives of each of the participating programs except for private and self insurance plans. These discussions were used to help define the local conditions and plans. In addition, the Consultant provided a half day seminar regarding the concepts of health insurance and HMOs to representatives of the PHB, PKTK, Dana Sehat, and DepKes. The outcome of these meetings and discussions was the development of the concept of the "third party administrator" (TPA). Although the final organizational arrangement described later in this report does not precisely follow all of the TPA concepts/functions, it is useful to understand how TPA activities are arranged.

A. Third Party Administrators (TPA)

Conceptually, a TPA provides administrative services under contract or agreement for an organization. Usually, these services involve the day-to-day operation of a health insurance program established by an employer for his employees and dependents. Functions that the TPA may perform include the following:

- Monitor and collect premiums
- Pay claims against the health plan of providers and others
- Administer coordination of benefits
- Run utilization review program
- Run quality assurance program
- Help create health plan/provider relationships
- Advise health plan and employers regarding program operation.

- Help develop and manage a management information system/electronic data processing activities.
- Provide general monitoring and control activities of the health insurance programs

In the province of Bali, the representatives of the programs involved along with the Consultant developed a general plan for integrating the programs. This general plan is provided below, but first, a suggested conceptual framework for the planning, development and operation of the integrated program is provided in the outline below.

B. Bali Conceptual Framework

1. First, the program goals and objectives need to be clearly defined and agreed to by all of the parties. The pilot program will integrate all of the health insurance activities in the Province of Bali under a coordinating body. The objectives might be to identify whether such an integrated approach will be effective in making health insurance available to all citizens of the Province, whether an integrated approach will be effective in making health insurance available to all citizens of the Province, whether an integrated program is more effective in controlling costs, stabilizing and making premiums and benefit packages more uniform, and whether public and private health insurance activities can co-exist side-by-side under the direction and management of a coordinating body.
2. An integrated coordinating body composed of representatives of the program. Participants will provide for policy formulation, development of program procedures, and overall program monitoring and evaluation. It should choose an organization that will provide day-to-day management of operations (PHB is currently designated as this "executing secretary").
3. The coordinating body and operations manager should create a staff which would complete the feasibility, planning, development and initial operations of the integrated program.
4. Finally, the operations manager would undertake normal operations of the program, and should provide the coordinating body with feedback regarding the program's ability to accomplish stated goals and objectives.

Logistically, such an effort as that described above will require substantial effort of a dedicated staff of professionals not now currently available. It will be necessary to obtain funding for the completion of situational analyses, feasibility studies, planning and program development. These funds will need to be provided by the participating programs, and/or from an outside source such as USAID. Care should be taken to involve all the participants in the initial decision making and program formulation. For example, the development of the program goals, objectives and concepts might be

developed in initial meetings in Jakarta among representatives of DepKes, PKTK, PHB, Dana Sehat and USAID. Meetings with the coordinating body in Denpasar might be held to add more form and structure to the concepts. Final program approval should then follow with a strong understanding of the tasks that need to be accomplished and the methods for accomplishment, e.g., tasks should be identified, staff defined, and funding obtained. In the following paragraph, the outcome of the initial meeting in Denpasar and the preliminary organizational structure for the pilot project is described.

C. Output of the Denpasar Meeting, June 14, 1989

Based on previous understandings (through a decree of the Minister of Health), task forces in both Jakarta and Denpasar will provide assistance in conceptualizing and directing the integrated program. In addition, there will be a Coordinating Body (CB) composed of representatives of all of the programs involved in the pilot and representatives of the medical profession, the pharmacy profession and public health association. The chairman of this body will be a representative of the Governor of the Province of Bali and the day-to-day "executing secretary" will be PHB. The functions of the coordinating body include the following:

- Advise the program components and the Executing Secretary on the activities of the integrated program.
- Monitor the activities of the program (especially the activities of the PPD regarding planning, finance, budgeting and enrollment, and the PPK regarding the delivery of health services).
- Provide policy formulation and development, and set policy.
- Establish and operate medical audit and assurance programs.
- Establish and operate utilization review programs.
- Establish and operate an electronic data processing system/management information system.

Thus, the Coordinating Body will empower PHB as the Executing Secretary to act on its behalf regarding the functions listed above. In effect PHB will be assuming the role of a TPA on behalf of the organizations involved in this consortium of insurance programs. Note that each program will continue to maintain their autonomy and will continue to establish its own internal operating policies. Each program will also continue to collect their own premiums as well as pay claims, develop capitation relationships and establish their separate benefit packages.

This is a logical first step in the development of this integrated insurance program for Bali. But, one would hope that as the program matures, the Coordinating Body would consider the usefulness of having PHB or another outside organization as the Executing Secretary/TPA assume more of the TPA functions mentioned earlier in this report. We

could speculate of how far the integrated program might progress regarding the integration of other functions that might be operated through the TPA concept. For example, is it possible to have the TPA administer the claims processing function for all or most of the programs? Could a basic and common benefit package be created and used by all of the participants in the integrated program, and could this package be community rated so that a common, average premium be used? These are some of the issues that face the Coordinating Body in the near future. By developing goals and objectives statements now, the Coordinating Body will more adequately address the answers to these questions before the program's form and structure becomes too set to allow for modification at a later date. Moreover, by developing a better understanding of the goals of the program, the overall conceptual framework will be better understood.

A situational analysis should precede this effort. Using secondary data the following areas should be considered in this analysis:

- Individual program goals and objectives
- Demography
- Social and economic situation
- Health status
- Health facilities and services
- Labor force
- Environment
- Description of the programs involved (i.e., PHB, PKTK, Dana Sehat, Private insurance and Employer Self Insurance programs).

With an understanding that these issues, the activities of the CB can then consider the macro issues faced by all of the programs involved. These include analysis and discussion of the following major topics:

- Integrated program goals and objectives
- Standard benefits
- Coordination of benefits among the participating programs
- Standardized premiums among the programs
- Market segmentation
- Organizational framework with PHB as the Executing Secretary.
- Legal framework

- Uniform data collection system
- Medical services delivery analysis
- Policy framework and ability to control

Finally, it might be useful to create a detailed understanding of the components of the integrated program by viewing these components for each program participant. In some areas the operation of the individual program is well understood, defined by law or regulation, or otherwise fixed; thus no further analysis is needed. Other areas will need considerable review and study. The following matrix identified the areas which may be considered at this step in the pilot project development.

MICRO ANALYSIS MATRIX					
<u>Issue</u>	<u>Program Participant</u>				
	<u>PHB</u>	<u>PKTK</u>	<u>D.S.</u>	<u>Private</u>	<u>Self-Ins.</u>
Standard Benefits	x	x	x	x	x
Market Mix	x	x	x	x	x
Premium analysis	x	x	x	x	x
ProForma Financial Statements			x	x	x
Standard Encounter and Claim Forms	x	x	x	x	x
Mgmt. & Admin. Structure			x	x	x
Financial Systems			x	x	x
Provider Arrangements & At-Risk Contracts	x	x	x	x	x
Miscellaneous		x	x	x	x

With these analyses completed, the integrated program can then be carefully designed, implemented, monitored and evaluated regarding its applicability to other provinces in Indonesia.

D. Integration of Dana Sehat in Bali

A subsidiary issue in the Bali pilot concerns the development of cooperative activities among groups of Dana Sehat so as to spread the insurance risks among larger groupings of individuals -- to bring together the risk pools of several small Dana Sehat. With these confederations of local cooperatives in place, participation in the Bali-wide integrated program of health insurance activities can then proceed more effectively. In this regard, representatives of the Dana Sehat, Depkes, USAID, the local chapter of the Indonesian Public Health Association and this consultant met to discuss the methodology for a feasibility study to study integrating several Dana Sehat under one organizational structure. It appears that the method to be used by the Indonesian Public Health Association is appropriate -- especially the analysis of need/demand by evaluating consumer opinion, provider opinion, and some application of available morbidity, mortality and disability data.

III. TRAINING EXPERIENCES AND APPRENTICESHIPS IN HMO OPERATIONS

There is a great need for Indonesians trained in the international operation of HMOs. Training activities could take many forms from the traditional academic approach to on-the-job educational programs and apprenticeships. After consultation with members of the PMU, PHB and PKTK the following activities are recommended.

1. First, several Indonesians should be selected to attend a special non-degree HMO training course in the U.S. Currently, it is recommended that six individuals from PHB and six from PKTK be chosen to complete the U.S. course. It was agreed that USAID would be requested to sponsor eight of these individuals, and two each be sponsored by PHB and PKTK. The program would be developed at a U.S. university that currently provides HMO management and operations training courses probably either at the University of Missouri, Kansas City or at The George Washington University, Washington, D.C. Two time periods were identified during meetings, but the earliest time frame for the initiation of study will probably be January 1989. In the meantime, several activities need to be undertaken, both in Indonesia and in the U.S. In Indonesia, the following should be completed:
 - a. Internal selection of candidates should be made with the names transmitted to USAID.
 - b. Each candidate should take the ALIGU test for English competency. Deficiencies should be corrected through intensive study of English.
 - c. Competency in English then should be demonstrated through a score of 550 or better on the Test of English as a Foreign Language (TOEFL) Exam.
 - d. Preparation and an introduction to the U.S. program should then occur with recommended readings, seminars and lectures. Individuals such as Dr. Rizali Noor, Dr. Brata Ranuh, Dr. Widodo Sutopo, and Dr. Tom D'Agnes might provide such lectures and discussions. Topics to be included might be the concepts of DUKM, health insurance in Indonesia, some principles of managed care, the efforts to carry out the concepts of DUKM, and so on.
 - e. Preparation of travel documents.
 - f. Initiation of travel and study in the U.S..

In the U.S. it will be necessary to choose the site for the academic preparation. Because a three month course of study and experiential learning activities are planned, the program will need to be completely developed, lecturers identified and committed and month-long internships established. Living accommodation will also need to be identified.

The preliminary course of study includes the following topics:

- The philosophy and concept of managed care
 - A short history of managed care
 - Organizational structures and models
 - Medical management
 - Providers
 - Customers, purchasers, payers, members, patients
 - Control, quality assurance, utilization review, standards, management information systems and electronic data processing
 - Managed care development activities and stages
 - Marketing, benefit package development, management of marketing department, enrollment procedures
 - Financial, HMO economics, actuarial activities, budgeting, financial control
 - Summary of day-to-day standard operating procedures in operation of HMOs, and at-risk arrangements
2. The objective of the U.S. training program identified in "A" should be to train "trainers" who can return to Indonesia and provide training activities in their companies. Thus, a commitment should be obtained from the individuals selected that when they return after their activities in the U.S., they will be involved in setting up and actively participating in training Indonesians regarding the management and operation of HMOs. When the U.S. group returns to Indonesia, they should meet and develop a curriculum and materials for on-going managed care training. It is hoped that they would put together a program of training activities, not just occasional seminar activities.
 3. The institutions of higher education in Indonesia should be evaluated regarding their currently offered courses that might be used to train HMO students in areas such as statistics, business administration, actuarial

- sciences, marketing, finance, personnel, health services administration and so on. In addition, arrangement might be developed with the University of Indonesia or others to teach special courses dealing with the internal operation of at-risk health insurance and delivery programs. The curriculum and course content could be molded on the special course offered in the U.S. in "A" above.
4. Training materials such as manuals of operation, audio and video tapes, home study program, and the like might be created regarding the internal operation of HMOs. These materials might be developed under agreement with experts in the U.S. and then produced and/or translated into Bahasa Indonesia for use in Indonesian training activities. For example the "script" for video tapes might be produced by U.S. experts and edited by Indonesian HMO experts. An Indonesian well versed in HMO operations might then present the material and be video taped. The tape could then be distributed widely for in-house educational training purposes. It might be useful to produce a complete series of audio and video tapes covering all of the areas described in "A" above. An additional activity should include the development and publication of technical assistance manuals that would then be made available to individuals and organizations involved in developing and operating managed care activities.
 5. One of the most important devices for smooth operation of a managed care program is the creation and use of "standard operating procedure manuals." These manuals describe in detail the step-by-step operation of the HMO in all areas of operation. It might be useful to develop a model manual of operation under agreement with U.S. experts, to be used in both training programs, in-house ongoing educational efforts, and in day-to-day operation of the HMO activities.
 6. In addition to the above activities, it might be useful for a national organization such as DepKes to actively develop a group of domestic consultants that could then provide technical assistance to organizations involved in developing HMOs and at-risk contracts. DepKes might also sponsor and make available the technical assistance manuals described above.

IV. PHB ACTUARIAL STUDY DESIGN

Meetings were held with representatives of PHB regarding the methodology for the collection of data that they could be used to complete actuarial studies of the PHB population. The methodology described in my report of August 1988 is modified as follows:

- Five sites will be identified for study. These will include two health centers in Java -- one urban and one suburban, and three sites outside of Java -- one urban, one suburban, and one rural.
- All PHB members that use these study sites will be interviewed and data collected from their medical records regarding use of services.
- A pretest at the three sites will be completed prior to January 1990. This intervening time will also be used for training personnel in the data collection activities. Any change in the methodology will then be made prior to January.
- Data will be collected for three months that represent different times during the year -- probably January, April and August or September.
- The current data reporting instruments will be the primary mode of data identification and collection. Because this daily report only indicates the aggregate level of activity in the health center, it is recommended that this reporting activity be changed to include information on the number of visits by diagnosis. In this way, PHB will begin to collect the data necessary to create rates of disease (by major diagnostic categories) for its populations. The result should be the creation of a "rate table" of mortality and morbidity for the PHB members.
- Data collected using the methodology described above will then be transmitted to the Jakarta office of PHB where it will be input into an SPSS or similar program for analysis, and the creation of tables. This activity will probably be contracted to an outside organization (University of Indonesia).
- Development of inferences, conclusions and recommendations will then be completed by the Central PHB office. The output should be a representative sample of the ambulatory health services activities of the PHB members that can then be applied to the total PHB population. With this data, it is anticipated that PHB will be able to complete actuarial analyses regarding its entire membership -- to be able to describe proposed use of services, and the costs of those services.

Our discussion also addressed the issue of collecting data from "users" rather than on the total population -- both users and non-users. It was the group's feeling that, when the rates created by this study were applied to the total PHB population, there would be a somewhat overstated level of need/demand for services developed. However, it was felt that it was better to be conservative in the estimations of need for services rather than to underestimate service use. In addition, to complete a study of all PHB members in the five areas selected would be prohibitively expensive. Currently, it is estimated that the suburban and rural sites have about 40,000 PHB members, while urban sites have about 60,000 members. About 20 percent of all PHB members use services at any one time. Thus, out of the total of about 224,000 PHB members registered at the five study sites, about 44,800 people will be included in our sample for each of the three months studies. If there are no repeat users there is a potential of 134,400 study participants; this is about 60 percent of the total population. With this level of members included, the confidence of the sample being representative of the total population becomes high.

Several other issues regarding the PHB capitation project were discussed. First, because the providers are under the coordination of the district health officer (DepKes), the whole capitation should go to the health officer who will then "manage" the money for the Puskesmas, the specialist referrals and the hospital care including drugs. There is a need for a special agreement from the Minister of Health to provide permission to the district health officers to manage the capitation payment from PHB. Second, because there may be the possibility that the health officer's "budget" level is lower than the monies available to PHB for the capitation, (e.g. the health officer's capitation rate request is lower than what PHB internally determines the capitation rate to be) a surplus could exist with PHB; how should this potential surplus or "profit" be used? Third, when should the capitation be paid -- before the beginning of the month or during the month? It was agreed that the capitation should be separated into two components: drugs and everything else. The drug component should be paid prior to the beginning of the month while the "service" component of the capitation should be paid sometime after the beginning of the month. Finally, the issue of administration and implementation of the capitation proposal was reviewed. It was agreed that much work should be completed prior to the initiation of the capitation operation especially regarding contracts with providers and the general "process" of administration. Training of personnel will be an important aspect of this last issue.

V. ASSISTANCE WITH PRIVATE SECTOR HEALTH INSURANCE INITIATIVES

The consultant was also involved in several activities that were directed at the development of ongoing or additional private sector health insurance initiatives. These included discussions with Drs. Noor, Brata Ranah, Marzolf, Soetopo, and D'Agnes. A half day lecture on managed care was provided to about 60 participants from all sectors of the health system. Other discussions were held with members of the PMU, USAID, and with representatives of Tugu Mandiri, St. Carolus Hospital, and the Islamic Hospitals System.