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HEALTH SECTOR FINANCING PROJECT

Ministry of Health
Republic of Indonesia

CONSULTANT REPORT SERIES

REPORT 26:

REVIEW OF THE DANA SEHAT
DEVELOPMENT

AUGUST 28 - SEPTEMBER 8, 1989



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

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ACRONYMS

Bank Pembangunan Daerah BKK	Area Development Bank Badan Kredit Kecamatan (Regency Credit Body)
Bidan BPSM DANA SEHAT Desa Dusun IAKMI	Midwife Bina Peran Serta Masyarakat Health Fund Village Unit of government Ikatan Ahli Ilmu Kesehatan Masyarakat (Institute of Public Health) Kantor Wilayah (area office of Ministry of Health)
KANWIL	Family health card Regency Chief of the Dusun Cooperation of Fotu Still Vendors Cooperation of Noodle and Meatball Makers Koperasi Unit Daerah Village Medicine Post Pengumpul dan Pengelola Dana Penyelenggara Pelayanan Kesehatan (Medical Care Providers)
Kartu Keluarga Kecamatan Kepala Dusun Koperasi Kaki Lima Koperasi Mie Bakso KUD Pos Obat Desa PPD PPK	Cooperation of Tofu and Tempe Makers Sub-district health center Savings/loan
PRIM Kopti PusKesMas Simpan/pinjam	

I. A REVIEW OF THE DEVELOPMENT OF A FEASIBILITY STUDY FOR A DANA SEHAT FOR KECAMATAN KERAMBITAN, BALI

From August 29 to August 31, Mr. Pratolo, an Indonesian actuary, and I met with Dr. Tangking and Dr. Darmasetiawan of Ikatan Ahli Ilmu Kesehatan Masyarakat (IAKMI) to discuss the progress this organization has made to date in preparing a feasibility study for a community based Dana Sehat in Kecamatan Kerambitan, Kabupaten Tabanan, Bali. The discussions centered on these areas:

- The process being used to design the Dana Sehat and the completeness, appropriateness, and uses of the data gathered to date (i.e., the secondary data on demographics and the cost and utilization of medical care, and the results of the focus group interviews).
- Specific areas of interest identified principally by Dr. Tangking.
- Pulling everything together and beginning to develop a preliminary structure for the Dana Sehat.

A. The Preliminary Structure

On the basis of the information at hand, some broad conclusions were reached during the three days about the direction of development of the Dana Sehat. These are summarized briefly below. It should be stressed that as work continues and additional feedback is gathered from the community any or all of these conclusions may change. For this reason it may be best if circulation of this report is limited so as not to preempt the work of IAKMI or create unrealistic expectations.

1. Participation

Election to participate would be at the level of the Dusun, with the entire Dusun opting in or out. This appears to simplify a number of things. Enrollment and the maintenance of eligibility information are easier, because the Dusun would be the smallest unit at which an election to participate or not can be made (i.e., records of participation can be on the basis of which Dusuns participate, rather than by family). Since the whole Dusun is covered, it may be possible to use Kartu Tanda Penduduk or Kartu Keluarga as ID cards. Finally, premiums only need to be specified to the Dusun level (i.e., no premium per family need to be calculated or billed). Aside from simplifying the billing and collection process by using an established infrastructure, it also allows the principle of gotong royong to work within the Dusun, since the premium within the Dusun can be allocated however the leaders of the Dusun deem best. In this way it is hoped that the Dana Sehat will extend to the poorer members of the community, who might not be able to pay it the premium is per family or per individual. If for some reason basing participation on the Dusun does not prove viable, using the Koperasi Unit Desa (KUD) is felt to be the next best alternative.

2. Benefits Plan

Because the results of the questionnaire indicate a lack of confidence in the Dana Sehat until it is proven and limited means vis-a-vis the required premium, it is felt best to begin with primary care only. In this way the premium is lower, and more people are likely to "see a return" for their participation quickly. A Rp. 500 deductible will be applied for visits to private doctors to help control utilization. A deductible should be unnecessary for visits to the Puskesmas, as the long wait at the Puskesmas is felt to be disincentive enough to over-utilization. Coverage would extend to consultations, medicine, immunizations, simple operations, routine lab, maternity, and examination of pregnant women.

3. Provider Network

Provider will include the Puskesmas (2), Bidan (5), and private doctors (5), serving the community.

4. Payment of Providers

Capitation will be tried first, as it is the desire of the Department of Health to experiment with these arrangements. This will likely be difficult and complex to set up (due to resistance from providers), but if possible, it would of course be quite effective in limiting cost.

B. Other Topics of Discussion

1. Premium Rate Calculation

The premium rate for the Dana Sehat was recalculated, and premium calculation techniques were discussed. In addition, a possible mechanism for dividing the premium rate among providers on a capitation basis was developed.

2. Management Information System

The needs for a management information system and the information required were discussed, particularly with respect to claim information. The practicalities of collecting the information from the providers and the means of storing the information were also covered.

3. Administration and Overhead Costs

Various aspects of the administrative system were touched upon, particularly with an aim to developing an initial estimate of the costs of operation of the Dana Sehat. The initial staffing and organization of the Pengumpul dan Pengelola Dana (PPD) were considered. It is intended that the PPD contain the only full time employees of the Dana Sehat, and that the PPD form the nucleus of the entire Dana Sehat.

C. Overall Conclusions

In general, the approach being taken to developing the Dana Sehat is sound. The data IAKMI has collected is appropriate and fairly complete, and it is being effectively used. It was not possible to review the results of the focus group discussion in any detail, as this information has only recently been collected and has not yet been completely summarized. However, it is clear that the idea of having focus group discussions is quite good and useful. The discussions serve a valuable purpose of education, and also make the community feel a part of the process of development of the Dana Sehat, which should later help achieve higher participation levels.

Because of the newness of the process of developing Dana Sehat of this type and the extensive changes that are likely to occur in the structure as more feedback is obtained and development continues, it is likely that several extensive discussions with focus group participants will be necessary. Later, as the process is refined and applied to the development of other Dana Sehat, a sharper focus should be possible from the beginning. This will improve efficiency and reduce the time involved.

IAKMI's scope of work is to prepare a final recommendation to be presented to a government based committee. As certain aspects of the Dana Sehat are quite complex, I feel it is important that this final recommendation be as specific as possible, with alternatives clearly prioritized where they are necessary. Leaving a lot of opportunity for discussion and analysis at the level of the committee (which is one step removed from much of the information and feedback collected) might unnecessarily confuse the delay implementation.

Much work remains to be done before the report can be submitted. The shape of the Dana Sehat is just beginning to emerge at present. There must be extensive discussions with all parties involved in the operation of the participation in the Dana Sehat. These discussions are necessary to fill in the gaps and optimize the chances that the end product will operate effectively and achieve a high level of participation.

D. Summary

I feel that the process for developing the Dana Sehat is a good one. It should be of considerable value as a prototype for the development of Dana Sehat in other areas of Indonesia, even though the nature of Dana Sehat may vary widely from place to place due to local conditions.

II. REVIEW OF THE DANA SEHAT FOR THE NON-WAGE BASED WORKFORCE IN DKI JAKARTA

From September 2 - 6, I reviewed the present structure of the Dana Sehat that have been formed in Jakarta by KANWIL. Time was spent gathering information from Dr. Hardywinoto and his staff, and visits were made to two of the Cooperatives that have established Dana Sehat (Mie Bakso and Primkopti). Because of the newness of the Dana Sehat and consequent lack of activity at the PPK (Only five claims to date), no providers were visited.

The conclusions reached during this review are summarized below, in the form of advantages of the current structure, areas that bear watching, and some general suggestions.

A. Advantages

1. Organization

The structure established is sound. Existing Cooperative infrastructure is used to good effect (i.e., to carry out the function of PPD), and formation of the BPPK at KANWIL creates an effective vehicle for monitoring and coordinating all the Dana Sehat while at the same time centralizing certain administrative functions (e.g., design and preparation of ID cards, payment of capitation) and providing for effective control and training of providers.

2. Control over Provider Network

Use of only Puskesmas and government hospitals should improve control, as these providers are already more or less accountable to KANWIL. It is intended that other providers will be added later, but the above providers should still represent a stable nucleus for the network.

3. Premium Sufficiency

The calculation of premium for the first period seems reasonably conservative, even when the likelihood of higher utilization of services due to the elimination of most out-of-pocket costs is taken into consideration. This applies to the calculation of the capitation payment to the Puskesmas as well.

4. Both Fee for Service and Capitation Will Be Tried

This will provide a broader basis of experience and comparison.

5. Sound Plan Design

From the standpoint of the Dana Sehat, the benefits plan for the capitation program is soundly designed. Benefits are meaningful, and costs are controlled (i.e., via capitation for primary care and the referral and package tariff systems for secondary and in-patient care).

B. Areas That Bear Watching

1. The Enrollment Process

The information required to be submitted before the I.D. cards can be produced is involved, particularly the passport photo requirement. The time required to complete the process of enrollment may therefore be considerable. Experience to date bears this out, as less than one half of the members of Primkopti and one third the members of Koperasi Mie Bakso have submitted all the required information after up to six months. The length of time may prove impractical, particularly given that the I.D. cards are only valid for one year (i.e., the process must be repeated each year).

2. Reporting Requirements (Administrative Burden)

Careful attention should be paid to the administrative burden that will be placed on the PPK and PPD to complete the periodic reports required by BPPK. In the case of the PPK, much of the information must be noted while the patient is being treated. This requires a continuous administrative discipline.

Additionally, it appears that the report required of the PPD might be simplified to eliminate the reporting of repetitive information (e.g., only the changes in enrollment information need be reported each three months).

3. Capitation

The potential downside of capitation should be guarded against. This downside is primarily undertreatment and excessive referrals.

4. Expenses Not Covered

These arise because of the impact of exclusions and limitations in the benefits plan. They are to be billed to the PPD by the PPK (i.e., the participant will have to pay nothing at time of treatment). Separating the benefit from not covered expenses and (if the Cooperative chooses) billing not covered expenses to the participant is a potentially tedious administrative function. In addition, the Cooperative will be advancing the cost of the not covered items, which will impact its cash flow negatively.

5. Premium Collection for Koperasi Kaki Lima

Premium is to be collected daily by a Cooperative official who will visit each Cooperative member. The record keeping necessary for this system and the logistics of collection are quite cumbersome.

On the other hand, it should also be noted that the premium collection mechanisms for the other Cooperative are very effective. Premium is assessed through an increase in the price of raw materials sold to Cooperative members. Unfortunately, this is not possible for Koperasi kaki Lima.

6. Collection of Data for Experiences Monitoring

The premium that has been calculated is based on existing data and appears conservative. However, utilization of services may be different once the Dana Sehat begins. It is important that sufficient information be collected to monitor premium rate adequacy and periodically update the premium calculation. At the least, type of service, cost (if not a package tariff), and some idea of when the treatment occurred (the month may be sufficient) is needed. Knowing which cooperative and which provider may also be desired for the analysis. More information (e.g., patient sex and age, type of illness) becomes necessary if more complicated premium rate structures are desired.

Exposure information (i.e., number of covered lives) is required as well, broken down into the categories for which separate premiums may be calculated (e.g., by Koperasi, perhaps by adult versus child, male versus female, etc.). The need for all this information must be carefully balanced against the burden its preparation presents to the PPK (see Section 2. above).

7. Fee-for-Service

At present, the fee-for-service program for Primkopti does not involve any cost sharing for primary care. Since the participants must pay first and submit claims for reimbursement, there may be no problem. However, the situation should be monitored for potential over utilization of services. It may be desirable to introduce some form of copayment, as is being contemplated (I believe) for medicine.

C. Suggestions

1. Mandatory Enrollment

Enrollment and record keeping are simplified if all members of the Cooperative must participate. This should be considered if it is not already the case. At the least, it appears at present that all members of all the Cooperative have elected to participate.

2. Establish a Central Reserve

A reserve could be funded by requiring each Dana Sehat to submit percentage of the premium (no more than 5 percent) to BPPK. This reserve would be used in the event that individual Dana Sehat run out of funds. This effectively spreads financial risk among the Dana Sehat.

3. Cover All Children

Covering only three children does not provide access to adequate medical care to the remaining family members. This may have negative impact on the health of the entire family. It may also be difficult for the Dana Sehat to control that coverage is limited to the three children chosen.

These problems could be averted if all children were covered. If it is necessary to show support to the Family Planning Program, this might be done by assessing a surcharge or extra copayment per visit to those families with more than three children.

D. Summary

The Jakarta-based Dana Sehat are off to a quick start with a reasonably solid organizational foundation. The true test will come over the next several months as participants begin to use the health services in significant numbers, taxing the administrative processes for the first time. During this period, it is essential that the areas mentioned above be monitored carefully so that any emerging problems can be identified and resolved quickly.

With careful nurturing, these Dana Sehat can grow to become an effective vehicle for providing coverage for health care costs to the non-wage based work sector in Jakarta.

III. AN ASSESSMENT OF THE DANA SEHAT IN CANDI ROTO

The following review of the Dana Sehat in Candi Roto is based on information gathered during the first day (September 8) of the Pertemuan Kerja Dana Sehat Candi Roto in Temanggung.

A. Overview

The Dana Sehat established for Kecamatan Candi Roto is easily the simplest of the models presently being tried. The premium is Rp. 100 per family per month, only primary care in the Puskesmas is covered, and much of the administration and operation of the Dana Sehat is informal, relying on the existing culture, traditions, and mechanisms of the community. Participation is mandatory, although it is possible for coverage to be suspended if the premium is not paid. Premium is collected at the level of the Dusun initially, and passed up through the government levels, with 25 percent remaining at the Desa level, and the remainder being invested in Badan Kredit Kecamatan (BKK--under the auspices of Bank Pembangunan Daerah) at the Kecamatan level. Premium is typically payable monthly, although it can be collected for longer periods of time if this is more convenient (e.g., based on harvests).

Premium collection began in June, with the actual provision of medical services to start in September. As of the beginning of September, Rp. 1.3 million had been invested at BKK, representing 75 percent of the premium for approximately 5,500 families out of 8,800 in the Kecamatan (the other 25 percent of the premium is at the Desa level, primarily for provision of supplemental medical assistance through the formation of Pos Obat Desa). The families not represented come from 5 Desas which have not yet submitted premium to the Kecamatan.

B. Some Specific Comments

For a variety of reasons ranging from the brevity of my stay in Temanggung and the format for discussion there to my lack of familiarity with local customs and practices on which so much of the operation of this Dana Sehat depends, it is difficult for me to come to firm conclusions about the Dana Sehat's prospects for success. In a number of areas, the Dana Sehat is clearly close to the minimum in terms of adequacy of systems and processes. On the other hand, there is clearly a strong, unified commitment on the part of the leaders of the Kecamatan to making the Dana Sehat work. Given this, the current structure of the Dana Sehat may be sufficient as a starting point.

The following are some specific impressions gathered during my day in Temanggung:

■ Premium of Rp. 100 per Family per Month

This premium is quite low, especially considering the facts that little if any provision for increases in utilization of Puskesmas services has been built in (the data is not very good), and that no copayment is required at time

of service. Apparently there are some other modest sources of funds (jempitan, funds from village level Dana Sehat, etc.) which can be used in an emergency. Even so, the fund has virtually no reserve if experience turns out to be worse than expected (the three month buffer of premium can only be used once). This is particularly important if running out of money might cause the population to lose faith in the Dana Sehat concept.

■ **Premium Collection**

The system of premium collection (i.e., by the Kepala Dusun) is very informal. If family heads have not paid by a certain date, the Kepala Dusun is to confiscate the family I.D. card. This process may be very difficult to actually implement, as it requires considerable discipline. In the next section a report is recommended to help impose this discipline.

■ **Management Reports**

- It may be useful to add a cumulative year to date column, in addition to last month totals;
- Exposure (i.e., number of family heads, spouses, and children covered) should be kept track of each month so that accurate utilization rates can be calculated;
- A report showing cash flow should be produced each month, showing fund balance at beginning of month, premiums received (and how it is split up between Desa and Kecamatan and among the various users--promotion, administration, claims, etc.), claims paid to Puskesmas, interest earned, fund balance at end of month. Each Desa should prepare such a report, also showing total premium due, amount received, and the number of ID cards in suspense to account for the difference between due and received premium. The Kecamatan PPD should prepare a summary report, including the amount of the fund on loan if simpan/pinjam is an option.

■ **Pos Obat Desa**

The budget for the Pos Obat Desa (perhaps Rp. 4,500/month per Desa) will be so tiny that it is difficult to imagine what, if any, meaningful medicine can be practiced there. However, the Pos Obat Desa may still be useful in controlling excessive Puskesmas utilization if they can be set up in some fashion as a gatekeeper. It is a concept definitely worth exploring. On balance, the Pos Obat Desa is an idea worth experimenting with.

C. Summary

The Candioto Dana Sehat has been put together with the barest minimum of resources needed to make success a possibility. Having said this, the core that has been established seems solid, and the commitment of the community is clearly high. What has been established so far is definitely worth continuing, and the experience gained, in its uniqueness, should be of significant value to Bina Peran Serta Masyarakat.

IV. COORDINATION OF DANA SEHAT ACTIVITY BY DIREKTORAT BINA PERAN SERTA MASYARAKAT

As Dana Sehat development increases, the challenge for Direktorat Bina Peran Serta Masyarakat (BPSM) of monitoring and controlling all the activity becomes more difficult. Until now, BPSM's approach has been largely reactive. It is probably time to begin to think about becoming pro-active--seeking specific information about the Dana Sehat on a regular basis.

The Dana Sehat can be divided into two categories, those under development and those already operational. The information required by the BPSM is different for the two categories. The following outlines some general ideas about the information that might be collected for the two types. It is assumed that BPSM's role in both instances will be that of observer--i.e., BPSM will have, in general, no active role in either the development or the operation of any Dana Sehat.

A. The Development Phase

The information needs of BPSM for developing Dana Sehat are assumed to be:

- To make sure development is consistent with the broad objectives of the Ministry of Health;
- To gather information about new ideas that are being tried so that BPSM can serve as a clearinghouse for the dissemination of techniques, information, etc., among the Dana Sehat.

One approach to gathering this information would be to require each developing Dana Sehat to complete and submit a standard questionnaire monthly. The questionnaire would ask for descriptions of each of the key aspects of the Dana Sehat, with a rationale for the approach used. The key aspects might include organizational structure, plan of benefits, participation and enrollment, premium level, frequency and collection, provider network, method of provider payment, and management information system and reporting. Questionnaires after the first might only be completed for aspects which have changed from the previous questionnaire. The information provided by the questionnaire could be confirmed/supplemented by visits to the Dana Sehat by BPSM once a quarter.

B. Operational Dana Sehat

Here the needs for information are different:

- To make sure the Dana Sehat is operating properly and is healthy financially; and

- To gather information about the effectiveness of new ideas that are being tried, for potential use by other Dana Sehat.

Once again, a standardized monthly report is probably the best way to get this information. As a start, the information should include number of participants (including a summary of ins and outs), a cash flow for the Dana Sehat (i.e., $\text{Fund Balance Previous Month} + \text{Premium Paid} + \text{Interest Earned} - \text{Claims Paid} - \text{Expenses} = \text{Fund Balance Current Month}$), premiums due and unpaid, loans outstanding if the fund allows simpan/pinjam, and perhaps a summary of claims paid (both number and rupiah) by type of service/provider.

In addition to the quantitative section, there should also be a written section describing noteworthy developments/occurrences and also any specific areas of interest of BPSM (e.g., new ideas being tried).

C. Summary

The above represents just a starting point for the gathering of information about the various Dana Sehat. I recommend that a reporting process such as this be developed and implemented as soon as possible. As more experience is gained with the existing Dana Sehat, and once the initial reports start coming in, the information collected can be expanded and refined.