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DEVELOPMENT OF A NATIONAL HEALTH EXPENDITURES DATA BASE AND REPORTING SYSTEM FOR INDONESIA

Contract No. ANE-0354-C-00-8030-00

November 1989

Report No. 19

PREPARED BY: Glenn Melnick, PhD

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I. PREFACE

A number of significant activities are currently underway in Indonesia to improve the effectiveness and efficiency of the health care system These efforts range from increased health insurance coverage to improved hospital management information and reporting systems As the health care system continues to evolve along with the country, policy makers will be called upon to make increasingly important and complex policy decisions with regard to the organization and financing of health care in Indonesia In anticipation of the need to make these decisions, the Ministry of Health has begun to develop the necessary analytic capacity to support decision-making The Health Economics and Policy Analysis Unit (HEPAU) within the Bureau of Planning is the designated unit for this purpose One of the most significant, ongoing projects within this unit is the development of a database and continuous reporting system to monitor and evaluate trends in national health expenditures

To facilitate development of this database and reporting system, the project has been conducted by a team consisting of both MOH staff and outside technical experts In that regard, Dr Glenn Melnick, a health economist with UCLA and the RAND Corporation, has been brought in as a consultant to provide technical assistance in development of the database and system

This report covers the consultancy of Dr Glenn Melnick for the period June 1989 through September 1989 which included activities in Indonesia and Los Angeles The consultancy had two major objectives

- Development of methods for constructing the component of the database covering government health expenditures for the period 1986-1990, and

- Development of a framework for estimating health expenditures by the private sector for period 1986-1990

Each of these major objectives is discussed in detail below

A. Objective 1 - Development of Government Health Expenditures Database and Reporting System

1. Background

Development of the data collection methods and instruments for Government health expenditures database covering the period 1986-1990 were completed in March 1989 Data collection began in April 1989 and was scheduled for completion by October 1989 Upon completion of the data collection phase, it was then necessary to review and edit the data in order to construct a comprehensive and integrated database This consultancy was structured to facilitate this process in two ways First, Dr Melnick, along with MOH and AID staff, conducted a number of field visits to observe and document the data collection activities Secondly, the results of these field visits were to be used to help develop the methods for editing and integrating the data into a standardized database Each of these activities is discussed below

2. Review of Data Primary Collection Activities

The process for collecting the primary data from provinces and districts was designed to provide consistent and reliable estimates of government health expenditures A positive aspect of the process was that MOH staff had substantial previous experience in collecting such data on a

major scale For this reason, it was possible to anticipate major problems and to design the process with these constraints in mind However, it was also recognized that a large data collection effort always encounters some problems and that, for this reason, it would be important to meet with field staff to discuss procedures, problems and observations

Based on this rationale several provinces were selected for site visits by teams that included Dr Melnick as well as MOH and AID staff These site visits were structured to include review of source documents at

- The province and district level,
- Hospital level, and
- Puskesmas level

Meetings were held with field staff collecting the data, and their methods and completed survey instruments were reviewed and discussed in great detail When possible, completed survey instruments were compared with actual source documents, discrepancies, ambiguous entries and other issues were identified and discussed

These site visits generated a number of important findings -- most of them generally positive First, there is fairly good and consistent understanding of the structure of the data collection forms and how they should be completed It appears that the training sessions, along with follow-up by central MOH staff to check how well the forms are being implemented, were effective The only sites that were using the forms incorrectly were those that did not provide MOH staff with completed forms and related source documents early in the process Second, there is tremendous excitement and support for this activity at the province level On the negative side, it appears that in some areas, it will be necessary to allocate salaries to different activities, since it is not possible to obtain the requested detail Also, it appears that data entry at the local level may lead to greater errors in the data and might better be centralized in the future

3 Methods for Review and Editing of the Primary Data

Once the data collection was complete, construction of the database could begin Before the data from each of the budget sources and areas could be merged, it was necessary to review and edit the data This process included review of the data for

- Outliers and implausible values,
- Inconsistencies, and
- Missing values

This process was undertaken by a team that included staff of MOH, Dr Melnick and programmer/analysts based at RAND and UCLA In the original plan these activities were scheduled to take approximately three weeks to complete They have taken far longer than expected, and, in fact, are still on-going as of this date Detailed review and analysis of the problems encountered and proposed solutions will be included in the report covering recommendations for future updating of the database However, it appears that stricter control of the initial data entry function would prevent many of the problems we encountered A simple

D-Base computer program that prevented the data entry staff from entering a record until all the fields were completed and totalled correctly would have helped eliminate many of the errors that we have had to identify and correct by hand

4. Development of Reporting System

An important part of the system is to provide a series of standardized reports designed to provide decision-makers with information in the form that will help them Numerous meetings were held with MOH and ISTI staff to design different reports that the system should produce on a routine basis Computer programs are currently being developed to produce the required reports in a systematic and comprehensive manner It is anticipated that this process will take two iterations A preliminary set of reports will be generated and distributed for review and comment Based on comments from MOH and ISTI staff, the system will be revised, and a new set of reports will be generated The programs that generate the reports will be written in SAS software, and copies of the final programs will be included as part of the database

B. Objective 2 - Framework for Private Sector Health Expenditures

While government health expenditures are an important component of total health expenditures, private sector sources play a significant role in financing health care in Indonesia In order to provide a comprehensive picture of health expenditure trends, it is essential to monitor private sources as well as public sources Unlike the government data, which, while voluminous, are fairly centralized, private sector data are highly fragmented The first step in constructing a private sector database is development of a framework which identifies the different types of private sector health expenditures and then matches available data to the different health expenditure categories in a systematic way During this consultancy, Dr Melnick gathered a broad range of information to aid in the development of such a framework The methods, results, and recommendations are described below

The development of the framework required information in several areas, including

- A list of the different categories of private sector health expenditures,
- A list of the potential sources of private sector expenditures,
- An inventory of available data, and
- Background on how different health organizations collect and store data

As in the case of the government data, MOH staff had previously developed estimates of private sector health expenditures Their methods and results provided an excellent foundation for addressing many of these issues To supplement the information available from MOH reports, numerous interviews were conducted with a wide range of agencies and organizations These interviews provided additional insight into how data are collected and stored by different organizations In addition, all available studies of private sector health expenditures were identified, inventoried, and reviewed Relevant findings and recommendations are summarized below

1. Private Sector Expenditures on Different Health Services

An important issue concerns the mix of different health services that are financed by private sector sources In constructing the database, it will be important to have more precise estimates for those services that represent a higher proportion of total expenditures than for those that represent a smaller proportion of total expenditures

Table 1 uses data from the previous MOH study of private health expenditures in 1985-86 to calculate the relative contribution of different services to total private sector health expenditures The two most important categories of services are drugs and hospitals Combined, these two categories represent almost 80 percent of total private sector health expenditures Private practitioners and clinics represent 14 percent and 5 percent, respectively It is interesting to note that private sector expenditures represented 65 percent of total health expenditures These findings suggest that it will be important to focus on getting more precise estimates of drug and hospital expenditures than on the other categories

TABLE 1

Calculation of Relative Contribution to
National Health Expenditures, 1985-1986
(Billions of Rupiahs)

Type of Expenditure	Amount (1985/86)	% of Private	Private % of Total	Govt % of Total
Hospital	593,117	0.389	0.246	0 094
Puskesmas	72,886	0 048	0 030	0 054
Public H prg	0	0	0	0 031
Drugs	633,099	0 415	0 263	0 062
Private Practice	225,205	0 148	0 094	--
Total Private	1,524,307	1 000	0 633	0 241
TOTAL - All Health Expenditures	2,406,952			
By Category				
MD-Spec	153907	0 101	0 064	
Paramed	36381	0 024	0 015	
Midwive	134750	0 009	0 006	
Cadre	21443	0 014	0 009	
Training	23000	0 015	0 010	0 017
Other	17632	0 012	0 007	0 083

SOURCE National Health Expenditure Review, BOP, MOH Table 8

TABLE 2

Data Sources for Indonesian National Health Expenditures Database, 1986-90

Type of Health Expenditure

Source of Funds	Hospital Govt.	Hospital Priv.	Health Center	Drugs	Public Providers	Health Programs	Training	Research/ Admin.
Government	1	na	1	1	n/a	1	1	1
Private								
Out of Pocket	1,4,5	2	1,4,5	3,4,5	7,8	na	--	--
Insurance	4,5	2	4,5	3,4,5	3-5,7,8	na	--	--
Employer	9	9	9	3,9	9	1	--	--
Foreign Aid	1	na	1	1	--	1	1	1

Data Source Codes

1 Public Sector Study - Current
2 Private Hospital Study - Oct - Dec
3 Drug Survey - Oct - Dec
4 ASKES - Dec - Jan
5 Insurance Company Study (ICS) - Dec - Jan
6 SUSENAS - 1986
7 SUSENAS - 1987
8 SUSENAS - 1990
9 Employer survey - Dec - Feb.

2. Framework Matching Data Source to Private Sector Expenditures

The proposed framework matching specific data sources to specific health expenditures by different private sector sources is presented in Table 2 The column headings indicate the different health expenditure categories The rows indicate the specific source of payment The numbers in the cells are codes which indicate the proposed data sources The data sources include a mix of existing and new databases For example, to estimate out-of-pocket expenditures for health centers, data from the nearly completed government sector database will be combined with data from proposed surveys of ASKES and private insurance companies Provided below is a summary list and discussion of the objectives and methods associated with each of the different data sources included in the framework Following a discussion, each of the considerations for combining the different data sources are reviewed

Summary List of Data Sources for Health Expenditure Database
and Proposed Time Period for Integration into Database

Public Sector Study - Current
Private Hospital Study, Oct - Dec
Drug Survey, Oct - Dec
ASKES, Dec - Jan
Insurance Company Study (ICS) - Dec - Jan
SUSENAS, 1986 - Jan
SUSENAS, 1987 - Jan
SUSENAS, 1990 - Jan 1991
Employer Survey, Dec - Feb

The data sources include a mix of existing data, as well as new data The role of each of these data sources and the methods required for collecting the data and integrating the data into the health expenditures database are described in detail below for each data source

The public sector study will provide detailed data on government-sponsored health expenditures for all of Indonesia This study is on-going and is described in detail elsewhere

The Objectives of the Private Hospital Study are as follows

- To provide an estimate of the total national expenditures to private hospitals,
- To distinguish out of pocket vs insurance (direct bill),
- To provide estimates of the average and variance in cost per admission for different types of admissions,
- To provide estimates of the distribution of services (i e , drugs, lab, etc) within the stay.

The methods for this study are summarized below The detailed methodology for conducting this study is attached

- Select a nationally representative set of hospitals based on the MOH master file of hospital characteristics (N=50-60 in 6 to 8 provinces)

- Develop data collection instruments

  - Hospital Level - Collect data for the available time period on a monthly basis (every other month),
    critical variables - total revenues, sub-categories (drugs) and percentage inpatient vs outpatient and insurance

  - Patient Level - collect a sample of bills (random) over the year (n=1000/hospital for most recent year),
    critical variables - total charge, distribution among services, percent insurance, patient diagnosis, age, sex, and address if possible (also if accident and surgery patient)

The objective of the Drug Survey is to estimate national drug expenditures for the selected time period

Duplicate the methodology used in the previous phase (Make sure we get the raw data for analysis by HEPAU)

- Review and Revise Survey Instrument (N=900)

- Develop weighting scheme for non-respondents.

- Review methods for estimate distribution costs

  - Possible survey retail prices for selected high volume drugs to estimate the amount of mark-up for different distribution points (i e., hospital, apottik, etc)

- Net out Drug expenditures from other categories to avoid double counting

The objective of the ASKES Study is to estimate insurance expenditures at government and private hospitals by ASKES

The overall approach would be to rely on secondary data from ASKES

- Review available data in detail

- Develop data collection instruments,
  critical variables - Total ASKES payments for. hospital inpatient vs outpatient, drugs, health center - by hospital and by district and province

- Receive raw data and integrate into database

The objective of the Private Insurance Company Survey is to generate estimates of total health expenditures by type and location of services by employers

The overall approach would be to rely on secondary data from Insurance Companies (N=10).

- Review available data in detail

- Develop data collection instruments,
  critical variables - Total Insurance payments for hospital inpatient vs outpatient, drugs, health centers - by hospital

- Receive raw data and integrate into database

The Objectives of the Analysis of SUSENAS - 1986 and 1987 are to develop independent estimates by HEPAU from SUSENAS from 1986 and 1987 and to develop capability to analyze SUSENAS data in preparation for 1990 SUSENAS data and to develop working files for integration into HEPAU health sector financing and utilization database

The method should be

- Request copies of tapes (full survey)

- Get data and inventory files and documentation

- Develop sub-set file with just health related info

- Read into SAS for analysis

- Develop and generate descriptive tables to review data.

- Develop analysis plans

  - Estimates for Public Sector Database,

  - Analysis of demand and supply relationships,

  - other

- Write programs and generate output

- Review output and revise programs

- Write up results

- Generate small working files for transmittal to HEPAU for integration into database

The objective of the Analysis of SUSENAS - 1990 is to provide estimates of health expenditures by source for both public and private sources

Methods

- Complete the field work and data collection

- Keypunch and edit data

- Review data and input into analysis software (e.g , SAS).

- Construct analysis files and analysis plan
- Generate estimates

This survey will provide the most up-to-date and comprehensive picture of national health expenditures These data can be used for comparison and reconciliation with data from other sources.

The Objective of the Employer Survey is to provide estimates of health expenditures by employers for different types of health expenditures

Methods

- Review methods and results from previous employer survey
- Revise methods, survey instruments and sample design
- Collect data and keypunch
- Review data and input into analysis software (e g , SAS)
- Construct analysis files and analysis plan
- Generate estimates

II. CONSIDERATIONS FOR COMBINING THE DIFFERENT DATA SOURCES

The framework presented matches the different data sources to the different components of health expenditures These are presented to indicate that there is information in a particular data set that is relevant to estimating the particular health expenditure However, the specific methods for combining the data in a comprehensive manner will depend on many different factors It will be essential to review each file and to determine how well the data cover each expenditure category for a given time period In some cases the estimates will cover all expenditures in a category and in other will provide only partial coverage In many cases the time period will not match exactly For this reason it will be necessary to develop a framework and method for interpolating the missing categories of expensive in order to provide on-going estimates of national health expenditures For example, the SUSENAS may provide an estimate of out-of-pocket expenditures for physicians for a single year, say 1987 It will be necessary to develop a method for estimating these expenditures in future years until actual data can be gathered to update these projections The methods can range from simple linear extrapolations to more sophisticated multivariate models Again, it will depend on the details of how well the data fit together in toto

III. PRIVATE HOSPITAL SURVEY DESIGN

The Health Economics and Policy Analysis Unit (HEPAU) is in the process of expanding its analytical capacity with respect to a variety of important national health financing policy issues This survey of a sample of private hospitals in Indonesia is designed to contribute to these objectives in two ways

- Provide estimates of the total expenditures by both consumers and third party payors to the private hospital sector during the period 1986-88 These estimates will be used as part of the on-going system to monitor and estimate national health expenditures in Indonesia

- Provide data on the costs and characteristics of patients discharged from private hospitals in different parts of Indonesia These data will become part of the policy analysis database that is currently under construction within HEPAU These data will be useful for generating actuarial cost estimates for emerging health insurance plans and for estimating future health care expenditures under different policies

This report provides the necessary information to conduct a valid and reliable survey of private hospitals in order to satisfy the above information requirements Specifically, this report includes the following

- The sample design and proposed sample selection

- The proposed hospital level survey instrument,

- The proposed patient level survey instrument, and

- Instructions for completing the survey instruments

Each of these is presented below

A. Sample Design and Selection

In order to determine the mix of hospitals to sample, it was necessary to examine the universe of private hospitals in Indonesia and their characteristics A diskette was provided by the Ministry of Health that contained data on the characteristics of all hospitals in Indonesia (N=1504) These data were reviewed in order to understand how hospitals were coded in terms of different characteristics Several MOH staff who are currently attending UCLA were instrumental in helping to understand the coding methods and reformat the data so that they could be used for sample selection Once the data were re-coded for our purposes, it was necessary to group hospitals into categories Hospitals were grouped based on several factors including

- Population density of Province,

- Sponsorship/ownership,

- Number of beds,

- Type of hospital

The tables in Appendix A present descriptive statistics on the hospitals based on these different classifications After reviewing the data, it was determined that for purposes of this study only private

short term general hospitals would be included in the universe for sampling. Excluded from the sample are specialty and mental hospitals This resulted in a total 287 hospitals to be included in the universe Tables 1 - 3 provide summary statistics of the universe hospitals

B. Proposed Sampling Methodology

The proposed sampling methodology is driven by the proposed applications of the resulting data As described above, the applications will be twofold estimation of national private hospital expenditures and analysis of patient level cost patterns As a result, the proposed sampling method is a proportionate one based on location and ownership

The specifications for the sample are provided in the table below

PROPOSED HOSPITAL SAMPLE CHARACTERISTICS

Location	Private	Religious	Total
Urban Hospitals	22	13	35
Mixed or Rural Hospitals	12	13	25
TOTAL	34	26	60

The final sample should consist of a randomly drawn sub-sample from each of these categories A list containing the universe of hospitals to draw from is included in Appendix B

Once the final set of hospitals has been determined, it will be necessary to gather both aggregate hospital level data as well as individual patient level data Because hospitals differ in size and the number of patients that they treat it is necessary to specify a two tiered sampling methodology The sampling methods for the patient level data are as follows

- Estimate the total number of admissions at each hospital
- For those hospitals with fewer than 5,000 admissions per year the sample will be 500 patients randomly drawn from each month during the year
- For those hospitals with more than 5,000 admissions, select a random ten percent sample

A simple and accurate method for selecting a ten percent sample is to order the patients in medical record number order and then select every tenth patient For example, select the first patient then skip nine patients and select the next patient, etc It is important that the sample be drawn from throughout the year (i e , different months), owing to seasonal factors

C. Survey Instruments

There are two sets of survey instruments One set is designed to gather data at the hospital level for a three-year time period The source documents include the hospitals' annual operating and financial reports The information requested includes information on utilization, expenses and revenues The second survey instrument is targeted at individual patients It is a single page per patient The source documents include the patients' bill upon discharge Data for the most recently completed fiscal year are requested (i e , 1988) This will allow cross referencing and reconciliation with the revenue and expense data reported at the hospital level

Both of these instruments have been designed to minimize the collection of unnecessary data elements and to provide the necessary information to estimate private hospital expenditures in Indonesia

APPENDIX A

Characteristics of Private Hospitals in Indonesia

RELIGIOUS AND CORPORATE-OWNED HOSPITALS

N ___ & CORP = 287 ALL HOSPITALS = 1517 RELIG GOVT PUB CORP __ IND)

SIZE SMALL = <100 BEDS MED= >100 & <250 BEDS LARGE= >250 BEDS

DENSITY RURAL = <50 POP/KM MIXED= >49 & <500 POP/KM URBAN= >

		ALL	SIZE			ALL
			LARGE	MED	SMALL	NUMBER OF BEDS IN FACILITIES
		# OF HOSPS	# OF HOSPS	# OF HOSPS	# OF HOSPS	SUM
DENSITY	HOSP					
(1) URBAN	CORP	77	6	18	53	7,917
	RELIGIOUS	61	10	18	33	9,075
(2) MIXED	CORP	65	1	7	57	3,898
	RELIGIOUS	53	4	8	41	4,816
(3) RURAL	CORP	11	0	1	10	579
	RELIGIOUS	20	0	2	18	1,375
ALL	CORP	153	7	26	120	12,394
	RELIGIOUS	134	14	28	92	15,266
ALL		287	21	54	212	27,660

RELIGIOUS AND CORPORATE-OWNED HOSPITALS

N ___ & CORP = 287 ALL HOSPITALS =1517 (RELIG GOVT PUB CORP MIL IND)

SIZE SMALL = <100 BEDS MED= >100 & <250 BEDS LARGE= >250 BEDS

DENSITY RURAL = <50 POP/KM MIXED= >49 &<500 POP/KM URBAN= >499 BEDS

		ALL	SIZE			ALL
			LARGE	MED	SMALL	NUMBER OF BEDS IN FACILITIES
		# OF HOSPS	# OF HOSPS	# OF HOSPS	# OF HOSPS	SUM
DENSITY	HOSP					
(1) URBAN	CORP	27	2	6	19	29
	RELIGIOUS	21	3	6	12	33
(2) MIXED	CORP	22	0	2	20	14
	RELIGIOUS	18	1	3	14	17
(3) RURAL	CORP	4	0	0	3	7
	RELIGIOUS	8	1	1	6	5
ALL	CORP	53	2	9	42	45
	RELIGIOUS	47	5	10	32	55
ALL		100	7	19	74	100

RELIGIOUS AND CORPORATE-OWNED HOSPITALS

N ___ & CORP = ALL HOSPITALS = (RELIG GOVT PUB CORP ___ IND)
SIZE SMALL = MED= LARGE=
DENSITY RURAL = MIXED= URBAN=

		ALL	%	SIZE			%			ALL	% Total
		# OF HOSPS	ALL	LARGE	MED	SMALL	SIZE			# OF BEDS	% OF BEDS
				# OF HOSPS	# OF HOSPS	# OF HOSPS	LARGE	MED	SMALL	SUM	
DENSITY	HOSP										
(1) URBAN	CORP	77	26	6	18	53	2	6	18	7,917	29
	RELIGIOUS	61	21	10	18	33	3	6	11	9,075	33
(2) MIXED	CORP	65	23	1	7	57	?	2	20	3,898	14
	RELIGIOUS	53	18	4	8	41	1	3	14	4,816	17
(3) RURAL	CORP	11	4	0	1	10	0	1	3	579	2
	RELIGIOUS	20	7	4	2	18	1	1	6	1375	5
ALL	HOSP										
	CORP	153	53	7	26	120	2	9	42	12,394	45
	REI IGIOUS	134	47	14	28	92	5	10	32	15,266	55
ALL		287	100	21	54	212	7	19	74	27,660	100

APPENDIX B

Proposed Survey Instruments for Private Hospital Study

I D A T A U M U M

NAMA RUMAH SAKIT . _____

NOMOR KODE RUMAH SAKIT. _____

ALAMAT _____

_____

PENYELENGGARA/PEMILIK. _____

TAHUN DI DIRIKAN _____

JUMLAH TEMPAT TIDUR YANG TERSEDIA _____

JUMLAH RUANG RAWAT DENGAN

a.	VIP	_____	TARIP/HARI	_____
b	1 TEMPAT TIDUR	_____	TARIP/HARI	_____
c	2 TEMPAT TIDUR	_____	TARIP/HARI	_____
d.	3 - 4 TEMPAT TIDUR	_____	TARIP/HARI	_____
e	5 - > TEMPAT TIDUR	_____	TARIP/HARI	_____

NAMA RS-RS YANG TERDEKAT DENGAN RS INI

RS PEMERINTAH	RS SWASTA
1 _____	1 _____
2 _____	2 _____
3 _____	3 _____
4 _____	4 _____
5 _____	5 _____
6 _____	6 _____
7 _____	7 _____

JUMLAH PENDUDUK KOTA INI _____

INCOME PER CAPITA PENDUDUK KOTA INI _____

II DATA SARANA/FASILITAS

A	RAWAT JALAN	1988	
1	UNIT GAWAT DARURAT	_____ ADA	_____ TIDAK
2.	POLIKINIK		
	2.1 UNIT PENYAKIT DALAM	_____ ADA	_____ TIDAK
	2.2 UNIT PENYAKIT BEDAH	_____ ADA	_____ TIDAK
	2.3 UNIT KESEHATAN ANAK	_____ ADA	_____ TIDAK
	2.4 UNIT KEBIDANAN DAN PENYAKIT KANDUNGAN	_____ ADA	_____ TIDAK
3	LAIN-LAIN UNIT		
	_____	_____ ADA	_____ TIDAK
	_____	_____ ADA	_____ TIDAK
	_____	_____ ADA	_____ TIDAK
	_____	_____ ADA	_____ TIDAK
	_____	_____ ADA	_____ TIDAK
	_____	_____ ADA	_____ TIDAK
	_____	_____ ADA	_____ TIDAK
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	_____	_____ ADA	_____ TIDAK
	_____	_____ ADA	_____ TIDAK

B	RAWAT INGINAP	JUMLAH TEMPAT TIDUR		
		1986	1987	1988
1.	UNIT PENYAKIT DALAM			
2	UNIT PENYAKIT BEDAH			
3	UNIT KESEHATAN ANAK			
4	UNIT KEBIDANAN DAN PENYAKIT KANDUNGAN			
5	LAIN-LAIN UNIT			

C PENUNJANG MEDIK/INSTALASI 1988

1	LABORATORIUM	_____	ADA	_____	TIDAK
2	RADIOLOGI	_____	ADA	_____	TIDAK
3	FARMASI	_____	ADA	_____	TIDAK
4	KAMAR OPERASI	_____	ADA	_____	TIDAK
5	KAMAR BERSALIN	_____	ADA	_____	TIDAK
6	INSTALASI GIZI/DAPUR	_____	ADA	_____	TIDAK
7	PALAYANAN STERILISASI	_____	ADA	_____	TIDAK
8	KAMAR JENAZAH	_____	ADA	_____	TIDAK
9	E K G	_____	ADA	_____	TIDAK
11	REHABILITASI MEDIK	_____	ADA	_____	TIDAK
12	E.E.G	_____	ADA	_____	TIDAK
13	LAIN-LAIN				
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
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	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK
	_____	_____	ADA	_____	TIDAK

III PELAYANAN KEPADA PENDERITA

JUMLAH PENDERITA PERTAHUN

A.	RAWAT JALAN	1986	1987	1988
1.	PENYAKIT DALAM			
2.	PENYAKIT BEDAH			
3.	KESEHATAN ANAK			
4	KEBIDANAN DAN			
	PENY KANDUNGAN			
5	LAIN-LAIN			
	JUMLAH			

B	RAWAT NGINAP	1986	1987	1988
1.	PENYAKIT DALAM			
2	PENYAKIT BEDAH			
3.	KESEHATAN ANAK			
4	KEBIDANAN DAN			
	PENY KANDUNGAN			
5	LAIN-LAIN			
	JUMLAH			

C	PENUNJANG MEDIK	JUMLAH KEGIATAN		
		1986	1987	1988
1	LABORATORIUM			
2	RADIOLOGI			
3	FARMASI			
4	KAMAR OPERASI			
5	PELAYANAN STERILISASI			
6	GIZI DAN MAKANAN			
7	KAMAR BERSALIN			
8	LAIN-LAIN			

IV SUMBER-SUMBER PENDAPATAN RUMAH SAKIT PEMBAYARAN DILAKUKAN OLEH

A

		PENDERITA/ KELUARGA (a)	PERUM HUSADA BAKTI (b)	ASURANSI LAIN (c)	TOTAL ASURANSI (d)=(b)+(c)	JUMLAH PEMBAYARAN (e)=(a)+(d)
RAWAT NGINAP	1986	_____	_____	_____	_____	_____
	1987	_____	_____	_____	_____	_____
	1988	_____	_____	_____	_____	_____
RAWAT JALAN	1986	_____	_____	_____	_____	_____
	1987	_____	_____	_____	_____	_____
	1988	_____	_____	_____	_____	_____

B PENDAPATAN RS DARI POS-POS YANG HARUS DIBAYAR OLEH PENDERITA RAWAT JALAN

NO	JENIS-JENIS POS	PENDAPATAN RS PERTAHUN (DALAM RUPIAH)		
		1986	1987	1988
1	KARCIS/JASA MEDIK			
2	LABORATORIUM			
3	RADIOLOGI			
4	OBAT			
5	LAIN-LAIN			
	-EKG			
	-CT SCAN			
	-REHABILITASI MEDIK			
	-			
	-			
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	-			

C PENDAPATAN RS DARI POS-POS YANG HARUS DIBAYAR OLEH PENDERITA RAWAT INGINAP

NO	POS-POS PENDAPATAN	JUMALAH PENDAPATAN PER TAHUN		
		1986	1987	1988
1	BIAYA PERAWATAN			
2	OBAT			
3	KAMAR BEDAH			
4	ABESTHESI			
5	KAMAR BERSALIN			
6	LAIN-LAIN			

V A

DAFTAR PENGELUARAN RSU

(DALAM RUPIAH)

NO	JENIS PENGELUARAN	PENGELUARAN RS PERTAHUN		
		1986	1987	1988
1	PEMAKAIAN BAHAN			
1 1	PEMAKAIAN OBAT-2 AN			
1 2	BAHAN PERAWATAN			
1 3	ALAT-ALAT TULIS			
1 4	BAHAN LABORATORIUM			
1 5	BAHAN RONTGEN			
1 6	KAMAR TINDAKAN			
1 7	BAHAN POLIKLINIK			
1 8	BAHAN MAKANAN (DAPUR)			
1 9	BAHAN CUCIAN			
1 10	BAHAN KAMAR JAHIT			
1 11	BAHAN BAGIAN TEHNIK			
1 12	BAHAN RUMAH TANGGA			
1 13	BIAYA BANK, BENDA-2 POS DAN TELEGRAM			
1 14	BIAYA TELEPON & TELEK			
1 15	BAYA ANGKUTAN			
1 16	PAJAK-PAJAK			
1 17	BIAYA TRANSPORTASI			
1 18				
1 19				
1 20				

V B PEGAWAI RUMAH SAKIT PADA TAHUN 1988

		GAJI RATA-RATA (Rp/bl)	JUMLAH TENAGA
	I. MEDIS		
1	PARAMEDIS PERAWATAN		
	AKADEMI PERAWATAN	Rp _____	_____
	PERAWAT	Rp _____	_____
	BIDAN	Rp _____	_____
	PEMBANTU PERAWAT	Rp _____	_____
	_____	Rp _____	_____
2	PARAMEDIS NON-PERAWATAN		
	APK	Rp _____	_____
	SAA	Rp _____	_____
	ATEM	Rp _____	_____
	APRO	Rp _____	_____
	AKZI	Rp _____	_____
	_____	Rp _____	_____
	_____	Rp _____	_____
	_____	Rp _____	_____
	_____	Rp _____	_____
	_____	Rp _____	_____
	_____	Rp _____	_____
3	APOTEKER	Rp _____	_____
4	DOKTER		
	UMUM	Rp _____	_____
	SPESIALIS	Rp _____	_____
	II NON-MEDIS		
1	SARJANA	Rp _____	_____
2	SMTA	Rp _____	_____
3	SMTP	Rp _____	_____
4	SD	Rp _____	_____

D A T A P E N D E R I T A

N A M A _____

UMUR PENDERITA _____ TH JENIS KELAMIN [ ] LAKI-LAKI [ ] PEREMPUAN

T A N G G A L MASUK RS ____ HARI ____ BULAN ____ TAHUN

KELUAR RS ____ HARI ____ BULAN ____ TAHUN

LAMA PERAWATAN (LOS) _____HARI

DIAGNOSA AKHIR (DESKRIPSI, BUKAN KODE ICD-9) _____

TEMPAT TINGGAL PENDERITA/ JARAK KE RUMAH SAKIT

_____

MASUK RUMAH SAKIT DARI RUANG GAWAT DARURAT [ ]

RUJUKAN [ ]

PERINCIAN BIAYA PERAWATAN PENDERITA INI

RUANGAN/PERAWATAN	Rp	_____
KAMAR BEDAH	Rp	_____
FARMASI/OBAT-OBATAN	Rp	_____
LABORATORIUM	Rp	_____
RADIOLOGI	Rp	_____
EKG/EEG	Rp	_____
HONOR DOKTER	Rp	_____
LAIN-LAIN	Rp	_____
	Rp	_____
	Rp	_____
	Rp	_____
JUMLAH	Rp	_____

YANG MEMBAYAR DAN JUMLAH PEMBAYARAN

PENDERITA/KELUARGA SENDIRI	Rp	_____
ASURANSI PERUM HUSADA BAKTI	Rp	_____
ASURANSI LAIN	Rp	_____
PERUSAHAAN	Rp	_____
LAIN-LAIN	Rp	_____
JUMLAH	Rp	_____

APPENDIX C

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