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Indonesia
Health Sector Financing Project



HEALTH CARE INVESTMENT AND FINANCING

Report 41

Prepared for:
Social Financing Component

April 1991



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TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	3
EXECUTIVE SUMMARY	1
SCOPE OF WORK	5
I. LEGISLATION REGARDING PRIVATE INVESTMENT	6
II. LEMBAGA SWADANA	7
III. HEALTH FINANCING/HEALTH INSURANCE	8
A. Public Insurance Schemes	8
B. Private Sector Programs	8
1. Tugu Mandiri	8
2. An Indonesian PPO	9
3. St. Carolus - A Hospital Based HMO	10
IV. FOREIGN INVESTMENT IN INDONESIAN HEALTH PLANS	12
VI. HEALTH INSURANCE/MANAGED CARE AS A CONCEPT	13
VI. CONCLUSIONS AND RECOMMENDATIONS	14
LIST OF INTERVIEWS AND PERSONAL CONTACTS	15
ACRONYMS	17

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EXECUTIVE SUMMARY

As a consultant for the International Science and Technology Institute, Inc. (ISTI), the author undertook a week and a half assignment to look at health care financing issues in Indonesia.

The demand and willingness for risk coverage by the community, and the ability cum interest of providers to supply, seem to be linked to rising income. Theory and the limited evidence available suggest that there is presently a strong demand for risk coverage amongst individuals belonging to the middle class economic strata of developing countries. Indonesia is experiencing a rapid growth of the middle class and, as the average Indonesian's income increases over time, the demand for quality health care will increase as will the demand for financial protection from the consequences of catastrophic illness.

The specific criteria for any type of Indonesian risk coverage scheme should be as follows:

1. Providing a service which the community can afford and is willing to pay for (the economic efficiency approach);
2. Promoting social equity and providing access through fair distribution of available health care services; and
3. Providing an effective means of collecting revenue for the underwriting of health care.

Distinctive problems that may plague Indonesian risk coverage schemes are the following:

1. Escalating administrative costs;
2. Incentives for overuse; and
3. Incentives for provision of lower than optimal quality services.

The need for the Indonesian government to be involved in risk coverage schemes is linked to:

1. The low availability of private insurance schemes;
2. The high cost of traditional indemnity health insurance; and
3. The increasing number of those who cannot afford insurance.

The following recommendations might serve to elucidate the role of the Indonesian government:

1. Propose regulations that produce an environment conducive to participation of the private sector and which promote fair market competition;
2. Ensure that the quality of care delivered in the Indonesian Managed Health Care Program or JPKM (Jaminan Pemeliharaan Kesehatan Masyarakat) schemes is optimal;
3. Ensure protection of the JPKM members financial contributions and the fiscal soundness of JPKM programs;

4. Promote information and education in the form of social marketing to the community about risk sharing schemes; and
5. Promote social equity through cross subsidization of the needy from the more affluent.

Future health underwriting schematic models in Indonesia, whether private or government, should try to achieve the following:

1. To control cost escalation;
2. To stimulate competition among risk sharing schemes;
3. To avoid poor quality services;
4. To prevent inequitable coverage patterns;
5. To prevent the adverse selection problem;
6. To provide promotive and preventive services; and
7. To fit in well with the JPKM 'managed care model' sponsored by the Ministry of Health (MOH).

Indonesia is moving from a highly centralized economy to a more decentralized market economy. Total public and private expenditures for health are low, about \$8/capita per year, with the GOI contribution being \$3.40/capita per year alone. The government would like the health care system to be supported more by those who use the services and can afford to pay for them. The MOH would also like to transfer more control and responsibility to the local health facilities through a concept called "Lembaga Swadana", which loosely means self-financing. The basic idea is that government hospitals would be allowed to retain and use their fees to finance their operations in an efficient and effective way to improve the quality of the services. Regulations are currently being formulated on how the concept is to be operationalized and implemented. Concurrently, national legislation supporting the "managed care model" is being finalized. This paper reviews PHB (Perum Husada Bakti, a parastatal providing health insurance for GOI employees) and PKTK (Pelayanan Kesehatan Tenaga Kerja, a health insurance fund for private workers) which are public insurance schemes.

PHB covers about 15 million government employees, dependents, and retirees. The premiums are deducted from the payroll and then allocated back out to the local health care facilities on a capitated basis, after retaining a certain percentage for administrative costs.

PKTK covers about 250,000 employees of wage-based companies funded from a 7 percent payroll deduction for disability. The scheme pays on a fee-for-service basis.

There have been several private sector efforts to enter the health care underwriting field. The current paper only reviews three of them.

Tugu Mandiri, a subsidiary of Pertamina, has a six year history of attempts to establish a "managed care" scheme. To date, those efforts have not been successful. The reasons are manifold but stem primarily from the Pertamina provider's reluctance to enter an "externally managed" financing scheme, especially

when it may result in negative financial consequences for themselves. Perhaps even a more fundamental obstacle for Tugu Mandiri has been repeated attempts to utilize expatriate expertise in a manner inappropriate to the Indonesian environment.

PT Ganesha is a general insurance company currently involved in delivering limited indemnity coverage through an Indonesian PPO (Preferred Provider Organization). This scheme covers about 100,000 members in five provinces. The scheme contracts with 460 providers, and for example, in Jakarta they contract with about 20 hospitals and 247 doctors. Reimbursement is on a fee-for-service basis with a general practitioner receiving Rp. 4,000,- for an office visit, and if the patient goes to a non-network doctor, then the scheme will pay Rp. 3,200,- or 80% of the visit. When a patient is admitted to the hospital, the latter informs the insurance company of the anticipated length of stay. There is a cap on its services and the basic packet pays for basic dental services and provision of eye glasses. One of the limiting factors of the program is that their information system will need to be improved and expanded. A second limiting factor is that of trained personnel.

St. Carolus Hospital is an example of a hospital-based Managed Care Program although, in fact, the managed care program is legally separate from the hospital foundation (much akin to Kaiser in the U.S.). The program currently covers about 4,900 hospital employees and their families through a network of five health centers, 14 health units and the main hospital. The program has had favorable experience over the last year and a half and plans to offer its services to an expanded market. Although this may pose a strain on the current facilities, St. Carolus has already begun exploring the possibility of contracting with other provider groups. One recommended approach might be a joint venture with other private investors, and the expansion and replicability of the model/plan.

The MOH has committed to the concept of a "managed care model" (JPKM) for the future of Indonesian health care delivery. Features of this commitment include:

- i. The availability of a basic package;
2. The capitation of doctors, pharmacies, laboratories, health centers and private sector health providers; and
3. Lembaga Swadana government hospitals.

The managed care model will authorize the JPKM organization to manage care through:

1. An adequate MIS;
2. Utilization review of services;
3. Supervision of the quality of care issues;
4. Management of rational drug use and treatment patterns;
5. Reimbursement mechanisms; and
6. Guarantee of accessibility and appropriate care.

It is evident that the MOH is in the process of testing various concepts and practices of managed care through a variety of JPKM programs. Significant technology and information transfer from the U.S. has already taken place. One strategy already under consideration which should receive careful consideration is that of joint ventures between U.S. and Indonesian programs. This option would provide not only the venue for significant technical cooperation, but also the potential for venture capital.

SCOPE OF WORK

The Scope of Work for the consultant to conduct a needs assessment and feasibility study for private investment in the Indonesian health sector are:

- 1. Review and comment on the existing legislation concerning investment into the private and government health sectors.**
- 2. Study current interventions and plans for their implementation with regard to the new concept of corporatization (Lembaga Swadana) and offer recommendations for private sector investment in the corporatization of health services.**
- 3. Outline the steps required for a needs assessment and feasibility study of private sector investment in relation to improvement of health care delivery and accessibility of care to the community irrespective of its economic stratification. The assessment and feasibility study should include alternate sources of health financing including health insurance systems and the role of local investors as well as foreign investors.**
- 4. Outline the steps required to initiate a hospital-based health plan that covers promotive, preventive, curative and rehabilitative care and feasibility in Indonesia, and describe the role of private investment in such a plan. Interview medical directors and hospital administrators in two or more private and general hospitals to address issues concerning the feasibility of private sector investment in a comprehensive hospital-based health plan.**

I. LEGISLATION REGARDING PRIVATE INVESTMENT

Depending on the sector, there are a few major impediments to foreign investment or the repatriation of profits. A potential foreign investor has to apply to the Investment Directorate, the BKN, to get approval.

In terms of the health sector, the Indonesian Government would like to attract more private investment (though not necessarily foreign) in the public and private health sector. Examples of this include:

1. Several applications pending to build new private hospitals, some by foreign companies.
2. Private investors purchased the MRI at Cipto Hospital. A medical equipment company donated laboratory equipment (knowing that they would have a market for their chemical reagents).

There may be interest in foreign private investment in health insurance or managed care because of the size of the Indonesian market. The major drawback is the low premium level which would be less than \$10 U.S. equivalent per person per month. It would be difficult to recuperate the cost of travel, technology and U.S. salaries. Although the transfer of technology could be significant, it would be difficult to finance.

II. LEMBAGA SWADANA

Lembaga Swadana represents a major reform. Currently, the majority of the cost of health care comes from user fees but goes directly to the central government treasury. Only 17 percent is returned to the hospital that collects it. Under this new concept, certain hospitals will be allowed to keep what they collect and use it for their operating expenses. The goal is to make the hospitals more accountable, efficient and self supporting, freeing up government funds for other health related costs.

Recommendations

The author appreciates the significance and complexity of Lembaga Swadana and would recommend that Indonesia also look at how other countries such as Jamaica approached this problem of letting hospitals keep fees. In addition, the Lembaga Swadana hospitals should be equipped to bill private insurance and to contract with managed care plans that may be developed in the future. There is potential for private investment in Lembaga Swadana hospitals, especially in equipment, as in the Cipto hospital.

III. HEALTH FINANCING/HEALTH INSURANCE

There are a number of public and private health insurance schemes. Each will be discussed in brief and suggestions will be made for further study.

A. Public Insurance Schemes

The largest, PHB, covers about 15 million government employees, military personnel and retirees. Two percent is deducted from the payroll and then allocated back out to local health care facilities on a capitated basis for health centers and a packet tariff system for in-patient services.

PKTK covers about 250,000 employees of wage-based companies funded by a 7 percent payroll deduction which also includes disability insurance. According to the Bureau of Planning, this amounted to a per capita expenditure of about \$12 in 1985-86. They currently pay on a fee-for-service basis, but have committed to developing a JPKM managed care scheme in the near future.

Recommendations for Future Study

It was not possible to meet with either of these organizations during the week in country. However, they are in an excellent position to affect the direction of the health care delivery system since they are one of the primary players. There should be a detailed study of how they will manage the transition from their current status to that of managed care and what resources in terms of technology, manpower, and capital will be required to effect this change.

B. Private Sector Programs

1. Tugu Mandiri

The Tugu Mandiri/Pertamina project was the most extensively evaluated of the private sector programs, but many of the observations may be applicable to other private sector programs. The original concept was to turn the Pertamina hospital system into a Health Maintenance Organization (HMO), marketing it first to the Production Sharing Contractors (oil company employees) and then to the market as a whole. After over six years of efforts, the project has not been successfully implemented. A number of primary reasons are discussed below.

Assumption of Risk by Providers

The Pertamina Doctors were not in favor of a system in which their incomes would be based on capitation. Currently, the Pertamina Doctors are among the most highly compensated in Indonesia. This compensation is in the form of salaries and liberal benefits. Their income is not based on performance or outcome.

Interviews with Pertamina Provider representatives indicated numerous mis-perceptions about capitation which included:

- That it is inappropriate for providers to be at risk (their job is to deliver care, the insurer's job is to bear risk);

- That it may lead to a double standard of care (an incentive not to deliver care), i.e., capitation pays for basic packet services while patients having other types of insurance allow for additional investigation and treatment creating a two-tier system of care;
- That it is seen as a "cop out" for not having good management, sound standard of practice, measurement of outcomes and real time feedback to doctors on their performance; and
- That capitation was designed to counter what was perceived as the perverse incentive of fee-for-service (to make more money by increasing volume), the tendency to order more than medically necessary, practice defensive medicine (against the potential of litigation), etc.

The Issue of External Control

The other issue which seemed to be the basis for the Pertamina Doctors' reluctance was that of "Control". Up to now, the Pertamina providers have essentially functioned autonomously. The prospect of relinquishing even a fraction of this independence to an external party is not considered an attractive option.

Recommendations for Further Study

The Tugu Mandiri-Pertamina managed care effort has reached a virtual impasse. If Tugu Mandiri is still committed to establishing a managed care program in Indonesia, alternative provider organizations should be considered as well as alternative markets (other than Pertamina employees). Given the resources already expended by USAID and the stationary inertia demonstrated by Tugu Mandiri, it would probably prove more fruitful to focus on other managed care programs to promote managed care in Indonesia. In terms of recommendations for Tugu Mandiri, options such as service contracts or joint ventures with foreign or domestic partners for management support and technology transfer should be considered.

2. An Indonesian PPO

PT Ganesha is a "loss" insurance company that has developed a Preferred Provider Organization (PPO) network throughout many of the populated areas of Indonesia. It covers five provinces and has a total of 460 providers under contract. In Jakarta, for example, there are 20 hospitals and 247 doctors.

Although PT Ganesha has a corporate commitment to develop the JPKM managed care model, they are currently only operating the PPO model with payments based on a negotiated fee-for-service. The benefit plan essentially consists of: 100 percent paid for in the network and 80 percent out of network up to a maximum allowable. For example, a general practitioner in network is paid Rp. 4,000,- for an office visit. If a person goes out of network, the company pays a maximum of Rp. 3,200,- (80 percent of the Rp. 4,000,-) even though the charge may be much more. This encourages people to use the network, but does not force them to. This is a good way to introduce people to the concept of managed care (by not being coercive), especially since the predominately "white collar" worker who can afford a private insurance plan will not want a limit on his freedom of choice.

From the company's point of view, this limits their exposure. They also have maximum allowable limits per year for in-patient, out-patient, dental and vision coverage. The coverage costs about \$15 per month per family.

If a patient is admitted to one of the contracted hospitals, the hospital must call Ganesha and tell them the admitting diagnosis, proposed procedures and anticipated length of stay. The following day, a nurse visits the hospital, reviews the chart, and assigns a target length of stay.

The health plan still has a relatively small membership (under 100,000) and has not reached the "break even" point yet. There are still problems with the benefit structure whose actuarial basis is still somewhat weak.

The current MIS system is based on a dBase program on a PC. A comprehensive MIS development plan will be needed to accommodate the projected expansion of membership.

Recommendations for Further Study

PT Ganesha has made an excellent start. Their proposed transition to the JPKM managed care model will require a careful assessment of organizational structure, technical capabilities, and personnel profile. Efforts should be focused at this assessment and development of the actuarial basis for the proposed product.

3. St. Carolus - A Hospital Based HMO

St. Carolus is a private, non-profit, Catholic Hospital with a more than 70 year history of delivering quality health care. During the past two years, a pilot project to develop a managed care JPKM scheme has been conducted utilizing the 4,900 hospital employees and their families. The provider network currently consists of St. Carolus Hospital, its five health centers and 14 more Catholic health units.

During the two year trial, detailed actuarial data on unit cost and utilization rates was collected. This represents a wealth of information, and is a model of what may be called the worst case scenario, in that hospital employees are notorious over utilizers of services. Analysis of this data reveals a reduction in both out-patient and in-patient utilization, improved or stable health status, and an increase in member satisfaction.

Based on the results of the pilot project, St. Carolus is now ready to begin to market their plan to other groups. They are going to not only cover the employees and families of a bank, but the bank is going to offer to pay the premium for clients with a minimum balance.

There is significant potential with the St. Carolus model. Plans for expansion include not only development of a larger provider network in Jakarta, through contracting, but expansion to other areas of Indonesia via Perdaki, the Catholic Hospitals Association.

Recommendations for Further Study

The St. Carolus JPKM program has two years of successful experience. Consideration is now being given to expansion of the program through various strategies. Expansion to other areas through the Perdaki network could prove to be an ideal method of promoting the development of managed care in the private sector. Assistance efforts should be focused on the conduction of a feasibility study of the Perdaki strategy and the development of an organizational plan.

IV. FOREIGN INVESTMENT IN INDONESIAN HEALTH PLANS

One aspect of managed care development in Indonesia which should be further explored is that of collaboration between JPKM programs and the U.S. private sector, either through joint ventures or other mechanisms. However, there are numerous constraining factors that must be considered:

- Health expenditures are extremely low which translates into low profit margins relative to the U.S. market.
- Managed Care is a new concept in Indonesia. Potential investors must be clear on the regulatory environment prior to risking investment capital.
- The fixed overhead costs of U.S. style managed care (HMO's) is very high relative to the potential gross revenues of managed care programs in Indonesia. This renders much of the management technology of U.S. programs prohibitively expensive and inappropriate for transfer to the Indonesian environment.

With these constraints in mind, perhaps the most fruitful strategy for collaboration at the present time would involve the importation of "discreet units" of technology which would lend themselves to adaptation to the JPKM environment, such as:

- Utilization review;
- Quality assurance;
- Standards of care;
- Benefit design;
- Contracting;
- Fee schedules; and
- Organization and management.

VI. HEALTH INSURANCE/MANAGED CARE AS A CONCEPT

Health insurance/managed care is a new concept in Indonesia. Health insurance in other countries insulated people from the cost of health care, and has been one of the major causes in the escalation of health care costs. This can be prevented with good benefit design. Indonesia has a long history of having people pay for a good portion of their health care "*out-of-pocket*." Currently, Indonesian companies either provide health care directly to their workers or set aside a portion of the employee's salary for health care and pay any bills up to that limit. At the end of the year, the employee may get the unused portion or roll it over to the next year. The concept of insurance (spreading risk among a large number of people) may become more important as the cost of health care becomes truly catastrophic to the individual and employer.

The other factor that may spur the growth in health insurance is the demand by skilled workers for greater benefits. This results in increasing competition among employers to escalate company benefits. Either the company or the employer are taxed for health care benefits, so a change in the law to make a health benefit nontaxable may encourage the growth in health coverage.

There is growing interest in health insurance among Indonesian companies such as Ganesha, Tugu Mandiri, Century Life and others. Up until the present time, general or "*loss*" insurance companies were allowed to write health insurance, auto and other "*non-life*" insurance policies. Life insurance companies were allowed to sell health insurance only as a rider on a life insurance policy. The law is being changed which will allow life companies to write health insurance (without the life insurance). Historically, companies have gotten into the health insurance business as a "*loss leader*" for the more profitable life and pension business and this seems to also be the motivation of Indonesian companies.

VI. CONCLUSIONS AND RECOMMENDATIONS

The new emphasis on the private sector and the "corporatization" of the public sector will help Indonesia achieve their goals of infusing more money into the health care system, making local hospitals more accountable and self-supporting. Unfortunately, the regulations for Lembaga Swadana, health insurance, and JPKM (managed Care) are currently in the process of development, rendering impossible specific observations at present. Indonesia does not need to go through the U.S. learning curve and make all of the mistakes we have made, even in managed care. It can leap ahead and develop a self adjusting system of managed care in which providers incorporate changes and change their behavior because they are involved in the whole process.

Managed care can be the vehicle used to introduce standards of care, better medical records based on diagnosis and treatment, fee schedules, quality assurance, utilization reviews and profiling of providers to improve individual performance. Real improvement in cost, quality, management and outcomes will occur when meaningful information is gathered and fed back to providers, management or the government. Systems that tie provider files, enrollment data, financial data and clinical data (diagnosis and treatment), do sophisticated reports, can be used in utilization review, do provider profiling, etc., have been developed over many years and can be adapted to the Indonesian environment.

APPENDIX 1

LIST OF INTERVIEWS AND PERSONAL CONTACTS

John Rogosch, Chief, Office of Population and Health

Joy Riggs-Perla, Deputy Chief, Office of Population and Health

Spencer Silberstein, Office of Population and Health

Dr. Brotowasisto, Director General, MOH

Dr. Boedihartono, Director, Teaching and General Hospitals, MOH

Dr. Soemarja Aniroen, Director, Private and Special Hospitals, MOH

Dr. Nyoman Kumara Rai, Director, Department of Planning, MOH

Dr. Soedibjo Sardadi, Director, HSFP, PIO/Hospital

Professor Rukmono, Long Term Consultant, HSFP, PIO/Hospital

Dr. Rizali Noor, Long Term Consultant, HSFP, PIO/Finance

Mr. Pratolo, Long Term Consultant, HSFP, PIO/Finance

Kevin Kingfield, The Futures Group

Dr. Nico Lumenta, CEO Cikini Hospital

Husein, Managing Director, Century Life

Indomen Saragih, Director, Ministry of Finance

Anthony Perram, First Washington Associates

Augustin Utama Jubahar, General Manager, Ganesha

Dr. Samsi, Director, Husada Hospital

Azis La Sida, Director, Project Management Unit, HSFP

Dr. Sonny Irawan, Director, Productivity and Quality Management

Gunawan Rianto, President, P.T. Indra Biama Mahesa

Kristano Santosa, Partner Productivity and Quality Management

Angelo Gargaliano, General Manager, American International Assurance Co.

ACRONYMS

BKN	Investment Directorate within Indonesian Government
Ganesha	Insurance company that developed a PPO network throughout many populated areas of Indonesia
GOI	Government of Indonesia
HMO	Health Maintenance Organization
HMS	Healthcare Management Services
JPKM	Jaminan Pemeliharaan Kesehatan Masyarakat
Lembaga Swadana	Self-financing or privatization of hospitals (organization of government hospitals)
MIS	Management Information Systems
MOH	Ministry of Health
MRI	Magnetic Resonance Imaging
Perdaki	The Catholic Hospital Association
Pertamina	Oil company
PHB	Perum Hus ada Bhakti, Government para-statal insurance company
PKTK	Pelayana Kesehatan Tenaga Kevia, a health insurance fund for private sector workers
PPO	Preferred Provider Organization
Tugu Mandiri	Insurance company covering employers of the Pertamina oil company