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PILOT PROJECT CAPITATION

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Author:

Paul F. Galvin

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Prepared by:

International Science and Technology Institute, Inc.
Suite 800
1129 20th Street, NW
Washington, D.C. 20036
Tel: (202) 785-0831
Telex: 272785 ISTI UR
FAX: (202) 223-3865

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A. RATIONALE OF CAPITATION

1. Reduce the government deficit (national and local).

2. Make the government health services attractive to commercial insurance groups.

3. Ensure improved health care services through care management and preventive care.

4. Establish an incentive system which has both reward and risk.

B. REQUIREMENTS OF CAPITATION

1. Create an integrated and interdependent system in which independent providers must work together in a single integrated medical system and conform to the same rules. This system will include private, teaching and regional medical services.
2. Monitor complete patient medical history. This includes monitoring and follow-up on the status of each patient for all services rendered, not just a review of the current episode of illness.

3. Effect operational change and control cost by reducing curative service and increasing preventive service and wellness program as well as seeking alternative forms of care. The reduction or transfer of fixed and variable cost and personnel will not reduce the deficit but will increase the availability of medical services.

4. Standardize the management system. This means collection of all meaningful data for services rendered to all patients in a single system and the establishment of a functional reporting system and a Chart of Accounts.

5. Establish patient care review program to provide a prospective review of a patient's needs and the cost of service, both of which should be determined before service is rendered. It also provides a system by which management can review the quality of physician care and health center performance.

6. Develop a reward system which encourage healthiness and is distributed equitably.

C. OVERVIEW OF CAPITATION

1. General

The capitation system is not just a reallocation of the method of payment, but a change in the operating philosophy. It is a statement to each of the providers that their responsibility about what funds are being delegated to their health center and the services that are to be delivered are different from fee for service medicine.

2. Members

The members are to seek all their benefits from the regional health center to which they have been assigned. These services will also be provided outside the region if medically necessary.

3. Physician

The primary care "gatekeeper" will monitor the patients' service regardless of the place of service or the cost. If the service cannot be delivered, there is an agreed upon mechanism to provide that service outside of the district but the gatekeeper will be responsible for the coordination of care.

4. Review

An oversight group will be established to provide assistance on a prospective basis that appropriate services are being rendered. There will be a "quality of care" review of all cases to determine if health care services are delivered appropriately.

5. Reimbursement

An appropriate capitation payment and reward/risk program at various levels of operation should be developed. This should be based on the actual membership which may be adjusted to reflect age and sex factors.

The capitation system has increased the physicians' work load because in addition to treating patients they must now manage medical service on a total patient care basis. For this service, there should be some reward or penalty based on the delivery of adequate services.

6. Conclusion

Capitation is a joint agreement between mutually consenting parties about the services to be delivered and the cost of these services. The objective is better patient care at a fair and reasonable price.

D. DELIVERY OF SERVICE

1. Perum Husada Bhakti (PHB)

Perum Husada Bhakti (PHB) is an employee administrative service organization. PHB receives its major funding from a two percent payroll deduction from all government employees. This two percent deduction has been established by law. PHB redistributes the funds to the various districts/regions on a paid claim basis. The exception to this payment system is the distribution of drug funds.

2. Regional Health Service

The delivery of health service must be through government health centers in the twenty-seven provinces. Employees in both the hospital and the health center are government employees. The physicians are employees of the central government but they report to the regional medical officer. The overall administrator of the health care and public health services is the regional health officer. This person reports to the central offices of the Interior and Health Services. All funding, regardless of sources, must go through the administrator's office of the Regional Medical Officer. In addition, this office coordinates free care and outside services for the district.

PHB must deal directly with the regional medical officer as manager and coordinator of service rather than deal directly with the providers of health care delivery services. There is no competitive bidding for services from any of the various providers. All providers who can deliver service of high quality at a fair price do not directly participate in the negotiation for the PHB contract. These providers in the private sector and teaching hospital are not directly involved in the coordination of patient service.

3. Health Center

The health center has a total of thirteen functions including health care delivery, public health administration, mobile clinical service, and the administering of immunizations. This is evident when reviewing staffing requirements as compared to actual delivery of visits with their capacity for delivery. In reviewing the Report of Cost of Public Health in Rural Indonesia by the School of Public Health of Indonesia, they stated that the average usage for clinic care is 42.6% (Attachment 1). It is assumed that health centers are established based on national directives as health service clearing houses and not clinic care needs for the area.

Capacity and Cost

Personnel:		A	B
Physician(s)		1	18
Nurse(s)		2	66
Midwife(s)		3	20
Dentist(s)		1	11
Total Direct Delivery		7	115
Paramedical		3	116
Other		-	175
Total Personnel		10	406
1.	Actual clinical care delivery	1,300	298,256
2.	Capacity for clinical care delivery (Attachment 3)	50,400	828,000
3.	Percentage of capacity	25.8%	36.0%
4.	Study (Attachment 1)	42.6%	42.6%
5.	Personnel cost (Attachment 3)	Rp. 13,200,000	Rp. 508,800,000
6.	Other cost (Attachment 2)	Rp. 13,800,000	Rp. 531,700,000
7.	Total cost	Rp. 27,000,000	Rp. 1,040,500,000

Cost Per Visit

A.	All cost as clinical care (line 7 ./. line 1)	Rp. 2,076	Rp. 3,489
B.	Clinical cost at study level (line 7 x line 3 ./. line 1)	Rp. 885	Rp. 1,486
C.	Health Center capacity	Rp. 536	Rp.1,256

These are general estimates on the cost per visit. This example shows a range of cost per visit of Rp. 536 to Rp. 3,489. The deficit cannot be reduced unless the true costs by function are known.

4. Hospitals

The government hospital in each district has various functions:

a. Inpatient care
b. Ambulatory service
c. Professional office for secondary care
d. Other - support services to the health center and Regional Medical Director

A standard accounting system needs to be established to determine the reasonable cost for each function.

Listed below is a sample of the distribution of personnel within a hospital:

Capacity and Cost

Physician	11
Medical	42
Others	43
	96
Personnel cost (Attachment 3)	Rp. 128,400,000
Other cost	Rp. 134,200,000
Total cost	Rp. 252,600,000
Patient days reports	20,373
Cost per day 100% of line 7	Rp. 12,888 per day
Cost per day 50% of line 7	Rp. 6,444 per day
Cost per day 80% of line 7	Rp. 10,314 per day

In order to avoid future problems in premium allocation, standards need to be established with regard to cost and personnel requirements for different functions.

The health care delivery system is staffed based on national standards and requirements. Cost containment may reduce supply cost, however, personnel should be reallocated to other areas such as wellness.

No consideration or discussion is included here on the teaching (class A) hospitals and private hospitals which use about 40% of the hospital cost. It appears they can be a vital link in establishing a good managed care program.

E. RECOMMENDATIONS FOR REVIEW AND CONSIDERATION

The PHB program is going to revise the distribution of payment to the medical districts based on membership rather than claims. In attachment I is a comparison of the requirements needed for a capitation program and the present system at PHB. The deficiency between the capitation requirement and the present system are items to be resolved.

Listed below are other areas of concern:

1. The need for an accurate membership listing for each region by district.

2. Identification cards embossed with all members' names and their designated health center.

3. A mechanism through which membership changes to the health centers can be made.

4. A procedure for determining the contracting agent for each region or district.

5. A decision on whether the health center or the primary care physician should be the gatekeeper.

6. The establishment of a standard dictionary of terminology for all functions and services.

7. The establishment of a functional chart of income and expense numbers for use at the regional medical director's office level.

8. The development of a national utilization standard by the regional medical directors in conjunction with the directors of PHB and the department of health services.

9. The establishment of a Quality Assurance Program by PHB to review the delivery of care to the members.

10. An examination of how effective the incentive system is if the contracting officer is not the provider to the health care delivery service.

11. An examination of whether the medical staff in each region can be organized into a producer cooperative for the delivery of care.

12. Determination of the alternatives for providing free care in the national and regional programs.

13. A decision on whether there will be required, national level reporting of necessary data such as staffing by function for hospital and health center for visits/patient days by category of payors.

14. A decision on whether standard cost accounting principles will be used to determine gross and net cost by function for all services.

15. A decision on who will administrate and "stop loss" insurance funds for the national office.

16. Determination of how interregional billing should be handled.

17. The establishment of a data system showing utilization by age and sex, to be used for future capitation.

18. A decision on whether all payors should be treated equally.

19. Establishment of patient/member criteria by age/sex for the delivery of preventive care programs, for example, annual physical.

20. Establishment of standards of service for patient days, admissions, and visits per member.

21. The need for a bottom-up and top-down capitation-based standard utilization and operating standard-cost basis.

22. A decision on whether patient hours at the clinic can be more flexible and not restricted to early morning hours.

23. The need to establish an operational review and analysis group to monitor utilization.

24. The need for management audits of the drug program to be conducted by selected regional physicians.

25. Establishment of an ongoing quarterly reconciliation system of identification card holders to payments distributed.

Attachment 1

Total Monthly Cost Of Government Health Services;
41 Subdistricts In Five Provinces

(Rupiah)

	Weighted Average (US$*)	%	Lowest	Highest
All Programs	3,889,800 (2,357)	100.0	1,916,225	5,890,546
Curative Care	1,657,900 (1,005)	42.6	804,951	3,223,940
MCH	384,500 (233)	9.9	42,342	1,039,346
Family Planning	581,600 (352)	14.9	55,955	2,465,943
Immunization	317,600 (192)	8.2	28,448	872,904
Other Programs	948,200 (575)	24.4	217,725	1,767,134

*US$1 = Rp. 1,650 in this and subsequent tables.

ATTACHMENT 2

PERCENT OF TOTAL COSTS IN COST COMPONENTS
BREAKDOWNS BY FUNCTION AND SUBDISTRICT (N=41)

	FUNCTIONS					
	ALL	CC	MCH	FP	IMM	OTHER
Capital	16.36	15.78	22.31	11.81	22.31	20.74
Staff	48.90	44.67	59.35	42.20	48.82	60.85
Supplies	29.56	35.74	13.38	41.43	23.49	8.94
Supervision, Operating, & Maintenance	3.23	3.20	3.73	2.37	2.67	4.06
Total	99.99	100.00	100.00	100.00	100.00	99.57

Attachment 3

PRODUCTIVITY

1. Operational 50 weeks per year. No coverage for two week vacation.

2. Working 6 days a week and 4 hours per day to provide direct patient care. Time allowed for indirect patient care and administrative service.

3. All health care providers should see at least 6 patients an hour (10 minutes per patient).

COST

1. Physician: Rp. 200,000 per month

2. Other: Rp. 100,000 per month

3. Other cost assessment up to 51.1% of total cost; personnel is 48.9% of total cost (Attachment 2).

Attachment 4

The following is a summary of the status of PHB as of September 6, 1988 as compared to other capitation programs.

Payment System

Fee for Service	Capitation	PHB
Per visit	Per member	Per ID card holder
Episode of illness	Case management	None1
No review of proposed services	Utilization review	None[1]
No medical record audit	Quality of care review	None[1]
Self referral	Referral approval; gatekeeper control	Primary referral; physician control
Fee schedule	utilization by age/sex; average cost	None
No profit sharing	Profit/loss sharing of medical service	Saving by district to be shared

[1]As of September 1988.