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**DANA SEHAT FOR NON-WAGE BASED WORKFORCE  
PILOT PROJECT - DKI**

**DESIGN OF A DANA SEHAT FOR KECAMATAN CANDI ROTO**

**#11**

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## DANA SEHAT FOR NON-WAGE BASED WORKFORCE:

### PILOT PROJECT -- DKI

Consistent with the plans of the Department of Health of the Government of Indonesia to expand the Dana Sehat concept throughout Indonesia, DKI Jakarta has been identified as the site of a group of pilot projects for Dana Sehat for the non-wage based segment of the workforce. The group is to consist of four different labor organizations (kelompok kerja) based in four kelurahans in Jakarta. This document outlines the design and initial implementation plan for one of the groups, the Kelompok Nelayan (Fishermen's Organization) based in Kecamatan Penyarangan, Kelurahan Pluit, in North Jakarta. It is anticipated that the model outlined here will be generally applicable to other labor groups chosen for the pilot.

Because of the very short time available for the preparation of this report, the report should be viewed as a preliminary document rather than as a final one. In some instances, concepts have not been able to be developed fully, and in others, alternatives are presented rather than making a possibly premature decision. It should also be kept in mind, however, that the planned pilot programs are new, and therefore any data collected will be of limited applicability. The best way to gather data and to learn will be by actually starting.

#### A. BACKGROUND

Several labor groups in various sections of Jakarta were visited, among them the Kelompok Nelayan in North Jakarta, clothing manufacturers and tofu producers in West Jakarta, and the Pusat Industri Kecil (PIK) in East Jakarta. As already mentioned, this report focuses on the first of these groups, as that is the group where research proceeded the farthest. The Kelompok Nelayan has 680 full members spanning all of North Jakarta. The largest of its sub-units, Muara Angka, with approximately 450 full members, was chosen for the pilot. Its members are located in Kecamatan Penyarangan, Kelurahan Pluit, and are particularly concentrated in Rukun Warga (RW) I.

In terms of medical facilities, RW I contains a Puskesmas (Rp. 300/visit) and a Posyandu. Kelurahan Pluit contains, in addition, 23 general practitioners, a variety of specialists, 5 pharmacies, two 24-hour clinics, a Balai Pengobatan (government-run) and a private maternity hospital. For inpatient and referral outpatient services, R.S. Karantina, a government hospital, is most commonly visited. Rumah Sakit Atma Jaya, Husada, and Sumber Waras are all closer, but also more expensive. For outpatient care the private facilities in the kelurahan are also used. The private maternity hospital is most commonly used for maternities.

The Kelompok Nelayan does not at present offer any Dana Sehat or other assistance with medical expenses to its members. It also does not yet have any Pos Kesehatan Kerja.

#### B. BENEFITS AND HEALTHCARE FACILITIES

1. Puskesmas and Balai Pengobatan Facilities -- Rp. 200/visit. The remaining Rp. 100 is payable by the patient as a co-payment to control utilization.
2. Outpatient referrals and R.S. Karantina -- Maximum of Rp. 25,000 per year, including specialist, drugs and lab tests.

3. Inpatient services at R.S. Karantina -- Maximum of Rp. 100,000 per confinement. Inpatient and outpatient referral services have been confined to R.S. Karantina because it is a government facility (and therefore cheaper and presumably easier to work with), it is commonly used for inpatient care already, and having only one facility simplifies administration and shortens start-up time. If R.S. Karantina alone proves not to be sufficient, other facilities can be added.
4. Physical exam -- This would be provided annually to family heads only. The exam would be performed by the Puskesmas.
5. Posyandu/Pos Kesehatan Kerja -- A budget would be provided to their facilities to offer programs for members of the kelompok. The specific programs have not been determined yet, although providing first aid kits for the fishermen is one possibility.

### C. PARTICIPATION AND PREMIUM

Participation would be voluntary on the basis of family unit. The entire family would be covered, including husband, wife, and all children (and perhaps dependent parents). Premium for the program is payable monthly, and has been developed on a per family head and on two per participant base (one the same for all participants, and the other a higher rate for the family head). The initial premium calculation is summarized in Attachment I. It is presented by component to facilitate development of alternate premium rates if benefits or assumptions change. Assumptions have been clearly identified to enable the same approach to be followed in calculating premium for other labor groups. The premium is appropriate provided at least 50% of the membership participates. If participation is less than this, a redesign of premium subsidy (e.g., by the kelompok) should be considered to stimulate further interest.

Nothing has been included in the premium to cover administration expense. It is assumed that the kelompok will be able to absorb this cost for its members (and possibly part of the rest of the premium as well, to improve participation). If not, a load of not more than 5% could be added to the premium for administration.

To help ensure solvency, a reserve equal to two months of premium for all participating members should be maintained in the fund as an approximate minimum balance.

### D. ADMINISTRATION

1. Premium collection -- Premium would be collected monthly by the Kelompok Nelayan, in the form of cash only. Ideally, the kelompok would be able to pay the premium out of its general revenues, and thus would not need to make a separate assessment to its members.
2. Fund management -- Ideally, the funds would be segregated from the general funds of the kelompok. If the fund became large, it would be desirable to invest part or all of the funds in a bank. Alternatively, a participant loan facility might be established, subject to there being a minimum cash balance on hand at any time.

3. Participant identification and receipt of services -- Participants should be required to enroll for a minimum of one year. The best way to do this is to allow movement in or out of the Dana Sehat once a year for a period of two weeks or so. A rule will need to be established as well for termination of coverage in the event of non-payment of premium, consistent with the philosophy of the Kelompok Nelayan.

Each participant would be given an ID card valid for one year. The Puskesmas would recognize this card and provide services while requesting only the Rp. 100 co-payment. Care provided by R.S. Karantina would require the ID card plus a referral slip from the Puskesmas. The annual physical would be scheduled with the Puskesmas.

4. Payment for services -- The Puskesmas and Balai Pengobatan would each send a report of visits by members of the Dana Sehat on a monthly basis. The Dana Sehat would then pay Rp. 200 per visit. A similar arrangement would apply for physical examinations.

R.S. Karantina would bill the Dana Sehat on a per confinement basis for charges up to Rp. 100,000. Charges in excess of this amount would be billed to the patient directly. For outpatient referral care, a couple alternatives are possible. The ID card could be marked with a grid up to Rp. 25,000, the limit for this benefit. As services were received, R.S. Karantina would mark the charges for them off on the grid, and bill the charges marked off to the Dana Sehat once a month. When the grid was entirely marked off, R.S. Karantina would charge the patient directly for outpatient services.

Instead of using the ID card, the participants could be required to report to the Kelompok Nelayan to receive a chit (perhaps similar to the ID card grid) before receiving outpatient services at R.S. Karantina. This affords greater control and allows the timing of ID card updates to be more flexible, but it is less convenient for the participant (particularly since R.S. Karantina is far away and the Kelompok Nelayan may have limited hours) and places an additional administrative burden on the kelompok.

It is best to avoid arrangements whereby the Dana Sehat pays in full first for inpatient and outpatient referral services, and then bills the excess over the benefit to the participant. This places an additional financial strain on the Dana Sehat and is difficult for participants to understand and accept as well.

The Posyandu and Pos Kesehatan Kerja would be funded with monthly budget payments from the Dana Sehat.

5. Data collection -- The Kelompok Nelayan should keep monthly records of enrollment (i.e., total number of families and participants), visits to the Balai Pengobatan and Puskesmas, refunds to R.S. Karantina for inpatient and outpatient care and their charges, number of physical exams, and budget amounts provided to the Posyandu and Pos Kesehatan Kerja. At least annually, this information should be used to check the appropriateness of the premium rates, according to a method similar to the one outlined in Attachment I.

## **E. IMPLEMENTATION PLAN**

Following are the basic steps that need to be performed in commencing the pilot project. They are generally applicable to pilots that may be started with other labor groups as well.

1. Confirm the ability of the Puskesmas, Balai Pengobatan, and R.S. Karantina to perform the necessary administration (e.g., accepting a co-payment, monthly billing to the Dana Sehat, keeping track of benefit limits and billing amounts in excess of the limits directly to the patients, etc.).
2. Define the programs to be provided through the Posyandu and Pos Kesehatan Kerja.
3. Present the benefits and premium to the Kelompok Nelayan officers. Revise benefits as necessary to meet budget and other considerations.
4. Plan with kelompok officers for presentation of the program to kelompok members and enrollment of participants.
5. Arrange for the preparation of ID card blanks.
6. Perform the final training at the Puskesmas, Balai Pengobatan, R.S. Karantina, Posyandu, and Pos Kesehatan Kerja.
7. Conduct the enrollment. If enrollment is much below 50%, consider presentation of the program to attract greater interest.
8. Fund the Dana Sehat reserve to at least two times monthly premium. This can be done with seed money from an outside source in the form of a grant or loan, with Kelompok Nelayan general funds, or by requiring the participants to contribute premium for two months before commencing operation of the Dana Sehat.

## **F. INITIAL EVALUATION**

The initial evaluation should be performed after six months of operation of the Dana Sehat (although the fund level should be monitored constantly during the early months to ensure solvency). The initial evaluation should consist of a review of premium rate adequacy by checking the funding of the Dana Sehat and using the data collected to develop a new premium rate (although the premium rate should be changed no more than once a year unless the fund is in danger of insolvency, to avoid disruption to the participants).

In addition, feedback regarding the overall operation of the Dana Sehat should be obtained by consulting participants and administrators at both the Kelompok Nelayan and the medical facilities involved. Six months will be too short a period for any final conclusions, but it should be possible to begin to refine the administration and other aspects at that point.

## **G. FUTURE DEVELOPMENTS**

A number of enhancements are possible as the Dana Sehat develops. These are merely listed here; whether or not they are pursued will depend on the direction and success of the Dana Sehat pilot, and the objective of the Department of Health.

**Additional medical services:**

- o **maternity**
- o **emergency medical care.**

**Additional medical facilities:**

- o **privately managed facilities**
- o **Dana Sehat-sponsored facilities, e.g., for the seasonal fishermen**
- o **higher levels of benefits for inpatient and outpatient referral care**
- o **preventive, promotional, and occupational health programs**
- o **reduction of existing government subsidies in the health area for Dana Sehat members**
- o **capitation as opposed to fee for service, both as an incentive to medical facilities to participate and be efficient, and as a means of reducing cost to members through greater efficiency.**

**Attachment I**  
**Premium Rate Development**

Cost/Participant/Month

1. Puskesmas and Balai Pengobatan

566 visits/month to the Puskesmas  
 2,800 people live in RW I  
 Approximate annual incidence rate =  
 $566 \times 12 / 2,800 = 240\% = 300\%$   
 (approximate because many people outside RW I may  
 use the Puskesmas, which many people inside may not)  
 Benefit = Rp. 200/visit  
 $300\% \times \text{Rp. } 200 / 12 =$  Rp. 50

2. Outpatient Referrals

Incidence = 10% of Puskesmas visits  
 (no data exist -- this is a rough guess)  
 Maximum benefit/year = Rp. 25,000  
 Average benefit = Rp. 18,000  
 $300\% \times 10\% \times \text{Rp. } 18,000 / 12 =$  Rp. 50

3. Inpatient Treatment

Incidence = 6% of participants per year from  
 PT Asuransi Timur Jauh data for Jakarta  
 Maximum benefit = Rp. 100,000 = average benefit  
 $6\% \times \text{Rp. } 100,000 / 12 =$  Rp. 500

4. Physical Exam

Puskesmas charge is assumed to be Rp. 500  
 Every family head gets one exam per year; at 5  
 members/family, incidence is thus 20%/participant  
 $20\% \times \text{Rp. } 500 / 12 =$  Rp. 9

5. Posyandu/Pos Kesehatan Kerja

Minimum participation = 50% = 225 families = 1,125 lives  
 If budget is Rp. 20,000/month;  $20,000 / 1,125 =$  Rp. 18  
 If medicine kit that lasts 6 months at a cost of  
 Rp. 80,000 is included for each 20 fishermen,  
 $(450 / 20) \times \text{Rp. } 80,000 \times 2 / 1,125 / 12 =$  Rp. 267  
 A) Total/participant = Rp.1,294  
        x 5  
 B) Total/family head = Rp. 6,470

Alternatively, if the medicine kit and physical  
 exam costs are borne by the fishermen only:

C) Total/fisherman = Rp. 2,398  
 Total other family member = Rp. 1,018

## DESIGN OF A DANA SEHAT FOR KECAMATAN CANDI ROTO

### A. INTRODUCTION

This report outlines the structure and basic implementation steps for a Dana Sehat for the general population of Kecamatan Candi Roto in Kabupaten Temanggung, Central Java. This Dana Sehat is intended to be a pilot for planned expansion of the Dana Sehat concept during Repelita V to cover 3 million individuals. Candi Roto was chosen because its local government structure, the existence of currently operational Dana Sehat in several desa there, and other factors make it a conducive location for development of a Dana Sehat on a larger scale.

The broad strategy followed in the design of the pilot Dana Sehat has been to capitalize on existing infrastructure, organizations, and administration processes to help ensure broad acceptance of the program by the population and smooth operation. An attempt has been made to emphasize and foster operations of the Dana Sehat at the kecamatan level, in the belief that this scale will ultimately be necessary if the Dana Sehat concept is to be expanded nationwide. However, much of the operation will initially be at a lower level to help gain the participation, loyalty, and confidence of the population. In addition, the existing Dana Sehat at the desa and local levels will be allowed to continue to operate, at least initially, as they are running successfully at present. Later on, it is hoped that the kecamatan-wide Dana Sehat will be attractive enough to encourage the smaller Dana Sehat to merge into it.

This initial plan for the Dana Sehat can be viewed as a compromise between the interests and capabilities of Kecamatan Candi Roto, and the longer term objectives of the Indonesian Department of Health. On the one hand, Candi Roto understandably wants something that will have a high probability of success, and Candi Roto, as would any other kecamatan, has financial, administrative, and other limitations in terms of what it can take on. The Department of Health, on the other hand, is viewing this as a pilot, which means trying new things and trying them on a larger scale. Fortunately, the interests are not incompatible, and hopefully the plan presented here represents an initial compromise that will be both satisfactory to all concerned and serve as a foundation for future development along the lines desired by the Department of Health as the condition of the pilot program permits it.

This document should be viewed as a preliminary description and implementation plan rather than a final one. The time available to prepare this has been quite limited, and it may also be that input from members of the team that traveled to Candi Roto and/or opinions of the individuals consulted in Candi Roto have not been fully or properly expressed or reflected here. Consequently, some ideas are not fully developed, and in other instances alternatives are presented rather than risking a possibly premature conclusion.

It should also be kept in mind, however, that the newness of this concept (or at least scale and the relative lack and/or inapplicability of existing data) means that far and away the most effective way to learn and gain data will be by doing. Perhaps the one area where extra care should be taken at the outset is with respect to the participation, support, and enthusiasm of the population, because if these are ever lost they will be difficult to recover.

As a final point, because of the tremendous variety of factors having an influence on the design of the Dana Sehat, and the high potential for these factors to vary from one kecamatan to another, it will be important to establish pilots such as this one in several kecamatans. This will help ensure that the experience gained will be broad enough to have application in the planned nationwide expansion of Dana Sehat.

## B. BACKGROUND INFORMATION -- CANDI ROTO

Candi Roto consists of 29 desas, and has a population of 44,100. There are two Puskesmas and two Puskesmas Pembantu within the kecamatan. In addition, a Puskesmas Keliling visits each desa at least once a month. The charge at all these facilities is Rp. 250. The only private medical practices in the kecamatan are the two doctors who work at the Puskesmas, a dentist who divides his practice between this and a neighboring kecamatan, and two company-owned Balai Pengobatan. For inpatient care, patients are usually referred either to the Puskesmas in Ngadirejo, the neighboring kecamatan, which has inpatient facilities, the government hospital in Temanggung, or a private Christian hospital in a neighboring kecamatan. There are 119 Posyandu in the kecamatan.

Each desa has at least one functioning Dana Sehat, however, only four desas have Dana Sehat that are used for curative medical care. With one exception the Dana Sehat in these four desas operate at below the desa level (usually dukuh). They are of two types. Under one type, participants go to the Dana Sehat first to receive Rp. 250. Under the other type participants visit the Dana Sehat first also, but receive a Kartu Tanda Pengenal, which they show at the Puskesmas. The Puskesmas then fills in a chit with the patient's name and information, and gives half to the patient, who gives it to the Dana Sehat. Once a month, the Puskesmas bills the Dana Sehat, which performs a reconciliation and then makes payment. Under both models, any Puskesmas facility in the kecamatan can be visited. Only one Dana Sehat, the one in desa Candi Roto, covers some of the cost of inpatient confinements. The amount paid is subjectively determined, based on the ability of the patient to pay, the size of the bill, and the amount of the Dana Sehat. Typically, the benefit from the Dana Sehat is supplemented with voluntary contributions from the Rukun Tetangga (RT) and family heads in the desa.

The Dana Sehat in all four desa are used for a variety of other purposes, usually related to the physical well-being of the community. All the Dana Sehat also allow members to borrow funds, which is a significant source of income to the Dana Sehat, as interest charged is quite high (5% and 10% per month in the two desa visited).

Among organizations in the kecamatan, the Koperasi Unit Desa is particularly well-managed and effectively run.

## C. BENEFITS AND HEALTHCARE FACILITIES

The planned Dana Sehat would offer some or all of the following services, depending on the ability of the members to pay the necessary premium:

1. Puskesmas services at the Puskesmas facilities in Candi Roto -- These would be paid in full by the Dana Sehat, or alternatively a small (probably Rp. 50) co-payment would be required to help control utilization. The former is probably better, since existing Dana Sehat pay the Rp. 250 in full. Persons who typically visit Puskesmas outside of Kecamatan Candi Roto would be assumed not to participate, to enable the initial program to be kept simple.
2. Inpatient care at the kabupaten hospital in Temanggung -- Up to a maximum of Rp. 25,000 per confinement.
3. Posyandu -- Funds from the Dana Sehat would be used to conduct desa level meetings once every four months or so in each desa. These meetings would involve Puskesmas personnel, would be focussed on providing encouragement and assistance to the cadre (in part to try to reduce the high 30% dropout rate for Posyandu cadre), and would take the place of the regular monthly Posyandu meetings at the dukuh level. A budget of Rp. 5,000 would be provided for each of these meetings from the Dana Sehat.

4. Health-related education and demonstration -- A budget would be provided for this purpose. Rp. 20/month/family head is assumed to fund this budget. The specific programs to be sponsored with these funds would need to be defined carefully; they have not been defined at this time.
5. Loan facility (simpan/pinjam) -- Once the fund achieved a certain size, participants would be able to borrow money from the fund subject to cash in hand of the fund not dropping below a certain minimum size. This minimum should be based on the monthly contribution per family member (perhaps two months' contribution per participating family head). The rate of interest would also be set at a fixed level consistent with existing government guidelines in this area.

This is seen as an important feature of the Dana Sehat, as it is something all members can take advantage of (i.e., even those who rarely visit the Puskesmas), and it provides revenue to the fund.

6. Related community-based uses -- If the Dana Sehat grows very large (perhaps 5 months' premium per family head or more), funds in excess of this amount could be allowed to be diverted for related community projects. This would serve as an incentive for low utilization, and also offer something to those desas who, because of their distance from the Puskesmas, may feel they do not get adequate or equal coverage for their premium.

#### D. PARTICIPATION AND PREMIUM

Participation and premium would be on the basis of family unit, with husband, wife, and all children (and possibly dependent parents) included. The premium is developed in Attachment I, and assumes a participation of at least 15,000 people (or approximately 3,000 family heads) throughout the kecamatan. This minimum participation is very roughly based on 40-50% of the population not insured elsewhere (e.g., under ASKES) electing to participate. Efforts should be made to ensure at least this level of participation, as at lower levels of participation adverse selection may drive costs up.

The premium calculation has been laid out in a "building block" fashion so that it may be easier to develop premiums for other benefit assumptions by substituting the necessary data into the formula. It should be kept in mind that this premium is only a rough estimate of the cost, as the data available is limited and not directly applicable. Only experience will reveal what the actual cost will be.

The premium has been expressed in rupiah. However, due to the prevalence of collecting premium in kind (e.g., rice) within the existing Dana Sehat and the feeling among the population that in-kind payments are less of a burden, this practice should be allowed as well. In addition, due to the relatively limited means of some of the population and the need to encourage broad support and participation, some flexibility should perhaps be permitted in terms of the amount contributed (e.g., allow contributions to vary somewhat based on means, while seeing that the average contribution remains more or less consistent with the premium in Attachment I). This may be quite difficult to manage and monitor, and it does not lend itself well to widespread replication in other kecamatans. However, this flexibility may be necessary at first to achieve the necessary "critical mass" in terms of participation to get the Dana Sehat started.

In-kind payments should be made every day, consistent with existing practice, while rupiah payments should be at least once a month and possibly more often due to the limited means of the participants.

To simplify administration and reduce the possibility of adverse selection, it must be possible to switch back and forth between the existing Dana Sehat for curative medical care and the new Dana Sehat. The simplest approach is to exclude residents of desa where these Dana Sehat exist from participation in the kecamatan with Dana Sehat. Alternatively, they might be allowed to participate, but only allowed to switch membership once a year (e.g., during the first two weeks of January), or not at all. Also, to avoid adverse selection, it will be necessary to require participation for periods of at least one year (again, perhaps by having an open enrollment period once a year).

It will probably be necessary to establish a policy regarding termination of coverage in the event of nonpayment of premium as well, perhaps consistent with the practice in existing Dana Sehat.

The Dana Sehat fund should probably have a buffer equal to one or two months of premium to ensure fund adequacy and stability. This could be accomplished by requiring premium payment for a few months before commencing coverage, or through the use of seed money, as will be discussed in the section on implementation.

## E. ADMINISTRATION

### 1. Premium Collection

Consistent with the existing Dana Sehat, this should be done at the RT level, perhaps coordinated by the wife of the RT. Discussions in Candi Roto revealed that community identity and a sense of participation and belonging tend to be much stronger at the smallest units of government organization, as opposed to larger ones such as kecamatan or even desa. Thus, fund collection would be coordinated at this very basic level to encourage participation and ease problems of collection, even though this necessitates a much broader administrative network.

### 2. Fund Management

This would be done at two levels. For the reasons described above, the bulk of the fund would be kept at the desa level (or, if absolutely necessary, the dukuh level). In the premium development, 85% of the premium is assumed to be kept at this level. The remaining 15% of the premium would be passed on to a kecamatan level fund. This money would be used as a margin fund in the event any desa fund dropped below a certain threshold (e.g., the "reserve" -- perhaps two months of premium in cash in hand) or was insufficient to pay a claim (e.g., inpatient). The funds for Posyandu and education and demonstration could also be sent to the kecamatan, if it made more sense to coordinate these programs at that level. However, at least initially, the portion of the premium sent to the kecamatan should be kept relatively small to further an association of the program with the local community and thereby encourage participation.

The fund held at the kecamatan level could also be used for kecamatan-wide health-related projects once it exceeded a certain size (i.e., a minimum balance that should be maintained). Use of the fund in this way would help the desas feel that they were getting something for the money they sent to the kecamatan (e.g., if there proved to be little need to subsidize the desa level funds, so the kecamatan level fund grew unabated).

### 3. Investment of the Fund

Desa level funds would be held, probably by the Kepala Desa, and invested in loans to members at a rate controlled by the Dana Sehat. Kecamatan level funds would be greater, and should probably be invested in a bank.

#### 4. Koperasi Unit Desa (KUD)

Because this organization is relatively strong in Candi Roto, it has been proposed as an alternative to the government units for premium collection and fund management. One of the advantages to this is that the KUD may be able to subsidize the premium payments for its members and stimulate participation. Use of KUD does present the possibility of some administrative confusion, since the KUD organization overlaps the boundaries of the government units (i.e., RT, RW) otherwise used for some of the administration. However, this problem is probably surmountable, and use of KUD would broaden the experience gained from the pilot Dana Sehat in Candi Roto. If the KUD is used, it would perform all of the administrative functions except those at the kecamatan level.

#### 5. Participant Identification

Under the system described here, the "eligibility information" would be maintained at the desa or perhaps even lower level. Since this is a level at which everyone knows everyone else, an informality in the keeping of this information is possible (i.e., the RTs and Kepala Desa can probably remember everyone who is participating). Given this, the simplest approach for utilization of services is probably to have each participant who wishes to visit the Puskesmas get a Kartu Tanda Pengenal from the desa beforehand. This would then be submitted to the Puskesmas, which would fill in a form in duplicate, keeping one and giving the other to the patient to be returned to the desa level administration. Once a month, the Puskesmas would send their copies of the form to each desa, where they would be reconciled with the desa's copy and payment would be made. This system has the added advantage of controlling utilization, as the patient must report to the desa first before receiving care. This system is used by some of the Dana Sehat now operating in Candi Roto, and seems to be working well. Aspects of this system are also used by many companies in Jakarta in providing similar benefits to their employees.

If the administration is moved up to higher government levels (ultimately the kecamatan), the informal system of eligibility recordkeeping and the requirement that a participant visit the administrative office before visiting the Puskesmas will become less practical. It will probably be necessary to adopt formal records and give each participant an ID card valid for a year or more when this happens.

It may also be true that the informal system will be difficult to apply within the KUD if this organization cannot be broken down to the desa level as well (e.g., if membership is large relative to the population of a desa, or the geographic area of the KUD membership is broad).

Inpatient services at the government hospital would require a Puskesmas referral, and thus would use the same system as that described above for participant identification. For other services provided with Dana Sehat funds (except the loan facility), presumably the Dana Sehat would not concern itself with whether or not non-participants benefited as well.

#### 6. Payment from the Fund

Puskesmas charges, as described above, would be paid on a monthly basis. Hospital charges would be paid directly to the hospital on a per confinement basis. Posyandu and education and demonstration services would be funded with payment of a monthly budget from the Dana Sehat. All of the payments would be made first from the desa level funds, although the payments for the last two could be from the kecamatan fund if coordination of these programs at this level made sense.

The kecamatan fund would be used, on a monthly basis, to maintain minimum cash balances in the desa funds (probably twice the monthly premium per participating family), and to pay claims at other times when desa funds are insufficient. Amounts paid to the desa funds would not be repayable to the kecamatan fund. If this does not satisfy desas which do not require funds from the kecamatan, annual bonuses could be paid to the desa funds which don't require any kecamatan funds during the year, or repayment could be required. Both of these alternatives complicate matters and therefore should probably be avoided if possible.

## 7. Data Capture

Data for calculating premium rates should be kept at the kecamatan level, and premium appropriateness should be reviewed using this data at least annually. At a minimum, each desa fund should send to the kecamatan fund administration the following information:

- o number of Puskesmas visits
- o number of hospital referrals
- o monthly payments from the fund by category (including budgeted items)
- o fund balance at beginning and end of month
- o summary of loan activity
- o number of families (and, if available, number of participants).

## 8. Compensation

To provide an incentive to those collecting and managing the fund, these individuals could be offered the loan facility at a reduced or zero interest rate. Providing only an indirect incentive such as this will help keep costs down. Since medical providers at the Puskesmas are salaried already and are asked to do relatively little extra work, no incentive may be necessary for them.

## F. IMPLEMENTATION STEPS

The following is a very general implementation plan. Only broad steps are identified as the details will depend on how the administration and other aspects of the program are finalized.

1. Review proposed benefits and cost with the kecamatan leaders and all the Kepala Desa. Make changes to benefits as necessary to fit the budget.
2. Review proposed administration with kecamatan leaders and all Kepala Desa. Ask the latter to hold similar meetings with RW and RT in their desa regarding aspects of the administration involving them. At this time, also, plan with these individuals for having desa or dukuh level meetings to explain the program and enroll individuals.
3. Conduct training at the Puskesmas and the government level.
4. Conduct the initial enrollment. If enrollment turns out to be far below the minimum desired, it may be necessary to rethink the design to encourage higher participation.
5. Initial findings: Ideally, the fund (at desa and kecamatan levels) should have a reserve equal to two months of premium before the operation begins. This could be done by requiring premium payment for two months before commencing the program, or providing seed money from an outside source in the form of either a grant or a loan.

If the latter is chosen, excess funds which accumulate at the kecamatan level (perhaps in excess of 15% of four or five months' premium) should be used to repay this loan first, plus any interest.

#### **G. INITIAL EVALUATION**

The first evaluation of the program should be performed after six months of operation (though fund levels should be checked monthly at first to make sure the financing of the program is stable and adequate). This initial review should consist of a detailed evaluation of premium rate adequacy by checking fund levels and developing a premium using claim data collected. However, as long as solvency of the fund is not in jeopardy, it is probably best to change the premium not more than once a year, as more frequent changes are disruptive to participants. The rest of the review should be collection of feedback from participants and administrators on the performance of the fund to date, perhaps by circulating questionnaires (e.g., one to each desa or dukuh), or by conducting local meetings. Six months will be too short a period of time in which to draw final conclusions, but it will be possible to consider refinement of the program at this point.

#### **H. FURTHER DEVELOPMENT**

Longer term, a number of enhancements are possible. These are only listed here, as their feasibility will depend on the success and direction of the initial pilot and the goals of the Department of Health.

- i. Expansion of coverage
  - a. Curative care -- referral outpatient care and greater inpatient coverage
  - b. Additional promotional, preventative, and other health services
- ii. Elimination or reduction in government subsidies in the health area
- iii. Shifting more administration to the kecamatan level to facilitate the expansion of the Dana Sehat concept nationwide
- iv. Introduction of capitation as opposed to fee for service, from the standpoints of both reducing cost by increasing efficiency, and potentially providing the Puskesmas and other health facilities an incentive to participate.

Attachment I  
Premium Calculation

Cost/Family/Month

1. Puskesmas Services Cost/Family/Month

Current visits/month = 1,350  
Current population = 44,100  
Annual incidence =  $12 \times 1,350 \div 44,100 = 37\%$   
increase to 100% to reflect higher average utilization  
of those who participate and the fact that  
some people leave the kecamatan for treatment  
Average family size = 5  
 $100\% \times \text{Rp. } 250 \times 5 \div 12 =$  Rp. 104

2. Inpatient Referral

Benefit limit = Rp. 25,000 -- assume it is  
reached each confinement  
P.T. Asuransi Incidence = 4%/year -- based on  
Timur Jauh experience for Jakarta of 5-6%,  
reduced some for expected lower utilization in rural area  
 $4\% \times \text{Rp. } 25,000 \times 5 \div 12 =$  Rp. 416

3. Posyandu

29 desas  
1 meeting/desa every four months  
Rp. 5,000 budget per meeting  
Assumed minimum participation = 15,000 lives  
= 3,000 families  
 $29 \times 3 \times \text{Rp. } 5,000 \div 3,000 \div 12 =$  Rp. 12

4. Education and Demonstration

Budget based on contribution equal to Rp. 20

TOTAL: Rp. 552

15% margin fund held at the kecamatan level 82.8

Rp. 634.8