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**EXIT/PROGRESS REPORT ON
CONSULTING TEAM ACTIVITIES FOR
PTTUGU MANDIRI FEASIBILITY STUDY
TO DEVELOP A
HEALTH MAINTENANCE ORGANIZATION
PRODUCT LINE OF BUSINESS**

#20

Author

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Jakarta, 17 April 1989

Prepared for:

Health Sector Financing Project
Ministry of Health
Republic of Indonesia

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TABLE OF CONTENTS

	Page
Exit Report	1
Appendix I: March 29, 1989 Report of Drs. Siddharta and Siddharta	8
Appendix II: April 14, 1989 Report of Drs. Siddharta and Siddharta	15
Appendix III: Final Data Request	18
Appendix IV: Data Check Lists	22
Appendix V: Revised Scope of Work	28

Jakarta, 17 April 1989

Drs. Rosnim Djaafar
President Director
PT Tugu Mandiri
Wisma Tugu
Jl. H.R. Rasuna Said

Kuningan, Jakarta 12910

Dr. Thomas R. D'Agnes
Chief of Party and Technical Coordinator
Health Sector Financing Project
International Science and Technology
Institute, Inc.

Ministry of Health
Bureau of Planning
Jl. H. R. Rasuna Said

Kuningan, Jakarta 12950

Re: Status of Tugu Mandiri HMO Feasibility Assessment / Business Plan
Project at Consultants' Departure From Indonesia

Dear Drs. Djaafar and D'Agnes:

As the American consultants who undertook to assess the feasibility of a Tugu Mandiri Health Maintenance Organization (HMO) and, if feasible, to prepare a business plan and an operational plan of action, we have completed the allotted four weeks in Indonesia and submit this status report on our activities, accomplishments and recommendations.

In summary, due to the lack of sufficient information--demographic, cost, utilization, health care provider, actuarial and other--we are unable to assess the feasibility or begin preparation of the business and operational plan; however, we will complete the original Scope of Work upon completion of a comprehensive data collection phase which we outline in this report.

Based on our overall observations, we have determined that the needed information is recorded and maintained in various places and formats and is retrievable for our purposes. The design and implementation of a comprehensive data collection process is vital to the success of this project and is of great importance to the Indonesian government's current five-year plan, Repelita V, and to the other health and medical service programs under the overall USAID Health Sector Financing Project. We are confident that the results from the data collection process will result in our ability to make the feasibility assessment and prepare the business / operating plans in support of Tugu Mandiri's goals and objectives as stated in the original Scope of Work.

The outcome of our efforts to date are: (a) a cohesive, knowledgeable team of American expatriots and Indonesian nationals who have favorable relationships with the sources of needed information; (b) refinement of the specifications for this information and several check lists / aids to facilitate collection; (c) identification of the multiple sources of this information; and (d) a Revised Scope of Work that contains a comprehensive strategy to collect the needed data from appropriate sources. This data, when received, will permit us to perform a feasibility assessment containing a business plan and an operational plan of action for a Tugu Mandiri HMO/managed health care system for the target markets.

We think this project (i) implements an Indonesian government policy set forth in Repelita V to encourage new health care financing approaches, (ii) offers insight into the causes of cost increases in health care delivery that are the basic reasons for the Repelita V policy and that will be useful to select and implement appropriate health financing methods to contain or reverse health care cost increases being experienced in health benefits sponsored by employers and the government, and (iii) orients and educates important Indonesian nationals involved in employee health benefits, their financing and provision. We recommend that this Revised Scope of Work to add necessary data collection be approved and the original feasibility assessment / business plan / operational plan be prepared in support of the target markets and other potential HMO / managed care markets upon completion of the proposed data collection process.

I. Background

In early March, we participated in a meeting at the ISTI office in Washington, D.C. to review and revise the Scope of Work for a Tugu Mandiri HMO feasibility assessment and business plan. Professor Robert Shouldice of the George Washington University School of Public Health also participated, along with Bob Pratt and Jennifer Beckett of ISTI. The original Scope of Work had been written in light of Professor Shouldice's visit to Tugu Mandiri earlier this year--especially his meetings with Drs. Djaafar and expatriate USAID and ISTI staff. The principal revisions were: deletion of the Pertamina active employees and their dependents from the project's target market and expansion for research on tax and legal ramifications of the HMO. We were also asked to consider appropriate methods of funding Pertamina retiree health benefits during an employee's active employment and to see if employee health benefit costs can be tax deductible under Indonesian corporate income tax regulations.

At the conclusion of his meetings in Indonesia, Professor Shouldice left a two page list of needed "Data Elements for HMO Planning" and in the Washington, D.C. meeting we were told to expect all the necessary data to be available for our review upon arrival in Jakarta; however, we received very little usable information during our four week stay in country.

Prior to leaving the United States we individually received subsequent briefings on the project in meetings and telephone conversations with Professor Shouldice and Bob Pratt. We received copies of a draft 1986 HMO Market Study and Business Plan for Tugu Mandiri (the REACH Report); however, that report was not accepted by USAID or Tugu Mandiri because its data was not supported and its recommendations were not specific or practical for implementation.

In light of the inadequacies of the REACH Report, we were instructed to prepare a report, if the HMO is feasible, that clearly explains to Tugu Mandiri staff the factual, statistical and financial basis for our conclusions/recommendations, in a form appropriate for Tugu Mandiri and Pertamina executive staff and Board of Directors purposes.

Upon our arrival in Jakarta, we established a reporting relationship to Jim Marzolf, M.D. of ISTI, with frequent contact with Tom D'Agnes who is ISTI Chief of Party for the project. We established offices in the Tugu Mandiri office suite and recognized Drs. Djaafar as the principal and Tugu Mandiri as the ultimate

client. We formed a working task force with Nanang Iskandar, M.D., Director Umum of Tugu Mandiri, Rochwan Muthalib, FLMI, Underwriting Manager of Tugu Mandiri, and Soejadi, Hospital Resources Development Chief in Pertamina's Central Administrative Health Bureau in Jakarta. R. Pratolo also joined the task force as actuary.

In addition, Hans Schaefer of PT Nagadi Ekasakti was engaged as the resources coordinator for tax and legal matters. Through Mr. Schaefer, Drs. Istama T. Siddharta, President-Director of the Drs. Siddharta & Siddharta independent accounting firm that is associated with Coopers & Lybrand, undertook the tax research and issued two reports which are attached as Appendices I and II. Dr. Liana S. Gunawan of Kantor Notaris Kartini Muljadi undertook the legal research in conjunction with Mr. Schaefer, and their report is expected.

II. Team Activities.

Our team or task force activities involved: (a) an extensive exchange of information between the expatriate consultants and Indonesian nationals to build mutual understanding, trust and a united approach to our project; (b) refinement of the list of needed information to incorporate specific needs of the actuary and consultants, as well as to accommodate Pertamina/production sharing contractor (PSC) actual operations and administrative processes; (c) identification of the sources of this information; and (d) planning how to collect this information.

Virtually all of the information submitted to the team was collected at Pertamina by Soejadi. During our first week in country, working from Professor Shouldice's list, Soejadi presented age data on the Pertamina retirees as well as the total number of retirees and widows and spouses covered for health benefits. He also presented a list of the total number of PSC employees by contractor. Soejadi reported that most of the required data was unavailable, especially with respect to the PSCs and specific financial and utilization data.

During the first week, Drs. Djaafar introduced us to Mr. Soeranto S., Director of PT Tambang Timah, the Indonesian national tin mining company, and a senior member of his staff because the tin mining company was experiencing similar increases in employee health benefit costs and Mr. Soeranto was interested in the HMO concept to help control costs and improve health care for Timah beneficiaries.

During the second week we met representatives of two PSCs-- Dr. Soeprawoto of Marathon Petroleum Indonesia, Ltd. and Marijke Salomo of Roy M. Huffington, Inc. Although not in his official capacity as Marathon Medical Director, Dr. Soeprawoto supported the Tugu Mandiri HMO project as offering an improvement in the quality and availability of health benefits for Marathon employees who currently receive a cash stipend monthly for most family outpatient care and who have usually spent the stipend and are unable to pay when a family member becomes ill. Mrs. Salomo was responsive to our questions. Both confirmed the availability of the information we need, but neither could provide information to us without instructions from their superior who probably would refer the matter to their home offices in the United States unless Pertamina requested their cooperation with us.

As we discussed the team's limited receipt of data and discouraging efforts to collect the balance, it became clear that a more specific list of needed information was essential to focus efforts properly. We were concerned that the project team was not

receiving full cooperation and that additional support was required from Pertamina and the Ministry of Health.

Early in the second week, we drafted a more specific list of data elements required for analysis and reviewed it line by line with team members. That dialog led to many revisions and, in the middle of the revision process, Drs. Djaafar suggested to us that the Indonesian team members did not understand many of the concepts and terms used in the data list. Accordingly, we spent the better part of the next day explaining the nature of our assignment, how HMOs operate in the United States, what our terms mean, particularly in the operation of an HMO, and how the requested information will be used in assessing marketing, finance and provider aspects of a potential Tugu Mandiri HMO. A copy of a feasibility study and business / operating plan completed for a US company was utilized to explain to team members, Drs. Djaafar and ISTI, just what is involved in the development of such a report. That orientation /education process resulted in a significant breakthrough. First, we were able to revise the information specifications so that everyone understood them, using many Indonesian concepts instead of American-- e.g. employment regulations describing employee health benefits instead of the American "benefit plan" or "benefit package". A copy of the final data request (excluding Tugu Mandiri organization/ capabilities/ resources relevant to the HMO which still must be identified) is attached as Appendix III.

Having completed the Pertamina and PSC information specification, we prepared five check lists to aid the team and the data gatherers in identifying what information is needed about each data source--Pertamina and non-Pertamina hospitals, their hospital based clinics, their free-standing clinics, PSC beneficiaries and Pertamina retirees. Because most Pertamina utilization information has active employee and dependent information combined with retiree / widow / spouse data and because active employee benefits are not budgeted separately from retiree benefits, we added employee data to the data request. A set of these check lists is attached as Appendix IV. They will indicate if each source has reported necessary information, but these check lists are not intended as answer sheets for submitting data.

Finally, we concluded that collecting this information for Pertamina retirees requires contact with the Pertamina Human Resources (including health) or Umum Direktur's department and the Pertamina Finance Department in the administrative office for each of Pertamina's seven operating regions (North Sumatra, South Sumatra, Dumai, Kalimantan, Cirebon, Cilacap and Sorong) and for Jakarta. This means collecting information from a total of 16 departments / locations because of the way Pertamina is organized with decentralized health facilities in each region. Some, but not all, of the needed employee and retiree information is available in the central administrative and finance departments in Jakarta.

For the PSC beneficiaries, limited information is available in the Pertamina Jakarta BKKA Health and Finance Departments. Most of the information is maintained at the 17 PSC offices. Some PSCs operate their own hospitals and clinics; and, therefore, we must determine how to collect and integrate the PSC beneficiary information and PSC health facility operations into Tugu Mandiri's business plan. At the request of senior executive staff of Pertamina, the PSCs will cooperate with our data collection efforts.

III. Comprehensive Data Collection - Revised Scope of Work

The team has devoted considerable thought to effective approaches for the collection of needed data from this geographically widespread network of potential data sources. We have concluded that the development of a formal information system and data collection process is required to support the conduct of a comprehensive feasibility study, and, if feasible, a business plan and operational plan of action as required for Tugu Mandiri. These actuarial studies will result in projected health benefit costs (premiums), as well as expected utilization and reimbursement rates for covered services. Feasibility and required provider arrangements in our final business/operating plan will be based on those actuarial recommendations. It is not possible to begin the basic actuarial studies for this project without the identified information.

It is clear, from the work of the consulting team that the information needed to support the completion of this project is available in Indonesia and must be obtained based on an expanded scope of work to add the data collection component. A draft copy of the Revised Scope of Work is attached as Appendix V. As agreed in our exit meeting with USAID we completed the expanded scope of work for data collection upon returning to the United States. We think that the new collection process will require extensive field work in country and approximately ten months with additional resources (focusing on data collection for three, representative, operating Pertamina regions, Jakarta and several representative PSCs), subject to a Tugu Mandiri/Pertamina decision to focus only on one region as a pilot site, which will reduce the costs, time and effort substantially, or to expand the data collection to all regions and PSCs which would substantially increase all three.

In light of feedback from ISTI and USAID on the unanticipated costs and time involved for this data collection effort, we propose three alternative approaches for data collection. Those alternatives are:

- A. Collecting needed data from all seven Pertamina regions and Jakarta headquarters, as well as from all seventeen PSCs.
- B. Collecting needed data from four representative Pertamina operating regions, from Jakarta headquarters, and from three to five representative PSCs. From this data, the actuary and we will be able to extrapolate and prepare actuarial projections, evaluate feasibility and, if feasible, prepare a business plan and operational plan of action for the full target market.
- C. Collecting needed data from one Pertamina region and PSCs operating in that region from which actuarial projections, the feasibility study and, if feasible, the business plan and operating plan will be completed for that region. That region will serve as a pilot from which experience can be evaluated. If the pilot proves successful, expansion to other areas can be planned.

Of the alternative approaches listed above, we recommend alternative "B". The sampling methodology used in alternative "B" will permit the actuary and consultants to extrapolate from the representative areas to assess overall feasibility and project the business and operating plan for all target markets throughout the archipelago. Alternative "A" is less cost effective than alternative "B". We do not recommend alternative "C" because it will not permit evaluation of the alternative

health care financing and delivery system for the entire target markets in a timely fashion, because it could result in employee/retiree health benefits in the pilot region that differ from those in other regions and because the results of implementation will not be significant with respect to national cost increase trends.

IV. PROJECT STATUS - SIGNIFICANT POLICY MEETINGS

To discuss the consulting team's progress and recommendations, the significant data problems encountered and proposed solutions, three joint meetings were held with representatives from USAID, the Ministry of Health, Health Sector Financing Project - International Science and Technology Institute, Inc. (ISTI), Pertamina and Tugu Mandiri during our last week in country. In each of these meetings, the project consultants presented the current progress and the scope of the data problems confronting the project.

It was concluded during the final meeting that the consulting team should develop and present to ISTI representatives a Revised Scope of Work to add a comprehensive data collection component to this project. This Revised Scope of Work is attached as Appendix V.

Further, it was agreed that the Ministry of Health would assume leadership by arranging and chairing "high level" meetings with Pertamina's top officials, the Ministry of Mines, USAID, and Tugu Mandiri to receive full support for this project. It was also agreed that the Ministry of Health would seek joint funding for the additional costs associated with the data collection which became considerably more complex and resource intensive than originally anticipated. The discussion of joint funding requirements should not occur until after Pertamina has agreed to support this project.

We strongly recommend that Drs. Djaafar be closely involved with the Ministry of Health in the planning and execution of these meetings, including the selection of participants, presentations during the meetings and follow-up activities. It was suggested that the consultants, Dr. Barnes and Mr. Wolff, be available for presentations during these meetings. Further consultant work is suspended until these meetings are favorably concluded.

V. CONCLUSIONS AND RECOMMENDATIONS

It is most important for all concerned to realize that the most critical component of this project and all of the other health sector financing projects is reliable data for sound decision making at the executive and Board levels. At the present time this aspect is missing from this project and is causing a substantial delay.

The second aspect of the project that must be accomplished in a timely manner is complete support by Pertamina and the Ministry of Health. Therefore, it is strongly recommended by the project team that the Revised Scope of Work (to add a comprehensive data collection process) be approved. Further, that the Ministry of Health maintain its new leadership position in this project by scheduling and chairing the necessary meetings with Pertamina, Tugu Mandiri, the other required organizations and us, if our participation can be beneficial in these critical discussions.

As previously stated, this project can be accomplished as outlined in the original Scope of Work, with some modifications to: (1) the successful collection of required

statistical, financial and management information and (2) the previous length of time for completion.

With respect to this data collection, the consultants recommend (and the actuary concurs) that we select three representative regions among Pertamina operations, Jakarta and three to five representative PSCs operating in or near the Pertamina regions selected. We will extrapolate from data collected from these sources to assess feasibility and, if feasible, prepare the business/operational plan of action for the entire target markets. This recommendation will reduce the time, effort and cost of data collection and permit us to address all target markets. We do not recommend other alternatives because they do not achieve project objectives in a timely manner.

We appreciated the opportunity to serve on the Tugu Mandiri/Pertamina/USAID/ISTI team and to further Indonesian efforts to improve health care financing options, as well as the availability of quality, cost effective health care in Indonesia.


James G. Barnes, D.P.A.

June 12, 1989
Date


Elliot R. Wolff, J.D.

June 12, 1989
Date

APPENDIX I

**Drs. Siddharta
& Siddharta**

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29 March 1989

Dr. Elliott Wolff

International Science and Technology Institute, Inc.

c/o Ministry of Health

Bureau of Planning

Kav. X-5 No. 4-9 Jl. H.R. Rasuna Said

Jakarta 12950

Dear Dr. Wolff:

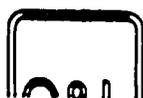
GENERAL TAX MATTERS ON HEALTH INSURANCE SCHEME

Following your request during our meeting in our offices on March 21, 1989, we set out below tax aspects related to the proposed health insurance scheme based on the current tax laws of Indonesia.

Background

2. We understand that the International Science and Technology Institute, Inc. ("ISTT") has been appointed by Tugu Mandiri ("Tugu"), an insurance company owned by Pertamina, to initially identify and appraise the various options available and, subsequently, describe and justify a recommended course of action for Tugu in developing a health maintenance organization and health insurance scheme ("HIS") which will:

- Initially, provide the plan to Pertamina and other oil contractors' retirees and;
- subsequently, expand the availability of the plan to the general business community.



It is proposed that the premium will be borne by both the employee and the employer, e.g., Pertamina.

3. Accordingly, ISTI is concerned about the tax aspects of the health insurance scheme and have requested our advice on the general tax aspects of such, viewed from both the employers' and employees' standpoint.

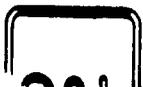
General Aspects

4. The applicable general principles relevant to the HIS issue are set out in the Income Tax Law, 1983, at :

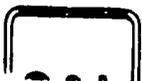
- Article 9 (d) - in determining taxable income, an employer may not deduct costs of ".....benefits provided by the taxpayer for the needs of employees";
- Article 4 (3) (d) - where services received in-kind are not deductible to the employer, then in turn, the benefit is not assessable to the employee.

5. The above general principles were clarified for health and insurance costs in Ministry of Finance Circulars dated 28 May 1984 (ref. no. SE-19/PA23/1984) and 7 June 1984 (ref. no. S-336/PJ23/1984). As a result, as far as the employer is concerned :

- (i) medical costs including health insurance premiums paid by an employer to an HIS are non deductible;
- (ii) all costs related to company owned health facilities providing free service and medication to employees are non deductible;
- (iii) company reimbursed medical expenses are non deductible to the company.



- (iv) should the receipt for the medical expenses be addressed to the employee instead of the company, the reimbursement is then deductible for the company.
6. The employee is not assessable for (i) to (iii) above but will be assessable on the income in (iv). Income from insurance proceeds, e.g. life, accident or health are not assessable for the individual.
7. Contrary to the initial spirit of the Income Tax Law as explained in paragraph 4, the Indonesian Tax Authorities have decreed that company contributions to the state pension fund (Tunjangan Hari Tua, or "THT") and Astek are considered as a tax deductible expense whilst being tax exempted for the employee (MOF Circular dated 28 May 1984). Historically, this treatment results from the Minister of Labor's opinion that the non deductibility of such expenses will strongly hinder the development of the pension fund.
8. In accordance with MOF Decree 947/KMK/04/1983, Indonesian citizens are not required to file personal tax returns if they are employed by only one company, with the understanding that income is not derived from other sources. The impact of this is considered below:
9. The only deductions allowable against an individual's assessable income are:
- (i) occupational allowance, i.e. 5% of gross annual salary, not exceeding Rp. 360,000 (MOF Decree 980/KMK/04/1984 dated 31 December 1983);
 - (ii) tax free income allowance, i.e. Rp. 960,000 for the individual and Rp. 480,000 for each dependent, limited to four dependents (Article 7 (1), Income Tax Law);
 - (iii) pension contributions to pension funds approved by the Minister of Finance, e.g., the state pension fund and ASTEK (Article 6 (2) Income Tax Law and MOF Circular dated 28 May 1984).



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ISTL, Inc.

GENERAL TAX MATTERS ON
HEALTH INSURANCE SCHEME

29 March 1989
Page 4 of 6

10. Several Production Sharing Contractors are governed by the old tax laws which, in a number of ways, differ from the 1984 Income Tax Law. In this context, the abovementioned aspects do not necessarily apply.

Current tax position

11. From the above paragraphs, it is clear that under current Indonesian Tax Regulations HIS contributions by the employer would not be deductible. On the other hand, the employee's contribution would also not be deductible on his or her individual tax return. This non deductibility from an individual viewpoint is further modified by most Indonesians' reluctance to submit tax returns so that, in the event of such contribution being allowed, it will generally still not represent a benefit for the individual.

Alternative options and possibilities

Request for tax treatment equal to THT

12. As explained in paragraph 7 and 9 (iii), THT and Astek contributions receive special concessional treatment. We believe that, based on your explanations that the Ministers of Finance, Health and Energy have expressed their strong support for the HIS, you should explore the possibility of similar tax treatment to THT and Astek being applied to the HIS. In our opinion, the possibility of success is distant.

Incorporation into employee salary

13. Another alternative would be to increase the employees' salary in accordance with the HIS contributions amount, whereby:

a. the employer would be able to charge the additional expense as salaries instead of HIS contributions and therefore, obtain tax deductability for such expense;

b. the employees are not being disadvantaged as their net take home pay is unaffected.

14. Under this approach, you should bear in mind that the salary increase should, with the exception of employees earning salaries below the tax free bracket, exceed the HIS contribution amount. The excess is the "gross up" amount whereby the contribution is grossed up in order to account for it being subject to income tax as part of the employee's salary. However, as the employees are mostly under the 25% tax bracket whilst the employer, (i.e., Pertamina) is in the 35% tax bracket, this alternative will carry tax benefits.

15. However, you should appreciate that Pertamina, being a state owned company, would most probably require approvals from the Ministers of Energy, Finance and Labor to increase employee salaries.

Conclusion

16. We believe that, compared with most other countries, the current Indonesian tax environment could be more conducive to the establishment of an HIS.



**Drs. Siddharta
& Siddharta**

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Dr. Elliott Wolff
ISTI, Inc.

**GENERAL TAX MATTERS ON
HEALTH INSURANCE SCHEME**

29 March 1999
Page 6 of 6

17. However, we also believe that a complex combination of internal and external factors in addition to tax will influence a company's decision on whether or not to embrace an HIS, whilst tax is not the decisive factor for such a decision.

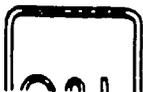
18. Should you require further information, please do not hesitate to contact myself or Mr. Ross L. Gavin, Chief Technical Advisor of this office.

Yours faithfully,
Drs. SIDDHARTA & SIDDHARTA
Registered Public Accountants No. D-2336



Drs. Istama T. Siddharta
Senior Partner

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APPENDIX II

**Drs. Siddharta
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14 April 1989

**Dr. Elliot Wolff
International Science and Technology Institute, Inc.
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Jl. H.R. Rasuna Said
Jakarta**

Dear Dr. Wolff,

HEALTH INSURANCE SCHEME

Following your request during our meeting in our offices on April 10, 1989, we set out below the tax aspects related to the proposed health insurance scheme as they affect Production Sharing Contractors.

2. In our letter of March 29, 1989 we set out the taxation regulations affecting your proposed health insurance scheme as they currently apply to most taxpayers. As noted in paragraph 10 of that letter, the current tax regulations do not necessarily apply to Production Sharing Contractors.
3. Article 33 (3) of the Income Tax Law, 1983 states that entities in the oil and gas sector connected with Production Sharing Contracts in effect prior to January 1, 1984 will continue to be subject to the Old Tax Laws rather than the Laws which came into effect on that date.
4. Under the Old Tax Laws, benefits-in-kind provided to employees will be deductible for the purposes of determining the tax of the employer but conversely, are assessable in the hands of the employee. The amount assessable to the employee is the cost to the employer.
5. It is our understanding that most Production Sharing Contractors presently operating in Indonesia are governed by Production Sharing Contracts signed prior to 1984 and therefore most employees of Production Sharing Contractors would be assessed on the cost of the health insurance scheme as it applies to each individual.

Drs. Siddharta
& Siddharta
in association with
Coopers
& Lybrand

(9)

Dr. Elliot Wolff
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HEALTH INSURANCE SCHEME

Page : 2 of 2
Date : 14 April 1989

6. If you require any further information, please do not hesitate to contact either myself or our Partner Advisor, Mr. Ross L. Gavin.

Yours faithfully,
Drs. SIDDHARTA & SIDDHARTA
Registered Public Accountant

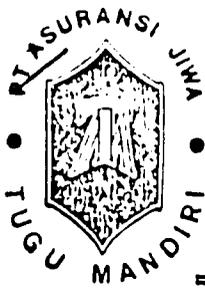


Dr. Istama T. Siddharta
Senior Partner

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APPENDIX III



PT TUGU MANDIRI LIFE INSURANCE CO

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DATA COLLECTION FOR REVIEW OF PERTAMINA AND PRODUCTION SHARING COMPANY HEALTH BENEFITS AND HEALTH CARE DELIVERY SYSTEMS

For each target market:

1. Pertamina retirees and their widows/spouses, and
 2. Production sharing company (PSC) beneficiaries,
- We need the following information. We, also, need the following information for active Pertamina employees and their eligible dependents in order to derive data for the retirees from Pertamina totals and in order to test PSC data for reasonableness.

- I. Health Benefits:
 - A. English copy of employee and retiree health benefits/employment rules including requirements for employee/retiree copayments and exclusions
 - B. 1986-1987-1988-1989 health benefit/rule changes for employees/retirees
 - C. Plan anniversary date/effective date for plan/rule changes and enrollment/eligibility
 - D. Pertamina share of premium or benefit costs; production sharing company share; employee/retiree share/contribution

For categories II through VIII below, location means an area where all health care for beneficiaries is provided by a network of owned and contracted health providers-except for rare tertiary referrals. All beneficiaries, utilization data and health care providers should be grouped by location for this data gathering.

II. Beneficiary Distribution

- A. 1987-1988-1989 number of employees and retirees by location, age and sex by benefit rules
- B. 1987-1988-1989 number of eligible dependents by location, age and sex by benefit rules

III. Health Care Delivery System

- A. List owned hospitals by location (including street address, if possible)
- B. List owned clinics by location (including street address, if possible)
- C. List NonPertamina hospitals with
 1. Provider reimbursement arrangements
 2. Recent total monthly reimbursement to each
 3. Number of beds by service
 4. Services available
 5. Physicians on staff by specialty
 6. Location (including street address, if possible)



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- D. List NonPertamina clinics, physicians, dentists, optometrists, pharmacists and other providers of health services and products with
1. Services available
 2. Provider reimbursement arrangements
 3. Recent total monthly reimbursement
 4. Number of examining rooms
 5. Location (including street address, if possible)

IV. Utilization and Costs

- A. 1986-1987-1988 total health benefit costs by target market, location and total
- B. For each target market and for Pertamina active employees and their eligible dependents, 1986-1987-1988
1. Number of hospital admissions per 1,000 beneficiaries per year by location and total
 2. Number of hospital bed days used per 1,000 beneficiaries per year by location and total
 3. Average length of hospital stay by location and total
 4. Average cost per discharge by location and total
 5. Number of outpatient physician visits per beneficiary by location and total
- C. 1986-1987-1988 average cost of inpatient and outpatient services for frequent diagnoses and frequently prescribed drugs by location and total for Pertamina employees and their dependents, for Pertamina retirees and their eligible dependents and for PSC beneficiaries

4/3/89

Page 2



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DATA COLLECTION FOR REVIEW OF OWNED PERTAMINA AND PRODUCTION SHARING COMPANY HEALTH FACILITIES

- V. Owned Hospitals
- Location (including street address, if possible)
 - Number of beds by service
 - Services available
 - Number of physicians on staff by specialty
 - Schedule of charges (tariffs) for each service/product
 - 1988 monthly cost of operation
- VI. Owned Clinics
- Location (including street address, if possible)
 - Number of square feet
 - Number of examining rooms
 - Services available (physicians by specialty, pharmacy, dental, laboratory, X-ray, etc.)
 - Schedule of charges (tariffs) for each service/product
 - Staff-number of employees in each job classification
 - Salary range for each clinic job classification including benefits and perquisites (functional facilities)
- VII. Map of Indonesia showing all PERTAMINA and production sharing company hospitals and clinics, showing which facilities are owned and which are contracted
- VIII. Administration
- Description of method now in use for quality assurance/facility monitoring/central review of facilities and/or care, with a copy of forms used for monitoring
 - Description of method now in use to report utilization of services/products and payment received from patients/employers/insurance companies for services/products to central office, with a copy of forms used for reporting
 - Description of other methods and procedures now in use for administration/medical director review or approval of the provision of health care services and products

We need the same information for other potential accounts.

21/2

APPENDIX IV

DATA ELEMENTS	HOSPITALS PERTAMINA AND NON PERTAMINA	HOSPITAL BASED CLINICS PERTAMINA + NON PERTAMINA	FREE-STANDING CLINICS PERTAMINA + NON PERTAMINA	PRODUCTION SHARING COMPANY EMPLOYEES & DEFENDENT	PERTAMINA EMPLOYEES	PERTAMINA RETAIREES
			A. FACILITY AND	UTILIZATION	DISCRPTION	
A. LOCATION OF FACILITIES	X	X	X			
A. NO. OF BEDS	X	X				
A. BEDS BY SERVICES	X	X	X			
A. TYPE OF SERVICE	X	X	X			
A. NO. EXAMINING ROOMS		X	X			
A. NO. OF ADMISSIONS	X					
A. NO. OF CLINIC VISITS		X	X			
A. NO. EMERGENCY RV VISITS	X					
			B. UTILIZATION AND	LENGTH OF STAY DATA		
B. NO. OF BEDS USED	X	X				
B. AVE. LENGTH OF STAY	X					
B. TOTAL POPULATION DATA BY SERVICE AREA	X	X	X			
			C. HUMAN RESOURCES -	MEDICAL AND DENTAL		
C. NO. OF PHYSICIANS	X	X	X			
C. NO. OF SPECIALIST	X	X	X			
C. NO. OF DENTIST	X	X	X			
C. DENTAL SERVICES	X	X	X			
C. NO. OF PHARMACIST	X	X	X			
C. NO. EMPLOYEE JOB CLASSIFICATION	X	X	X			
C. SALARY RANGE BY CLASSIFICATION	X	X	X			
			D. HUMAN RESOURCES -	MEDICAL AND DENTAL		
D. NO. EMPLOYEE BY CLASSIFICATION				X	X	X
D. SALARY RANGE BY CLASSIFICATION				X	X	X
			E. COSTS DATA	HOSPITALS, AND CLINICS		
E. MONTHLY COST OF OPERATIONS	X	X	X			
E. CHARGE SCHEDULE FOR SERVICES	X	X	X			
E. TOTAL HEALTH BENEFIT COST				X	X	X
E. AVERAGE COST PER DISCHARGE	X					
E. AVERAGE COST OFPATIENT SERVICES BY DIAGNOSIS	X	X	X			
E. AVERAGE COST OF SERVICES BY BY DIAGNOSIS (ICD-9)	X	X	X			
			F. BENEFITS POLICIES, AND	GUIDELINES		
F. PROVIDES REIMPESEMENT ASSESSMENTS				X	X	X
F. SCOPE OF SERVICE				X	X	X
1. COVERED SERVICES				X	X	X
2. NON-COVERED SERVICES						
			G. QUALITY ASSURANCE	DATA/PROGRAMS		
G.						

11

DATA COLLECTION FOR
REVIEW OF PERTAMINA AND PRODUCTION SHARING
COMPANY HEALTH BENEFITS AND
HEALTH CARE DELIVERY SYSTEMS

BENEFIT, BENEFICIARY AND GENERAL INFORMATION NEEDED

I. BENEFIT AND BENEFICIARY INFORMATION

BENEFIT SPONSOR	BENEFIT DESCRIPTION IN ENGLISH	LIST OF HEALTH CHANGES				BENEFIT CHANGE EFFECTIVE DATE	COST SHARE/CONTRIBUTION		
		1985	1987	1989	1989		FERTAMINA	FSC	EMPLOYEE
FERTAMINA RETIREES/ SPOUSES WIDOWS									
FERTAMINA EMPLOYEES/ DEPENDENTS									
PRODUCTION SHARING COMPANY BENEFICIARIES									

II. BENEFIT COST INFORMATION

REGION	TOTAL HEALTH BENEFIT COSTS						AVERAGE NUMBER OF BENEFICIARIES BY AGE AND SEX								
	FERTAMINA RETIREES WIDOWS/ SPOUSES		FERTAMINA EMPLOYEES DEPENDENTS		FSC BENEFICIARIES		FERTAMINA RETIREES/WIDOWS/ SPOUSES			FERTAMINA EMPLOYEES DEPENDENTS			FSC BENEFICIARIES		
	1987	1988	1987	1988	1987	1988	1987	1988	1989	1987	1988	1989	1987	1988	1989
I. NORTH SUMATRA															
II. SOUTH SUMATRA															
III. BALIKEMBATAN															
IV. CUMAI															
V. CIRERON															
VI. CILACAP															
VII. SOFONG															
VIII. JAVA/JAKARTA															
IX. TOTAL															

III. OTHER

A map of Indonesia showing all owned and contracted hospitals and clinics



DATA COLLECTION FOR REVIEW OF PERTAMINA AND PRODUCTION SHARING
COMPANY HEALTH BENEFITS AND HEALTH CARE DELIVERY SYSTEMS

HOSPITAL F. FINANCIAL DATA ELEMENTS NEEDED

REGION	MONTHLY AVG OPERATING COSTS /PAYMENTS		ADMISSIONS /1,000		BED DAYS /1,000		AVERAGE LENGTH OF STAY		AVERAGE COST /DISCHARGE		AVERAGE OUT PATIENT VISITS/BENEFICIARY/YEAR		AVERAGE TOTAL COST FREQUENT DIAGNOSES	
	FERTAM	FSC	FERTAM	FSC	FERTAM	FSC	FERTAM	FSC	FERTAM	FSC	FERTAM	FSC	FERTAM	FSC
I. NORTH SUMATRA TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*														
II. SOUTH SUMATRA TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*														
III. PALIMANTAN TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*														
IV. DUMAI TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*														
V. CIREBON TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*														
VI. CILACAP TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*														
VII. SOFONG TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*														
VIII JAYA/JAKARTA TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*														
IX. TOTAL OWNED HOSPITALS CONTRACTED HOSPITALS OTHER RELEVANT INFORMATION														

* For example, name of owner of owned hospitals

DATA COLLECTION FOR REVIEW OF FERTAMA AND PRODUCTION SHARF'S
 COMPANY HEALTH BENEFITS AND HEALTH CARE DELIVERY SYSTEMS

HOSPITAL NON FINANCIAL DATA ELEMENTS NEEDED - FERTAMA (FERTAM) & PRODUCTION SHARF & COMPANIES (PSC)

REGION	NUMBER HOSPITALS & BEDS BY SERVICE		SERVICES AVAILABLE		NUMBER MDs BY SPECIALTY		TARIFFS		QA/FACILITY MONITORING SYSTEM		UTILIZATION/BILLING REPORTING SYSTEM		UTILIZATION APPROVAL SYSTEM	
	FERTAM	PSC	FERTAM	PSC	FERTAM	PSC	FERTAM	PSC	FERTAM	PSC	FERTAM	PSC	FERTAM	PSC
I. NORTH SUMATRA TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*	4													
	2													
II. SOUTH SUMATRA TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*	5													
III. PALIMPTAN TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*	4													
IV. DUMAI TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*	2													
V. CIBEON TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*	2													
VI. CILACAP TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*	1													
VII. SOFONS TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*	1													
VIII. JAVA (MARTA) TOTAL EACH OWNED HOSPITAL EACH CONTRACTED HOSPITAL OTHER RELEVANT INFORMATION*	5													
IX. TOTAL OWNED HOSPITALS CONTRACTED HOSPITALS OTHER RELEVANT INFORMATION														

* For example, name of owner of owned hospitals

APPENDIX V

REVISED SCOPE OF WORK AND BUDGET

This Revised Scope of Work differs from the original Scope of Work in that it adds a data collection component which is essential in order for the subsequent Feasibility Study and Business/Operational Plan to be based on reliable facts. The steps inherent in the data collection phase are further elaborated in the "Addition to Scope of Work to Gather Needed Information" which is attached to this Appendix.

Assignment:

The consultant team will assist PT Tugu Mandiri to assemble necessary information, conduct a feasibility assessment and, if feasible, prepare a business plan and an operational plan of action for Tugu Mandiri to establish a health maintenance organization/managed health care product line of business.

Expected Outputs:

1. Data Collection.

This essential first phase should provide orientation, education and retrieval assistance to the regional and headquarters Finance and Umum Departments of Pertamina and the administrative and field offices of the Production Sharing Contractors (PSCs) so that the information needed for actuarial projections and business/operational planning is available to the project team as soon as possible. This information is listed in Appendix III to the 17 April 1989 Consultants' Exit /Progress Report.

Activities:

- a. Prepare a presentation, including written materials and data output formats, to orient and educate departmental staff responsible for needed information.
- b. Assist in computer software development to facilitate extraction of needed information available in computer databases through Indonesian national programmer assigned to team part-time.
- c. Answer questions and work with departmental staff in regions and Pertamina headquarters/PSC administrative offices to retrieve needed information.
- d. Assemble information received from all sources and compile it for actuarial and planning purposes, including computer software programming and data input to facilitate those efforts.

2. Feasibility Assessment and Business Plan.

This document should present the organizational arrangements and a financial/business analysis for the two options which Tugu Mandiri will pursue to develop an HMO health insurance product. The two options are:

- To establish an HMO with Pertamina's Production Sharing Contractors (PSCs), Pertamina retirees and veterans as the primary markets.

- 9 To establish an HMO with Pertamina's 50,000 active employees and their dependents as a second market. Because most available health care utilization and cost data for retirees is not separated from the corresponding data for active employees and because health services are not budgeted for each group separately, the effects of separating the two groups should be shown side by side.

Activities:

- a. Review the existing business plan developed by REACH and assess the organizational model which has been proposed in that report for the HMO with Pertamina employees as the primary market.
- b. Work with domestic consultants to establish the legal feasibility for Tugu Mandiri to offer an HMO/managed health care product for the target markets of this feasibility study.
- c. Work with domestic consultants to ascertain the tax consequences of establishing an HMO/managed health care product for both Tugu Mandiri and its prospective clients.
- d. If feasible, develop a persuasive, convincing justification for Tugu Mandiri to develop an HMO/managed health care program and identify the capital requirements which the HMO will contain. To the extent advisable, the consultants will use Option II-E in the REACH report as a model.
- e. Develop an HMO/managed health care model and persuasive justification for choosing that model for Tugu Mandiri to offer to Pertamina's PSCs, Pertamina retirees and active employees. The model should include organizational arrangements between Tugu Mandiri, providers and members, identify the source of providers, and specify the types of contractual arrangements that Tugu Mandiri will need to establish with those providers.
- f. Do a financial analysis for the model developed in activities d and e above. The financial analysis should:
 - Create the actuarial assumptions upon which the premium will be calculated.
 - Create the financial assumptions upon which all financial projections will be based.
 - Use these assumptions to create expense, revenue and profit/loss statements.
 - Relate these to levels of enrollment in the process of doing a breakeven analysis.
 - Develop a capital budget.
 - Do a breakeven analysis.

- Create a financial model (funds flow analysis) which tracks sources and uses of funds.

3. Operational Plan of Action.

Develop a network chart for the pre-operational and operational phases of the models proposed in Section 2. The network chart should use a PERT/Gantt or similar networking technique to plan activities over time in critical sequence, and contain clear instructions for clarification and interpretation.

Activities:

- a. Recommend an appropriate organizational structure for the proposed HMO/managed health care model.
- b. Develop a recruitment and staffing plan which identifies the numbers and types of personnel that must be hired, and job specifications for each managerial position.
- c. Develop a training and manpower development plan. This plan should be based upon the management arrangements that Tugu Mandiri will use to operate the HMO during the pre-operations and start-up phases. If the decision is made to subcontract management to a third party, training can be done on site. If Tugu Mandiri decides to operate the HMO itself, the training plan should identify the types of personnel to be trained, areas of training and the format and sites of training.
- d. Design a detailed benefit package with service units.
- e. Design a structure and configuration for the health service delivery system to be used in the HMO, including the contractual arrangements which must be made with the providers.
- f. Identify the management systems which must be developed, e.g. MIS, utilization, finance, personnel, etc. and suggest components of the different systems.
- g. Determine the hardware and software requirements which will be needed to support the management systems.
- h. Suggest the technical assistance requirements which will be needed to operationalize the HMO.

ADDITION TO SCOPE OF WORK TO GATHER NEEDED INFORMATION AND BUDGET FOR DATA COLLECTION PHASE

Assignment and Statement of the Problem

The development of a formal information system and data collection process is required to support the conduct of a comprehensive feasibility study which, if possible, will contain a business plan and operational plan of action for the development of a Tugu Mandiri Health Maintenance Organization (HMO)/managed health care financing and delivery system. It is clear from the work of the consulting team--including meetings, review of available documents and other observations--that the information needed for completion of the original Scope of Work is not yet available to us or usable for this project. Adding this process to the original Scope of Work will generate the required utilization data, financial data, provider and other information needed to accomplish the original Scope of Work. Therefore we are compelled to recommend to the management of this project--USAID, the Ministry of Health and Tugu Mandiri--that a formal data collection process be added and completed prior to preparation of a feasibility study report and, if feasible, a business plan and operational plan of action pursuant to the original Scope of Work.

We recognize that this data collection process was not budgeted in the original Scope of Work and that it will substantially increase the cost of this project. In feedback on our draft exit report, ISTI and USAID expressed concern over this increased cost. Accordingly, we submit three proposals for the data collection effort--

- A. Collecting needed data from all seven Pertamina regions and Jakarta headquarters, as well as from all seventeen PSCs.
- B. Collecting needed data from four representative Pertamina operating regions, from Jakarta headquarters, and from three to five representative PSCs. From this data, the actuary and we will be able to extrapolate and prepare actuarial projections, evaluate feasibility and, if feasible, prepare a business plan and operational plan of action for the full target market.
- C. Collecting needed data from one Pertamina region and PSC operating in that region from which actuarial projections, the feasibility study and, if feasible, the business plan and operating plan will be completed for that region. That region will serve as a pilot from which experience can be evaluated. If the pilot proves successful, expansion to other areas can be planned.

Of the alternative approaches listed above, we recommend alternative "B". The sampling methodology used in alternative "B" will permit the actuary and consultants to extrapolate from the representative areas to assess overall feasibility and project the business and operating plan for all target markets throughout the archipelago. Alternative "A" is less cost effective than alternative "B". We do not recommend alternative "C" because it will not permit evaluation of the alternative health care financing and delivery system for the entire target markets in a timely fashion, because it could result in employee/retiree health benefits in the pilot region that differ from those in other regions and because the results of implementation will not be significant with respect to national cost increase trends.

The following outlines suggested additions to the original Scope of Work which we will complete within six working weeks in Indonesia after completion of the data collection and actuary's report.

I. Work Required

- A. Obtain support of Ministry of Health and Pertamina (BKKA, Umum Director and Finance in regions and headquarters)
- B. Identify sources of needed information and staff resources for data orientation sessions
- C. Authorize/direct gathering and provision of information
- D. Format data for collection
- E. Process/assemble data
- F. Consolidate/compile data for actuary and other consultant reports
- G. Review health facilities and data systems

II. Resources Required

A. Core team - Tugu Mandiri	Nanang Iskandar, M.D. Rochwan Muthalib
Pertamina	Soejadi
ISTI	Elliot Wolff James Barnes
Actuary	R. Pratolo
Tax	Istama Siddharta
Legal	Lione Gunawan/ Hans Schaefer

B. Additional Staff

- 1. Two financial data/systems managers - U.S.A.
- 2. Computer programmer - Indonesia (loan)
- 3. Translator - Indonesia (loan)

C. Other resources

- 1. Lap computer for word processing and financial analysis/spread sheets.
- 2. Second PC for data consolidation and statement/report writing.
- 3. Expenses for visits to Jakarta and the regions for meetings with the team, Pertamina and the production sharing contractors (\$1,000 from Jakarta per person per visit to country).
- 4. Expenses for travel to Indonesia from U.S.A. (\$3,000).

Three trips each for Wolff, Barnes and four trips for two financial/systems managers.

5. Expenses for orientation programs (bring 6 Pertamina health/finance staff from three regions to Jakarta for one week and meet PSC representatives in Jakarta).
6. Expenses for actuary's assistance in data gathering, as well as actuarial report and business plan.
7. Expenses for translator - approximately 20 days.
8. Additional, minor participation by attorney, tax advisor and their coordinator.

D. Timing

1. Orientation/formatting data by Wolff, Barnes, two financial /systems managers (2 months each), actuary, translator and computer programmer.
2. Follow-up by Wolff and Barnes - 2 months each.
Two financial/systems managers, actuary and computer programmer - 3 months each.
3. Completion - 10 months.

BUDGET FOR DATA COLLECTION PHASE

The fees and other budget items reflected here are based on a comprehensive data collection process of approximately ten months duration which we expect to be required in light of our progress with the project team during our March/April visit. The costs reflected and the suggested time frame are based on accomplishing the data collection for alternative "B", previously cited. The expatriate consulting team consists of Dr. James G. Barnes, Mr. Elliot Wolff and two information systems/data specialists. We anticipate that over the ten month period there will be three trips each to Indonesia by Dr. Barnes and Mr. Wolff and four trips by the information systems/data specialists. In an effort to accomplish as much of the front end requirements as possible, the first trip by Dr. Barnes and Mr. Wolff is based on thirty-six (36) days with the remaining two trips at twenty-four (24) days each for a total of eighty-four (84) days. The information systems/data specialists time in country is based on four trips of thirty-six days each for a total of 144 days. The chart on the following page reflects these costs.

Budget for Data Collection Phase

Consultant Fees <u>1/</u>	Days	Non-Gov't Daily Rate <u>2/</u>	Amount to be Paid by Client <u>3/</u>	USAID/ISTI Daily Rate	Amount to be Paid by USAID	Total Compensation
Barnes	84	\$614.23	\$51,595.00	\$285.78	\$ 24,005.52	\$ 75,600.52
Wolff	84	\$614.23	\$51,595.00	\$285.78	\$ 24,005.52	\$ 75,600.52
Data Analyst	144	\$354.22	\$51,008.00	\$285.78	\$ 41,152.32	\$ 92,160.32
Data Analyst	144	\$355.22	\$51,008.00	\$285.78	\$ 41,152.32	\$ 92,160.32
Computer Programmer	40	-----	-----	\$ 40.00	\$ 1,600.00	\$ 1,600.00
Interpreter	20	-----	-----	\$ 20.00	\$ 400.00	\$ 400.00
Total	396	NA	\$205,206.00	NA	\$132,315.68	\$337,521.68

Budget for Data Collection Phase, Con't.

Travel Expenses	Number of Trips	Non-gov't daily Rate	Amount to be Paid by Client	Per Trip Costs Including Inter-island Travel	Amount to be Paid by USAID	Total Travel Costs
Barnes	3	NA	-----	\$4,000.00	\$12,000.00	\$12,000.00
Wolff	3	NA	-----	\$4,000.00	\$12,000.00	\$12,000.00
Data Analyst	4	NA	-----	\$4,000.00	\$16,000.00	\$16,000.00
Data Analyst	4	NA	-----	\$4,000.00	\$16,000.00	\$16,000.00
Computer Programmer	-----	NA	-----	\$2,000.00	\$ 2,000.00	\$ 2,000.00
Interpreter	-----	NA	-----	\$4,000.00	\$ 4,000.00	\$ 4,000.00
Total	14	NA	-----	NA	\$62,000.00	\$62,000.00

Budget for Data Collection Phase, Con't.

Per Diem Rates	Days	Non-gov't Daily Rate	Amount to be Paid by Client	Rate	Amount to be Paid by USAID	Total Per Diem Costs
Barnes	84	NA	-----	\$108.00	\$ 9,072.00	\$ 9,072.00
Wolff	84	NA	-----	\$108.00	\$ 9,072.00	\$ 9,072.00
Data Analyst	144	NA	-----	\$108.00	\$15,552.00	\$15,552.00
Data Analyst	144	NA	-----	\$108.00	\$15,552.00	\$15,552.00
Computer Programmer	40	NA	-----	NA	-----	-----
Interpreter	20	NA	-----	NA	-----	-----
Total Per Diem		NA	-----	NA	\$49,248.00	\$49,248.00
Total Costs - Data Collection Phase			\$205,206.00		\$243,563.68	\$448,769.68

36

1/ Actuary's assistance in the data collection effort is under an existing contract between R Pratolo and ISTI, the details of which we are not aware.

2/ The amount listed in this column shows the daily consulting rate that Pertamina, Tugu Mandiri and the Ministry of Health will need to pay in excess of the rate paid by USAID/ISTI in order for the consultants to complete this project.

3/ The amount listed in this column shows the total amount to be paid by Pertamina, Tugu Mandiri and the Ministry of Health per listed consultant for the stated number of consulting days.