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**SOCIAL FINANCING STUDIES
PKTK ASSESSMENT AND PROPOSED MODEL**

12

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INTRODUCTION

This report reviews the consultancy activities of Robert G. Shouldice, D.B.A. January 8, 1989 through February 16, 1989 regarding Pemeliharaan Kesehatan Tenaga Kerja (PKTK) assessments and model design provided to USAID/Jakarta. This work was part of the Social Financing studies under the International Science and Technology Institute, Inc. (ISTI) Contract No. ANE-0344-C- 00-8030-00. Primary activities were conducted at the Jakarta offices of PKTK and Asuransi Sosial Tenaga Kerja (ASTEK), although site visits and interviews were also held in other locations in Jakarta, Surabaya (East Java), Bandung (West Java), Lampung (South Sumatra) and Denpasar (Bali). A workshop on the subject was also held in Ciloto at which the consultant presented a paper with discussion.

Activities included the following:

1. Review the findings of the comprehensive assessment of the PKTK program which has just been finalized by ASTEK and the Ministry of Health (DepKes) in light of the current PKTK model.
2. Design a revised model for the PKTK scheme which takes into account the findings of the PKTK assessment.
3. Attend the National Workshop which will be held to consider the findings of the PKTK assessment and present the design for the revised PKTK model.

Thus, the consultant assisted Dr. Oemy R. Syarief, the Activity Coordinator for PKTK, and a study group composed of members of ASTEK and DepKes, to design a revised model for the PKTK scheme based upon the results of the comprehensive assessment of the PKTK program which was carried out in six cities.

METHODOLOGY

The following steps were used to carry out the scope of work. First the consultant met with the study group chaired by Dr. Oemy. During the first week the group reviewed the output of the three domestic consultants who had conducted PKTK assessments in the areas of marketing, actuarial, management, finance, etc. These findings were presented at the National Workshop by the individual domestic consultants. This consultant then presented the findings of the study group as well as his own opinions regarding the issues for the new PKTK model. Second, site visits to three sites were conducted to see, first hand, how the sites managed and delivered medical services. Third, the consultant then met with the study team collectively and individually to discuss the possible models available to them. Finally, the study group developed its ideas regarding the model - some of which are reported in this document. Note that this report provides opinions of the expatriate consultant that may differ from those of the study group.

THE NATIONAL WORKSHOP

The workshop provided an opportunity for representatives of the six study sites and others to express the opinions and concerns about a new PKTK model. After hearing the reports of the consultants (please see Appendix A for a copy of this consultant's workshop paper) the workshop members concluded that:

- * the PKTK program should be a compulsory system,

- * the management and organizational structure of the program should remain as it is currently structured, but with some improvements,
- * the structure should ultimately be redefined as a division of ASTEK or some other restructuring,
- * capitation should be used wherever possible,
- * and that delivery of services should use a combination of approaches -- i.e., the delivery system should fit the environment and characteristics of the local region.

Other conclusions were reached, but these were the major points. This consultant had some concerns about the lack of participant analyses of the structures proposed and thus the ultimate conclusions drawn from the workshop.

After the workshop, the study team met to discuss the workshop findings. The consultant was asked to prepare his thoughts in the form of a working paper to be used by the study group. This paper is provided in Appendix B; it contains most of the final recommendations of the consultant regarding the "new" PKTK model.

CONSULTANT'S RECOMMENDATIONS:

This consultant's recommendations, by and large, are provided in Appendices A and B. However, the following discussion regarding the PKTK organizational structure provides my revised opinion on this subject. Note that I recommend three stages of change regarding the PKTK model.

Immediately, actions should be taken to improve the operation of the existing PKTK structure. These would include a redefinition of the policy making role of the BKS (Badan Kerja Sama) with delegation of authority and responsibility for the operation of the PKTK program to that body by both MOM and MOH. BKS in effect should become a "governing board" setting policy and controlling the operations of the regional PKTK structures through establishment of reporting procedures. Likewise, the joint activities of the BPKD (Badan Penyelenggaraan Kepesertaan dan Dana) and the BPPK (Badan Penyelenggaraan Pemeliharaan Kesehatan) should be vested in a coordinator or "regional operations manager" who will be responsible and accountable for the operation of the regional PKTK -- but who will have the authority to carry out the operations of the program regionally. This regional manager should be appointed for an indefinite term with continuation in the position based on performance. Moreover, the regional manager should report and be responsible only to the national BKS board. The regional Advisory board can continue to provide advice and counsel to the regional manager, but would have no authority to regulate his/her activities.

As described in Appendices A and B, the individuals working at the regional level from MOM and MOH should have the same working hours and pay scales.

There has been much concern and jockeying by individuals in both the Department of Health (via PHB) and the Department of Manpower (via ASTEK) for control of the PKTK program. Both organizations have responsibilities for the well-being of the program based on law. This internal discord has tended to add to the general problems faced by the regions, and has tended to reduce the program's overall effectiveness.

Obviously, recommendations that do not take into account realistic appraisals of the political and cultural climate are of little value. In this situation, it appears that the ASTEK system is the stronger player both politically and organizationally. Even though there still remains some question

about its ability to effectively manage its operations outside the PKTK program, ASTEK would be this consultant's second choice of homes for the PKTK program; e.g., make PKTK a directorate of ASTEK. If this were to occur, it would be important to maintain as much autonomy of the PKTK program from the general ASTEK programs as possible. Again the questions of unity of command, control, and accountability through the use of a managing director should be addressed.

Third, as soon as possible, the current structure described above should be replaced with a separate operating entity that would be autonomous -- not a part of either the MOH or MOM bureaucracy. Therefore, I recommend that either a separate Perum or a private corporation be established for PKTK. The governing board of such an organization could be composed of individuals elected or appointed from both Ministries thus representing the wishes and mandates of both, and carrying out the requirements of the joint decree. As described in Appendix B, an executive would be hired with complete authority and responsibility for the management of PKTK programs. Again, regional operating managers may also be utilized as described above.

Finally, the issues of the internal operating activities of the PKTK program are addressed in Appendix B. Regardless of which of the above umbrella organizational structures are ultimately adopted, these recommendations would apply to the operations of the PKTK program. It is recommended that these internal changes be made as soon as possible.

APPENDIX A

PKTK NATIONAL WORKSHOP

January 17-18, 1989

Presentation by

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ISSUES REGARDING THE DEVELOPMENT OF A REVISED PKTK MODEL FOR THE INSURING AND DELIVERY OF HEALTH SERVICES TO ASTEK ENROLLEES

INTRODUCTION

As you understand, the ongoing assessment of the PKTK system in six provinces is now in its final stages. My role in this process has been as an advisor during the review and assessment -- meeting and discussing the findings of the assessment with your domestic consultants and the PKTK study team. I have also had the opportunity to review, firsthand, the operation of the PKTK model currently being used in Surabaya in East Java. And, after this workshop I will be traveling to Bandung in West Java and Lampung in South Sumatra to observe your PKTK operations in those two locations. These observations and discussions have greatly assisted me in understanding the overall scheme as well as the unique arrangements and issues in each of the six sites. In this paper I review the issues and concerns, as I see them, for the development of a revised model or models that may be used by the PKTK system in the future. These thoughts are offered, not as methods set in concrete by which the PKTK system should be operating, but as ideas for discussion during this workshop. It would be my hope that the workshop participants can then develop a revised model, or models, that can be utilized in the future. Indeed, my objective during my consultancy with you during the next few weeks will be to assist and facilitate the development of this new model.

PHILOSOPHICAL ISSUES

Voluntary vs. Compulsory: Our discussions began by considering several of the major, philosophical questions or issues that face the PKTK program. Foremost was the question of whether the program should remain a voluntary program as it is now established, or whether it should become compulsory under the force of law and regulation. Under a voluntary arrangement employers have the choice of either using the PKTK insurance mechanism or offer their employees the opportunity to enroll in another private insurance plan. This free market approach provides the opportunity for choice for the employer -- choice of health insurance plans for their employees. It also means that a competitive environment is created where the PKTK health plan must actively compete with the private insurance companies for employers, and secondly, for the membership of the employees to enroll in the PKTK system. Obviously, the PKTK program must be able to offer the employer an attractive price or premium and a comprehensive benefit package if PKTK wants to be successful. Moreover, the PKTK system must use medical care facilities and services that are similarly attractive and useful to the enrolled employees or members. Without appropriate pricing, benefit packages, and services the PKTK program would not be successful in a voluntary, competitive market place.

A second issue regarding voluntary enrollment must also be considered -- that of adverse selection or what I would rather just call "selection." In a voluntary, competitive market, there is a tendency for people to choose health plans based on their need for care, their perception of the quality, accessibility, availability, continuity, and so on. Given choices among competing health insurance programs offered by employers, employees will choose the plan that best fits their financial and health services needs. If the PKTK program is perceived by employers and employees as a "high cost" alternative using "low quality providers," there will be lack of selection of the PKTK program and the program will not be successful in enrolling members. We have, in fact, observed this outcome in some of the six PKTK sites under study. Secondly, there is a tendency in the voluntary system for another kind of "selection" problem -- that of unbalanced enrollment by class or rank of employee. It appears that given a choice, only the low level employees choose the PKTK system mainly because of the perceived low level of available health services in the PKTK system. Because there may be greater or different need for care by this class of enrollees, the PKTK system may find that it cannot fulfill the objectives of the program.

The use of a compulsory system also has its advantages and disadvantages. The major advantage of the PKTK program is one of marketing; employers would have to offer the PKTK program to employees. In this situation, the local PKTK office would not have to aggressively market to employers. Other insurers would be effectively cut out of this health insurance market. The major disadvantage is one for the employee; they would be locked into a system which they may perceive as high cost with low quality. The question may be asked by employees forced into this system: "for nearly one-tenth of our salary, why do we have to use low quality Puskesmas or government hospitals? Why isn't the system better?" And, many of the higher paid employees may prefer to use services of private physicians and hospitals outside the PKTK system. Thus, the question that, I think, the policy makers must address is whether a compulsory system provides sufficient incentives to the PKTK system to improve its operation, reduce its costs, and improve its delivery components.

A modification of the compulsory system that this workshop might consider is as follows. The compulsory legislation and regulations might be enacted so that all employers are required to offer the PKTK option to employees. However, the employers may, at the same time, offer other health insurance plans to their employees that compete with the PKTK program. This approach would provide for a similar free market approach described above in which the PKTK system would be forced by competition to be product competitive. The only disadvantage is that the PKTK program might not be price competitive since it may be, by law, locked into a seven percent premium -- while other insurers could charge less. This might be resolved by requiring all insurers to charge the same amount, let's say seven percent. Or, the system may be designed whereby the employers are required, again by law, to deduct seven percent from employees' wages and deposit these withholdings in a federal account. Employees would then choose the health plan they desire (assuming that the employer offers PKTK as well as private health insurance plans) and the government agency would then pay the premium to the appropriate health plan on behalf of the employee. In fact, the government agency administering such a program might negotiate preferred prices (premiums) with the insurance companies, thus creating savings in the system. Savings would be used to develop a reserve for the national program and, at some point, might be used to help reduce the seven percent withholding level that employees pay.

The PKTK study group, of which I was a part, has determined that a compulsory system with legislative enforcement should be used.

Organizational Structure: A second philosophical issue concerns the operationalization of the letter of agreement between the Ministry of Health and Ministry of Manpower signed March 1985. Paraphrasing, the decree suggests that both ministries play a role in the operation and management of the PKTK system. In effect this method of organization does not meet the basic management

principle or concept called "unity of command." According to management theorists, it is not possible to have two individuals managing the same work unit; the outcome would be disaster. Decisions would not be made in a timely fashion, or might not be made at all. Scapegoating would occur, and subordinates would be confused. Productivity would suffer and ultimately the organization would fail.

The PKTK study group observed this problem in most of the six provinces and have arrived at three possible alternative arrangements. Total authority and responsibility to operate and manage the PKTK program would be assigned to the alternative chosen.

1. A separate division within Perum ASTEK which would maintain separate accounting and booking of the PKTK program.
- 2.a. A subsidiary company of ASTEK and the Ministry of Health.
- 2.b. An independent and separate corporation to operate and manage the PKTK system -- probably a new Perum.

Choice of the alternative is one of the main issues of this workshop and should one of the first issues to be considered. In that regard may I offer some comments. First, it appears that there is substantial concern both in the Ministry of Health and Ministry of Manpower that the March 1985 letter of agreement is not being carried out if only one of these two Ministries participates in the management of the PKTK program. Second, rivalry for control of the PKTK system will be a problem in the current dual management system and during a transition period to a new unit management system. Power struggles and political maneuvering will occur. Third, it is unlikely that government money will be available for the institution of a new Perum or corporation to operate PKTK; funds to finance such an alternative must come from current operations of the program. Finally, the workshop should consider the legal issues of establishing a unit to manage the PKTK program -- is it legal to establish a joint venture, or a separate division of ASTEK, or to set up a new corporation or Perum?

Premium: A final philosophical issue that is important to our discussions is the question of premium. Currently, premiums are set at seven percent of wages, although several of the provinces use maximums and minimums, ceilings, or flat amounts with several different rates in effect. Obviously, the establishment of a premium structure relates to many issues including the legal basis for the premium, the effect of price competition from other private health insurance plans, the ability of employers to pay the premium, whether participation in the PKTK program is voluntary or mandatory, the "hidden tax" effect of a compulsory premium, and the social welfare effect of a nationalized health insurance program. Without a thorough review of these issues, along with others such as a complete actuarial study, decisions regarding premium level and approach cannot be made. However, realistically, the program must go on; it must continue to operate even though such analyses are incomplete at this time. It seems that this workshop must take a stand on what it feels is the most appropriate pricing and premium policy that can be used in the immediate future. However, it should also be the recommendation of this workshop that the issues identified above be studied and addressed as soon as possible so that permanent policies regarding the premiums can be created for the PKTK program.

To assist the workshop participants in this regard, the PKTK study group recommends that premium be set at seven percent of wages with a Rp. 300,000 per employee per month ceiling.

Another issue that needs some clarification is the idea of using a premium based on a percent of wages or a set amount of money. In the latter model, using actuarial studies, PKTK might identify an actual Rupiah amount to describe the premium such as Rp. 6,000 per employee per month. The premiums for spouses might be identified as one and one-half times Rp. 6,000 or Rp. 9,000 for employee

and spouse, and two and one-half times Rp. 6,000 or Rp. 15,000 for family coverage. This last approach is used to set premiums for all health insurance programs in the U.S. including private and public or government sponsored programs like Medicare and Medicaid.

HEALTH SERVICES DELIVERY ISSUES

The PKTK program must be a balanced program of health insurance (financing) and health services delivery, otherwise it will not be effective in carrying out its objectives. As such the premiums must be realistic, fair and related to the risks of illness of the enrolled population. Likewise, the delivery of medical services must be appropriate, accessible, convenient, and of high quality. Employers and employees alike must consider the PKTK program to be of "good" value for the price. From this perspective the PKTK study group evaluated the available delivery modes regarding "patient satisfaction" and the consumer's perception of the PKTK program in each of the six provinces. It was the study group's opinion that greatest employer and employee satisfaction would be obtained if the PKTK program utilized primary care providers "dedicated" to the PKTK population. In order of preference, the study group felt that 1) the use of special PKTK clinics with salaried physicians, 2) the use of solo private primary physicians, and 3) the use of private physicians using PKTK facilities were the best methods of providing primary health services to PKTK members. Obviously, the group also recognized the need to use Puskesmas in regions where it might not be possible to establish a special PKTK facility or where obtaining physicians was difficult. Additionally, some consideration of cost of setting up such special clinics was addressed; based on the experience of some provinces, it was shown that modest facilities could be inexpensively rented, equipped and operated. It is my opinion that these health services should emulate the private physician's practice in the private sector. Remember, the PKTK program is competing with private health insurance programs but is also competing in the delivery area with the private physician.

Hospital services, likewise, should be arranged so that there is a dedicated inpatient service available to the PKTK member. But, because of the inordinate cost of establishing and operating hospitals, use of government and private hospitals will probably continue to be the method of inpatient delivery in the PKTK program. This does not preclude the development of special arrangements with private hospitals for PKTK members, and the use of better accommodations in government facilities. Ultimately, the ideal situation for the PKTK program would be for the program to own and/or lease its own hospitals and operate them for the use of PKTK members. Preference could be given to the program's members with services made available to non-program individuals on a space available basis.

Payment for both outpatient and inpatient services will probably be a combination of full fee-for-service, negotiated (discounted) fee-for-service, and capitation. Ultimately, the PKTK program will want to move to capitation because of the incentives for physicians and hospitals to control inappropriate utilization of services and drugs.

Finally, supplying of drugs will probably continue as currently structured; e.g., drugs supplied by PKTK, supplied by physicians and hospitals, and supplied under agreement or contract with pharmacies. Again, the best approach to control the prescribing and cost of drugs would be to include drugs in the capitation to physicians and hospitals. This would give the providers of care incentives to limit drugs to approved formulary, to use generic drugs, and to negotiate discounts with drug suppliers. The use of discounted pharmacy arrangements would add to the PKTK member's convenience in obtaining drugs and would also help control costs.

ASSESSMENT ISSUES

The domestic consultants focused on five major aspects of the six PKTK provincial systems. These included:

1. organization,
2. management,
3. health services,
4. membership and premium collecting, and
5. financial and actuarial issues.

In its review, the PKTK study team used the five major headings for its review of the six sites, but separated each major heading into several subcomponents. In all, the study group analyzed nine sub-issues and thirty-one sub-sub-issues; these are provided on the assessment matrix with major activities on the vertical axis and the six sites listed horizontally. After in-depth discussion of each cell, the study group arrived at consensus regarding their opinions or preferences of the issue in the cell. Then, cell by cell, each of the six sites was ranked using a scale of 1, equalling low (based on the study group's opinion/preference), to 5, equalling high study group opinion/preference. Based on this rigorous, measured approach the following total scores were obtained:

| Rank | Site/Province | Score | Percent of Perfect Score |
|------|---------------|-------|--------------------------|
| 1 | Surabaya | 23 | 51.1 |
| 2/2 | Bandung | 20 | 44.4 |
| 2/3 | Jakarta | 20 | 44.4 |
| 4/5 | Denpasar | 15 | 33.3 |
| 4/5 | Lhokseumawe | 15 | 33.3 |
| 6 | Batari | 13 | 28.9 |

A total of 45 points was available. Since the top score awarded by the study group was 23, there seems to be some room for improvement in the operation of the PKTK program in all of the provinces. For example, Surabaya, with the top score of 23 points, met only 51.1 percent of the PKTK study group's expectations for the program.

The major areas of deficiency included the aspect of organizational structure; no site received more than 2 out of a possible 5 points. This low ranking related to the lack of "unity of command" in four sites, lack of full time administration in four sites, and generally not establishing functioning administrative units according to the March 1985 letter of agreement. However, as we have described earlier, there needs to be a reassessment of the process by which the letter of agreement has been operationalized. With clarification of this last point, I expect the sites to make substantial improvements in this area.

In the area of management, most of the sites lacked an operating management information system, did not use utilization control of service delivery, and generally lacked control of the operations of the PKTK system. Two exceptions were noted; in Jakarta and Surabaya there appears to be either strong control of the organization and/or good application of utilization control.

Membership and marketing were areas in which the study group also found deficiencies. Uniformly, there appears to be no long or short term market planning and thus little follow through on a marketing plan. Although the study group recognized the short term marketing efforts in Jakarta,

Bandung and especially in Surabaya, it felt that major improvements in this area were needed if the PKTK program was to be successful.

In another problem area, premium, there seems to be an extended time between when the premium is due from employers and when it is actually paid. Additionally, there are administrative problems in transmitting the money from the collection point to the health plan. Better turn around time in the transfer of collected funds, therefore, needs to be addressed.

None of the sites was involved with the use of actuarial analyses to determine the risks and thus the costs associated with their enrolled groups. And in Batam, the study group noted a deficit from operations probably due to its very high costs of the medical benefits provided, the high cost per ambulatory visit and the highest rate of contacts to a health services provider per enrollee per year (3.3). Further study of the need for services among members in Batam may explain these relatively high costs and service use. In all but one site, Jakarta, the PKTK program was not covering the full costs of hospital care for its enrollees. Denpasar has the lowest cost per ambulatory visit probably due to the use of a full capitation with the physicians (which also included drugs) while maintaining an average contact rate per member per year of 2.4.

Finally, from a political perspective, there seem to be some problems in operation of the system in Batam because the program is caught between the Department of Health and the Batam Authority. Similarly, the study group found that there were problems in both Surabaya and Denpasar because the Department of health was not involved in the operation of the PKTK programs as originally structured.

CONCLUDING STATEMENT

In general, the six sites have provided us with the opportunity to see what works and what doesn't, and to see where the major problems lie. Each site is unique in its structure, its relationship with its providers, and its relation to the marketplace. Thus, no one PKTK model can be applied uniformly throughout Indonesia. However, there are uniform components that can help create models which, at least, will accomplish the objectives of the joint decree, that will be efficient and productive, that will have cost and utilization controls, that can compete effectively in the private marketplace, and that will meet the health services needs of workers. The common elements appear to be:

- * A single unit responsible for administration and arranging for the delivery of health services.
- * The use of strategic planning and marketing to improve the use of resources and to prepare the PKTK plan to enter the competitive marketplace.
- * The use of capitation contracts with providers that also include drugs in the capitation rate.
- * The use of a computerized management information system to keep track of operations and utilization -- so corrective action can be taken in a timely fashion.
- * The use of "dedicated" PKTK ambulatory facilities and hospitals for exclusive use of PKTK members.
- * The use of actuarial analyses in the financial planning and budgeting process so that risks are understood, and so that the system can be financially controlled more adequately.

APPENDIX B

STUDY GROUP PAPER REGARDING PKTK MODEL ISSUES BY

ROBERT G. SHOULDICE
25/1/89

As requested, here are some of my ideas, concerns and opinions that I provide for your discussion.

COMPULSORY INSURANCE SYSTEM

As we have discussed, I would prefer that a voluntary (i.e., competitive) health insurance system be developed in Indonesia. My thought would be that regulation be passed that requires all employers to pay the premium for and make available health insurance coverage to their employees plus dependents. Several variations are possible:

1. Completely free market where the PKTK system competes with private health insurance companies for opportunities to enroll employees and dependents.
2. Regulation that requires all employers to, at the least, offer the PKTK health insurance program to employees and dependents. In this alternative, the employer would also be allowed to offer competing private health insurance programs to employees, at the same time. The PKTK program would have to effectively compete with these private insurers for enrollees. Incentives to provide comprehensive benefit packages and attractive health services delivery would be the outcome.
3. Regulation that requires all employers to exclusively offer the PKTK program. No other health insurance program would be allowed to compete with the PKTK program.

In all of these options the employers could pay premiums directly to the insurer on behalf of the employees, employers might pay the total premium to the government with the government then paying the premium to the insurance company. In this last situation, the principle of "mutual assistance" would be assured. In fact, the government might be able to negotiate discounts on premiums from insurers because of bulk or quantity purchases.

BENEFIT PACKAGE

My feeling is that the PKTK program should cover a basic set of health services benefits that are uniform throughout Indonesia. If a voluntary system, described above, is used, private insurers should be required to offer this basic set of benefits. We should discuss and make a recommendation on this subject. Further, if additional, optional benefit packages are to be provided, the employee should be required to pay the additional premium for this additional health insurance coverage. This might be described as the PKTK "basic" package for all employees and their dependents, and a "supplemental" package purchased by the employee.

PREMIUM

I prefer a premium arrangement where the objectives of "mutual assistance" are fully operational. In a situation such as this one where the employer is paying the premium on behalf of his employees and their dependents, the issues are those regarding the employer not the employee. Thus, we want to be assured that the total money collected covers the cost of the PKTK program for its enrolled members. Thus, premiums should be set by determining program costs plus reserves, and dividing these total costs by the total member months for the time period. The result will be an average, fixed Rupiah premium paid by the employer. I do not support a seven percent premium with a Rp. 300,000 ceiling since it does not meet the principle of "mutual assistance" or normal health insurance concepts of spreading the risks among all participants regardless of health status or income level.

Our major concerns regarding premium are 1) to cover our total costs of the PKTK program, and 2) to make the program attractive to employers so that they will willingly participate in the program. So it should be simple to administer, simple to explain, and not seem to be a major financial burden on employers.

SERVICE DELIVERY

I agree that the PKTK program should use a combination of ambulatory and inpatient service delivery options, and that the PKTK members should have a choice every six months of ambulatory delivery site.

ORGANIZATION

I believe that we can divide this area into two issues -- 1) the umbrella organization which might be described as the policy making body, and 2) the operating unit. As we have discussed there are several alternatives for the umbrella organizational structure. These include the use of an "improved" existing system, the creation of a division of ASTEK, the creation of a division of PHB, the development of a freestanding corporation, and the development of a new Perum. My preference is for the development of either a new corporation or a Perum. The advantage of the corporate form is its flexibility, its ability to raise capital, and its ability to have a strong management capability. Similarly, the new Perum would have the same advantages but may have problems attracting sufficient capital for development and early operation; it is obvious that the federal government will not fund the new Perum. The use of divisions of either ASTEK or PHB creates opportunities for power struggles and other negative political issues. Finally, the use of an "improved" current structure may be valuable as a stopgap measure until the new organizational structure is in place.

Although I have provided my preference of umbrella structures above, I would not presume to recommend one model over another. It might be useful for the group to analyze the advantages and disadvantages of each model and come to consensus. This analysis should, however, include discussion of at least the following issues: ability to meet the spirit of the joint decree, control of operations, autonomy of action, ability to make decisions and policy in a timely fashion, unity of command, ability to unify and integrate the individuals from ASKES and Ministry of Health into a cohesive unit, ability to raise sufficient capital for operations and improvement of services, and political ramifications of the models.

The second issue -- that of the internal operating structure -- requires us to consider several issues. These include the following:

- * Unity of Command where there is one individual who has the authority and responsibility to operate and manage the organization. This authority is derived from the PBK in the existing structure or the board of a new corporation. This also requires that both the delivery (line) personnel and the administrative (staff) personnel be accountable and under the direct authority of this manager rather than reporting to either the Ministry of Health or ASTEK.
- * Same conditions of employment for all employees -- under which the working hours and pay scales are the same.
- * Superior-subordinate relationships where the PKTK local manager has the right to "command" and all employees of the PKTK local program have the duty to obey the requests of the manager.
- * Full time employees of the PKTK program -- dedicated to the operation of the program.

THE NEW MODEL

My ideal PKTK model would have the following characteristics.

- * Umbrella organization with autonomy to manage its own internal affairs without outside interference.
- * Board of Directors (or policy making body) -- Board having complete authority to operate the PKTK program.
- * Board appointing (hiring) a full time executive director (ED) who would have the authority to operate the PKTK program as he/she felt best. The ED would be held accountable for the operation of the program by the Board.
- * Provincial Operating Managers (POM) appointed by the ED; their responsibility would be for the local operation of the PKTK program and they would report to the ED only. Both the operating manager and the ED would be full time.
- * A provincial advisory body to assist the POM in obtaining community input.
- * All employees of the PKTK national and provincial programs would be full time with the same conditions of employment.
- * Delivery of services would be arranged through contracts or agreements with local providers (physicians and hospitals) or through specially established PKTK clinics (for primary care). Thus, the program would use a combination of provider elements particularly suited to the local or regional PKTK site conditions.
- * Premiums collected regionally would be used regionally, with a set percentage sent to the national PKTK office for national operations and reserves.

MARKETING

Finally, there seems to be no substantive marketing effort undertaken either at the national or the regional level. It would be useful to develop policies, benefits, and programs that would then be communicated to employers and employees. In effect the program should develop target markets, and market mixes (statements of the products or services, prices or premiums, place of delivery, and promotion or educational/communication activities) for each of the target populations. Then, these marketing strategies and plans should be implemented. There should be feedback after operation of the program to assure that marketing targets are being met. In addition, the regional managers or designated employees should provide account maintenance -- to obtain feedback about the day-to-day operation of the program, and to resolve problems as they arise.