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**ASSESSMENT OF PKTK IN SIX PROVINCES
(ORGANIZATION, MANAGEMENT AND HEALTH SERVICES)**

#16

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INTRODUCTION

An assessment of the PKTK system in six locations was carried out as part of efforts to develop a prepaid health service system for workers in Indonesia. The selected locations were Lhokseumawe in Aceh province, Batam island in Riau, Jakarta in DKI Jakarta, Bandung and Garut in West Java, Surabaya in East Java, and Denpasar in Bali.

The objective of the assessment was to develop a model of financing health services for workers, supported by a prepaid mechanism. The model will be tested in a selected area, evaluated and improved and then be used as a basis for expanding the system in other areas.

Specifically, the assessment focused on five major aspects of the system:

1. organization,
2. management
3. health services,
4. memberships and premium collection, and
5. financial and actuarial.

The assessment of these aspects was assigned to three local consultants. The first consultant was responsible for the first three aspects, the second consultant for the fourth aspect (memberships and premium), and the third consultant for the fifth aspect (financial and actuarial).

This report addresses the first three aspects: organization, management and health services. The approach in this assessment describes the current system as it is -- identifying problems, strengths and weaknesses of the system -- and, finally, formulates recommendations for the proposed model.

I. ORGANIZATION AND MANAGEMENT

A. Legal Aspects

PKTK's organization structure is based on a letter of agreement between the Ministry of Manpower (MOM) and Ministry of Health (MOH) signed in March 1985. Basically, in the agreement stated that health care for workers should be provided within the framework of the principles of health development and the principles of manpower development in Indonesia. Therefore, coordination between the two ministries is essential in developing PKTK.

The agreement also specified the role of the two ministers in determining the funds required to operate the PKTK system, including deciding premium size. The collection and allocation of funds from the participating companies are managed by MOM. Operationally, this is done by Ferum ASTEK (ASTEK), a quasi-governmental insurance company set up to provide workmen's compensation. The coordination and quality control of the health services is managed by MOH.

The two ministers established a coordinating body, Badan Kerja Sama (BKS), whose members represent the two ministers. BKS formulates policies, establishes standards of services and cost, and monitors and evaluates the implementation of PKTK.

B. Organizational Structure and Units

The organizational units composing the structure of PKTK, based on the principles implied in the MOM and MOH letter of agreement, are presented in diagram 1.

Most of PKTK's operational activities of PKTK take place at the provincial level where BPKD (Badan Pengelola Kepesertaan dan Dana) is responsible for marketing and enrolling PKTK members and collecting premiums. BPKD's personnel supposedly consist of provincial ASTEK office personnel. An example of this unit is the one found in Jakarta, seen in diagram 2.

BPPK (Badan Pengelola Pelayanan Kesehatan) is managed by provincial health office staff. This unit is in charge of coordinating and controlling the provision of health services for the workers. An example of this unit, also found in Jakarta, is shown in diagram 3.

According to the current arrangement, a unit should be established to coordinate the activities of both BPKD and BPPK. This unit is headed by a person selected alternately either from BPKD or BPPK. Each person is in charge for a six-month term.

Another unit involved in provincial PKTK is an Advisory Body or Badan Pembina PKTK (BP-PKTK). The role of this body is primarily to provide assistance to BPKD and BPPK in policies as well as operational aspects of the PKTK program in the area. The members of this body are comprised of representatives from other relevant sectors, such as the local government officials, local MOM and MOH offices, etc.

Diagram 1: Organizational Structure of PKTK

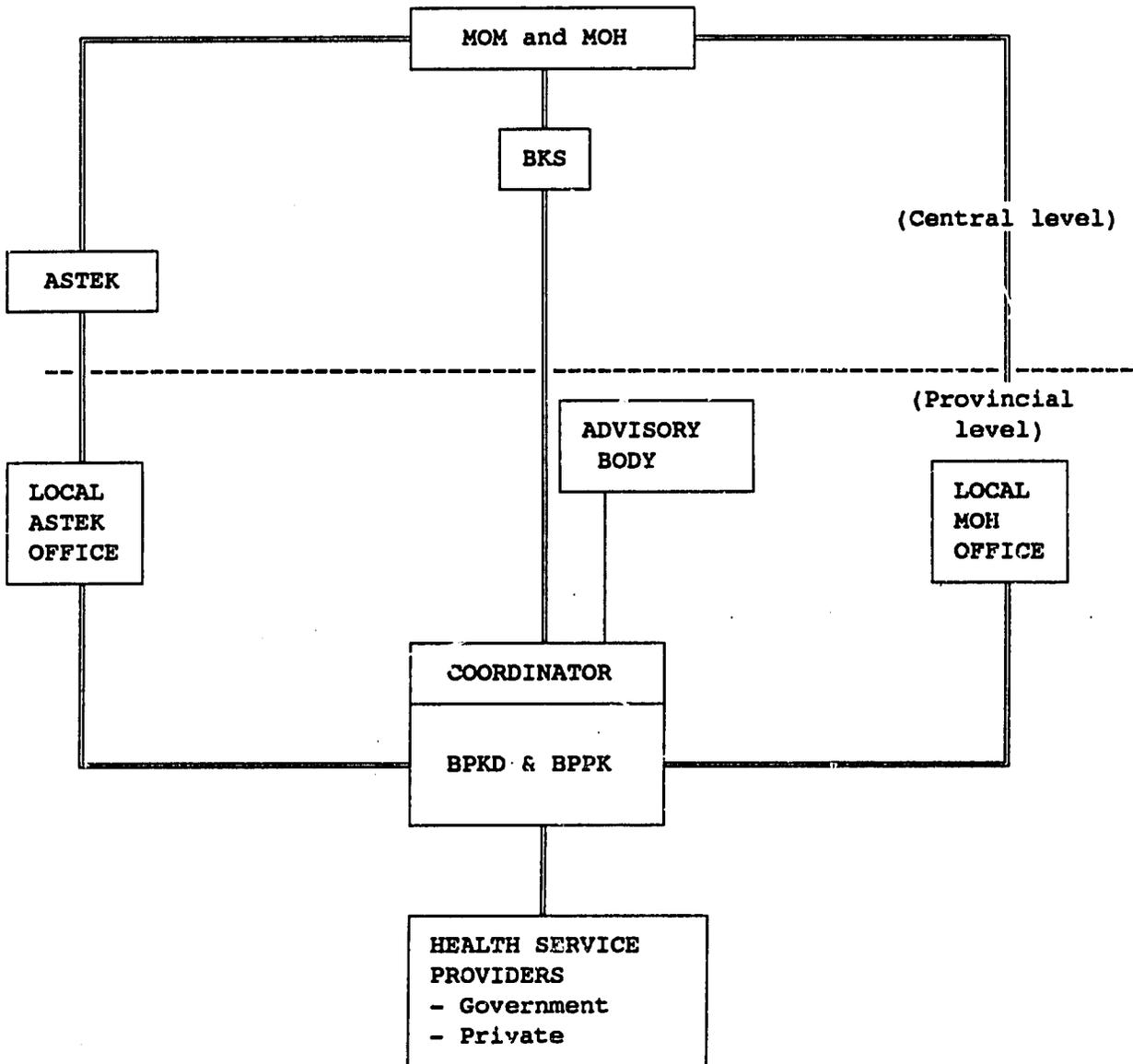


Diagram 2: BPKD

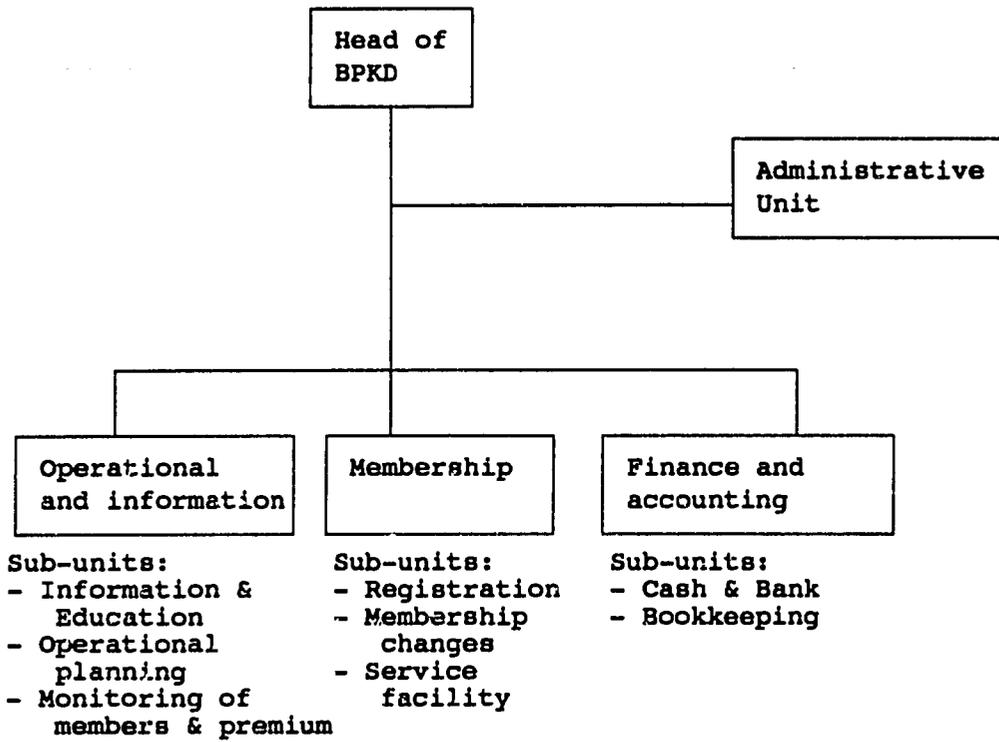
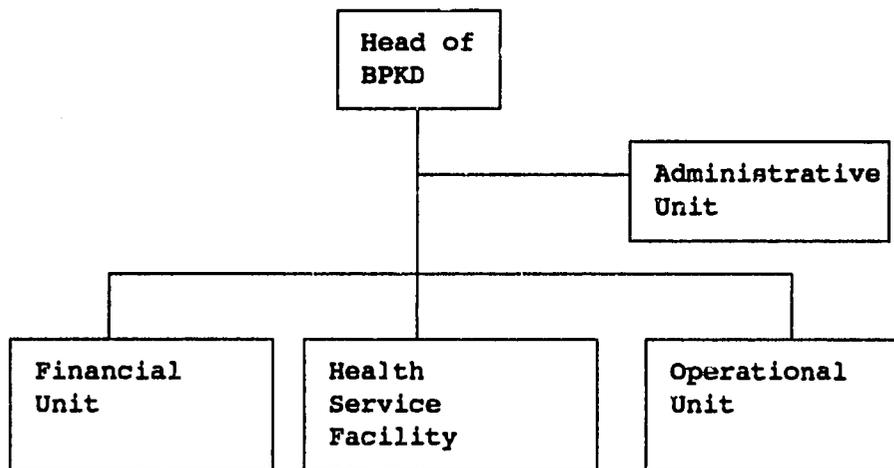


Diagram 3: BPPK



The providers of health service are health service networks owned either by the government or the private sector. This includes, for example, health centers, hospitals, maternity clinics, doctors in private practice, dispensaries etc.

Conceptually, the functioning of the system within the framework of the organization can be described as the following. BPKD and BPPK, assisted by BP-PKTK, formulate a PKTK program plan. The plan includes setting objectives and targets, estimating premiums and revenues, determining service packets to be provided and planning a network of health service providers.

Following up the plan, BPKD will carry on the marketing of the PKTK program to recruit employees through their company. This unit will collect the agreed premium from the company and allocate the collected funds in the following pattern:

- 8% for BPKD operation,
- 10% for BPPK operation,
- 70% for providing health service,
- 2% for supporting BKS activities at the central level,
- 10% for reserve.

A different allocation is found in Surabaya, where PKTK is solely operated by the local ASTEK office (the functions of both BPKD and BPPK are executed by the ASTEK office). An amount equal to 7.5% of the premiums is deposited in a bank.

Allocation of Collected Premium in Surabaya

70%	Health services,
10%	Operational cost,
10%	Reserved,
7.5%	Bank deposit,
2.5%	Clinic maintenance.

In addition to these tasks, BPKD is also in charge of monitoring the memberships (new members or drop outs) and passing the information to BPPK. BPKD also provides the employees and their employer information about the mission, the advantages and benefits of PKTK, as well as the expected participation of the employees and employers required to ensure the success of PKTK.

Also, following up the plan, BPPK will negotiate with potential providers on the issues of quantity and quality of service packet, amount and method of payment to the providers, and monitoring the utilization of services by the employees.

C. Implementation of Organization and Management

1. Organizational Issues

Six provinces were visited during August to December 1988 to see how the organization and management of PKTK is working. It turns out that actual implementation exhibits wide variation

between places, different from the conceptual design explained above. The difference is summarized in Appendix 1.

a. BP-PKTK

First, there is no consistent way of establishing a BP-PKTK. In Aceh, the BP-PKTK was established by the Governor in April 1988. This unit has not been functioning, partly because no funds are allocated to support its activity as there is no clear earmark for BP-PKTK from collective funds. The members of this unit all reside in Banda Aceh (the capital of the province) while the PKTK program is implemented in Lhokseumawe, a district capital about 6 hours drive from Banda Aceh. To assist and supervise the PKTK, BP-PKTK requires a considerable amount of money, mostly for transportation.

Similarly, BP-PKTK in Batam is also not functioning. It was established in April 1987 and no assistance or involvement in PKTK planning or implementation has been conducted.

In Jakarta the function of BP-PKTK has been taken over by BKS, which was established by MOM and MOH in April 1985.

A functioning BP-PKTK was observed in West Java. This unit has assisted the Governor, BPKD and BPPK in formulating PKTK policy in the province. It also has organized a meeting with all District governments in the province to initiate PKTK in each district.

A unique circumstance is found in Surabaya. All management functions of the PKTK program are solely carried out by the local ASTEK office. BP-PKTK has not been established in Surabaya.

In Bali, BP-PKTK was established by the Governor in April of 1986. Its main function is to assist the formulation of policy in regard to PKTK development and provide assistance to BPKD and BPPK in operating the system and to submit reports on the progress of PKTK to the Governor. The head of this unit is the Vice Governor, assisted by the Head of the provincial office of MOH and MOM. It was stated by the BP-PKTK members that this unit has not been functioning thus far.

b. BPKD

In all places BPKD was established formally by the local ASTEK office, except for Jakarta where it was by the central ASTEK office. However, the organizational structure and personnel of this unit is not clear. Most of the personnel assigned to carry out BPKD functions are personnel of the local ASTEK office who also hold a certain structural position in the office. In fact, in most cases the activities of BPKD have been implemented by the Division of Special Programs, a unit under the provincial ASTEK office.

c. BPPK

Except in Surabaya, BPPK is organized by the local MOH office. The unit was formally established by the Provincial Health Officer, except in Jakarta where it was established by the Governor.

As already mentioned above, in Surabaya the functions of BPPK as well as BPKD are carried out by the local ASTEK office.

d. Coordinator

Given that most personnel of both BPKD and PKTK are at the same time also in charge of certain responsibilities either in ASTEK or local MOH offices, the role of coordinator became essential. However, it is apparent in the six provinces that this unit has not been functioning satisfactorily.

In Aceh it was found that a coordinator has never been appointed. In other places, such as in Batam and Bandung, even though a coordinator has been appointed, there is no strong evidence that the coordinator position is functioning as it should.

2. Management Issues

a. Line of Authority

Membership, funds and health service facilities are three essential components in a prepaid health service system such as PKTK. How the control over these three components is managed will determine the performance of the system. Integrated and coordinated control is absolutely required since all three components interact with one another. For example, control over the quality of services will affect the marketing of PKTK, the retention of current members and the recruitment of new members. It also affects funding requirements and allocation. Control over the membership will affect the size of funds available as well as the quantity of services needed. Similarly, control over the funds also affects the quantity and quality of services as well as the capacity to carry out marketing activities.

Under the current arrangement, the authority to control the three components is distributed according to the structure of the organization. BPKD controls the memberships, collection and allocation of funds. BPPK conceptually controls the quantity and quality of services. Therefore, coordination of the two units is critical.

In the assessment, evidence indicated that coordination of the two units is not easy. As experienced in Surabaya and Denpasar, BPKD faced difficulty in dealing with the member employees and employers due to their complaints about the quality of ambulatory health services. BPKD cannot modify the services, which were provided through government health centers. It is also difficult for BPPK to initiate change in the health center because the health center carries out many other functions. A fixed allocation of funds restricts the room for BPPK to initiate improvement of health services. Under the current pattern of allocation, the use of the funds by BPPK is limited to operational expenses such as paying the providers. Opportunity to invest in a new facility is not feasible if BPKD and BPPK are not operating as a unified entity.

The root of this problem is the ambiguous status of BPKD and BPPK. A unity of command is a basic requirement for an effective organization. First, it is not clear which unit in MOH is responsible for supervising BPPK. This leads to lack of authority for BPPK to perform interventions at the MOH service facility. Secondly, most personnel of both BPKD and BPPK still have other responsibilities in MOH or ASTEK; they are not really full-time personnel of PKTK.

As a result, control over the three essential components is performed in a fragmented way by fragmented units. It is hard to ensure a "bi-partics" concept in such a situation. In this situation health service providers will emerge as a separate party in the system and collaborate with PKTK in a "payer and receiver" relationship. On one side PKTK has no control over the performance of the services, and on the other side, the provider does not have a sense of belonging to the system.

b. **Different Status of BPKD and BPPK Personnel**

Another problem in integrating BPKD and BPPK is differences in the system of personnel management applied to government employees and to ASTEK employees as a quasi-government company. The two systems provide different salary scales and working hours and even career development. ASTEK employees receive higher salaries than MOH employees, but have longer working hours. To some extent these differences would affect working relationships in the organization.

c. **Planning and Marketing**

Even though the goal of PKTK has been clearly stated in many documents, goals have yet to be elaborated into specific objectives. There is no document containing a systematic plan, starting, for example, from a quantitative target of membership and description of a plan of action to accomplish the target.

It is obvious that the success of PKTK is very much dependent on the number of workers enrolled. However, observation in the six provinces did not uncover evidence that systematic marketing activities have been conducted. Even though in some places a quantitative target was stated, there is no plan of action in the form of market research or needs assessment to estimate the potential enrollees.

Again, the planning activities actually should be done together by both BPKD and BPPK. In Batam, for example, where the number of participating employees and companies is still low (12.5% of the total 4,300 workers on the island) the first meeting between BPKD, BPPK, the health services provider and the MOM representative was held when the assessment team initiated a meeting to discuss various issues and problems and their potential solution. The fact emerged that many of the participants in the meeting, especially the personnel of the service provider, did not have access to information about the PKTK program. In response to low enrollment, they have expressed an interest to be involved in marketing activities, such as joining the marketing team (BPKD) in providing information to employers and employees on the island.

d. **Monitoring and Information System**

Readily available information on the membership situation, financing and service utilization is needed if PKTK is expected to respond appropriately in controlling the system.

Significant changes in the workers' status (layoff, contract termination, transfer, etc.) can be monitored in all six provinces. Even though the mechanisms are not uniform in each province, in most cases, it is done by updating membership information based on data obtained from the employer.

Even though complete data is available for each employee (such as age, marital status, number and age of dependents), the data has not been analyzed to become meaningful information. For example, no age distribution is calculated, which would enable a calculation of utilization rate by age group to in turn provide a basis for making future premium adjustments.

Upon request of the assessment team, the PKTK in Batam, Jakarta, Surabaya and Denpasar were able to provide data on expenditures covering at least two preceding years (1987 and 1988). (Lhokseumawe and Bandung were not requested to provide data.) It is also possible to break down the expenditures by item (salary, drugs, other), or by type of service provider (hospital, health center) or by type of services (ambulatory care by general practitioner or by specialist, inpatient

care, medical procedures, etc.). Before, such a break down was not made routinely, such as on a monthly basis. As will be shown in section 2 of this report, the breakdown of the expenditures can be used to estimate the cost by type of services per PKTK member. A monthly estimate of the cost in this way will enable an evaluation of the trend of expenditures over a period of time. Trends are not only useful for future planning but are also useful in controlling costs. In the event of unusual increases, action can be taken to determine the cause and follow up with specific intervention.

The third most important type of information concerns utilization of health services. Similar to membership data, a calculation yielding rate per member has not been performed. The consultant has tried to estimate contact rate by age group for ambulatory care in Batam using existing data and additional data collected by service units (on utilization) and by BPKD (on demographic characteristics of the PKTK members). This will be explained in section 2 of this report. It seems that the utilization rate can also be broken down by diagnosis.

e. Premium Collection

Critical to the survival of PKTK is the collection of premiums. In May 1988, PKTK in Jakarta reported that 53 (69.7%) out of 76 participating companies had not paid the premium. The unpaid premiums amounted to almost Rp. 40 million. Of those 53 companies, 28 had delayed the payment for 1 month, 17 companies for 2 months, 5 companies for 3 months, 2 companies for 4 months and 1 company for more than 5 months.

There are no data available on the magnitude of delayed payment for other provinces. However, the Jakarta figure indicates a potential threat to the sustainability of PKTK operation, which might also happen in other places.

The reason for delayed payment is unknown. No specific effort was made to uncover the cause during the assessment. This is an important aspect which requires serious attention in the future. First, each area should assess the magnitude of the problem as has been done in Jakarta. Secondly, the respective companies can be contacted to find out the causes. Thirdly, BPKD should take special action based on the findings.

II. HEALTH SERVICES

A. The Packet of Services

Basically health service packets provided for PKTK members follow the comprehensive packet prepared at the national level by MOM and MOH. The standard services are contained in a booklet available to the members. The booklet prepared by Jakarta PKTK lists and define nine categories of services:

1. First level ambulatory services
2. Second level ambulatory services (referral)
3. Inpatient services
4. Special care (ICU, ICCU, etc.)
5. Special services (eyeglasses, hearing aid, dental protheses, etc.)
6. Delivery
7. Diagnostic procedures
8. Drugs and medical supplies
9. Emergency

A "limit and maximum" is applied for certain benefits listed above. Inpatient service is limited to the "class II" ward in a government hospital, or "class III" ward in a private hospital. A maximum of Rp. 50,000 is given for hearing aids.

In Surabaya, the employees and employer are given various options of maximum benefits, corresponding to the amount of premium they are willing to pay. For example, for a single (unmarried) employee, a maximum of Rp. 400,000 benefit is given if the premium is Rp. 2,500. The benefit will be raised to Rp. 500,000 if the premium is Rp. 3,000. Similarly, for a married employee, a benefit of Rp. 500,000 is given for a premium of Rp. 5,000. The benefit is raised to Rp. 600,000 if the premium is Rp. 6,000, etc.

Premium and Maximum Benefit of PKTK in Surabaya

Premium	Maximum Benefit
Unmarried employee	
2,500	400,000
3,000	500,000
3,500	600,000
Married Employee	
5,000	500,000
6,000	600,000
7,000	700,000
8,000	800,000
9,000	900,000
10,000	1,000,000
11,000	1,100,000
12,000	1,200,000
13,000	1,300,000
14,000	1,400,000

B. The Providers

The type, number and owner of facilities providing services also varies among areas. They are summarized in the following table. For ambulatory services the choice for PKTK is either collaborating with government health centers or private clinics or establishing its own clinic. Jakarta is typical of PKTK, heavily relying on health centers for ambulatory services. On the other hand, Surabaya is typical of PKTK, relying on its own clinics. Batam is an example of PKTK relying on private clinics and hospitals.

There were problems raised with regard to the use of health centers. In Surabaya, the MOH office considered involvement of health centers in the PKTK service system would not earn additional revenue for the center. This is due to the law requiring that revenues collected by a government facility must be submitted to the government treasury. Providing services to the PKTK members will only bring additional work to the overloaded health center without additional compensation.

Moreover, dissatisfaction was also expressed by employees and employers in Surabaya and Denpasar. Several complaints recorded were the inaccessibility of health centers the inconvenience resulting from overcrowded patients, and the quality of drugs, considered much lower than that of drugs patients usually received from their company's clinic before shifting to PKTK.

Further discussion with PKTK personnel (both BPKD and PKTK) in Jakarta led to a conclusion that the three alternatives (government health centers, private clinics and PKTK's own clinic) each has its advantages and disadvantages.

Government health centers may be the only choice available in an area. Establishing a new clinic will require a considerable investment. However, as stated above, it difficult to control the quality of services since the health centers generally also have other programs to be executed.

Using private clinics as another alternative may ensure a more simple procedure for the patient and even better quality of service. However, it is a concern that the clinic may be out of control in containing costs, especially in using or prescribing drugs.

The advantage of PKTK having its own clinic is full control over clinic performance, both in terms of service quality and efficiency. The clinic, as in Surabaya, can be established in a location close enough to the work place or to the workers' residential area.

The concern with owning a clinic is the amount of investment required. PKTK in Surabaya overcame this problem by minimizing the cost in two ways. First was by renting a simple building for a certain period of time (average 2 years). The second was by recruiting newly graduated medical doctors who were waiting for government appointments. These doctors work temporarily for relatively low salaries.

PKTK HEALTH SERVICE FACILITIES IN SIX PROVINCES

Location	Type of Facility	Number	Ownership
Lhokseumawe	Ambulatory Clinic	2	PKTK
	General Practitioner	10	Private
	Specialist Clinic	3	Private
	Hospital	1	Provincial hospital
	Dispensary	5	Private
Batam	Hospital	1	Batam authority
	Health Center	2	1 Batam authority
			1 Private foundation
Jakarta	Health Center	31	MOH
	Dental Clinic	13	MOH
	Maternity Clinic	24	
	24-hour Clinic	1	
	Hospital	20	3 Central MOH 4 Army hospitals 11 Private hospitals 2 Local government hospitals
Bandung	Health Center	9	MOH
	Ambulatory Clinic	3	PKTK
	Hospital	4	3 District hospitals 1 Provincial hospital
Surabaya	Ambulatory Clinic	13	PKTK
	Hospital	3	1 Navy hospital 1 Private hospital
	Dispensary	13	Private
Denpasar	GP Clinic	2	Private
	Health Center	?	
	Hospital	1	Government
	Dispensary	1	

C. Utilization

In order to see variation in the effectiveness of service facilities given the three alternatives mentioned above, a comparison of utilization rate and unit cost of certain services is made between Batam, Jakarta and Surabaya and Denpasar.

UTILIZATION RATE/MEMBER/YEAR AND UNIT COST

	BATAM	JAKARTA	SURABAYA	D'PASAR
Ambulatory (GP)	3.30	1.73	2.40	2.45
Ambulatory (referral)	0.06	0.19	0.06	0.03
Hospital admission	0.058	0.033	0.001	0.03
Bed day	0.24	0.26	?	?
Length of stay	4.42	6.88	?	?
Cost/visit (GP)	5,669	3,912	2,143	735
Cost/visit (referral)	3,976	5,576	12,154	
Cost/admission	114,080	283,686	66,608	59,293
Cost/bed day	26,993	34,360	?	?

(The rates and costs were estimated based on 10-month period data, January - October 1988.)

The table above shows that Batam, Surabaya and Denpasar are characterized by high rate of 1st level ambulatory services utilization and a low rate of 2nd level ambulatory services utilization (referral). In contrast, Jakarta has a high rate of specialist utilization and low rate of ambulatory services utilization.

The high utilization rate in Surabaya may be related to the high accessibility and convenience of its clinic's services. In Batam, the high rate may be related to the quality of services, such as that of drugs given or prescribed.

The low utilization of health centers in Jakarta may be due to problems similar to those experienced in Surabaya (before establishing its own clinics) and in Denpasar (before shifting to GP clinics). It may be related to overcrowding, unavailability of doctors or inadequate clinic hours.

In terms of cost, a low unit cost for 1st level ambulatory service is found in Denpasar (Rp. 735) and Surabaya (Rp. 2,143). A higher cost is found in Jakarta (Rp. 3,912) and Batam (Rp. 5,669). As already explained above, Surabaya operates its own clinics for 1st level ambulatory services while Jakarta and Batam pay "outside" providers on a capitation basis such as health centers or private clinics.

Despite concerns about high investment cost, Surabaya experience has indicated that PKTK owned clinics can yield a high utilization rate and low cost service (a cost effective output). Using privately owned clinics as found in Batam may yield a high utilization rate. But the cost is the highest among the three alternatives.

Quite surprising is the high unit cost of secondary ambulatory service in Surabaya (Rp. 12,154), much higher than those of Batam (Rp. 3,976) and Jakarta (Rp. 55,579).

D. The Perception of Health Service

Many of respondents interviewed in the six provinces mentioned difficulty in controlling the services by PKTK. This problem is primarily experienced in government health centers and hospitals as well as private clinics and hospitals.

In Batam, BPPK faced the problem of the rising cost of drugs. The purchase of drugs is controlled by the Batam island authority and BPPK perceived that the type and amount of drugs given for PKTK members are much higher than the essential drug standard. On the other hand, the doctors in the clinics complained that the patients usually refuse to receive drugs below the quality they received from their company clinic prior to enrolling in PKTK system.

Most officials of BPKD and BPPK interviewed expressed similar opinions on the effectiveness of government health centers in providing the expected quality of services for PKTK members. Health centers, especially in big cities, are usually visited by 75 to 100 patients each day. It is almost impossible for health center doctors to give special treatment to PKTK members during usual working hours. Moreover, the health center is also responsible for many other community programs which require health center personnel to go to the field, e.g., supporting the "integrated health post." Therefore, even less time is available for providing care in the health center building.

Opening the health center in the afternoon is one alternative which was implemented in Jakarta. However, most doctors interviewed stated that the incentive they receive (around Rp. 125,000 per month) does not compensate for the opportunity they might get from having their own private clinic in the afternoon.

In Surabaya, both PKTK clinic personnel and ASTEK officials perceived that the clinics have been operating satisfactorily in terms of delivering cost-effective basic ambulatory health services for workers. However, many of the clinic doctors who are appointed based on a three-month contract expect that their status would be changed to be full-time PKTK or ASTEK personnel.

E. Payment to the Provider

A capitation-based payment is applied to all facilities providing ambulatory services, except for PKTK clinics such as those found in Lhokseumawe (2 clinics), Jakarta (1 clinic), Bandung (2 clinics) and Surabaya (13 clinics).

In Jakarta, in addition to the capitation amount, PKTK also pays the health center charge according to the number of visits made by a PKTK member. This is done because all revenue generated from treating patients must be submitted to the government treasury, as required by the law. The amount of revenue is calculated based on the number of patients treated multiplied by the health center charge (tariff).

For secondary ambulatory care and hospital services, the payment is on a fee-for-service basis. Usually, the charges applied have been negotiated and agreed upon by PKTK and the respective provider.

III. DISCUSSION AND RECOMMENDATIONS

A. Selected Issues

PKTK has been implemented under the assumption that the system is compulsory. However, for most employers and employees, PKTK is a substitute for an existing health care system. From the employer or employees point of view, the decision to join PKTK or not will be based primarily on two considerations:

1. Will PKTK provide at least similar or even better quality services?
2. Will the cost for the employer or employee be at least similar or even cheaper than the existing system?

This is the biggest challenge faced in developing PKTK. As observed in the six provinces, low enrollment, dropouts or complaints always related to the issues of the quality of services, ranging from the accessibility of its location, the procedure of getting the services, the quality of drugs used, and the appropriateness of clinic hours.

On the cost issue, determining an optimum premium and cost containment are critical to the sustainable PKTK. Threat of deficit is imminent in some places, such as Batam. This may result from too low a premium, over utilization of services, or uncontrolled cost of services.

Improving the future organization, management and health services of PKTK must lead to finding solutions to the two main issues.

B. Organization and Management

1. Management Functions in PKTK System

As stated in the beginning of this report, the three major elements of PKTK are the market (inclusive of employers and employees), the money (premium) and the services. The management of PKTK therefore is basically the management of the three elements. Controlling the behavior of the three elements and their interaction as desired by the system is primarily the function of PKTK management. Added to this is the control of information on the three elements mentioned.

a. Controlling the Market

The market for PKTK varies between groups and even varies between workers within the group. In the planning stage it is necessary to assess certain characteristics of the workers such as the number, type of occupation, occupational status, age structure, income level, morbidity pattern, perceived need for health services, health seeking behavior, residence distribution, options of health services available, etc. The results of this assessment are needed to set the objective to be accomplished, plan the quantity and quality of services to be marketed, and determine an acceptable premium.

In the implementing stage, controlling the market means maintaining the enrollment and compliance of the members in contributing premiums regularly and in utilizing services according to the predetermined standard.

All functions mentioned above constitute the marketing function which must be translated into specific tasks. These tasks will further determine the development of an appropriate organization to accomplish the task.

b. Controlling the Fund

The management of PKTK must have the capability and authority to consolidate and manage all funds available. A fixed allocation as now applied in the system will restrict the room for management to implement needed maneuvers in controlling PKTK operation. The cost of services may exceed the 70% level or the cost of BPKD activities may also exceed the 10% level of the collected premium. A more realistic allocation, for example, is an annual budget plan based on program planning.

The management also must have a certain flexibility to generate income if there is an opportunity for it. In Surabaya, 10% of the collected premium is deposited in a bank to generate interest.

Preceding the use of funds is the task of collecting premiums from the members. This must be done as a routine task. Consequently, the management function includes monitoring the payment to identify noncompliant employers, and planning and implementing specific actions.

Also included in the controlling of the funds is estimating budget requirements to support the entire operation of PKTK. This includes estimates of the monetary value of the risk of illness (estimates of pure premium) and estimate of load, i.e., the cost attributed to the investment and operation of PKTK. It is strongly recommended that when a model of PKTK management and organization has been formulated, a cost analysis should be done. This analysis will yield the estimate of both investment and operational cost. Decisions then can be made as to whether these costs shall or shall not be accounted for in setting up the premium.

c. Controlling Health Services

The PKTK management role in this aspect is controlling the production, distribution and consumption of health services. This includes the control of service quality and quantity within the limit of the available budget. This function can easily be performed if PKTK acts as the provider of the services. In the case of using secondary providers, control over the services is limited by contractual agreement established by PKTK and the service provider.

d. Controlling Information

Controlling information is related to the three major elements of PKTK as mentioned above. If management functions in the three elements can be translated into various specific tasks, the need for specific data and information can also be identified. An information system for PKTK should provide the needed data and information.

Those are four elements of PKTK which should be managed properly. The assessment conducted in the six provinces shows that the management of those elements, in most PKTK units is not totally unified as a separate autonomous entity. This will be discussed in the following section.

2. Basic Organizational Requirement

a. Total Distribution of Functions and Tasks

Basically an organization is developed to absorb all functions or tasks leading to the accomplishment of a specific objective. In other words, all tasks must be distributed to all units comprising the organization. This implies that the structure of an organization reflects the tasks or functions which must be performed.

The question then is whether all functions of controlling the four basic elements of PKTK have been distributed totally to all units of the PKTK organization. Apparently all functions have been distributed even though the level of authority to perform the functions varies among places. As has been mentioned, fixed allocation of funds does not allow consolidated control over the fund, such as shifting the allocation when and where it is really needed.

b. Unity of Command

All functions mentioned are interrelated. Therefore, there should be an autonomous authority to coordinate or integrate the functions. It seems that the division of PKTK into BPKD and BPPK under the current situation does not ensure a unity of command within the organization, especially in a place where the "Coordinator" is not functioning. In most places, the PKTK organization is actually a consolidation of the local health office and the ASTEK branch office in a province. It is not an integrated entity with autonomous authority to perform all of the functions. As stated by some PKTK personnel interviewed, PKTK is sometimes seen as an auxiliary program attached to either ASTEK or local MOH programs.

c. Alternative Organizational Setting

The following are some alternatives proposed to improve the effectiveness and efficiency of PKTK organizations in the future. Findings in the assessment lead to the conclusion that PKTK would be more effective and efficient if it had full autonomy from the beginning.

ALTERNATIVE I

The PKTK organization is maintained as it is now, regulated by the joint decree of the two ministries. There is BPKD affiliated to ASTEK, BPPK affiliated to MOH and a Coordinator. The difference between this alternative and the current condition is several changes in personnel assignment. That is, the assignment of both MOH and ASTEK personnel to PKTK should release them entirely from any structural position and functional responsibility in either MOH or ASTEK. This would provide PKTK all full-time staffs.

Following this assignment, MOH and ASTEK delegate full autonomy to PKTK to make decisions and execute all functions discussed in this report.

Another essential change required is the strengthening of the authority of the coordinator and the clarifying of functions. Also the term for the coordinator should be extended beyond the existing 6-month period to not less than 2 years. This will allow the coordinator to develop and implement a certain course of policy and programs.

The advantage of this alternative is for PKTK to gain direct support from both MOH and ASTEK, such as subsidy for the salary of PKTK personnel or backup funds when necessary.

The weakness of this alternative is the difference in status and rewards received by MOH personnel from that of ASTEK personnel. Therefore, another change required in this alternative is to secure some amount of funds within the PKTK system to equalize the benefits received by its employees.

Another potential weakness is the difficulty of expanding the PKTK organization when the volume of its work has grown. Under this alternative, recruitment of new staff is still subject to MOH and ASTEK allocation of personnel.

ALTERNATIVE II

PKTK is established as a totally separate and autonomous company. It can gain support from various shareholders, including ASTEK and PHB (quasi-government health insurance company for government employees) or others.

This alternative allows PKTK to grow independently. In the future it may establish its own health service network. It also can accommodate the principles of health development and manpower development as directed by the two ministries.

The disadvantage is the enormous amount of capital investment needed. Even though a loan can be secured, it will take quite some time to have an appropriate number of enrollees.

This alternative will be affordable in the long run.

ALTERNATIVE III

PKTK is developed as a subsidiary company to ASTEK. It has a full autonomy to manage. Similar to Alternative II, PKTK may accumulate funds from shareholders.

This alternative allows PKTK to collaborate closely with ASTEK, since both are dealing with the same target: the workers. Furthermore, PKTK may obtain loan support from ASTEK.

The weakness is the possibility of the development of distance between PKTK and MOH, which might become a barrier to the collaboration between MOH and to MOM as stated in the joint decree.

d. Alternative for Health Services

The distribution of available health services facilities may not match the distribution of workers. Moreover, the number of potential enrollees is also different between places. Therefore, in this stage of its development, PKTK should allow a wide range of alternatives for health service provision. The decision should be adjusted to the local condition.

ALTERNATIVES FOR AMBULATORY SERVICES

The first choice for ambulatory care is for PKTK to establish its own clinic, provided that a doctor can be placed to manage the clinic. The decision to open a clinic must consider whether the number of enrollees is enough to cover the cost. The second choice is private clinics and GP private clinics, and the last choice is health centers.

Should the health center be the only choice available for a certain location, the following arrangement must be ensured: special clinic hours for PKTK members, drugs supplied by PKTK, and if the health center doctor is unable to devote adequate time for PKTK patients, assigning another doctor should be considered.

Due to the fact that most service cost is spent for the cost of drugs for ambulatory services, it is strongly recommended that PKTK manage the supply of drugs for ambulatory service. If non-PKTK facilities were used, such as health centers, private clinics or GP private clinics, agreement must be established that PKTK is to supply the needed drugs to the respective facilities. If a pharmacy (dispensary) is involved, a standard drug list should be made effective such as that of "Essential Drug List" (EDL) or "ED-plus."

ALTERNATIVE FOR REFERRAL AND HOSPITAL SERVICES

It is recommended that PKTK should not establish its own facility for referral and hospital services. This is to avoid the problem of the investment and operational costs which would be incurred.

Collaboration can be made with various health service providers, government or private, such as hospitals, maternity hospitals, etc. A fee-for-service payment can be negotiated.

A requirement to enable PKTK to control the quality and cost is a standard of service. This should be done as a separate activity in developing PKTK in Indonesia.

APPENDIX 1
ASSESSMENT MATRIX

Appendix I

ASSESSMENT MATRIX

Major Aspects	Lhokseumawe	Batam	Jakarta	Bandung	Surabaya	Denpasar
1. Organization (Structure)	- Special program insurance aspect - Service aspect Regional Health Office (RHO)	- Special program RHO & Health Services - Gov. Authority of Batam	- Insurance aspect task force - Team approach - Health Services RHO	- Same as Lhokseumawe	- Insurance and medical aspect by special program	- Same as Lhokseumawe
BP-PKIK	- Established 4/88 but not functioning - No allocated funding from collected funds - Member of unit resides in Banda Banda not Lhokseumawe	- Established 4/87 but not functioning	- Functioning - Provided by BKS April 85	- Functioning - Assisted in developing policy	- Provided by local ASTEK office	- Established but not functioning
BPPK Health	- BPPK established	- BPPK established	- BPPK established	- BPPK established	- Function carried out by local ASTEK office	- BPPK established; no longer functioning
BPKD Administration	- Established by local ASTEK office - In most cases BPKD activities carried out by local ASTEK office personnel; BPKD activities implemented by Division of Special Programs/ ASTEK	- Same	- Established by central ASTEK office	- Same	- Same	- Same
Coordinator	- Not been appointed 1	- Not alternatively appointed or proper functioning 1	- Not alternatively appointed or proper functioning 2	- Not alternatively appointed or proper functioning 2	- Functions carried out by local ASTEK office 2	? 1
2. Management						
A. MIS	A. Manual	A. Manual	A. Computerization	A. Manual	A. Manual	A. Manual
B. Utilization	B. No	B. No	B. Apply utilization control	B. No	B. No	B. No
C. Control	C. Weak--dual 1	C. Weak--dual 1	C. Weak but team approach 3	C. Weak--dual 1	C. Strong 3	C. Weak--dual 1

ASSESSMENT MATRIX (page 2)

Major Aspects	Lhokseumawe	Batam	Jakarta	Bandung	Surabaya	Denpasar
3. Health Services						
A. Facilities	A. Central clinics	A. 2 private clinics	A. 37 Puskesmas	A. 3 PKTK clinics	A. 13 PKTK clinics	A. Private M.D.s
B. Consumer opinion	Salaried M.D.s	2 Puskesmas	2 PKTK clinics	9 Puskesmas	Govt. hospital	Govt. hospital
C. Type of services	Central/private physicians, Govt. hospital	Govt. hospital	Govt. & private hospital	Govt. hospital	PKTK & private pharmacy	Provider drug supply
D. Location of facility	Private & PKTK pharmacy	B. Satisfactory	Provider, PKTK & private drugs	B. Satisfactory	B. Good	B. Satisfactory
E. Access stability	B. Good	C. Comprehensive	B. Poor	C. Comprehensive	C. Comprehensive	C. Unknown
F. Delivery & procedures	C. Comprehensive	D. Poor	C. Comprehensive	D. OK	D. OK	D. OK
	D. OK	E. Not complicated	D. Some concern	E. Complicated	E. Not complicated	E. Not complicated
	E. Not complicated		E. Complicated			
	3	3	2	4	5	3
4. Membership						
A. Covered	A. 7,140	A. 1,512	A. 15,270	A. 8,172	A. 32,683	A. 1,767
B. Rank	B. Mixed low, middle & high	B. Mixed	B. Mixed low & mid	B. Lower paid	B. Mixed low & mid	B. Mixed low, middle & high
C. Age 20-35	C. Same average age	C. Same	C. Same	C. Same	C. Same	C. Same
D. Total eligible	D. 25,750	D. 7,628	D. 40,000	D. 45,791	D. 40,000	D. 17,000
E. Penetration	E. 27.7%	E. 8.6%	E. 38.2%	E. 17.8%	E. 81.7%	E. 10.4%
	2	1	3	2	3	1
5. Marketing Plans						
A. Long range	A. None	A. None	A. None	A. None	A. None	A. None
B. Short term	B. None	B. None	B. None	B. None	B. Exist	B. None
C. Implementation	C. Not aggressive	C. Not aggressive	C. Not aggressive	C. Not aggressive	C. Active	C. Not aggressive
	1	1	2	2	2	1
6. Premium						
A. Collection rate	A. 1-2 months	A. 1-2 months	A. 1-2 months	A. 1-2 months	A. 1-2 months	A. 1-2 months
B. System	B. 7% with max & min	B. Ceiling same for all enrollees	B. 7% with max & min	B. 7% with max & min	B. Flat rate w/ 10 different rates	B. 7% with max & min
C. Rp. transfer	C. Late	C. On time	C. Late	C. On time	C. On time	C. On time
	1	2	2	2	2	2
7. Financial						
A. Cost of medical benefit	A. 3,034 down to 1,514 pmpm	A. 4,509 pmpm	A. 2,000 pmpm	A. 609 pmpm	A. 641 pmpm	A. ?
B. Cover benefit, overhead & administration	B. Yes	B. Yes	B. No	B. Yes	B. No	B. Yes
C. Cover full hospital cost	C. No	C. No	C. Yes	C. No	C. No	C. No
D. Surplus/deficit	D. Surplus	D. Deficit	D. Surplus	D. Surplus	D. Deficit (?)	D. Surplus
E. Provider's payment	E. Capitation for outpatient; hospital negotiated price	E. Same	E. Same fee for service per visit	E. Same/staff model; fee for service for hospitals and specialists	E. Salaries; fee for service for hospitals and specialists	E. Full capitation including drugs; fee for service for hospitals and specialists
F. Cost per unit	F. Rp. 5,700	F. Rp. 5,700	F. Rp. 3,900	F.	F. Rp. 2,240	F. Rp. 735
G. Contract rate /member/year	G. 3.3	G. 3.3	G. 1.7	G. 3.5	G. 2.4	G. 2.4
	2	1	2	3	3	3

ASSESSMENT MATRIX (page 3)

Major Aspects	Lhokseumawe	Batam	Jakarta	Bandung	Surabaya	Denpasar
8. Actuarial Analysis (Financial Planning 70%)	None Yes 1	None Yes 1	None Yes 1	None Yes 1	None Yes 1	None Yes 1
9. Political	No problem 3	Program caught between Health Department and Batam Authority 1	No problem 3	No problem 3	Health Department not involved 2	Health Department no longer involved 2
TOTAL POINTS	15	12	20	20	23	15

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