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**REVIEW OF THE ASSESSMENT METHODOLOGY FOR THE
PKTK PROGRAM**

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A. SCOPE OF WORK

The consultant's Scope of Work was to: 1) review the terms of reference and methodology developed to assess the PKTK schemes; 2) make recommendations for improvements in the assessment methodology if any were needed; 3) assist with the collection of data for the assessment in two cities; 4) participate with the assessment team in analyzing the information; 5) participate in the workshop at which preliminary findings and recommendations would be presented and 6) make recommendations to the Project Management Unit, to USAID and to ISTI regarding subsequent steps needed with regard to the assessment of the PKTK schemes.

This report is organized into two sections:

- I. Review of Assessment Methodology
- II. Findings and Recommendations.

B. BACKGROUND

The consultant had a very extensive schedule and program prepared for him by Dr. Rizali Noor, Chairman of the National Steering (Coordinating) Committee and Dr. Ny. Oemy Syareef who coordinated all the assessment activities, logistical arrangements and chaired the assessment sessions.

The original planned sequence of events for conducting the assessments was for the consultant to review the assessment methodology and meet with the assessment team to agree on any needed changes. After agreement on the methodology and process, the actual assessments were to begin. Because of difficulties and conflicts with scheduling, several of the assessments were begun before a review of the methodology was completed. Because of the schedule of the field assessments the consultant was not able to review the methodology in detail until after the visits to the field were completed.

This trip is the first visit by the consultant to Indonesia. There are many things he does not understand regarding the culture, customs, organization of the government and ways of doing things. His lack of knowledge of Bahasa Indonesia has been a barrier to increasing his level of understanding. In completing the Scope of Work the consultant has attempted to be sensitive to the culture and customs of Indonesia and to the individuals he has worked with. It is hoped that nothing in this report will be offensive to anyone nor is it directed toward any individual. It strives to be understanding and helpful in making progress toward improving the standard of living and access to health services for the people of Indonesia.

The consultant wants to express his appreciation and thankfulness to all the people he has dealt with during this visit. Everyone has been very helpful, understanding, and, most of all, patient with the consultant. It is hoped that this report in some measure repays their kindnesses.

C. REVIEW OF ASSESSMENT METHODOLOGY

General Comments

The assessment methodology and process is a significant step forward in moving the PKTK program from a pilot or experimental program to one of general implementation throughout Indonesia. Much more information is known today (and will be known as the data is analyzed) than was known before the assessments were conducted. This knowledge, though not necessarily complete for each assessment, will be very useful in making recommendations for changes and in the development of the "model" scheme.

The concept of involving expert domestic consultants and of forming review teams is considered by this consultant to be a good strategy. The role of the central office in developing the assessment strategy and instruments is also considered to be very appropriate.

Several suggestions are made for consideration on how the process might be improved.

1. Assessment planning: sufficient time does not appear to have been spent on the preparation of the survey instruments. Some of the questions asked of employees or their employees seemed inappropriate in that the information should be available from the BPKD office. (Specifics will be reviewed later in this report.) Also, some questions were confusing to the consultant; this may be due to the difficulty of translation or they may not be clearly stated to begin with. It is unknown to the consultant if the survey instruments were "field tested" and revised before being used. It is usually better to do so but does require more time.

The planning for the field visits seemed rushed. One visit was postponed because the region was not prepared for the review. It is not known how much information and lead-time the region (schemes) had with which to prepare for the assessment, however, it didn't seem to be enough in several cases. A specific suggestion is made that in the future serious consideration be given to having the schemes complete questionnaires and reports in advance. These should be sent to the central office which would distribute them to the review team. The review team can then conduct a desk review of the material ahead of time. A meeting of the review team in advance of the field visit would enable discussion and consensus of the areas of concern that can be focussed on during the visit. This would enable more effective use of the review teams and the scheme's resources in the assessment process. The areas of concern identified in the desk review should be shared with the scheme prior to the field visit so they can be better prepared for the review. In addition, the review team would be much more knowledgeable about the scheme and able to conduct a more helpful review.

2. The consistency, quality and comparability of the information gathered in the assessment process would be greatly improved if the review team was the same for all reviews. This may not be practical but should be given consideration. The advantage of this is that the assessment skill level will be increased for the team with each review -- they will learn what works and what doesn't in the assessment process and thereby can make improvements. Regional people may still need to be involved and can learn a great deal from the process but the key core team should be the same. This core should represent the major functional areas being reviewed (e.g., management, health services, etc.). If this were done it might mean a change in the role of the domestic consultants unless they could commit to each field visit. Perhaps the role for the domestic consultants could be a heavy involvement in the planning of the instruments and methodology and in the review of the information and results of the assessments.

3. The third suggestion is that there needs to be some very clear thinking about what data to collect and access. A concern is that the survey instruments seem to be a compilation of everyone's questions without an understanding of why that information is needed or how it will be used in assessing the progress (or success/failure) of a scheme. This concern also applies to the Management Information System (MIS) which is generally thought to mean computers. The PKTK program could fall into the trap of a lot of organizations in having the "Data Jungle - Information Desert" disease. Too many times administrators or supervisors don't take the time and effort to think through what information is really needed to make decisions or manage. They, therefore, ask all the questions they can think of; the result is "data jungle" -- so much data -- and no one knows what to do with it. This particularly happens when people providing data do not ask how or why it is needed. In reading through the survey forms there is the question of how or why some of the data is required. Before another assessment process is conducted the survey instruments might be reviewed with this in mind. It is a very difficult task to accomplish.

Gaps in the Assessment Methodology

The assessment methodology has a strong focus on the organizational and management areas of the operation of PKTK. It also emphasizes the gathering of valuable information from employers and from employees. These areas are important and should not be minimized in any way.

The consultant, however, based on his experience with Health Maintenance Organizations (HMOs) in the United States, has identified areas that do not seem to be covered or included in the assessment methodology or process. These are:

- 1) legal and contractual issues with members and/or employers,
- 2) relations with and attitudes of physicians and other providers,
- 3) overall market assessment,
- 4) operations review, and
- 5) financial review.

1) Legal and Contractual Issues. The consultant is aware that the Indonesian society is not prone to file law suits. (That is something no one should want to see develop here.) However, there was no review, to the consultant's knowledge, of the contract (verbal or written) between the employer and/or the employee and the PKTK scheme that specifies the services to be provided in return for the premium paid. (In the consultant's terms this is referred to as the "Subscriber Contract.") One of the areas usually reviewed is this "subscriber contract" to make certain the scheme is providing the services it is responsible to provide. There are some general questions that ask about services offered (Form E) but these are very general and not as specific as would be included in a "subscriber contract review." A related area is that there seemed to be a lack of understanding on the part of employees and members about the services provided. The consultant is unaware of material that is given to the employee either before or after he joins the PKTK scheme. This area didn't seem to be covered in the assessment specifically. It may have been brought up by some members during their interviews.

2) Relations with and Attitudes of Physicians and Other Providers. To the consultant's knowledge there was no systematic gathering of information directly from providers of services regarding their participation with the various schemes. There was ample input from those physicians and dentists who are involved in the administration and management of the schemes, such as the area's Medical Director or the Puskesmas' Medical Director. It didn't seem to be necessary to determine the attitudes of support or concerns of the private physicians who treat PKTK members on a fee-for-service or capitation basis in their own offices or of hospital administrators. It would seem to be important to get this kind of input; this may be an example of the consultant's lack of understanding or that the input has been received and

the consultant is unaware of it. What would be very helpful is a brief narrative description of the health delivery system used by each scheme (two pages at most) accompanied by a list of physicians, dentists, and other providers with the hours they are available to service PKTK members and a map of the area indicating location of service points. A specific form could be developed that could be used everywhere and would provide a clear understanding of the delivery system in each scheme.

Information was gathered in some areas regarding the procedures and administrative policies that are used to control utilization. As membership grows, improved utilization management procedures will need to be implemented. They will need to be supplemented with quality of care review procedures to make certain that under-utilization is not occurring.

3) Overall Market Assessment. What was lacking in the review surveys was an overall picture of the market of the particular service area of a scheme. What the consultant would find very useful is a narrative description of the population of the service area by major industries or employment classifications, such as:

agriculture	:	_____
manufacturing	:	_____
banking	:	_____
service industry	:	_____
government	:	_____
e'tc.	:	_____

and then a chart which lists the major employers in the area by size of employment force. On this chart those firms that are members of ASTEK and members of PKTK could easily be shown. It is also important to gather information regarding the health insurance benefits and cost of each of the larger employees' programs (maybe every employer with over 100 employees, depending on the size of the service area). This is the first step in developing a "market intelligence system." It will enable the scheme to adjust its benefits, premium rates and services to the needs of the employers and employees of the service area. From this information base the scheme can make better plans for a marketing strategy and to begin to make projections of enrollment growth. This is very important in being able to build a meaningful budget.

The employer and employee surveys were very beneficial. The consultant was very impressed with the openness and willingness with which employers and employees participated. The assessment team got excellent quality input from these people both in terms of things that were going well and concerns that they had.

4) Operations Review. Some of the questions relating to Management Review would get input to some of the areas of operations review. However, there seemed to be a specific gap in the area of claims processing and claims management. In future assessments it will be important to review the claims processing activity by determining the numbers of claims processed each day; the average length of time it takes to process a claim; the accuracy of the amount of the payment in accordance with the benefit or provider contract; and, of particular financial importance, an assessment of the accuracy of "Incurred-But-Not-Reported" (IBNR) claim. This is an estimate of the cost of services that have been authorized by a provider and/or been given and yet no claim (or bill) has been received requesting payment or reimbursement. This will become a significant issue and concern for PKTK as it continues to grow and expand. A specific policy and procedure needs to be developed at the central office level and then implemented in every scheme to make certain that any financial report accurately (or as accurately as possible) states its IBNR.

5) Financial Review. The final area where there was a gap in the assessment methodology is in the financial area. The consultant is aware that this area was deliberately not included in the survey instruments developed (a few questions were getting at some of the issues but not in-depth) because Prof. Brian Able-Smith was doing the financial viability review. Prof. Able-Smith's presentation at the PKTK workshop on 1 September indicated that four of the six schemes he reviewed were covering their medical benefit with the 70% of the revenue allocated to the medical benefit. Surabaya and Batam were not. I agree that Prof. Able-Smith's assumptions are reasonable and that his formula for making the calculations is correct. I only caution that the accuracy of the numbers that go into the calculation cannot be verified with a high degree of confidence. There could be substantial variation in the numbers because they are, by current practice, on a cash basis and do not include an estimate for IBNR. Prof. Able-Smith has recommended that the schemes charge back to the "month-of-service" the expenses for that month. This is a start in addressing the IBNR issue. Because there is no way, at the present time, to handle this differently or obtain a more accurate estimate, I concur with Prof. Able-Smith's numbers. My comment is that because they are based on "cash" numbers and not accrued numbers with IBNR estimates they can only get worse. This means that they are not conservative; as an example, if there is only one hospital admission for which the bill has not been received for a prior month (such as June) then the numbers can, in reality, only be worse than those presented. Therefore, a factor or assumption should probably be added to the calculations to present a more conservative picture.

In addition, work should be done to determine the allocation of administrative expenses for both BPKD and BPPK to see if the 8% and 10% allowed for administrative expenses is adequate. The consultant's experience is that total administrative expense should be somewhere between 10-12% for a PKTK type program. As members in each scheme grow the administrative percent should continue to decrease to around 6-8% depending upon marketing expenses.

In future assessments the overall financial performance of each scheme should be reviewed against a specific plan and budget.

Comments on Specific Survey Instruments

The following are comments on the different survey instruments. The intent is to provide this input to help make improvements for future use.

1) Questionnaire for Company. It has been the consultant's experience to only ask the employer questions you don't have the answers to from any other source or to verify information you already have. Overall this seems to be a good instrument. Questions 2 d, e and f, however, do not seem appropriate. This information should easily be available from the PKTK staff. Also the question about "3 year trends" does not seem practical for most companies considering the age of most of the schemes.

Question 3 e does not appear to be appropriate. The BPKD should have this information. Questions 4, 5 and 6 seem very appropriate.

It might be helpful for future assessments to develop separate survey forms for companies that participate and those that do not. For those that do not participate different information is needed. (See comments about marketing information gap.)

2) Questionnaire for Employee. The questionnaire was primarily designed for an employee who was a member of PKTK. For this purpose it was well suited.

It was not clear to the consultant why these questions would be asked of someone who wasn't a member. Again a separate questionnaire or method may be needed to determine the level of interest in joining, the image of PKTK or level of awareness of the PKTK program in an area.

3) Forms A, B and C. There is a lot of duplication of the questions asked in these forms. The consultant is aware that they were to address three different organizations: BP-PKTK, BPKD, and BPPK.

Form B under Section c. "The implementation of the planned activities" has some very important questions. These questions seem appropriate for the BPPK (Form C) questionnaire as well. The consultant is not aware how Forms A, B or C were filled out or answered during the assessment. It seems that these could be sent in advance, returned and be part of the suggested "desk review" in preparation for field visits.

4) Forms D and E. The information requested on Forms D and E are very appropriate and needed. It seems like real progress is being made in developing the capability to provide utilization and cost information. Many of the suggestions of Prof. Able-Smith from his February visit are being implemented in this regard.

D. FINDINGS AND RECOMMENDATIONS

In reviewing the assessment process and methodology suggestions or recommendations have been made throughout this report. Also, findings or observations from the assessment visits that the consultant made to Bandung, Garut, Lhokseumawe, Jakarta and Semarang have been included.

This section will include overall impressions and findings and specific recommendations for the PKTK program. It is very difficult for the consultant to make recommendations because there are so many things that he doesn't understand or know. Therefore it is hoped that these suggestions may serve as "thought-starters" or discussion points for the PMU, USAID, ISTI and those involved from the MOH and MOM responsible for making any changes.

Marketing and Sales

A very basic issue for the entire PKPK program is whether the program should be voluntary or compulsory. The original concept was for the program to be compulsory for all employers who participate in ASTEK. Because of the experimental aspects of the pilot schemes they are currently voluntary programs in which ASTEK employers can choose to enroll classes of it employees. In some schemes (Semarang, for example) the majority of PKTK members do not come from ASTEK employers (only 1 of 125 companies). In none of the schemes reviewed was there a marketing strategy in place. In one scheme it was indicated that their sales approach was NOT to enroll ASTEK employers, but was to seek out smaller employers who did not offer any health benefit. Unfortunately this approach could lead to several negative impacts, such as an increase in administrative costs to handle enrollment changes and adverse selection, or enrolling people who may have more illness than the average because they have unmet needs. From a society perspective this may be very desirable but is this the goal of the pilot projects?

The questions of "voluntary or compulsory" must be answered before spending much effort on developing marketing strategies. If the schemes were to continue to be voluntary then a much more detailed understanding of each market area (as stated earlier) will be critical to future success. It will determine who sells the product and how it is sold and priced. Most schemes have relied on the ASTEK staff to enroll new members. In most cases the BPPK is not pleased with the results. In a couple of schemes (including Jakarta) the schemes have hired their own marketing personnel.

The most common method of determining revenue for the program is the "7% of salary" approach. This amount might be successful and result in sufficient revenue for the programs to operate if they were compulsory. As long as the schemes are voluntary, there is no way to receive the needed amount of revenue. The incentives that currently exist because of the "7%" method encourages the employers to enroll only their lowest paid employees. This is what is happening quite frequently. One scheme (Semarang) has developed a separate premium rate (Rp. 1200 per month per member) which is the primary product it now sells. This has enabled the scheme to support some of the low pay "7%" groups.

The policy question of "Voluntary/Compulsory" needs to be clarified as soon as possible. If the pilot schemes are going to remain voluntary then they need to develop specific marketing strategies and premium setting procedures to move away from the "7%" method. An important aspect of a marketing strategy if the schemes are voluntary is the compensation of sales personnel. Some type of bonus or incentive system may need to be considered along with greatly improved sales skills through sales training.

Uniform Accounting and Reporting

It was/is very difficult to determine how different schemes are performing and to make meaningful comparisons of performance without standardized accounting and reporting requirements. The consultant does not understand the amount of authority that the central administrative office has over what happens in the regions, but it is critical that a standard Chart of Accounts with standard definition-of-terms and accounts be implemented. This extends to standard reports with standard procedures for compiling and calculating the figures. This may be occurring in some schemes but it needs to be much more unified. This will be a major effort that will pay big dividends through better policy discussions based on more accurate information. The effort of Prof. Able-Smith on reporting utilization figures is a big step forward.

Planning and Budgeting

This is an area that is somewhat related to standardized reporting. The consultant is not aware that there are specific budgets or plans for each scheme for each month or quarter. By "each scheme" is meant a budget that ties the BPPK and BPKD administrative expenses in with the medical benefit costs. In order to improve the discipline of management, a uniform annual planning, budgeting and reporting process is needed. The planning and budgeting should be "driven" by the number of members enrolled or reasonably expected to be enrolled.

Management and Organization

This is, without doubt, the most difficult area about which to comment. However, the consultant thinks it is important to offer his opinion. In order to get the PKTK scheme off the ground, it was decided that they would be pilot programs. These programs were and are dependant on several major areas of government for their success. Thus the organization structure developed as it has; it has served a useful purpose. The question must be asked and answered, "Will the current structure enable and support the

expansion of the PKTK schemes in the future?" It is the consultant's understanding that a specific goal in Repelita V is for 20% of the population of Indonesia to be covered by a PKTK scheme. This means that by 1992-1993 over 30 million people would be covered by PKTK. The consultant does not believe the structure, as it is today, is working well. There is no way that the current structure can support the type of organization that PKTK needs to have moderate growth, let alone growth of the magnitude contained in Repelita V. It is assumed that the organization structure set up for PKTK is itself a "pilot" and therefore there may be flexibility and an expectation that it should/could change.

From the field assessments, the consultant heard many employees of both BPPK and BPKD say that the structure was not working. The success of each scheme seems to be in direct proportion to the level of effective communication and coordination that was taking place between the local BPPK and BPKD. In one or two cases this seemed to work well (even here, though, people didn't like the structure) but in others it was quite poor.

There needs to be clear and understandable lines of authority and decision making. The more simplistic these can be, the more they function well. The consultant recommends that the organizational structure of PKTK be reviewed at the highest levels and changes made to clarify and simplify the structure. Numerous management studies have been performed regarding organizational structure. Most of them, in one way or another, say that the employees need to understand the structure and relate to it in order for them to do their job well. It is clear that the current structure is not understood by the employees of either BPPK or BPKD nor is it understood by the employers in the community. The organization structure was specifically cited by several employers as a major concern/barrier for them in dealing with the PKTK scheme. They could not understand how service problems their employees had would be resolved.

There are at least four organizational structure alternatives that could be considered. (There are probably many more but they might not be clearer or simpler.)

- 1) PKTK could become formally a part of ASTEK.
- 2) PKTK could become formally a part of DEPKES (or ASKES).
- 3) PKTK could become an independent quasi-governmental unit like ASTEK and ASKES.
- 4) PKTK, as a program, could be privatized, with the Ministry of Manpower and the Ministry of Health becoming regulating agents for the PKTK schemes.

The third alternative could begin to be achieved by strengthening the role of the Coordinating Committee by giving it more authority for "line" decisions and involving it more in day-to-day management and operating issues.

The consultant cannot make any assessment of the advantages or disadvantages of each alternative. That will be for the key people involved to discuss. It is very clear, however, that some organizational structure changes must be made to improve morale and performance of the schemes and to be prepared for future growth and expansion.