PROGRESS IN INSTITUTIONALIZING HEALTH ACCOUNTS IN INDONESIA: WHERE NEXT?

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PROGRESS IN INSTITUTIONALIZING HEALTH ACCOUNTS IN INDONESIA: WHERE NEXT?

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ACRONYMS

BPJS	*Badan Penyelenggara Jaminan Sosial* (Social Insurance Administration Organization)
BPS	*Badan Pusat Statistik* (Bureau of Statistics)
JKN	*Jaminan Kesehatan Nasional* (National Health Insurance)
PPJK	*Pusat Pembiayaan dan Jaminan Kesehatan* (Center for Health Financing and Health Insurance)
MOH	Ministry of Health
UI	University of Indonesia
USAID	United States Agency for International Development

1. WHAT IS HEALTH ACCOUNTS INSTITUTIONALIZATION AND WHY IS IT IMPORTANT?

Health Accounts institutionalization is defined as the "*routine government-led and country-owned production and utilization of an essential set of policy relevant health expenditure data using an internationally accepted health accounting framework*" (WHO 2011). Health Accounts provides data on spending in the health sector that can help diagnose health financing challenges, inform solution design, and help monitor the effect of reforms. Health Accounts data show who is funding the health sector and how health resources flow from source to end use, by disaggregating spending by various classifications such as the risk-pooling mechanisms, types of providers, and health goods and services that are purchased. Institutionalizing Health Accounts ensures a cycle in which health spending data are regularly produced and used to make more informed decisions about health financing reforms, in a process that is government-owned and -led. Health Accounts provide an objective evidence base from which stakeholders can collectively diagnose health financing challenges and monitor if reforms are having their intended impact, such as the impact of national health insurance – in Indonesia, called *Jaminan Kesehatan Nasional* (JKN) – on reducing out-of-pocket spending by households.

The Health Accounts institutionalization framework developed by the World Bank's Technical Advisory Group for Health Accounts (World Bank 2011), which includes representatives from the Organization for Economic Cooperation and Development (OECD), World Health Organization (WHO), United States Agency for International Development (USAID), and Bill and Melinda Gates Foundation, defines Health Accounts institutionalization in terms of four dimensions: (i) there is demand for Health Accounts and Health Accounts results are used, (ii) production is sustainable, (iii) dissemination is effective, and (iv) Health Accounts data are combined with other datasets, or "translated", to conduct in-depth policy-relevant analysis.

According to this framework (Figure 1), Health Accounts are fully institutionalized when:

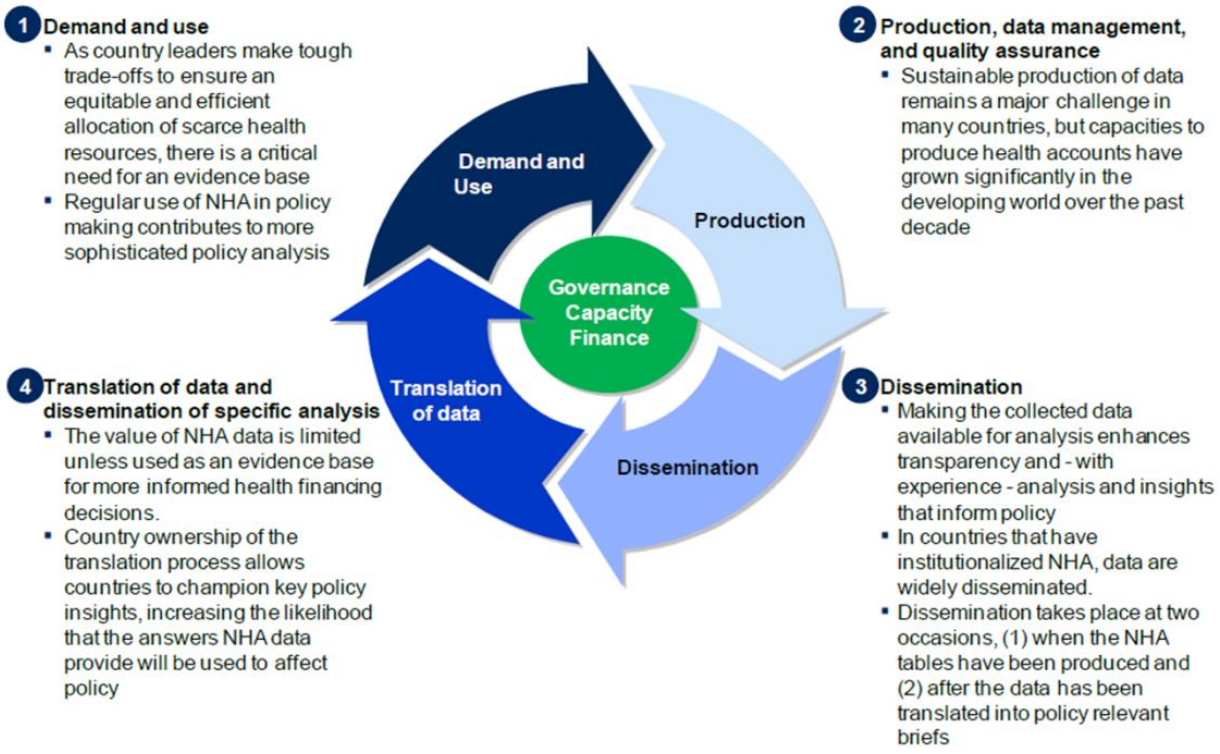
1. Country leaders and policymakers understand the value of Health Accounts data to inform decision making and have a strong demand for the information generated.
2. Countries are able to produce Health Accounts on a regular basis and in a timely manner so the results can inform annual planning and budgeting exercises. To ensure this – and to avoid the cost of doing primary data collection specifically for Health Accounts – countries must move toward conducting Health Accounts using routinely collected data. Over time, countries also should move toward integrating data collection for different expenditure-tracking exercises (Health Accounts, National AIDS Spending Assessments, and Public Expenditure Reviews).

   Institutionalizing production also requires the careful documentation of the methodology used, assumptions, limitations, and lessons learned so Health Accounts exercises are more resilient to staff turnover.
3. Countries disseminate Health Accounts results widely and publicly, both before and after conducting further analysis. Countries that have institutionalized Health Accounts often have an established national repository of spending data to ensure public access e.g. a website. Dissemination of translated data should be adapted to specific stakeholder groups as much as

possible, by analyzing and presenting the data in a way that responds to each stakeholder group's concerns and interests.

4. Health Accounts data are routinely translated into a format that is user-friendly and that responds to the concerns of specific audiences. This may need additional analysis using additional data – such as health status, wealth quintile, health utilization, disease burden, and macroeconomic data – to help policymakers answer the "so what" questions, make informed health financing decisions, and monitor progress of government reforms.

Figure 1. Framework for Health Accounts Institutionalization



Source: World Bank 2011

In addition to the four dimensions of the institutionalization cycle, there are three enabling factors that can strengthen the links in the cycle: strong governance, good human and institutional capacity, and adequate financing. Strong governance means there is clear definition of roles and responsibilities for stakeholders, including clear stewardship of the Health Accounts process, and production is housed in an institution that is suited to that role. There must be adequate individual, institutional, and environmental capacity to implement the cycle. Environmental capacity refers to the policy environment (e.g., leadership to promote evidence-based decision making), data environment (e.g., the availability of HMIS or household, employer, NGO surveys), and the human resource environment (the availability of health economists, statisticians and health accountants). Making the production of Health Accounts more cost-effective is also key to having a sustainable Health Accounts process.

2. HFG SUPPORT TO INSTITUTIONALIZE HEALTH ACCOUNTS AND PROGRESS TO DATE

2.1 HFG's technical assistance to PPJK and UI

The Health and Finance (HFG) project, funded by USAID, provided technical assistance with Health Accounts to both the Indonesian Ministry of Health's (MOH's) Center for Health Financing and Health Insurance (*Pusat Pembiayaan dan Jaminan Kesehatan*, PPJK) and the University of Indonesia (UI) as outlined below. This assistance particularly contributed to institutionalizing dimensions 2, 3, and 4 of the Health Accounts Institutionalization Framework (Production, Dissemination, and Use). The HFG project:

a. Provided initial and refresher training in the:
    i. System of Health Accounts (SHA) 2011 framework that underpins Health Accounts,
    ii. WHO-recommended Health Accounts Methodology, and
    iii. Health Accounts Production Tool, a software designed by USAID, WHO, and HFG to rationalize the production of Health Accounts.
b. Facilitated relationships between PPJK/UI and institutions that provide data to the Health Accounts teams, e.g., collaboration with the World Bank and the Central Bureau of Statistics (*Badan Penyelenggara Jaminan Sosial*, BPS) for household data, and with the Social Insurance Administration Organization (*Badan Penyelenggara Jaminan Sosial*, BPJS) for JKN claims data.
c. Provided technical backstopping throughout the Health Accounts process, for example, brainstorming how to resolve bottlenecks or gaps in data collection, how to weight NGO, insurance and employer private sector spending, and how to map certain spending to SHA 2011 classifications.
d. Increased the technical capacity of the local team by supporting the development of a user guide that documents the methodology used to produce Indonesia's Health Accounts, including key data sources and key assumptions. The guide will help (i) prepare new staff who will be in involved in Health Accounts in Indonesia in the future and (ii) ensure consistency of Health Accounts of different years.
e. Supported policy brief development through a storyboard exercise and technical review of the policy brief on health prevention and promotion spending in Indonesia.
f. Supported two full-time consultants for PPJK for six months. PPJK eventually recruited them as full-time staff, paid by the MOH budget and dedicated to Health Accounts.
g. Supported institutionalization of District Health Accounts in seven pilot districts by sensitizing the districts to the value of spending data for policy, providing insights into the crosswalk of district- and national-level Health Accounts, and financially supporting the technical review of each district's Health Accounts.

2.2 Progress with Health Accounts institutionalization

2.2.1 Cross-cutting factors: Governance and financing

In Indonesia, the PPJK Health Expenditure Analysis team is officially mandated to analyze spending data to inform health financing policy. PPJK decided to bring Health Accounts production in house in 2016. It wanted to lead the production so that it would (i) internalize the methodology and be better able to interpret and analyze the data, (ii) have greater control over the production process, leading to faster validation and publication of Health Accounts results, and (iii) expedite requests for spending data coming from government units. Its production of Health Accounts would facilitate a closer link between production and use: "*it is critical to ensure that the 'institutional home' feels sufficiently comfortable with the data to ensure an effective link to policy*" (World Bank 2011).

HFG conducted an institutionalization assessment in 2016 to inform its further technical support (Bhuwanee, 2016). It identified existing challenges and solutions to institutionalizing Health Accounts. Major challenges were:

- Limited PPJK understanding of the SHA 2011 framework and Health Accounts methodology
- Slow government validation of data, which hinders wide use of the data
- Limited PPJK capacity to interpret and use health spending data to inform policy, despite being mandated to analyze health financing in Indonesia

The options that HFG provided focused on the institutional arrangement for future Health Accounts exercises, including which organization is best placed to (i) produce, (ii) interpret, and (iii) use Health Accounts data (Table 1).

Table 1. Options for Health Accounts institutional arrangements

Option	Comments
1. Production by MOH, led by PPJK	• PPJK-led process with targeted support from other MOH units, e.g., Bureau of Planning, Bureau of Finance
2. Production by diverse technical team, led by PPJK	• Build capacity of broad group of stakeholders who can contribute to the production team led by PPJK, e.g., National Institute of Health Research and Development, UI, Airlangga University, Hasanuddin University, Gadjah Mada University, Bapelkes, BPS
3. Contract out production to UI in short term; build up to PPJK-led production in medium term	• MOH contracts out production to external organization, e.g., UI, with close PPJK involvement that leads to a PPJK-led process in 2-3 years

When PPJK launched the 2015 Health Accounts in 2017, it chose to pursue Option 1: PPJK would oversee and steer the 2015 and 2016 Health Accounts, with the technical support of UI and HFG. Since then – with less than two years of technical assistance – PPJK's engagement in and leadership of the Health Accounts process has significantly increased. PPJK leadership has steered the 2015 and 2016 Health Accounts process, and has developed relationships with UI, BPJS, BPS, and the Financial Services

Authority (*Otoritas Jasa Keuangan*, OJK). On the production side, the PPJK team took responsibility for the MOH's spending data collection, mapping, and analysis, with close mentorship and coaching from UI. In the future, PPJK plans to take the same responsibility for other government spending such as from other ministries, JKN, and sub-national entities. PPJK delegated to UI the collection, mapping, and analysis of other data sources (household, NGO, employers, social and private insurance, donors, and others) but with close oversight to ensure PPJK understood the methodology for these other data sources. The PPJK-UI collaboration has been a productive one that has enabled the production of two Health Accounts in less than two years, while building PPJK technical capacity and paving the way for a partnership that can sustain production of Health Accounts.

On the dissemination side, UI led the development of a policy brief using 2015 Health Accounts data. In the future, it is recommended that PPJK take on a greater role, and eventual leadership, in the targeted analysis of Health Accounts data for different audiences, including the development of products such as technical notes and policy briefs. This will enable PPJK to fulfill its mandate to use data to inform health financing policy.

PPJK also took greater financial ownership of the 2015 and 2016 Health Accounts by funding all necessary workshops with key stakeholders, including at the district level, and hiring two full-time staff members.

2.2.2 Dimensions of the Health Accounts Framework

Production

PPJK, with the support of UI and HFG, produced the 2015 and 2016 Health Accounts in accordance with the SHA 2011 framework. These exercises estimated total health spending; all sources of spending were captured and the team maximized the use of all existing data sources. It was the first time in Indonesia that the exercises disaggregated spending by disease. Improvements were made to the estimation of spending by households and sub-national governments, in order to remove double counting. Estimates of spending by NGOs, employers, and insurance firms also improved, due to improved weighting methodology. Going forward, additional data sources could be made available to the Health Accounts team, or refined, to improve the accuracy of health spending (see Section 3 for details).

The capacity of PPJK to lead Health Accounts production in the future has increased. Having led the data collection and mapping of MOH health spending, at least five members of PPJK now have increased knowledge of the SHA 2011 framework and Health Accounts methodology. PPJK also now has a user guide that documents the methodology for producing the Health Accounts in Indonesia; it is a reference for the current team, and for future team members.

PPJK demonstrated strong stakeholder engagement, for example, by emphasizing the validation of government data. The team met with key MOH units, such as Health Services, and Prevention and Promotion, to review the spending and disaggregation.

As a result of HFG assistance, more districts have been sensitized to the value of District Health Accounts for policy and planning. HFG presented to over 15 districts about how data from District Health Accounts can be used for district-level policy and planning, including examples from other countries. At least seven districts have produced District Health Accounts that were reviewed by PPJK and UI. In district and national-level discussions, HFG observed that there is strong motivation at both levels to produce District Health Accounts. The existing District Health Accounts framework can facilitate this production (with minor adjustments to align the framework with SHA 2011). There is existing technical capacity and experience to produce District Health Accounts, although this varies by province and district.

Dissemination

PPJK now has a greater appreciation of the importance of disseminating Health Accounts results widely. Preliminary results were shared with the stakeholders who had provided data, including BPJS and BPS. There is a need to validate results more quickly so that stakeholders can start using them; for example, 2015 results were finalized in 2017 but were not validated until a year later. This is somewhat outside the PPJK's control, because the results have to be validated by an inter-ministerial committee, but PPJK's continued advocacy for prompt validation will help.

Sharing and discussing in detail with the Minister of Health the 2016 Health Accounts results was the first time that this had been done. The lively discussions gave the Minister a better appreciation of the state of health financing; for example, the low levels of government spending on the community and primary care levels got the Minister's attention. PPJK should encourage these types of discussions, so more policymakers are aware of health spending and whether spending is aligned with national priorities.

Translation of data

PPJK also now has a better appreciation of ways to package and use Health Accounts data to inform planning and budgeting. For example, a policy brief looking at prevention and promotion spending was developed as part of the 2015 Health Accounts. Additional themes were discussed with PPJK for analysis in the future, including the effects of JKN on out-of-pocket health spending. PPJK should take leadership of secondary analysis, and development of such types of products going forward.

3. REMAINING CHALLENGES AND POTENTIAL SOLUTIONS FOR INSTITUTIONALIZATION

3.1 Maintain stable roster of Health Accounts experts

It is important that PPJK (and MOH) continue to commit human and financial resource to Health Accounts, since this will help PPJK achieve its mandate of producing analysis to inform health financing analysis. PPJK recently hired two full-time staff who are dedicated to Health Accounts, which is commendable. As these staff members gain experience, they will be able to take on a greater leadership role and train other staff who join the team.

Staff continuity is essential: having a stable, experienced staff will sustain the technical and leadership capacity, and commitment to produce and use Health Accounts that has developed in PPJK over the past two years. Over that time, five PPJK staff were thoroughly trained in Health Accounts, and it is important that these technical experts continue to support the exercise. If they must be rotated, PPJK should maintain some connection with these staff, so that they can, at a minimum, coach and mentor new staff.

While the technical capacity of PPJK has increased, technical leadership is still somewhat concentrated in the UI team. UI has a long history in producing Indonesia's Health Accounts, which has resulted in a UI team with deep Health Accounts knowledge and experience. However, UI staff also can be moved around. So again, to ensure continued Health Accounts technical expertise, it is important to (i) ensure that existing experts coach and mentor staff who are new to Health Accounts, and (ii) document the experts' knowledge and insights about producing and using Health Accounts. Over the long run, health financing (and resource tracking) modules should be incorporated into more health program curricula in universities across Indonesia, to ensure a continuous pool of technical experts.

3.2 Deepen relationships with stakeholders

In conducting the 2015 and 2016 Health Accounts exercise, PPJK (and UI) developed strong working relationships with key stakeholders such as BPS, BPJS, and the districts. These relationships are crucial for the ongoing development of Health Accounts, because these institutions provide much needed data on health spending. PPJK should maintain these relationships, and continue to communicate to these institutions the importance of the data they provide and the value of the Health Accounts results to them. A Memorandum of Understanding has already been developed for BPJS and BPS. PPJK also should emphasize to them the need to share complete data in a timely manner to avoid delays in the Health Accounts exercise; in 2017, there were delays in getting JKN spending data from BPJS and the data received were incomplete.

At the district level, understanding of, and capacity to do, Health Accounts varies by district. Engaging with districts, especially those with less capacity, will be important so that Health Accounts becomes an instinctive tool that they choose to use in their day-to-day planning. PPJK might also consider using peer-to-peer learning, having districts that are experienced in District Health Accounts (e.g., Cilegon) train, mentor, and coach nearby districts with less experience. PPJK can then play a coordination role to

compile the data, ensure consistency in the way the methodology is applied, and conduct quality reviews. This process started in seven pilot districts in 2018, in conjunction with UI and HFG.

3.3 Disseminate Health Accounts data quickly and widely

The importance of dissemination in the Health Accounts process should not be underestimated. Insightful and important Health Accounts results and analysis can remain "on the shelf" if not shared with the right stakeholders. Health Accounts information can be disseminated in written products (e.g., reports, policy briefs, press releases), social media messages, and events (policy roundtables, annual health sector reviews, annual budget negotiations). A study conducted in 2018 found that countries that had used Health Accounts results to make a tangible changes to policy scored 43 percent higher on "dissemination" than countries that had not used Health Accounts results (Bhuwanee, Cogswell, and Ashagari 2018).

The objective of dissemination should be to make the Health Accounts results quickly, publicly, and widely available. One challenge in Indonesia is to shorten the length of time it takes to publish results. The policy relevance of results is greatly diminished when it takes two years to validate and publish those results, as it did with the 2015 and 2016 results. A second challenge is to make Health Accounts results accessible; a recent Google search for "Indonesia Health Accounts" provided preliminary results for 2013 only. This inaccessibility prevents stakeholders such as policymakers, researchers, and civil society from using the results.

In addition to helping increase the use of results, dissemination helps to reinforce the relationship between the Health Accounts team and those who provide data, such as BPJS, BPS, and Ministry of Home Affairs. By promptly receiving, understanding, and using results, these stakeholders will realize how important it is that they provide the data requested by the Health Accounts team and how the results can help them in their planning and other work.

3.4 Refine, and continue to maximize use of, secondary data sources

The step in the Health Accounts process that has the greatest impact on the accuracy and timeliness of results is data collection. The WHO recommends that Health Accounts increasingly use secondary data. Use of secondary data both reduces the cost of a Health Accounts exercise and helps ensure the data produced are available quickly after the fiscal year and in time for annual planning and budgeting cycles.

Indonesia benefits from having a significant amount of high-quality, detailed secondary data, which should be exploited. It is recommended that PPJK continue to refine data on the private sector.[1] To do this, it should, for example:

a. Work with BPS to include health spending questions in household, NGO, and employer surveys that will enable an accurate disaggregation of spending.
    i. For example, the Susenas survey may want to follow the standard health expenditure module that is used by Demographic and Health Surveys.[2]

[2] More details on data sources and data gaps can be found in PPJK and University of Indonesia (2018).
[3] Available at http://dhsprogram.com/publications/publication-dhsqm-dhs-questionnaires-and-manuals.cfm

ii. Future NGO surveys might want to ask NGOs about their activities and spending on those activities in order to facilitate mapping to the function classification.

iii. In the past, PPJK/UI conducted their own survey of employers about health spending. Going forward, the Health Accounts team may want to negotiate with BPS to have health spending questions included in the BPS's regular employer survey. For a marginal cost, the Health Accounts team would obtain data from a bigger sample of employers and on a regular basis.

b. Work with BPJS to obtain complete data on utilization and spending. From the P-Care database, capitation and non-capitation payments to *Puskesmas* (community health clinics) by ICD-10 should be made available to the Health Accounts team. From the INA-CBG database for hospitals, claims data for CBG and non-CBGs should be provided. In 2018, a sample of hospital claims data disaggregated by ICD-10 codes was available from BPJS; this is an important data source for the Health Accounts team to calculate accurate distribution keys by function and by disease. Hopefully this sample will also increase over time. While PPJK also has a hospital claims database, it is recommended that the Health Accounts team use the BPJS's official, and verified, JKN claims database and that all JKN utilization data used for disaggregation also come from BPJS.

c. The Health Accounts team should work closely with the costing team to ensure that future costing studies include all costing elements necessary for disaggregating health spending. The last hospital costing study conducted by PPJK's Tarif team does not include prevention costing, which prevents an accurate disaggregation of hospital spending by curative and prevention services.

d. The PPJK team should maximize the use of the data in SIMRAL to increase the accuracy of sub-national spending, and to avoid the need for assumptions when disaggregating health spending. SIMRAL, the Ministry of Home Affairs' e-budgeting system, shows budget allocation by province and by district; it has details that can distribute spending by provider and by function. It does not yet include realization (spending) but this should be available next year, in time for the 2018 Health Accounts.

3.5 Continue concurrent efforts at sub-national level

Continued efforts to support the districts to produce their Health Accounts is needed to ensure a minimum level of quality. For example, the seven districts that were supported in 2018 mapped much of their spending to administration, which was corrected once PPJK and UI conducted quality reviews. PPJK will also need to decide whether disaggregation of certain spending, such as salaries, is done by individual districts or whether a standard distribution key (produced at the national level) will be applied across all districts. PPJK will need to assess whether districts currently have the capacity and data to calculate distribution keys. As district-level capacity increases, PPJK will want to decide whether the District Health Accounts continue to cover only locally-generated revenues (while the other sources of revenue are collected at the national level for the national-level Health Accounts), or agree on a way for districts to incorporate all sources of spending into their Health Accounts. It is understood that the District Health Accounts currently include government spending only (including JKN) and exclude household, and other private sector, spending.

The governance structure for institutionalizing Health Accounts at the district level needs to be strengthened. An upcoming government decree will mandate districts to do District Health Accounts. This is necessary but not sufficient to ensure District Health Accounts are produced. The demand for producing District Health Accounts has to exist, as does the technical capacity. At least three factors

inhibit institutionalization at the district level: buy in from local leaders that health is more than just a District Health Office issue that needs investment; the perceived complexity and value of Health Accounts; and weak data systems that make the production of Health Accounts cumbersome and that render disaggregation of spending difficult. Possible strategies to help address these are (i) national recognition programs as a non-financial incentive to produce Health Accounts by creating "friendly competition" between districts, and (ii) use of existing government communication channels to the districts to share the benefits of tracking spending to districts. For example, districts could be shown how other districts use Health Accounts data for policy and planning, and districts could exchange advice, such as do's and don'ts for producing Health Accounts. The government could also capitalize on successful districts for peer-to-peer learning, for example, by establishing focal points in "successful" districts who can provide real-time support (by visiting neighboring districts, through web chat rooms, or Whats App groups). These efforts will require close collaboration between the MOH and the Ministry of Home Affairs, which oversees sub-national issues.

There are also technical issues to be addressed to ensure that the District Health Accounts use a sound and consistent methodology, and that it is consistent with the National Health Accounts. During this year's support to seven districts, PPJK and UI provided quality assurance around mapping decisions; these need to be incorporated into the District Health Accounts module and distributed to the districts. As discussed above, a pool of resource tracking experts beyond PPJK and UI needs to be created to provide this type of technical support and to coach the districts on a sustainable basis.

Most importantly, PPJK will need to continue its efforts to institutionalize Health Accounts at the district level. Advocacy with the district teams will need to focus more on the value of District Health Accounts for their own policy and planning, and less on the need for District Health Accounts to compile the National Health Accounts. Otherwise, if the message is that District Health Accounts is useful for the national level to produce National Health Accounts, production of District Health Accounts will become a "box-checking" exercise for the districts and will not give them sufficient motivation to dedicate scarce resources to produce them. Districts must be motivated to produce District Health Accounts for their own purpose and have the capacity to use the results to look at issues such as resource allocation, efficiency, and the link between spending and achievements.

ANNEX A: BIBLIOGRAPHY

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