The Challenges of Monitoring TB Expenditure in Indonesia

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Julie Rostina, David Collins, Firdaus Hafidz and Laxmi Zahara
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Abstract

In many countries tuberculosis (TB) control programs are scaling-up the detection and treatment of TB cases to reduce the burden on patients, their families and society. This will result in significantly increased costs over the next few years until prevalence begins to fall. At the same time, donor funding is reducing in some of these countries and the challenges of generating domestic resources for financial sustainability are starting to be recognized. To ensure that domestic financing is increasing in line with the needs it is important to monitor expenditures in a timely and regular fashion. This can, however, be difficult as health programs are often financed from several different sources and some of these expenditures are difficult to monitor. This is even more difficult in countries where government is decentralized and where private providers play a significant role.

In Indonesia, the National TB Control Program (NTP) monitors domestic TB expenditures so that it can advocate in areas where financing is too low. The NTP is also required to report domestic expenditure to the Global Fund against AIDS, TB and Malaria to show how program sustainability is progressing. Since the Indonesian Government is decentralized this includes collecting data from 33 provinces and 486 districts. Unfortunately, the provincial and district reporting rates are very low and the figures are sometimes unreliable. Also only government budget expenditures are reported due to difficulties in collecting information from non-government organizations (NGOs) and from insurance schemes. An alternative data collection system, District Health Accounts, which is being rolled out in Indonesia, could provide a more comprehensive view but is not a viable alternative to the NTP data collection system in the medium term as they do not cover all TB expenditures, they are only conducted in a few districts every year, and it takes a long time to prepare them.

An analysis of the data collection options and challenges indicates that it is not feasible to monitor some elements of domestic TB expenditures in a routine and timely way – namely TB expenditures made by private for-profit and non-profit organizations, expenditures made by patients and expenditures at public health centres. The only TB expenditures that can be monitored in a routine and timely way are those made from government TB budgets and hospital reimbursements for TB made from the national social health insurance scheme.

We recommend continuing to use the NTP data collection and reporting system but it should be strengthened. This includes making improvements to the provincial and district data collection forms, following up on non-submitted forms and greater analysis of the reports and feedback to the provinces and districts. We also recommend removing the requirement for provinces and districts to provide data on non-government expenditures.
We recommend, however, that the NTP collect data from the national health insurance provider on hospital TB claims and payments. Unfortunately, since public and private primary care providers are paid on a capitation basis, it will not be possible to collect TB expenditure data for those providers. However, the total of government budget expenditures and hospital insurance payments should cover a large part of domestic expenditures on TB and can serve as a good indicator of government commitment. Additional analysis of the overall financing picture can be performed using a costing and financing model.

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**Key Words**

Monitoring, TB, tuberculosis, budgets, expenditure, financing, decentralized government, Indonesia.

**Disclaimer**

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- Provincial Health Office staff of West Nusa Tenggara
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See a list of some specific people interviewed in Annex 1.

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<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APBD I</td>
<td>Anggaran Pendapatan dan Belanja Daerah I</td>
</tr>
<tr>
<td>APBD II</td>
<td>Anggaran Pendapatan dan Belanja Daerah II</td>
</tr>
<tr>
<td>ATM</td>
<td>AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>CSR</td>
<td>Corporate social responsibility</td>
</tr>
<tr>
<td>DHA</td>
<td>District Health Account</td>
</tr>
<tr>
<td>DIPA</td>
<td>Daftar Isian Pelaksanaan Anggaran/Approved Budget Allocation List</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, TB and Malaria</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>Jamkesda</td>
<td>Jaminan Kesehatan Daerah</td>
</tr>
<tr>
<td>MDR-TB</td>
<td>Multi-Drug Resistant TB</td>
</tr>
<tr>
<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSH</td>
<td>Management Sciences for Health</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
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<td>P2JK</td>
<td>Pusat Pembiayaan Jaminan Kesehatan</td>
</tr>
<tr>
<td>PMU</td>
<td>Program Monitoring Unit</td>
</tr>
<tr>
<td>PPTI</td>
<td>Association Against Tuberculosis and Lung Disease</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TO</td>
<td>Technical officer</td>
</tr>
</tbody>
</table>
Executive Summary

In many countries tuberculosis (TB) control programs are scaling up the detection and treatment of TB cases to reduce the burden on patients, their families and society. This will result in significant increases in costs over the next few years until prevalence starts to fall. At the same time, donor funding is reducing in some of these countries and the challenges of generating domestic resources for financial sustainability are starting to be recognized. To ensure that domestic financing is increasing in line with the needs it is important to monitor expenditures in a timely and regular fashion. This can, however, be difficult as health programs are often financed from several different sources and some of these expenditures are difficult to monitor. This is even more difficult in countries where government is decentralized and where private providers play a significant role.

Indonesia has made great strides in expanding tuberculosis (TB) control over the last few years, with significant assistance from donors, such as the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the United States Agency for International Development (USAID). However, major challenges remain with regards to scaling-up coverage to meet the need for services, especially related to the growing problem of Multi-Drug Resistant TB (MDR-TB).

While there are presently substantial external funds for the TB program these are expected to diminish greatly over the next few years as Global Fund grants are reduced, due mainly to improvements in the Indonesian economy. The government is developing a sustainable financing strategy which aims to eliminate dependency on these grants and which focuses on increasing government budget allocations, generating revenue from insurance and corporate social responsibility, and improving cost-effectiveness and efficiency.

The NTP monitors domestic TB expenditures so that it can advocate in areas where financing is too low. The NTP is also required to report domestic expenditure to the Global Fund against AIDS, TB and Malaria to show how program sustainability is progressing. Since the Indonesian Government is decentralized this includes collecting data from 33 provinces and 486 districts.

This study was conducted to assess the NTP system for collecting and reporting domestic expenditures and, if necessary, to see how it can be strengthened. It included reviewing the data collected by the NTP and comparing a sample with District Health Account (DHA) data collected by the MOH. It also included interviews with TB program managers in three provinces to verify the two sets of data. The findings showed that there were significant problems of incomplete and delayed submission of reports to the NTP. Reporting levels were low – only 66% of provinces and 47% of districts submitted reports in 2012 and only 32% of districts submitted reports in both 2011 and 2012. In addition there was no sign of improvement, with reporting levels worse in 2012 than in 2011. It was noted that the data
were often incomplete and inconsistent, reportedly because the data collection and entry requirements were not clear.

Expenditure by activity (e.g. training) was not often provided although the data are, reportedly, easily available. While expenditure by activity is not currently required by the GFATM, the NTP would like to analyse these data because it may be requested in future. The reporting of donor expenditures and private funds was very low because the data is hard to collect.

The DHAs provide a more comprehensive analysis of TB expenditure than the NTP system, although it also has gaps. However, the rolling out of the DHAs is very slow and the numbers of districts covered remains low, with only 102 of 486 districts having completed them in 2012. Even fewer of these have covered more than one year which is necessary for trend analysis. The number of DHAs completed in 2012 is fewer than the number of districts that submitted the NTP’s TB Expenditure reports. In addition, it can take many months for districts to prepare DHAs, whereas the NTP forms can be completed with budget data within one month of the end of a fiscal year.

There is, therefore, no advantage in using the DHAs to monitor national TB expenditures instead of the NTP forms, at least until the DHAs are produced in more than 50% of the same districts every year and they are produced more quickly.

An analysis of the data collection options and challenges indicates that it is not feasible to monitor some elements of domestic TB expenditures in a routine and timely way – namely TB expenditures made by private for-profit and non-profit organizations, expenditures made by patients, and expenditures at public health centres. The only TB expenditures that can be monitored in a routine and timely way are those made from government TB budgets and hospital reimbursements for TB made from the national social health insurance scheme.

We recommend continuing to use the NTP data collection and reporting system but it should be strengthened. This includes making improvements to the provincial and district data collection forms, following up on non-submitted forms and greater analysis of the reports and feedback to the provinces and districts. We also recommend removing the requirement for provinces and districts to provide data on non-government expenditures. We recommend, however, that the NTP collect data from the national health insurance provider on hospital TB claims and payments. Unfortunately, since public and private primary care providers are paid on a capitation basis, it will not be possible to collect TB expenditure data for those providers. However, the total of government budget expenditures and hospital insurance payments should cover a large part of domestic expenditures on TB and can serve as a good indicator of government commitment. Additional analysis of the overall financing picture can be performed using a costing and financing model.
1. Background

**General background**
Indonesia has made great strides in expanding Tuberculosis TB control over the last few years, with significant assistance from donors, such as the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the United States Agency for International Development (USAID). Donor funding covered a substantial part of total spending on TB in 2011 and the GFATM grants have played a major role in program success (Jarrah et al, 2013 and Collins et al, 2013).

However, much still remains to be done to reduce the impact of TB in Indonesia, where the economic burden from TB is estimated to be as much as USD 2 billion for the newly infected patients in one year (Collins et al, 2013). Major challenges relate to the scaling up of coverage to meet the need for services, especially relating to the growing problem of Multi-Drug Resistant TB (MDR-TB). This scaling-up will result in significant increases in service delivery costs, from an estimated US$ 77 million in 2011 to US$ 118 million (excluding inflation) in 2016 (Jarrah et al, 2013).

Due to Indonesia’s economic improvements over the last few years donors are reducing their support for the AIDS, TB and malaria control programs. The GFATM is in the process of gradually reducing its grant funding in total and for specific elements. Indonesia is committed to increasing domestic financing for the ATM programs to ensure that they are financially sustainable (Mustikawati, 2013).

The Ministry of Health (MOH) has developed a sustainable financing strategy (exit strategy) which has 4 main elements: increasing funding from insurance, increasing government funding, increasing assistance from corporate social responsibility (CSR), and ensuring the efficient and effective allocation and use of resources (Kemenkes RI, 2012; Brands and Hafidz, 2013).

Increasing government budget spending on TB control is one of key elements of the sustainable financing strategy. It is important to monitor this spending to see if it is increasing in line with targets and to assess if the budget is adequate for the needs.

**Decentralization**

In 1999, Indonesia rolled out a Law No. 22, 1999 on Local Government has decentralized central government authority’s to local governments in all government administrative sectors, except for security and defence, foreign policy, monetary and fiscal matters, justice, and religious affairs. The main objectives of regional autonomy are to promote better
delivery of government services and to raise the level of local government accountability (Usman, 2002).

The decentralization, which was implemented in 2001, had a large impact on the government system including the health system. Districts were given full discretion in prioritizing sectors for development and can decide how much to allocate to health. Although there are guidelines on health spending they are not enforced.

The local budget (APBD) for TB control is generally quite low due to donor funding and because there are competing health priorities. The Central government has no power to control and supervise local budgets. A challenge in accurately capturing all the expenditures on TB control is that the funding is spread across several budgets including BINFAR for drugs; Finance Bureau of the Ministry of Health (MOH) for salaries; NTP for reagents; and BOK Health Operational Support Funds¹ for operational costs.

Under the routine government financial management system, local government budgets and expenditures are not systematically reported to the Central level. Some health facilities also receive funds from private sources (Corporate Social Responsibility and private donations) which are not reported to the Central level and are therefore currently also not captured in the calculations of the total available domestic funding for TB.

**TB financing mechanisms**

Domestic expenditure on TB is financed from several sources. The main ones are as follows:

- Government budgets at national, provincial and local government levels;
- Social and private insurance;
- Local donors;
- Patient out-of-pocket contributions;
- Private companies (corporate social insurance);
- Employers (with private health services or who pay for patients at other health facilities).

Government budget funding is one of the main sources of funding for TB control. It comes from the central level, from 33 provincial governments and 486 district governments².

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¹ Allocations from national to support decentralization.
² For the purpose of this report municipal governments are included under districts.
The Central Government budget is mainly allocated for the procurement of drugs and laboratory reagents and for developing norms, standards and procedures. Provincial government budgets are mainly used for the training and supervision of district TB staff.

The other main source of funding is social insurance from the new National Health Insurance Scheme (JKN). Other expenditures on TB are made by private institutions, particularly NGOs and private companies, and out-of-pocket payments made by patients.

**TB Expenditure Monitoring Systems**

In order to accurately measure changes in TB financing it is necessary to have data from all provinces and from at least 70% of the districts which should be representative of the country as a whole. Data are needed for at least 3 consecutive years to show trends.

The National Tuberculosis Control Program (NTP) has an expenditure monitoring system which is managed by the GFATM Finance Officer who is based at the NTP. These data are used to prepare an annual TB Expenditure Monitoring and Evaluation report. The Officer sends reporting forms to the provinces each year with a request to collect and report expenditure data from their districts together with provincial expenditure data. The completed forms are to be submitted to the NTP. During the period 2009 to 2013, the NTP sent out the form in December with a deadline of the end of January for submitting the completed report.

Each District Health Office (DHO) and Provincial Health Office (PHO) is supposed to provide the TB budget figures for the current fiscal year and the expenditures for the previous fiscal year. For example the reports requested in December 2013 requested the budget data for 2014 and the expenditure data for 2013. The budget figures are used as a proxy for expenditures because districts reportedly spend the full amount that was budgeted and no more. The PHOs are supposed to collect the completed reports from all districts in their area and submit them to the NTP. The results are used by the NTP to measure domestic financing progress and highlight where advocacy efforts should be focused. The results are also reported by the NTP to the GFATM as part of the monitoring of the achievement of domestic financing targets.

In a separate process, the MOH, through its Centre for Health Financing & Insurance (Pusat Pembiayaan dan Jaminan Kesehatan/PPJK), is rolling out District Health Accounts (DHAs). DHAs are geographical sub-sets of National Health Accounts (NHAs) aimed at providing a comprehensive overview of health expenditures at the district level. DHAs are intended to help inform policy-making about allocations to the health sector and programs and
contribute to the medium term and annual planning and budgeting processes. In Indonesia they cover all public expenditure on health at the district level plus data from insurance reports and annual household economic surveys. The DHAs have sub-accounts for TB, HIV/AIDS and malaria.

2. Objective

The overall purpose of this study was to assess the current NTP TB expenditure reporting system and see if it can be improved.

The specific objectives were as follows:

a) To review the system that provides TB expenditure data in terms of quality and completeness;

b) To identify the weakness and challenges; and

c) To propose changes to the system, if needed.

3. Methodology

This study was carried out by reviewing the NTP expenditure reporting data base and by analysing a sample of provincial and district reports for 2011 and 2012. The provinces were selected based on the availability of DHA and NTP expenditures in 2011 and 2012. In addition, copies of DHAs were obtained from the MOH in West Nusa Tenggara Province. These were then compared and analysed. In addition, a selection of documents were reviewed (Annex 5). Interviews were then conducted with national, provincial and district managers who are involved in the preparation, submission and analysis of the reports, and also with people involved in the development of DHAs. The strengths and weaknesses were compiled and improvements were identified. The results were then discussed and agreed upon with GFATM Officer at the NTP.

4. Findings

The NTP and DHA systems were assessed in terms of completeness of reporting, completeness of data and accuracy of data.

NTP reporting

The review of the NTP database showed significant under-reporting (Table 1). Of the 33 provinces, only 21 submitted reports in 2011, 22 submitted reports in 2012 and only 18
(55%) submitted reports for both 2011 and 2012. Also some of the provincial reports that were submitted did not have all the reports for their districts.

In terms of districts only 281 of 486 (58%) submitted reports in 2011 and only 229 (47%) in 2012. And only 154 (32%) of the districts submitted reports for both 2011 and 2012. The lack of continuity is perhaps because technical assistance was provided to some districts for 2011 but not for 2012. The figures show that not only is reporting low, but also there was no improvement from 2011 to 2012.

The delays in reporting were also identified as a problem. During 2009–2012, some provinces submitted their reports in February while most did not submit them until the middle of the year. The delay is generally due to the fact that the staff are already very busy, they do not believe that this monitoring is useful for them and no feedback on the data has been provided to them.

The NTP form was developed in 2009 and was revised in 2012 (Annex 2). The current version includes a category for program activities (Annex 3) as well as for budget and actual expenditures. No guidelines were developed because it is considered to be simple.\(^3\)

Based on the completed reports it seems that data reported to the NTP primarily covers the budgets that are managed by the TB Control Program Officers, which only comprise the provincial funds (APBD I) district funds, (APBD II) and GFATM funds. National funding (APBN) distributed to provinces and districts was only reported by 8 provinces and 1 district in 2011, and by 12 provinces and 2 districts in 2012. The provinces and districts do not report TB

\(^3\) Two provinces have proposed improvements for the TB expenditure monitoring form. Bali has developed its own TB reporting form which it used for 2013.
expenditure incurred by NGOs and External Institutions. Also expenditure from non-government sources (e.g. insurance and private health institutions) was not included because it is not reflected in the local government budgets and the data are difficult to obtain.

Details of expenditure on activities, which is requested on the current forms, were only provided by 8 (38%) out of 21 provinces that submitted reports and by 111 (40%) out of the 281 districts that submitted reports in 2011. In 2012, the expenditure was only provided by 14 (64%) of the 22 provinces that submitted reports and 132 (58%) out of 229 of the districts that submitted reports. From these figure, it can be seen that many provinces and districts are not committed to reporting data on activities even though it is available. One reason may be that there is no common understanding of how expenditures should be categorized.

The NTP has prepared some descriptive analyses of the data but no deeper analyses have been conducted. An annual report of the figures is submitted to Global Fund to monitor commitment of the government.

**District Health Accounts (DHA)**

The DHA Team attempts to collect data from all sources. This is feasible because the members of the DHA team come from different institutions in the district such as DHO, hospital and BAPPEDA (planning bureau), and the team usually is formed through a decree of local government. Therefore, they have better access and authority to get information.

The DHAs goal is to cover all 486 districts by the end of 2014. However, only 102 districts prepared DHAs in 2011 and only 80 in 2012, fewer than in 2011. Districts are supposed to prepare them each year but many of the ones that prepared them in 2011 did not repeat them in 2012.

One of the provinces that have produced DHAs is West Nusa Tenggara. The production of DHAs in this province was supported by GIZ (GTZ) during 2007-2009 and the province has continued to produce them without support since that period. Some districts have made it a requirement to form DHA teams and provide incentives for them.

DHAs provide comprehensive health expenditure data, but it takes a significant time to develop the reports. For example, in West Nusa Tenggara, it takes almost one year to prepare the reports, which means they are not ready at the beginning of the year when they
are needed for planning and budgeting. The main factors that cause these delays are the inadequate availability of data, poor financial reporting at the facilities along with the time and effort that are required for team members who already have full time jobs.

Accuracy of NTP and DHA data

As part of this analysis we reviewed and compared the TB budget figures from the NTP database with the District Health Account figures (Table 2). We selected Jambi Province, one of the few provinces where districts had produced both NTP and DHA reports.

Table 2. Comparison of NTP and DHA data for districts in Jambi Province, 2011 (IDR millions)

<table>
<thead>
<tr>
<th>Districts</th>
<th>KOTA JAMBI</th>
<th>KAB BATANG HARI</th>
<th>KAB KERINCI</th>
<th>KAB MUARO JAMBI</th>
<th>KOTA SEI PENUH</th>
<th>KAB SAROLAN GUN</th>
<th>KAB TANJUNG JABUNG TIMUR</th>
<th>KAB TANJUNG JABUNG BARAT</th>
<th>KAB TEBO</th>
<th>KAB MERANGIN</th>
<th>KAB BUNGO</th>
</tr>
</thead>
<tbody>
<tr>
<td>APBN</td>
<td>3.6</td>
<td>22</td>
<td>-</td>
<td>22</td>
<td>-</td>
<td>0</td>
<td>10</td>
<td>19</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DONOR</td>
<td>134.9</td>
<td>83</td>
<td>95.23</td>
<td>-</td>
<td>26</td>
<td>0</td>
<td>45</td>
<td></td>
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<tr>
<td>APBN DEKON</td>
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<tr>
<td>APBD KABUPATEN/KOTA</td>
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<tr>
<td>APBD PROVINSI</td>
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<tr>
<td>TOTAL</td>
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<td>95</td>
<td>79</td>
<td>26</td>
<td>-</td>
<td>56</td>
<td>19</td>
<td>79</td>
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<td>-</td>
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<td>NTP</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APBD II and DAK</td>
<td>100</td>
<td>163</td>
<td>0</td>
<td>128</td>
<td>26</td>
<td>0</td>
<td>0</td>
<td>110</td>
<td>28</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

Note: There were no DHA figures for Kabupaten Merangin and no DHA or NTP figures for Kabupaten Bungo.

The analysis showed that NTP and DHA figures are significantly different for almost every district. The following reasons were identified in interviews with managers:

- **Confusion about is supposed to collect and submit the NTP and DHA data.** An officer of the PHO Jambi stated, for example, there was different understanding about who should prepare the reports which results in the collection of different data.

- **Different definition and perception of finance data.** There is a lack of clarity about what finance data should be collected and reported among the people who prepare both the NTP report and the DHA report. This results in inconsistent and different figures.\(^4\)

- **Double counting of expenditure.** This happens where people measure financial flows at different points in the system. For example, the Special Allocation Budget (*Dana Alokasi Khusus/DAK*) is counted as expenditure by the central government, in some cases, for example, GF grant expenditure is reported by the province as it is the primary recipient while in other cases it is reported as district expenditure since the district carries out are did the activities. As a consequence there can be double counting.

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\(^4\) In some cases, for example, GF grant expenditure is reported by the province as it is the primary recipient while in other cases it is reported as district expenditure since the district carries out are did the activities. As a consequence there can be double counting.
but it is transferred to the districts, where it is then included in the local report (under APBD2). As a general rule, when netting out transfers, the expenditure should be assigned to the originating level, in this case, central government but this is not clearly understood. Therefore, more guidance is needed on budget sources in the NTP monitoring form.

A challenge in both NTP and DHA data reporting is the collection of data from the private sector and external institutions. Local government does not have clear authority to collect data from NGOs. In Bali, for example, the province has difficulty in getting data from the Association Against Tuberculosis and Lung Disease (PPTI) and from companies providing Corporate Social Responsibility funds. A separate challenge for collecting NGO data is there are different ways to provide funding support to a province or district. Support can be in the form of cash given to a district, in which case the district knows the amounts. But the NGOs can also incur the expenditure itself and, in this case, the district may not know the amount. In such cases getting the information from the NGOs can be difficult. While it is more feasible to capture non-government health expenditure in the DHAs it is still difficult to get some of that data specifically for TB, especially from private health care providers.

Summary

Domestic expenditure on TB can come from the following sources:
- Government budgets at national, provincial and local government levels;
- Social and private insurance;
- Local donors;
- Patient out-of-pocket contributions;
- Private companies (corporate social insurance);
- Employers (with private health services or who pay for patients at other health facilities).

Of the above sources the current NTP system is only able to capture expenditure from government budget sources. Expenditure from local donors, private companies (CSR) and employers should be captured under the DHAs but it is difficult to collect and not all of that expenditure can be identified as relating to TB.

National Health Insurance, called Jaminan Kesehatan Nasional (JKN) in Indonesia, already finances a significant amount of TB treatment costs and is expected to cover a greater proportion of these costs in future. Insurance payments for TB are provided in the form of capitation payments to primary care providers (private clinics and public health centres) and
as case-based payments to hospitals. It is not easy to collect this data from the providers but data on claims and payments related to TB should be available from the JKN database. This would only be feasible for hospital services, however, as it is not possible to separate capitation payments made to public and private primary care facilities by type of treatment.

Patients should not currently be making out-of-pocket payments to public facilities for TB services and once the whole population is covered by national health insurance there should be no out-of-pocket payments for TB at public or private facilities. It may be possible to check this by including specific questions included in health and economic household surveys but it will take time and would not be available every year.

All respondents agreed that the DHA form provides more details than the TB form but they feel that the DHA form is too complicated.

5. Conclusions

While the TB expenditure reporting system has been widely used and has been helpful for reporting, for example to the GFATM, it has some weaknesses:

- The data do not provide a full picture of expenditures because they exclude funding from NGOs, communities and CSR.
- The data are incomplete and inconsistent because the data collection and entry requirements are not clear.
- Reporting levels are low – only 66% of provinces and 47% of districts submitted reports in 2012 and only 32% of districts submitted reports in both 2011 and 2012.

Although the NTP reporting system has weaknesses, using data from the DHAs is not a feasible alternative, at least in the next few years. The number of districts preparing them is low and does not appear to be increasing. In addition, it can take many months for districts to prepare DHAs whereas the NTPs forms can be completed with previous-year expenditure data and current-year budget data within one month after the end of the previous fiscal year.

There is, therefore, no advantage in using the DHAs to monitor national TB expenditures instead of using the NTP system, at least until the DHAs are produced in more than 50% of the districts every year and they are produced more quickly.

5 Data would also have to be obtained from Jamkesda, the district level social insurance scheme, which will be folded into JKN later.
At least for the next few years it is best to strengthen the NTP’s reporting system in terms of the quality and completeness of the reported data and in terms of the number of districts and provinces that submit the forms. We recommend, therefore, that the NTP system continue to be used for monitoring TB expenditures but that the system is strengthened.

Insurance is a key source of financing for TB and will become more significant over time as it is expected to fund most of TB diagnosis and treatment. The NTP reporting system will not be able to capture this data locally as it is not reported to the District Health Office and it would be difficult to collect this from public and private providers. We, therefore, recommend that the data be collected by the NTP from the JKN and Jaminan Kesehatan Daerah (Jamkesda) and included in the calculation of domestic financing. This would not include insurance payments to primary providers which are paid by capitation but should cover hospital costs.

In addition, an overall picture of the sources of TB financing can be produced with a costing tool such as the TB Service Costing Tool which projects the costs and financing sources over a number of years using a mixture of normative, budgeted and actual costs. 6

6. Recommendations

This proposed new form provides columns for budget and expenditures for the same fiscal year. This needs to be amended to indicate that provinces and districts should report expenditure data for the year just ended and budget data for the year just starting. Using this system the NTP has more advanced information on government commitments and allocations. Since the reported expenditure and budget data cannot be compared on the form it will be possible to compare the previous year expenditure with the previous year budget figures which was provided in the previous year. Reducing and simplifying the data requirements will make it easier and faster to complete and submit the forms.

We believe that the NTP data collection and reporting system can be strengthened with a few improvements, which are as follows:

- Simplify and improve the TB expenditure data collection form and provide guidelines on who should complete the form and what data should be reported (see proposed form in Annex 4).

- As part of the simplification, clarify the categories to be used for activity requirements for reporting expenditures by activity.

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6 This tool is currently being used to produce this analysis for the national TB financing roadmap.
• Remove the requirement for expenditure of non-government information; the requirement for expenditure of GFATM funding which is available from the NTP Headquarters; and the requirement for other non-government expenditure which can be collected from the DHA reports.

• The NTP should collect data on hospital insurance claims and payments from JKN and Jamkesda for hospital TB services by district and include the data in the calculation of domestic financing.

• Make the timely and complete submission of the TB Expenditure reports a requirement for provinces and districts to get/release their new budgets.

• Use the national TB Service Delivery Costing tool with the addition of the financing component to provide an overview of costs and financing sources for a current year and projections for future years.

• Analyze and compare TB expenditure reports during the national TB monitoring and evaluation meetings.

• Hold annual district meetings with NGOs and external institutions to get information on their TB program expenditures.

• The NTP should provide training to the provincial and district TB officers using the new forms and guidelines.

• The NTP should conduct analysis of the data collected and provide feedback to the provinces and districts. Announce “best provinces and districts for reporting and highest sustainability” each year. Rankings should be based on comparable figures such as expenditure per capita.

• Encourage strong advocacy and commitment among decision makers and staff at provincial and district level on an importance of monitoring TB finance data.

• Use the financing data together with TB cost data, disease burden and economic burden data for advocacy in provinces and districts where local government commitment is low and with private companies for CSR contributions.

• In addition to strengthening the TB expenditure reporting system it will be important to assist with the TB element of the DHA system and to use that system for more in-depth analysis of TB expenditure relative to other health expenditures. This can be done as follows:
  o Provide training to the Provincial TB Program managers and have them assist the DHA Teams to collect the data on TB expenditure, as they have thorough knowledge on health expenditure and its source of information.
  o Conduct an annual analysis of the financing of TB (as well as on AIDS and malaria) using a sample of DHAs. This analysis could be done by the universities based on a standard analytical framework.
ANNEXES
### Annex 1. People Met and interviewed

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
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<td>BawaWuryaningtyas</td>
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<td>2.</td>
<td>Sadikin</td>
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<td>KaSie P2</td>
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<td>Provincial Health Office of Bali</td>
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<td>7.</td>
<td>Kurniasari</td>
<td>Researcher</td>
<td>PusatKajianEkonomiKesehatan</td>
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<td>Researcher</td>
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<td>9.</td>
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<td>KasiePencegahanPenyakit</td>
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<td>Budiman</td>
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<td>Rahmi</td>
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<td>Laila Faulia</td>
<td>PHA and DHA Coordinator</td>
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<td>13.</td>
<td>Muhammad Wahyudi</td>
<td>Former DHA Coordinator</td>
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### Annex 3. Description Category of Domestic Funding Form from NTP

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<th>No</th>
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<td>Training/Workshop/Meeting</td>
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<td>2</td>
<td>Procurement of health equipment and devices</td>
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<td>3</td>
<td>Procurement of drugs</td>
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<tr>
<td>4</td>
<td>Cost of procurement process</td>
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<td>Infrastructure and procurement of other (non-health) equipment</td>
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<td>6</td>
<td>Communication material</td>
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</tr>
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<td>7</td>
<td>Monitoring &amp;Evaluation</td>
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<td>Support to communities</td>
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</tr>
<tr>
<td>9</td>
<td>Planning and administration</td>
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## Annex 4. Proposed TB Expenditure Monitoring Form

### Proposed TB Expenditure Monitoring Form

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<thead>
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<th>No.</th>
<th>Name of Province and District</th>
<th>Activity</th>
<th>National Budget (APBN/Dekon)</th>
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</table>

### Guidance:

1. Column of Name: Name of Province and District or City
2. Column of Activity: Name of Activity
3. Column of APBN: Total of expenditure of national funds in previous fiscal year and total budget for current fiscal year managed by province and districts. APBN which are included Sharing budget (DBH), General Allocation Funds (DAU), Special Allocation Funds (DAK) and Health operational Support funds (BOK).
4. Column of APBD I: Total expenditure of provincial funds in previous fiscal year managed by province and districts
   Column of APBD II: Total expenditure of provincial funds in previous fiscal year managed by province and districts.

To avoid duplication, province will only report budget managed by province and district will only report budget managed by district/city and puskesmas.
Annex 5. Bibliography


Center for Health Research, University of Indonesia. GTZ. District Health Account Training Material, 2007

Centre for Health Research, University of Indonesia. Health Financing Analysis of the TB Programs in 7 Districts of 4 Provinces in Indonesia, 2006.


