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A Methodology For The Private Sector Resource Mobilization Study

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Resources for Child Health Project

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**A METHODOLOGY FOR THE
PRIVATE SECTOR RESOURCE MOBILIZATION STUDY**

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I. INTRODUCTION

Generally speaking, the objective of the proposed study is to estimate private (distinguish public) expenditures for health services of all kinds including those supplied by public (government) providers. The instant exercise seeks to develop a methodology for conduct of this study.

The appropriate format for assembling this information and the degree of precision required of the estimates will depend upon the use to which the findings are to be put, i.e., upon why the findings are wanted. Interest in these findings appears to be, in the main, rather general in nature. For example, there is interest in measuring what might be characterized as the nation's "economic effort" on health account, public plus private expenditures for health care as a percent of GNP. Also, comparing private and public expenditure may contribute to understanding an important structural feature of the nation's health economy -- namely, the extent to which the rate of resource allocation to health services is determined by the decisions of individual marketeers in private markets versus collective (political-process) consumption decisions. It is perhaps reasonable to assume that for adequate service to interests of these kinds, the proposed study need not generate findings of great detail and precision.

In the design and conduct of the proposed study, it should be kept in mind that the study may provide an opportunity to assemble some information, in addition to expenditure information per se, which may be more directly responsive to certain public-policy issues and questions. For example, looking forward to a period of relative fiscal stringency, the GOI would like to reduce the fiscal burden imposed by health services on the public treasury (the fisc) as much as feasible consistent with equity objectives. One strategy pursuant to this goal is to regard the nation's health-services sector for planning purposes as comprised of complementary public and private subsectors, each to play its appropriate role. Thus, on the supply side, private sector provision of some services, e.g., hospital services, may reduce the burden on the fisc that would have been entailed by the necessity for government to provide these services. And, on the demand side, an increase in private financing of the demand for government supplied services, say hospital services, may in a direct way reduce the burden on the fisc.

Given the foregoing picture of potential complementary relationships between the public and private sectors, what information do we need about private-sector financing arrangements to help inform the development of policy in this area? It would seem clear that one category of information relevant for these purposes would be information on the terms of access to care in various private-sector practice setting -- that is, the money (and other) cost to consumers of obtaining care. The equity implications of greater reliance on private providers depends in part on such terms of access. And, thinking about private demand for government provided services at various levels of fees may be informed by data on terms for access to alternative care in the private sector.

Thus, although the proposed study is intended in the main to make findings on rates of private expenditure for health services, it might also be worthwhile to assemble information on prices paid by consumers for care (an important component of terms for access to care), in various private-care settings.

These considerations may be regarded as exemplary of what may be a more general opportunity afforded by the proposed study. Thus, in thinking about the design and conduct of the proposed study, we should keep a weather eye to the possibility of collecting (with little or no increase in cost of the study) additional categories of information which may be responsive in a direct way to particular policy issues, problems and question.

II. CONCEPTUAL FRAMEWORK: GENERAL CONSIDERATIONS

The proposed study is to look at expenditures on current-account (routine) and capital-account (development) and, apparently, some projections for future years are called for. Depending upon how it is done, this could be a formidable enterprise. To hold the resource commitment to the study within cost-effective bounds, we will want to design it with an eye to the actual uses to which the information to be assembled are to be put. We may begin with some preliminary considerations in each of these domains.

Current-Account Transactions

It will prove useful to look at private current-account expenditures for health services from both the demand side (making payments) and the supply side (receipt of payments) of these transactions.

A. DEMAND SIDE: CATEGORIES OF PRIVATE PAYMENTS

1. Consumer out-of-pocket payments for services.
2. Premiums due/paid by individuals as beneficiaries of various private insurance/prepay schemes.

Total premium income will cover health benefits for the beneficiaries and the cost of insurance services provided by and profits for the carriers.

3. Employer expenditures for health services they provide directly to employees/dependents (i.e., with own facilities, hired staff).
4. Employer expenditure for health services purchased from outside.
5. Private payments (e.g., tuition) for education/training in various health professions/occupations.
 - a. Physician
 - b. Nurse
 - c. Pharmacist
 - d. Lab Tech/Assistant
 - e. Other?

6. Other?

B. SUPPLY SIDE: CATEGORIES OF PROVIDERS WITH RECEIPTS FROM PRIVATE SECTORS

1. Public (government) hospitals and health centers.
2. Private hospitals and health centers, private clinics.
3. Factors of production used in employer direct-service plans.
4. Pharmacies.

5. Schools/training centers for the various health professions/occupations.
6. "Private practice" by various providers (i.e., free-standing, noninstitutional provision of services usually on a fee-for-service basis).
 - a. Physicians
 - b. Nurses
 - c. Midwives
 - d. TBAs
 - e. Traditional Healers
 - f. Other?
7. Insurance carriers (receipts for insurance services provided).
8. Other?

Demand item A5 and supply item B5 refer to the two sides of the market for health manpower education/training. These items are in some ways rather different in nature from the other items in these lists. Although current-account from the point of view of the schools providing these services, these expenditures are also in a sense on capital account (development account), i.e. they represent investments by individuals in so-called "human capital" formation. From a publicpolicy and health-planning point of view, this is apt to be a particularly interesting category of expenditure; see some discussion of this point to follow.

This conceptual framework directs attention to the categories of information we will require. Thus, developing a methodology for estimating private expenditures for health care entails in good part devising observation regimens to assemble the information for each of the demand-side and supply-side items. (As will appear, this is more easily said than done).

Explicitly recognizing and distinguishing the supply side and the demand side of these transactions may be helpful in a number of ways. For some items it may be possible to make estimates from both sides -- say reported or estimated receipts of providers for services rendered and reported consumer expenditures for these same services. Comparing the two may provide some sense of the validity of the estimates. More generally, we know that in fact the sum of the demand-side items must equal the sum of the supply-side items, i.e., the total of private payments must equal the total of receipts from this source. Of course, owing to measurement problems, we cannot expect the sums of the estimated items on each side to be equal. Nevertheless, looking for this kind of balance may again help to provide some sense of the probable validity of our estimates.

Explicitly recognizing and distinguishing the supply side and the demand side of these transactions should help to protect us against double counting -- i.e., against inadvertently including in total expenditures both payments for services and receipts for those same services.

There are reasons in addition to those set out above for looking at these transactions from both sides -- namely, we have a substantive interest in both categories of information. Thus, we will be interested in how the

total of private expenditure is distributed among the various health services activities and programs -- as depicted on the supply side. And, whatever the total and distribution, we will want to look to the demand side to see how this private demand for services was financed. The important distinction here is between social financing of the demand for these services. Indeed, in various ways, this distinction may be of more interest than the distinction between private and public (government) expenditure per se. Transactions in health-services markets may be private on one side and public on the other. Thus, private out-of-pocket payments finance part of the demand for government-provided hospital and health-center services. And, public social-financing programs, such as ASKES, may finance part of the demand of privately-provided services. Although payments from a program such as ASKES derived from mandated payroll taxes are not in any conventional sense "private", they are an important component of social financing of the demand for care, at least in the public sector and to some extent, as matters stand in the private sector. There is public-policy interest in the extent of such social financing and the private-sector study may provide a good opportunity to assemble some of this information.

In setting priorities for the development of the proposed private sector expenditure study, it would seem appropriate to attend first to the design of observation regimens or programs to measure current rates of expenditure on current account -- leaving until later the question of what projections of these rates we should seek to estimate and how this might be done.

Expenditures on Capital (Development) Account

For each health-services production process (activity), expenditures on current account are a continuing process, year in and year out. Expenditures on capital account, on the other hand, are episodic and perhaps at irregular intervals -- the capital stock put in place by each episode of spending on capital account yielding up its services over future years. To know any one year's work of expenditure on current account (say, for 1986) is much more informative about the structure and performance of the health economy than to know any one year's worth of expenditure on capital account. For any given year, relative rates of spending on current account in the private and public sectors say a good bit about the relative size of these sectors in the nation's health economy in that year. The same cannot be said for knowledge about relative rates of spending on capital account for any given year, e.g., this knowledge tells us nothing about the relative size of the capital stocks in the public and private sectors, but only about additions to these stocks in that year. The history of expenditures on capital account is "embodied", as it were, in the capital stocks in place at each point in time. To know this history, we need never to have estimated the rate of expenditure on capital account in any given year -- rather, we just look to the capital stocks themselves, i.e., take an inventory of the physical facilities. Thus, for example, it is reported that currently 30% of inpatient hospital bed capacity is in the private sector and 70% in the public sector -- a meaningful statement about the relative size of the public and private hospital-services sector (neglecting for present illustrative purposes the problem of evaluating the service capacity of a "bed's worth" of capital stock in the two sectors).

In the domain of private sector expenditure on capital account, for health-policy-development and health-planning purposes, we are apt to be less interested in expenditure during, say, the last year, and more interested in plans for future expenditures, i.e., projections in this sense are apt to be of central interest. Information on future investment spending in a sector speaks to the future capacity of the sector to produce output. Since the demand for capital goods is derived from the demand for the outputs they help to produce, producers' investment plans reflect their projections of future demand for these outputs. (In this sense, information on future investment plans might be said to inform projections of future expenditure on current account).

To make matters more definite, consider the hospital services sector. Indonesia's health-sector plans appear to call for greater reliance upon private sector inpatient hospital capacity in the future, e.g., the proportion of private beds to all beds is expected to increase from its present 30% to, say, 50% (or even more) in the near term. If these events are to obtain, there must be in the near term considerable expenditure on capital account in the private hospital sector (the amount depending in part upon the extent to which currently excess capacity may prevail in the sector). Is this a realistic expectation? Information on planned investment spending in this sector can help to inform the answer to this question. In our design of the proposed private sector expenditure study, we will want to think about what observation regimens are most appropriate to yield this information. Similar considerations will apply to other sectors.

It has been suggested above that collecting information on expenditures in private markets for health services might afford an opportunity to collect additional information about the structure and performance of these markets which would be useful for health policy and healthplanning purposes. As the discussion in this section has perhaps suggested, put more generally, one category of such useful additional information concerns the supply response to demand events in these markets. For example, the question whether in a given private market, say for a category of health manpower, there is apt to be an efficient supply response to increases in demand? We will direct attention to this feature of private market structure/performance where appropriate in what follows.

Estimating Private Expenditures for the Categories of Payments and Receipts

During this exercise, we have been seeking to determine where information on these expenditures might be obtained and we have been thinking about observation programs to assemble this information. In this way we have made a start on the design of programs to assemble this information for each of the categories -- the pages to follow discuss our findings with respect to sources and make some suggestions with respect to possible sources and observation programs which might be followed. In pushing the proposed study forward from this point, it will be necessary to follow up on our preliminary findings and suggestions to develop definite research programs/procedures to assemble the information for each of the categories.

Demand Side Item 1:

Consumer Out-of-Pocket Payments for Services

SUSENAS would appear to be potentially the major source for these findings. Periodically (on a three-year cycle) this survey reports monthly per capita expenditures for "Health" broken down into a few categories, e.g., cost of doctors, cost of nurses, etc. (See, for example SUSENAS 1984, Table 6, p. 133 -- the 1987 survey including the health module will be going into the field in about one month).

There has been some question whether the SUSENAS findings are an accurate account of household expenditures for health services. Perhaps some analysis of survey procedures could help to cast some light on this. The health module is a very short one, only nine questions. If information of this kind is to be required by the MOH on a regular basis, attention should be given to the possibility of cooperating with SUSENAS on possible changes in the health-module format which might yield more confidence in the findings (e.g., perhaps a longer format with room to try to get at the same information through a number of questions the replies to which might check on each other). The Director of the Bureau of Social and Population Statistics has expressed interest in such an enterprise (it appears that the Bureau from time to time fields "special order" surveys in this sense). Of course, if the Bureau were to field a more extensive health module, additional funds would have to be found to support the enterprise. It appears that the Bureau could put such a special health module into the field as early as 1988 (although that is not a regular year on the health-module cycle).

Another possible source of information in this domain is the National Institute of Health Research and Development Household Health Survey, the third of which, for 1985-86, has just been completed. This is a large survey of potentially great interest. Preliminary findings from this survey are just now being reported and it is not yet clear how suitable a source it will prove for estimating household expenditures for health services. The private sector expenditures study should follow up on this, e.g., examining survey instruments and procedures from this point of view.

Demand Side Items A3 & A4:

Employer Expenditure for Health Services for Employees

Private Enterprises

Perhaps the major source of information in this domain is a 1984 survey sponsored by ASKES of 173 small and medium size firms in Jakarta. Resort was had to the survey because no other source for the required information could be found. This suggests that if additional information of this kind is to be assembled, additional survey work will be required.

The published report of the ASKES survey (a copy of which has been supplied to the team) should be reviewed to determine if the findings can be regarded as representative for at least the small and medium size firms in

Jakarta. This study found that employers were, on average, spending an amount for health services for their employees/dependents equal to about 20% of payrolls. Prima facie, this appears to be a very high rate of expenditure for these purposes, although it is probably a rather smaller proportion of total employee compensation (made up of payrolls plus various fringes, some in kind). It is interesting that other sources of information, e.g., individuals with some first-hand knowledge in this domain (although they have not conducted systematic inquiries), seem to agree that frequently employer expenditures are at about this rate.

Information on the distribution of private enterprise employees outside of Jakarta by size of firm would help to information a judgement about the ASKES survey findings might be supplemented to provide an estimate for Indonesia as a whole. Thus, if much of this employment was concentrated in relatively few large firms, relatively few selective inquiries of these firms might provide enough additional information for at least a rough estimate of these expenditures for the country as a whole.

More generally, a judgement will have to be made in the course of conducting this study what resource commitment to an observation program to refine the estimate of private sector employer expenditures for health care would be justified (e.g., in light of the use to which the information is to be put).

Public Enterprises

This category is made up of "semi-autonomous" enterprises such as perums, etc. Expenditures by these employers for health services for their employees are regarded as private sector expenditures for purposes of this study. It appears that each of these enterprises is associated with the appropriate ministry -- in which case, reporting procedures might be such that these ministries would be a source of information about enterprise expenditures for health plans. In any event, this possibility should be checked out. If additional survey work is necessary in this domain, it might well be facilitated by the concentration of these employees in relatively few large enterprises.

Supply Side Item 1:

Public (Government) Hospitals and Health Centers

Here we wish to estimate revenue from fees charged by these facilities for services provided. It appears that making these estimates will be a fairly straightforward matter owing to various government sources for the required information. Indeed, it appears that this information has already been assembled for the vertical hospitals and those at the provincial level. This leaves the lower level local government hospitals. Information on revenue from fees for these facilities is reported to the provincial government level such that an examination of records at the provincial level will yield the necessary findings. It is our understanding that process to assemble these findings is already underway.

Some of the charges for services provided by government facilities will have been paid out-of-pocket by consumers. Other charges will have been paid by ASKES on behalf of their beneficiaries. Other charges will have been paid by employers on behalf of their employees. Ideally, we would like to partition total revenue receipts into these components -- e.g., pursuant to analysis of the relative importance of out-of-pocket and social financing of the demand for services in this market. It is not yet clear how this might be done although it would appear that the ASKES part might be sorted out for aggregates of facilities (e.g., by province) from their own records of benefits paid.

Supply Side Item 2:

Private Hospitals

It is not yet clear how best to assemble information in this domain. A potentially promising possibility, however, would appear to be to work with the Indonesian Hospital Association on this. The Association has been relatively recently constituted. All hospitals, public and private, are eligible for membership. So far, the Association has been concentrating its efforts on certain special problems, e.g., the matter of informed consent and other professional-liability problems. It is the longer-run aim of the Association however, to in various ways standardize hospital administration and management procedures, budgeting procedures, and the like. This means that in the longer run the Association will be interested in collecting some of the data from its members that is required also for purposes of the private sector expenditure study. The study should follow up on this working with the Association to see what would be entailed in fielding a questionnaire through the Association to determine private hospital revenues from services provided and the sources of those revenues (e.g., out-of-pocket payments, ASKES, employer payments). The study could consider providing some funding for such a survey which would be jointly designed with the Association and carried out in the main by the Association.

A large proportion of private hospital beds are in church-related institutions and it appears that these institutions have their own hospital associations, e.g., The Christian Hospital Association and, it is our understanding an Islamic Hospital Association. These private hospital associations are a potential source of information on revenues from services provided which should promptly be checked out; they are very likely sources for the information required.

Supply Side Item 4:

The Pharmaceutical Sector - Drugs/Medications

This sector includes 4,200 pharmacists, about 2000 pharmacies (chemists' shops), 280 firms producing pharmaceuticals, and 900 distributors. Only about 5% of pharmaceuticals are imported as finished products. This industry is under the purview of the Directorate of Food and Drug Control. The firms in the industry file reports with this agency, including the value of sales. There is no price control of drug prices.

According to the Directorate, last year the value of manufacturers' shipments in this industry was the equivalent of US\$ 600 million (at the old exchange rate). Of this amount, 15% went to government (all programs, e.g., Impres, health departments, military) and 85% moved in private markets. It is estimated that the markup at the retail level averages to about 1.75 times the factory price (higher in some markets, lower in others) which would make the value of retail sales about US\$ 890 million equivalent, this in the private sector.

Obviously, from the point of view of private expenditures for health care, this is a very important sector. Fortunately, these data appear to be readily available from the Directorate. Our study should assemble these data over several recent years with an eye to measuring the recent trend in these expenditures.

Supply Side Item 5:

The Non-Physician Health-Manpower Training Sector

It appears that there are some 21 recognized health-manpower occupations/professions. We would like to estimate private expenditures for the services for the schools which train for these occupations. It is most feasible to make this estimate from data obtained from the schools (supply side).

These schools come under the purview of the Health Manpower Education Center. The Center assembles some information on the performance of these schools, e.g., since 1984, the number of graduates from each of the schools.

QUERY: Does the Center now assemble, or might the Center quite readily assemble, certain budget information for these schools -- particularly, for each, total revenue from private sources and from public sources? Could this be done, for example, by the center's simply requesting each school to report these data? If not, how alternatively might these data be assembled? Could Center staff accomplish this without assistance? If not, what kind of assistance would be required?

An important question for understanding the economics of the medical (health) economy in Indonesia is that of what determines the capacity of these schools (number of places), particularly as these determinants may effect the articulation of demand events and supply events in markets for health manpower. For example, do private schools respond to increases in the demand for their services by increasing their rates of output? The answer to this question may be important for manpower planning in this domain. If private school output is a significant part of the total and if these schools do so respond, then health manpower markets would feature a kind of "automatic" adaptive response of supply events to demand events -- thereby reducing the necessity for the planners to rely on projected manpower "requirements" in evaluating the adequacy of training-sector capacity.

It should be remarked that it may be the case that various of these schools are motivated to so respond but are precluded from doing so by any of various obstacles (e.g., shortfall of capital). In this case, the most useful kind of manpower planning might be market-structure planning to reduce or eliminate obstacles to a prompt market-supply response to demand events. The point here is that, in the course of studying the health-manpower training sector to determine the rate of private expenditure for these services, it may be possible to gain some better understanding of how this manpower market functions. Perhaps the proposed study can make use of this opportunity.

Supply Side Item 6a:

Private Practice by Various Providers: Physicians

The Indonesian Doctors Association enrolls some 18,000 dues-paying members in 11 chapters and 146 branches. This membership is believed to represent 90% of the professionally active physicians in the country. (Although physicians are not required to join the Association, they are encouraged to do so.) By law, IDA is the only professional association for physicians. Specialty groups are part of the Association's organization structure. Of the 1,500 or so new graduates from the medical schools each year, at least one-third cannot be posted by the government health departments. Since such a period of service is required for licensure, a problem is created. It is not clear what the patient-care status of these physicians is.

It appears, that for some years, physicians going into private practice have required the "approval" of the IDA. In recent years the process has been formalized with an accreditation office created in the IDA to do this. Thus, the Association knows which of its members are in what kind of private practice where.

The IDA has recently submitted a proposal (seeking funding) to the Bureau of Planning, MOH, for a study it would undertake to determine expenditures for private-practice physicians services. Although the study would be restricted to the larger urban areas, it would presumably cover most such physicians. Our private sector study should follow up on this proposal, discussing it in more detail with the IDA. At present, it seems likely that the proposed IDA study will prove the best way to make findings in the private market for physicians services. For one thing, physicians might be less reluctant to cooperate with such a study sponsored by their own professional association than were such a study attempted under other aegis.

Supply Side Item 6b:

Private Practice by Various Provides: Nurses

Making good estimates of private expenditures for these services is not an easy matter. The straightforward approach would be to ask a suitably selected sample of nurses what their earnings were from private practice. There seems to be agreement in all quarters, however, that this approach

would be unavailing, that such a question simply would not be answered candidly. A part of the difficulty inheres in the dubious legal status of much such practice. And then there is always the suspicion that the tax man may be somewhere in the background of any such query.

Nevertheless, some estimates may be attempted. The Indonesian Nurse Association claims some 80,000 members, organized into provincial and district chapters (each of the chapters maintains a roster of its members). The association believes that its members represent about 90% of the active nurses in Indonesia (although the basis for this belief is not entirely clear). It is the feeling that these nurses would respond candidly to an anonymous questionnaire on how they divide their time between various practice settings, e.g., public hospitals and clinics, private hospitals and clinics, private practice. Many of the nurses will be working in more than one practice setting, e.g., say, a government hospital and private practice.

QUERY: By what procedures might a probability sample of Association members be surveyed to obtain this information? For example, if a questionnaire were mailed to chapter officers, might they be counted on to administer it to randomly selected members and return it?

Information on the allocation of nurse time (or other physical-unit measure of service output) between public and private practice settings would be of considerable interest. It would, for example, speak in a more meaningful way to the relative size of the public and private nursing-services sectors than would, say, data on expenditure for nursing services in the private and public sector¹. If desired, however, one could make a rough conversion to value (expenditure) units by assuming a "representative" price for units of services rendered.

Although working from the supply side of the market there may be no better way to make estimates of expenditures for nursing services, we should not suppose that the procedures outlined above will yield very precise estimates. Consequently, we might attempt to supplement any such findings with findings on this same magnitude derived from the demand side of the market -- i.e., reported consumer expenditure for nursing services. A major source here would appear to be the periodic SUSENAS household expenditure surveys which report household expenditures on "health" including the health category "cost of nurses" (see SUSENAS National 1984, Table 6, page 113). The meaning of the "cost of nurse" item (and of other health items, e.g., "cost of care") should be discussed with those

¹More generally, in the context of medical-services markets such as those in Indonesia, monetary-unit measures of "resource mobilization" are difficult to interpret in a meaningful way. In what sense is a "rupiah's worth" of some resources allocated in, say, the deluxe private sector, to be compared with a "rupiah's worth" of that same resource allocated in the government sector or the traditional sector? Whatever that sense, it is not, presumably, in terms of health status impact.

knowledgeable about SUSENAS survey procedure to determine if the data reported under these headings will be suitable for the kind of estimate we want for the proposed study. Another possible source of such information might be the Household Health Survey, the third of which (for 1985-86) has just been carried out by the National Institute for Health Research and Development. The findings from the field work for this survey are just now being processed, only a few preliminary reports are as yet available. It is not yet clear whether the data to be reported by this survey will be suitable for the kind of estimation wanted for the proposed study.

Supply Side Item 6c:

Private Practice by Various Providers: Midwives

Making good estimates of private expenditure for these services is not an easy matter. The straightforward approach would be to ask a suitably selected sample of midwives what their earnings were from private practice. As with the nurses, however, and for much the same reasons, there seems to be general agreement that this approach would be unavailing.

Nevertheless, some estimates may be attempted along the lines suggested previously for the nurses. The Indonesian Midwives Association enrolls some 13,171 members organized into 27 provincial chapters and 263 local branches. The Association believes that its membership represents about 90% of the midwives active in Indonesia. It is the feeling that these midwives would respond candidly to an anonymous questionnaire on how they divide their time between various practice settings, e.g., public hospitals, public clinics, private hospitals and clinics and private practice. Many of the midwives will be working in more than one practice setting.

QUERY: By what procedures might a probability sample of Association members be surveyed. For example, if a questionnaire were mailed to chapter officers, might they be relied upon to administer it to randomly selected members (according to a rule our proposed study would suggest) and return it?

As with the nurses, information on the allocation of midwives' time (or other physical-unit measure of service output) between public and private practice settings would be of considerable interest. And, as with the nurse, if desired, one could attempt a rough conversion to value (expenditure) units by assuming a "representative" price for units of services rendered. (This assumption in the case of the midwives would have to take into account the circumstance that they price on an income-related sliding scale).

Although there would appear to be no more promising estimating procedure working from the supply side, it must be recognized that the procedures outlined above cannot be expected to yield a very reliable estimate of private expenditures for private practice midwives services. Consequently, the question arises whether it might be possible to supplement any such findings with estimates from the demand side -- i.e., reports of consumer expenditures for these midwives services. Again, the periodic SUSENAS

household expenditure surveys might be a source here, although it is not clear from the way the published survey findings are reported whether this is the case. Inquiries should be made on this score.

It may be remarked (for this context and others) that if the findings on private expenditures for health services to be yielded by the proposed study are to be required on a continuing basis, it would pay to investigate the formats and procedures employed by regular, ongoing survey activities (e.g., SUSENAS) to see if they might readily be modified to yield better information for these purposes.

Supply Side Item 6e:

Private Practice by Various Providers: Traditional Healers

The traditional healers operate only in the private sector. They appear to be "unorganized" -- they have no professional association. Health sector policy appears to recognize the traditional sector as a complementary component part of the nation's total health care system. These practitioners appear to be in some sense under the purview of the recently established Directorate of Community Participation which operates certain training activities for them. However, it appears that neither this agency nor any other assembles information on the structure and performance of this sector, e.g., the number of traditional healers is not known.

For the foregoing, among other reasons (e.g., to some extent, traditional healers are reimbursed in kind), it is probably less feasible to estimate expenditures for these services than for any other category of health services. Even if a good estimate of such expenditures were in hand (imputing values for in-kind payment as appropriate), however, one may question its significance for informing national health planning and policy making. Thus, it may be argued that relative expenditures in this sector, more so than for any other sector perhaps, will fail as a measure of the relative importance of the sector in any non-trivial sense. This is not to say, however, that such expenditure information would be of no interest, e.g., it would help to inform thinking about the equity implications of the way in which the demand for these services is being or might alternatively be financed. (What resource commitment to research to obtain this information would be appropriate is a matter for discussion.)

A large array of traditional medications (many of which are preventive/promotive rather than curative per se) are dispensed in the traditional sector. Five firms are in the business of manufacturing such medications, they operate under the purview of the Directorate for Traditional Drugs. A figure for total sales for these medications can be obtained from this Directorate. (A rough estimate from another source puts this at about US\$ 40.0 million equivalent.)

Evaluation of this sector presents a number of problems. On the one hand, there seems to be very general agreement that the traditional sector is an important supplier of services, that many, if not most, Indonesians utilize these services -- especially in the rural areas (where these may be the most readily obtainable services). On the other hand, surveys such as the

recently completed third Household Health Survey find virtually no utilization of traditional-sector services. Similarly, SUSENAS finds levels of spending by households for traditional sector services far lower than one might suppose to be the case based on the general impression that this is a very important sector. Various theories are put forward to explain this discrepancy, e.g., that survey interview personnel and procedures are such that respondents are reluctant to testify to use of these services.

A good understanding of the traditional sector's structure and function would seem to be important for national health planning and policy development -- e.g., as part of the overall utilization picture, who gets what kinds of services where and on what terms of access. What kind of investigation of this sector might be appropriate for our instant purposes (those of the private sector resource mobilization study) is a question which needs some discussion.

Supply Side Item 6f:

Private Practice by Various Providers: Dentists

The Indonesian Dentists Association claims about 4,000 members organized into 53 branches. About 50% of the dentists are in full-time private practice. Of the 50% working in government posts, about 60% do some private practice. Of the 300 newly graduated dentists each year, about 100 are absorbed by government. One problem here is that most of the dentists are women many of whom are reluctant to take posts in rural areas. In addition to professional dentists, some dental work is performed by practitioners in the traditional sector (a distinct occupational category of "Tooth Repair" workers).

In our general discussion with a representative of the Dentists Association, we really did not explore the question of how an estimate of private sector expenditure for dental services might be made. We should follow up with the Association on this. Query whether these services comprise a small enough part of total private health-services expenditures such that a fairly rough estimate will serve for present purposes?

Supply Side Item - Other:

Medical Laboratories

These laboratories report to and are subject to some regulation administered by the Centre for Health Laboratory Services of the Ministry of Health. The law sets out staffing standards and service standards to which the labs are supposed to conform. Physicians order lab services in the course of working up their patients but the patients are billed directly for these services, i.e., rather than these services being reflected in the physician's bill to the patient. (This would seem to diminish the prospect that the physicians survey might yield findings on expenditures for lab services). The Centre's current roster contains 374 laboratories with the location of each.

It is not yet clear what the best way of estimating expenditures for lab services will be. The laboratories do not report sales figures to the Centre. There is some doubt that a survey of these businesses is a practical way to obtain the information. However, the Indonesian Clinical Laboratory Association (Jakarta) should be consulted with respect to the feasibility of this or other approaches. These laboratories are subject to taxation as are other businesses -- suggesting that perhaps the fiscal authorities could be a source of information. Here again inquiry will be required to determine whether this is a likely prospect (e.g., questions with respect to the confidentiality of returns?).