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**INDONESIAN HEALTH PLANNING PROCESS**

**REPELITA V**

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## EXECUTIVE SUMMARY

This report describes and evaluates the health planning process involved in preparing the Indonesian Fifth Five Year Health Plan (Repelita V). In Indonesia health planning is taken seriously as a guide for implementation, making this process particularly important.

In general the process was an extremely effective model of how health planning should be done. It developed a means of determining rational priorities through a series of well defined stages. The process was guided by basic documents incorporating the general philosophy, principles and basic structure of the health system. It followed a sequence of 1) situation analysis, 2) problem definition, 3) policy analysis, 4) program and targets. The process provided continuity and stability from one planning period to the next, while also allowing modifications that emerged during each stage.

The process also provided an excellent basis for three functions of health planning: 1) improving the planning skills at other administrative levels; 2) providing a basis for negotiation and consensus building within the Ministry of Health and with other agencies; 3) establishing specific programs and targets to guide implementation.

The Repelita V process was particularly effective in developing mechanisms for incorporating greater participation of the provincial and district levels -- broadening the planning process which had been dominated by the central (Pusat) level.

The process also began to introduce greater priority to four major areas: 1) community based activities (Posyandu), 2) health financing, 3) increasing efficiency through improved management, 4) the development of targets for activities that did not traditionally have targets. However, while these priorities emerged clearly in the situation analysis and policy analysis stages, they were only partially incorporated in the programming and targeting stage.

While the planning process was a particularly strong one, there were some areas of weakness which could be given greater attention in the future. This report recommends:

- 1) greater attention to the development of indicators and targets for priorities which have not had quantified targets in the past -- especially for financing, management and community level activities;

- 2) expanded efforts to continue to incorporate "bottom-up" planning from province and district levels;
- 3) clearer guidelines for policy analysis stage;
- 4) more time and effort given to the programming and targeting stage -- including the introduction of cost and budget analysis and more rational estimates of manpower needs;
- 5) greater intersectoral participation;
- 6) consideration of administrative reform of the central level of the Ministry of Health;
- 7) holding of seminars on key issues requiring on-going policy and program decisions -- such as Posyandu, financing, management issues;
- 8) further improvements of information used for the situation analysis;
- 9) increasing national budget for health planning in order to avoid dependence on foreign sources of funding for this crucial activity.

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Of course, the responsibility for judgements,  
interpretations and errors in this report is completely mine.

## I. INTRODUCTION

This report is designed to give an evaluative review of the planning process for the health sector in the Fifth Five Year Plan (Repelita V). Planning in general and health planning in particular is more important in decision-making in Indonesia than in many other countries. The health planning process that has been developed over the course of four previous five year plans promotes more rational allocation of health resources, utilizes data of increasingly high quality, engages the participation of important intersectoral institutions, and involves increasing "bottom-up" planning. In this consultant's judgement, the health planning process in Indonesia is a model of good health planning with important lessons for other countries.

In this report I will first review the analytical perspective to be used in the evaluation. This introduction will then be followed by a description of the health planning process in Indonesia, an evaluation of the strengths and weaknesses of the process, and recommendations for future planning efforts.

### A. Analytical Issues

We often expect health planning to approach a model of rationality in which the planned activities of the national institutions are designed to address the predominant health problems of the nation. This rational model of decision making would have the health planning process generally follow a sequence of:

- a. data collection
- b. analysis of health situation
- c. identification of problems and priorities
- d. definition of goals and objectives based in part on problem identification and on socio-political normative directives for the health sector
- e. consideration of various alternative policies, strategies and programs to address the problems and priorities

f. selection of the maximizing policies, strategies and programs

g. specification of targets for implementation of programs in the period of the plan

h. identification of appropriate agencies for implementing planned activities

i. establish basis for monitoring of implementation and evaluation of progress toward goals and targets.

Considerable effort in health planning is designed to help national planning efforts improve their planning process in order to better approximate this rational model.

It should also be recognized, however, that health planning has a variety of functions that might not follow the same rationality as this model. There are three major functions of health planning that should also be taken into account in any national health planning effort:

a. The Education Function -- health planning can be an effective tool for educating the implementing units within the Ministry of Health in order to upgrade their capacity to plan their own activities in a more rational manner. This activity is particularly important in systems that are attempting to decentralize decision-making.

b. Bureaucratic Politics -- health planning can be an effective means of creating consensus, working out internal conflicts, gaining commitments for coordinated activities among different sectors, levels and divisions within and outside the Ministry of Health.

c. Establishing the Basis for Implementation -- target setting, defining tasks and responsibilities among different administrative units. It is particularly important that the planning process establish measurable targets that can be used in monitoring and evaluation of on-going implementation.

Each of these separate functions may follow a logic that differs from the logic of the Rational Model of technical health planning. Health planners should take these logics into account if they want their plans actually to be implemented by the institutions responsible for the planned activity. A plan which ignores these functions is not likely to exert much influence on policy formulation and implementation.

The following analysis will consider the Indonesian health planning process in terms of how it approximates the Rational

Model and how it accommodates the three logics of institutional education, bureaucratic politics, and implementation.

## II. DESCRIPTION OF INDONESIAN HEALTH PLANNING PROCESS

The basic process of developing the Five Year Plan began with a consideration of several basic documents (including previous Five Year Plans) which set basic principles and structures for planning. The first step was the development of a health component in the General Guidelines for State Policy (GBNH) which was established and approved to guide the whole planning process in all sectors. Then the health sector developed an analysis of the situation and the identification of priority problems. The next stage built on the situation analysis to establish broad policies to address the problems. Finally, the policies were used to guide the programs and targets that formed the last stage of the planning process.

The health sector plan was developed by DEPKES to be integrated into the National Five Year Plan by BAPPENAS in a final stage before it is to be submitted for final approval in time to begin in April 1989.

### A. Basic Guidelines and Prior History

Health planning has a long history in Indonesia. The process explicitly builds on the prior efforts and modifies them to reflect current problems and priorities.

Planning is based on several basic documents which have established general principles and structures which guide each five year plan. The basic ideological guidance for the government -- Pancasila -- offers broad governing principles that shape all plans. The basic health structure is established by the National Health System (SKN), and general guidance for the series of five year plans is established by the Long Term Plan. In addition, each five year planning process produces a general document -- the Broad Guidelines for State Policy (GBHN). The GBHN is approved by the Parliament as general guidance for all sectors as they develop their portions of the Five Year Plan. As with the rest of the process, the GBHN is expected to reflect continuity and stability and is modified only incrementally.

These basic documents have formed the basis for the series of Five Year Plans from 1968 to the present. They have been incorporated and modified by each Five Year Plan and the

process has been cumulative as each plan grows out of the previous plans.

The long process of planning has stressed the need for continuity and stability and allows modification only within relatively limited boundaries. It is generally a conservative process which nevertheless has room for technical incremental changes.

It is important to note that from Repelita III there was an effort to involve the provinces in the process. This has been defined as the combination of "top down" and "bottom up" planning. However, the "bottom-up" process was mainly data collection and the presentation of lower level requests for resources -- the provinces and kabupaten were not significantly involved in the development of the "top down" plan. They were not involved in meetings in which national level plans were developed, did not significantly influence the setting of national level priorities, did not contribute to the selection of national policies and programs. As Prof. M. Schaefer noted in mid 1987: "[the central, provincial, and district levels] do not interact, except on the basis of submitting paper; decisions at each level are discrete, without people from one level being involved in decision making at the next higher level. Since the process of arithmetic summation is considerably different from that of representational negotiation, it is difficult for bottom-up planning to make itself felt."

In the midst of Repelita IV a budgetary crisis brought on by the drastic decline in oil revenues forced a reallocation of budgets and a major change in programs and plans that had been established at the beginning of Repelita IV in the more halcyon days of higher oil revenues. This crisis led BAPPENAS and the Ministry of Finance to cut the carry-over budget, reducing the development budget significantly, and forcing DEPKES to suspend the inauguration of new major construction programs.

The budget crisis had a significant impact on the implementation of planned health programs. Its immediate effect was to reduce the Development Budget, which supported much of the primary health care initiatives in Child Survival, by 65%. This reduction brought a decline in immunizations and severe reductions in material and financial resources at the Puskesmas and Posyandu. Since the Routine Budget supported salaries which could not easily be cut, it was maintained at previous levels. Since much of the hospital costs are covered in the Routine Budget, the hospital sector was not as severely restricted as the primary health care program. Nevertheless, the hospitals were also forced to reduce spending and plans to construct new hospitals were suspended. It should be noted, however, that hospital construction which had been initiated --

such as the hospitals in Sulawesi that were supported by a World Bank loan -- were continued.

The longer-term implications of this crisis was that the construction objectives of Repelita IV for hospitals and Puskesmas were not reached, and the Posyandu system (which had not been explicitly planned in the design of Repelita IV but which became the vehicle for achieving some of the health services goals of Repelita IV) was not implemented in as complete a manner as it might have been -- immunization objectives may have been particularly hurt.

The decisions forced by the budget crisis appear to have been made at the high policy levels with very little input from an extensive planning process. The adjustment was made in special interministerial committees (including BAPPENAS and the Ministry of Finance) during the 1985-86 annual planning and budgetary process. While Pusat Bureau of Planning was involved in these decisions there was little input from lower administrative levels. Planning for this imposed adjustment initially also appears to have been done in annual terms, with little attention to implications for longer term planning objectives.

However, in 1986 DEPKES began a review of Repelita IV, a process which might have articulated a reprogrammed plan for the remainder of the five year period. Four working groups were created to evaluate: 1) Unit Costs of facilities, 2) Mobilization of Resources, 3) Manpower, 4) Reallocation. While the analysis of unit costs, mobilization of resources and manpower were done in the working groups, these reports were not widely circulated and did not become the basis for a wider planning process. The crucial "reallocation" analysis, which was to articulate decisions about reprogramming and presumably define the adjusted targets and programs, was never completed.

While the analysis that was done for this review did have influence in the development of Repelita V (for instance, many of the individuals involved in the working groups would later participate in similar working groups for Repelita V and would draw on the documents they prepared for this review), the adjustment to the budgetary crisis was largely an ad hoc affair, a missed opportunity to utilize the crisis to further develop the planning process.

#### B. Broad Guidelines for State Policy -- GBHN 1988

The current Five Year plan formally began with the development of national level guidelines called the GBHN. These guidelines were to establish broad policy objectives and areas of concern that were to be the focus of the national planning effort. They were developed in a process that involved the

central MOH, the President's Commission (11 officials) and the Parliament. The development of these guidelines preceded the actual Repelita process by several years but the final guidelines were not given formal approval until March 11, 1988, after the planning process within the MOH had already advanced several stages. The MOH process used the draft 1988 GBHN to guide the its process. This draft was approved without change by the Parliament in March 1988.

Officials from Depkes prepared the early drafts of the 1988 GBHN beginning in 1986. Dr. Hapsara, one of the Eschelon 1 Staff Advisors to the Minister, and previously the Director of the Bureau of Planning, was Chairman of the working group that prepared the drafts. Other Staff Advisors and important Eschelon 2 and 3 officials of Depkes were members of the working group. Many of these officials would later form the core of the three central level (Pusat) working groups for Repelita V.

The GBHN working group reviewed past policy statements -- SKN, Repelita VI, GBHN 1983 -- and current studies and other research. It actively consulted with other related sectors. They then drew up a proposed draft, submitted it to Eschelon 1 (the Director Generals, Secretary General and Staff Advisors) and the Minister who then sent it on to the President's Group of 11 and to the MPR (National Assembly). Interestingly enough, while BAPPENAS set initial guidelines, the Planning Ministry was not particularly involved in this part of the review process. After this review, a formal draft GBHN for all sectors was returned to the ministries to be used as a guide in the initial stages of the Repelita V process.

Besides the specific guidance for the health sector, the GBHN also stressed the importance of Repelita V as a preparation for the anticipated "take-off" toward self-sustaining industrial development in Repelita VI. As part of this process Repelita V is to establish the basis for this new "industrial society" with particular emphasis on the productivity of workers. This emphasis would be interpreted by the health sector as a need to emphasize occupational health and safety and the health of adult workers as priorities.

The 1988 GBHN for the health sector has 6 sections and is considerably more inclusive than the 1983 GBHN. It supports several existing policies that were also priorities of the 1983 document and had been incorporated into Repelita IV:

- 1) a priority on preventive activities that are provided by integrated services and involve community participation,

2) priority programs include communicable disease control, nutrition, clean water and sanitation, environmental health, maternal and child health and family planning,

3) emphasis on extension of coverage to low income and remote areas,

4) concern to improve the quality of health services, manpower and drug supplies

However, several new emphases were identified:

1) a major new concern with self-financing through social insurance schemes

2) specific identification of Puskesmas and Posyandu as priority services

3) less emphasis on increasing manpower and facilities and more emphasis on improving services

4) special attention to traditional medicine and traditional healers

The GBHN is a broad and vague guide to policy goals and objectives. It does not clearly identify trade-offs in its identification of priorities -- for instance, while preventive programs are given priority the guidelines do not suggest that curative efforts will be curtailed -- nor does it clearly specify the institutional policies, programs or targets to be sought. It does however, establish the initial basis for discussion of policy and sets a somewhat new agenda for this health planning period.

### C. Situational Analysis and Problem Priorities

In early 1987, DEPKES began internal planning to develop the data base for a situational analysis which would review progress toward achievement of Repelita IV targets and identify problem priorities to be addressed in Repelita V.

As in Repelita VI, the development of the data base and the situational analysis was to involve the active participation of provincial and, where possible, regency level health officials. The provinces were alerted to the need to prepare for data collection and some provinces began initial efforts early in 1987.

In April, the Planning Bureau requested assistance from USAID to implement an extensive process for the Repelita V.

USAID then provided funding for technical assistance, administrative support, workshops, and travel for both the Central (Pusat) participation and that of the provinces and regencies (districts -- Kabupaten).

At the central level several seminars were held with economists and other social scientists to provide technical advice about the general expectations for the period 1989-1993. The presentation of the economics seminar appears to have been the most important. The economists gave little hope that the economy would achieve its earlier growth rates over the coming five year period. Health planners and other top officials became convinced that the Ministry would have to work within an assumption of static, if not declining, national budgets for health care. This impression may also have been explicitly laid down by BAPPENAS and the Ministry of Finance.

At the Pusat level, working groups which included representatives from most of the relevant institutions -- BKKBN, Ministry of Women's Role and Participation (PKK), Ministry of Education, Ministry of Internal Affairs, etc. -- but, significantly, not the Planning Ministry (BAPPENAS), or the Ministry of Finance. The working groups were divided into separate units to examine the environmental situation, health status, and health services. These working groups were to examine the achievements of targets established by Repelita IV, review the GBHN draft and other basic documents and describe the situation in each of their areas in order to define problem priorities for the health sector in the next five year planning period.

At the national level each of the Directorate General Offices (Dir Jen) participated in the planning effort and some presented separate analyses. In addition, the Bureau of Planning introduced its own series of analyses, including several studies done in conjunction with external consultants. Particularly important were the contributions to financial analysis. Several major initiatives in health financing, manpower, and utilization of health facilities, which had received increasing attention in the planning bureau in recent years, were thereby introduced into the planning process through the working groups.

Studies and projects related to manpower and management issues appear to have been less influential in the development of situation analysis of these issues. In particular, the pilot projects of CHIPPS (which provide lessons in management, decentralization, training, immunizations and efficiency), seem not to have had an explicit influence on the process.

The Bureau of Planning prepared specific guidelines for planners at the Pusat level and in the provinces. In October

and November these guidelines were disseminated to the provinces to assist them in the collection of data and in the identification of priority problems. All 27 provinces also received "local technical assistance" in the form of a one day workshop conducted by Pusat planners to assist the provincial level develop its own situation analysis.

The guidance for the development of the situational analysis identified data necessary for consistent reporting of health situations and problems in the provinces. The data in itself helps define priorities since a focus on particular indicators makes them targets which are likely to shape programs toward addressing those problems. Basic demographic data and health status data were specified -- IMR, Crude Death Rate, .... -- as were several indicators of health system facilities and manpower -- number of facilities and manpower, BOR, LOS, etc.

The guidelines also presented the priorities established in the draft GBHN 1988 and from the expert seminars, introducing the need to consider such issues as social financing, efficiency, manpower constraints, and traditional medicine and healers.

All 27 provinces have a Kanwil staff (under DEPKES authority). One of the Kanwil divisions is Planning, Programming and Evaluation (PPE) which includes health planners many of whom have received the Indonesian equivalent of an MPH (SKH) and some have received advanced training in health planning and administration. Even those without SKH have received short courses in planning. The Kanwil staff also includes divisions for Administration, CDC, Food and Drugs, Health Services and, in the larger provinces, a separate Manpower division to oversee educational facilities.

At the province level, many other institutions were also drawn into the planning process. The most important was the Dinas office. While the Kanwil is the administrative unit of DEPKES responsible for setting policy in the province, Dinas is the province's administrative arm responsible for operational administration of the health services in the province. Under the Ministry of Internal Affairs, the provincial government has its own budget and "owns" many of the health facilities -- both Class A and B hospitals. Considerable overlap in activities and tasks between the Kanwil and Dinas staffs makes for complications in the implementation, even though the same official heads both offices and is appointed by DEPKES.

In addition to Dinas, the provincial representatives of the Planning Ministry (Bappeda), BKKBN, the Ministry of Education and the Faculty of Medicine (if appropriate), Ministry of Public Works (for water and sanitation), Ministry

of Women's Role and Participation (PKK), and the Statistical Office also would participate in the Provincial Health Planning Working Groups. In the most effective provinces, the Health Planning Working Group was divided into three separate groups to define the environmental, health status, and health services situations.

Many provincial sources of data would be utilized especially from Dinas, Kanwil, and the Provincial Census Bureau. In addition, some studies available from the Pusat level of DEPKES were utilized to draw up the provincial situational analysis.

In a "cascading" process, the provinces were supposed to involve the regency or district (Kabupaten) level in the health planning process. In East Java, where the process appears to have been most completely implemented, Kanwil officials estimated that about half of the regencies actually were fully involved in the planning process. While most, if not all, of the 37 regencies in East Java submitted their own regency situational analysis, only half were sufficiently developed to be used in the provincial planning process. In addition, two regency directors were included in the working groups of the Kanwil level. Other provinces tended to have much less participation of regency officials in the planning process. For instance, in NTB, only one regency official was actively involved in the planning process, even though there had been two years of health planning efforts in the province during preparation for the World Bank project.

Part of the reason for this variation in the participation of Kabupaten officials in the provincial planning process was the delay in the approval of AID funding for this phase of the process. Wealthier provinces could afford to absorb the costs of meetings and travel for kabupaten participation, while poorer provinces often did not take the risk. The funding was finally available in February, after the provincial situation analyses were completed.

At the provincial level, the district situation analyses were incorporated into the provincial situational analysis and submitted to DEPKES Bureau of Planning.

In January 1988, the provincial situation analyses were reviewed in a special workshop in Ciloto. This workshop involved the health planners and other health officials from the working groups at Pusat and the Health Planner and Kanwil from 9 provinces. The provinces that participated in Ciloto were selected on the basis of size and on the "quality" of the Kanwil and planning staff. The workshop reviewed the situation analyses of each province and made comments for revisions at the provincial level. The three working groups at Pusat level

also presented their situational analyses for review at the conference.

The documents prepared for Ciloto were of varying quality. Several provinces presented well developed and carefully analyzed situational analyses. They also used these analyses to identify priority problems for the next five year plan. The presentations were logical and complete. However, many other provinces presented partial analyses and poorly developed problem priorities. The variation probably reflected the different planning capabilities of the kanwil staff and the interest and motivation of other institutions at the provincial level.

The three working groups of Pusat level were charged with the development of consensus among many different actors both within and outside DEPKES. Their documents reflected the complexity of trying to reach compromise among competing interests. They also reflected the lack of clear and consistent data for some of the priority areas -- especially for finance, administrative and management issues.

A synthesis of the documents presented by the three working groups stressed the following points [NOTE: THE FIGURES PRESENTED HERE ARE NOT NECESSARILY THE MOST ACCURATE FIGURES AVAILABLE -- THEY ILLUSTRATE THE ISSUES RAISED IN THE DOCUMENTS BUT HAVE NOT BEEN CHECKED FOR ACCURACY AND SHOULD NOT BE QUOTED IN OTHER DOCUMENTS!!]:

Health Status: Considerable improvements in health status have occurred during the Repelita IV period, reaching or exceeding targets in several key indicators. Infant mortality which had been 90.3 in 1983 had dropped to 70 by 1987 and was expected to fall to 62 by the end of Repelita IV. Low birth weight rates also fell from 14% to 8.2%. Nutritional status is also improving with a drop for undernourished under fives from 33% to 12%. Endemic goiter dropped to 20%.

Nevertheless, main causes of death and morbidity continue to be diseases that can be prevented by an effective primary health care program. Respiratory infections, diarrhea, tetanus, malaria and hemorrhagic fever were the major problems. Maternal mortality of 4.5 per 1,000 live births is still high.

Coverage: Coverages in primary health care is increasing. 64.2% pregnant mothers are seen in health facilities; 49.4% of the eligible couples are active family planning acceptors; immunization coverage for DPT is 33.7%, polio 3% and TT2 is 45.9%; 26.5% of the underfives have been weighed; and oralite is used in 39.6% of the cases of diarrhea.

**Health Services:** The Posyandu system has expanded rapidly, from 90,499 early in Repelita IV to 134,786 by 1987, reaching a ratio of 1,287 persons per posyandu. The hospital system has also expanded and been upgraded -- reaching 110,201 beds in 1,376 hospitals (public and private), however it has fallen below the targets set in Repelita IV. The only exception is that the number of hospitals promoted from C-class to B-class exceeded the targets.

**Water and Sanitation:** Provision of water and sanitation remains below targets for Repelita IV with only 45% of the urban and 30.5% of the rural population enjoying clean water. Only 37.5% of the rural population has family latrines. In rural areas less than 50% of the sources provide bacteriologically safe water.

**Manpower:** Health manpower in almost all categories increased considerably during Repelita IV. The ratio of physicians to puskesmas increased from 0.7 to 0.9, and in hospitals the ratio of physicians per bed increased from 1:7 to 1:6. Paramedics in puskesmas showed the most dramatic increases more than doubling their numbers to reach a ratio of 6.8 paramedics to puskesmas. However, dropout rates for Kaders in Posyandu remains high with an expectation that 60% will drop out in the first six months after training.

**Instruments and Equipment:** Medical instruments and equipment for all facilities showed some improvement over the period.

**Health Expenditure:** The total health expenditure and the allocation of the government budget for health remain low (only 2.5% of the GDP and 2% of the national budget, respectively) compared to figures from other developing countries. The public sector is responsible for only 40% of total expenditure and almost all of the private expenditure is for curative care and medicines.

**Medicines:** While domestic production of pharmaceuticals has increased from 20% to 98%, most of the primary materials are imported. Wholesalers and retailers have also increased considerably. Use of traditional medicines is also on the rise.

#### Summary of Health Problems:

a. Infant mortality is still high due to low levels of income per capita, low levels of maternal education, early marriages and high parity, as well as lack of access to health care services, poor water and sanitation and low immunization rates.

b. maternal mortality rate is still high, nutritional status of pregnant women is low and anemia rates are high.

c. birth rate in Indonesia is still high, although there has been a significant decline recently.

d. preventable diseases continue to be the major causes of mortality and morbidity.

e. there are increasing environmental problems associated with industrialization and increased cultivation.

f. health facility increases have not yet reached targets for puskesmas and sub-centers, as well as hospital beds.

g. utilization of hospital services is low, with district hospital BOR at less than 50%

h. drop out rates for kader is too high.

i. there is a "personnel imbalance": 1) between the production of manpower and the capability of establishing job opportunities, 2) geographic distribution, 3) by categories of health personnel, institutions and specialization.

j. most of the raw material for production of medicines is still imported; drug prices are still out of the reach of the majority of the population; supply and distribution of medicines remains a problem.

k. total and government expenditures on health still remain too low.

l. managerial problems inhibit the efficiency of the health services; weaknesses exist in the health management information system, evaluation, supervision and control, research and development and health laws.

In addition to the working groups, the Evaluation Unit of the Planning Bureau and one of the Expert Advisors, Dr. Rizali Noor, developed a separate analysis of the financing issue, with the assistance of Dr. Ascobat Gani of the School of Public Health and members of the Evaluation and Reporting Division of the Bureau of Planning. This analysis drew heavily on earlier analysis by Dr. Ridwan Malik and on several consultants' reports. The analysis depicted the implications of the projected lack of growth in the economy. It clearly showed that the Repelita V would have to begin with the assumption that no real increases in public sector support could be expected. With this assumption, Repelita V would be the first

plan in Indonesia with a focus on redistribution and upgrading of existing resources rather than a focus on expansion of services.

Other special reports, such as one on manpower, were prepared by Pusat Bureau of Planning and presented as part of the documentation for each member of the Rakerkesnas.

Finally some of the Directorate Generals, in particular those of Community Medicine and of Medical Services, prepared their own separate statement of situational analysis and priority problems from their own perspective. The fact that each of the major Directorate Generals prepared a separate analysis reflected the failure of these powerful administrative rivals to accept the consensus of the working group on Health Services Working Group. It also suggests the relative autonomy of Directorate Generals and the failure to achieve integration of ministerial activities at the Pusat level.

### Rakerkesnas

The process of developing the situational analysis and problem priorities came to a culmination in the annual National Health Meeting, Rakerkesnas, in February 1988. This conference was to develop a final assessment of the situation and priorities and make suggestions for 1) the consolidation of Repelita IV during its last year (April 1988-March 1989) and 2) the general policies for Repelita V. The consolidation would occur within the yearly planning/programming exercise that is the regular task of the annual Rakerkesnas. It focused on an evaluation of the achievement of Repelita IV targets, the necessary modification of those targets (for instance the restrictions on health facility construction) and the projected activities that could be followed in one year to come closer to the modified targets.

The central task of the Rakerkesnas, however, was to begin the next phase of the planning process: the development of a policy analysis that would later guide the formulation of targets and programs in the last phase of constructing the plan. The Rakerkesnas was not charged with the actual formulation of policy, but rather was to review the situational analysis and problem priorities developed in the preceding phase, bring that analysis to a final point and provide the basis for a subsequent development of the policy statement that would guide the development of programs. The actual development of policy would take Rakerkesnas conclusions into account as the initial and central basis for this process.

Rakerkesnas involved the presentation of a synthesis of the Pusat working groups' analyses, summaries of the provincial level documents, presentations by other sectors (PKK, etc.) and

a special speech by Rizali Noor on the financial constraints. The Dir Jens and top Pusat directors as well as senior health officers and health planners from all the provinces attended the meeting. In addition, related ministries and institutions, especially those with representatives in the Pusat working groups, attended. They were divided into six new working groups each of which was charged with providing an analysis of selected topics and the review of the summary reports of a number of provinces.

The provinces presented a summary of their situational analyses, which in general conformed to the Pusat working group analyses. There was however, a tendency for provinces to place greater priority on two areas that Pusat had relegated to lower priority: hospital construction and the upgrading of existing hospitals, and the desire for additional specialized manpower. The provinces clearly saw the Rakerkesnas as a forum in which to argue for their traditional demands for more Pusat resources for facilities and manpower.

The provincial documents also did not have very complex or detailed analyses of financial, administrative and manpower situation in the provinces. They tended to focus on data for which they had clear indicators -- IMR, BOR, etc. and only vaguely referred to priorities in financing, administration and manpower, for which they did not have specific indicators in the planning guidelines. [with partial exception of the administrative problem of conflict and duplication between Kanwil and Dinas at provincial level]

The process of this review resulted in a confirmation of most of the priorities established by the Pusat working groups. However, the Rakerkesnas did add a significant new emphasis which had not been addressed in previous documents. Several working groups felt that the priority for maternal and child health and the focus on IMR as a major target had meant that the health needs of other important sectors, particularly those of productive workers, was left out. They felt that some index of quality of life should be used as a target and that the health needs of productive workers merited greater priority, especially since the GBHN in general placed such a priority on productivity. Unfortunately, the situational analyses only vaguely referred to these problems and there were no consistent data collected to support these priorities.

After the Rakerkesnas, the Bureau of Planning prepared a long synthesis document that reviewed the results of the meeting and presented a synthesis of the materials and discussion of the meeting.

#### D. Policy Analysis and Policy Statement

In conjunction with the preparation of the draft synthesis of the Rakerkesnas, the Bureau of Planning, next prepared for the development of the Policy Analysis and Policy Statement which would be approved by the Eschelon 1 officials in DEPKES. The process developed for this stage involved the preparation of an initial draft policy statement which reviewed the situation and problem priorities that emerged in Rakerkesnas and matched them with five policy initiatives designed to address those problems.

The synthesis of Rakerkesnas and the draft policy statement were used as a basis for developing a questionnaire for the provinces and for establishing five intersectoral working groups at Pusat level.

The questionnaire for provincial in-put into the policy analysis phase asked open-ended questions about several priority issues. While all provinces received the questionnaire, the key nine provinces (which previously had participated in Ciloto) were visited by Bureau of Planning personnel to discuss and collect the province questionnaire. The ideas gleaned from these questionnaires were then summarized in a separate document.

The province questionnaire was not designed to develop consensus from the provinces so much as to gain additional insight from province officials to be incorporated into the Pusat-developed policy analysis. It was felt that general policy guidelines should be defined by Pusat and that the provinces should follow these national policies in the later planning stage when they develop their own targets and programs to achieve those national priorities.

At the same time as the provincial questionnaire was developed and distributed, five intersectoral working groups were created at Pusat level. These working groups were defined by the Panca Karya Husada (major programs) which had been adopted in the Long Term Plan: 1) health services, 2) manpower, 3) drug and food, 4) nutrition and environment, 5) management and law. The last group also included financing -- an issue which was not clearly defined in the Long Term Plan.

Each working group engaged in brainstorming for the development of a policy analysis to define: 1) objectives, 2) strategies (activities), and 3) broad targets. Each working group had officials from the appropriate units within DEPKES, as well as representatives of other agencies and private sector groups. Over a three week period they reviewed the situation analysis and synthesis of the Rakerkesnas and developed five broad policies.

During this phase there was some confusion over the concept of policy analysis, and clear guidelines for consistent development of objectives, strategies and targets was never achieved. However, the exercise was useful in developing consensus and in establishing the basis for the Planning Bureau to write the synthesis document for the policy analysis section of the final plan.

The five working groups established for the policy analysis stage presented their analysis to a workshop in Ciloto at the end of May. The workshop included invited representatives of other sectors (BKKBN, private sector associations, etc.) and from the provinces. There were also several special studies that were reviewed at this workshop -- including a review of factors related to health status in Yogyakarta and an analysis of occupational health issues.

After the workshop presentations, the Planning Bureau prepared a synthesis document based on the situational analysis, problem identification and the policy analysis that had been developed through consensus-building exercises. This synthesis also took into account Eschelon 1 comments and discussion of the meeting in Ciloto.

Eschelon 1 appears to have approved the working group presentations. However, they warned that targets should be conservatively established so that BAPPENAS would not hold them to unrealistic goals.

The final synthesis document was to form the basis, along with the working group presentations, for the development of the programming activities.

The synthesis document is a fairly accurate, although much shortened, condensation of the work previously presented. It presents a logical and consistent argument drawn from the situational and problem analyses, and the policy analysis of the working groups, including the provincial inputs.

The synthesis document also established 18 target areas that were to be addressed by working groups and by the provinces in the development of the programs and targets:

- 1) reduce crude death rate from 6.8 to 6.3 per thousand, infant mortality rate from 62 to 50 per thousand live births, and child mortality to 6.5 per thousand.

- 2) increase life expectancy from 59 to 64 years.

- 3) reduce morbidity from diarrhea to 3% and from malaria to less than 1% in Java and Bali and 4% elsewhere; contain dengue and eradicate schistosomiasis.

4) reduce protein caloric deficiency 10% in children under five years in Java and Sumatra and 20% in the other islands. Reduce endemic goiter by 50% in Java and Bali, 30% in Sumatra, and 10% in the other islands. Reduce nutritional anemia in pregnant women by 20% and Vitamin A deficiency by 30 to 50% in endemic areas.

5) increase attendance of births by trained health personnel from 45% to 65% and early detection of pregnancy by 70%. Reduce maternal mortality from 4.5 to 2.25 per thousand.

6) increase immunization coverage of infants, children under 12 months and pregnant women to 80%. Decrease neonatal tetanus to less than 3 per thousand live births.

7) assure that all Puskesmas have at least 13 programs and increase the quality of services at this level -- including supervision of occupational health efforts.

8) assure that all "C" type hospitals have services for oral surgery, rehabilitation and orthodontia, as well as mental health services. "C" and "D" hospitals provide family planning, immunizations, maternal and child health and emergency services. Assure that all "D" hospitals have at least two specialty services and provide technical support for referral.

9) Centers for Sub-specialty Services and Centers for National Referral Laboratories be installed in "A" and "B" and private hospitals.

10) mental hospitals provide care for drug addiction.

11) essential drugs be available in public and private sector at affordable prices. increase the production and distribution of essential drugs

12) make safe and effective traditional drugs available in health services. research and evaluate 10 traditional drugs.

13) increase clean water coverage from 45% to 60%. increase use of toilets in village areas from 37.5% to 55%.

14) increase inspection of urban food services to 50% and increase inspection of pesticide industries to 50%.

15) determine manpower distribution according to work load capacity. increase the community and private sector participation in the development and motivation of health manpower.

16) improve the information systems, administration, and research and development in health services.

17) improve the legal basis for rights and responsibilities in health services, and clarify regulations of personnel status.

18) increase the coverage of health insurance to 20% of the population. improve cost recovery and decrease the public subsidy to 40% for hospitals and 60% for Puskesmas.

#### E. Program and Target Stage

This stage of the planning process was to build on the established programs of Repelita IV but to modify them according to the new directions and policy analysis that had been established during the earlier phases of the Repelita V planning process.

Unfortunately, the process of planning at this stage was accelerated, shortening the anticipated period for programming and targeting by two months. It is not clear why the process was shortened, however, the reduction in time available for this stage of the process was to affect the quality of the final documents by limiting the time for careful review, consensus building and participation of the province and other sectors. The documents produced during this period were not as clearly developed and sometimes failed to incorporate key achievements of the policy analysis phase. Inconsistencies among programs began to appear.

The Planning Bureau selected working groups for the development of the programs and targets. Repelita IV programs were to be followed as the categories for program development, with some minor modifications.

The eleven programs established were: 1) Community Health Services; 2) Referral Services; 3) Communicable Disease Control; 4) Nutrition; 5) Food and Drug; 6) Education, Training and Personnel Management of Health Workers; 7) Community Health Education; 8) Water and Sanitation; 9) Research and Development; 10) Efficiency of Health Administration and Physical Structures; 11) Manpower Planning.

The members of each group were selected from the appropriate units of DEPKES and an effort was made to be sure that at least one, and often more, participants in each program group had participated in an appropriate policy working group

before. While there was some participation of intersectoral representatives in the program working groups, there were fewer such participants than had been in the policy groups. This choice was unfortunate since it is important for programmed activities to be consistent among sectors and it is particularly useful to have private sector participation at this stage.

In some cases the Repelita IV programs did not easily translate into activities that logically follow from the five broader policies -- for instance the policy for Management and Law had originally been concerned with developing policy for information systems, private sector, drug management and financing, in addition to management and law. While a consistent policy was developed in the policy analysis stage, the policy was to be implemented by several different programs: "efficiency" of the health (for management and law), research and development (for information systems), food and drugs (for drug management) and the private sector and financing appear to have been vaguely treated by all other programs.

While it is not necessary to have programs directly tied to policies -- since some policy directives indeed should be applicable to many programs -- the use of two different logics for the establishment of five policies and eleven programs did leave some gaps and confusion that might have been avoided had all the programs been logically developed out of the five policies.

In the midst of the process of program and target development, Bappenas provided new directives in a meeting in August. They stressed six points: 1) the need to stress efficiency because of budget limitations; 2) increase in quality through specific program activities; 3) clear programmatic distinctions for intersectoral coordination to reduce overlapping and duplication; 4) emphasis on "operation and maintenance" and not on the creation of new facilities; 5) increase participation of community and private sector; 6) focus specialities in few facilities and do not try to provide specialties in all hospitals. Bappenas also asked that greater attention be given to demonstrating clearly how program activities would achieve targets.

This message was basically a reiteration of the initial guidance which stressed the limited central budget for Repelita V. It is consistent with the overall estimates of Pusat and its commitment to stay within the current budget ceilings. Despite this message, the Bappenas meeting also suggested that they will try to increase the health budget from 2% to 3%, which would mean that health would receive 50% increase in funding. This suggestion, however, appears not to have been

taken seriously by Depkes, which operated under the restricted budget assumption.

It was at this juncture that it became clear that DEPKES would have to accelerate the process. The original target date that the Bureau of Planning established for the completion of the programming and targeting stage was the end of October or beginning of November. At this time, DEPKES was expected to turn in its draft of the five year plan to Bappenas. At the beginning of August Bappenas made it clear that a draft plan had to be submitted the first week in September -- speeding up the process by two months and requiring all the activity related to programming to be accomplished in one month.

It is not clear why the process had to be accelerated. There may have been a change in plans at Bappenas which forced the acceleration, or there may have been a failure of communication between Bappenas and DEPKES.

The acceleration of the planning process at this stage was to have seriously detrimental effects. There was insufficient time for consensus building and careful consideration of policy statements in the design of the programs. The plans for careful integration and inclusion of the provinces in this stage had to be severely curtailed. In addition there were many changes in personnel throughout DEPKES after the new Minister was appointed in April. Many officials involved in this stage of the process had only recently been appointed to their new positions and were forced to rush through the programming stage while beginning their new jobs.

At the Pusat level the 11 working groups that were formed to develop policy had to rush through the process of developing coherent programs. Some of the working groups were more successful than others in developing programs that reflected the previous policy analysis, others seemed to use the Repelita IV program without much modification.

The process through the policy analysis stage had been developing several new directions that would have made this plan a significant departure from previous plans. New emphasis was given to:

- 1) the Posyandu,
- 2) the need to improve management and financing in order to achieve greater efficiency and to utilize alternative financing mechanisms, and

- 3) the need to develop specific targets for these new activities so that health activities would have standards by which to judge achievement of policy objectives in these new areas.

It was essential that these new initiatives be turned into specific program activities if the plan was to have a significant impact on implementation of these new activities.

Repelita V planning process had also emphasized the participation of provincial and kabupaten levels in the planning process and much had been accomplished during the situational analysis and policy analysis stages.

The acceleration of the process and decisions to follow the established Repelita IV programs tended to undermine these new initiatives of Repelita V.

First, the emphasis given the Posyandu in the GBHN, situational analysis, and policy analysis was diluted. Most of the community health services program focused on the Puskesmas activities. While Posyandu is supported by Puskesmas and planning of health resources tended to take into account the need to support Posyandu, there were no specific targets established for activities in this priority area. While this emphasis may change in the final drafts of the programming and greater emphasis could be given, it is unusual that such an important priority was not clearly turned into specific programmed activities. More important, targets for this activity, which could help emphasize and evaluate these programs, were not established. Since there are many basic questions about the design and implementation of Pcsyandu, it would have been important to establish a consensus about the general objectives and specific activities that should be achieved during the five year period.

The "efficiency" program which addressed issues of management improvement was not well developed to specify activities and targets -- indeed, the activities and targets developed in the policy analysis working group on management and law were more detailed and specific than what was produced by the program working group. Issues such as decentralization, development of information systems, and specific focus on supervision and monitoring were not addressed in terms of specific activities and targets. The program did call for significant training efforts in management and administration, however, no effort was made to estimate the training needs for these activities.

Since management improvements were objectives of all previous plans it would have been appropriate to develop

targets so that specific activities could have been pursued and evaluated in this crucial area.

Finally, the efforts to emphasize financing objectives -- both efficiency and alternative financing mechanisms -- were scattered throughout the other programs rather than given specific emphasis as they had been in the policy stage. While it is appropriate for all programs to include these issues, it would have been more effective for the plan to emphasize this area by giving it a specific program -- much as it has for manpower and management (programs that also cross all other programs). In addition, since several major activities are being initiated in this area, with support of AID and World Bank especially, programs and targets for these activities would be most appropriate.

The current plan will have a specific set of policy targets for health financing (one of only 18 policy target sets) but no clear programmed activities for achieving those targets.

At the province level the acceleration of the programming stage had a clearly detrimental effect. The Planning Bureau was not able to provide the kind of guidance for provincial programming and targeting that had been planned. As a result the quality of the different presentations varied widely. Areas which should have been relatively uniform were not -- categories, targets, etc. will be hard to mesh because, even Pusat did not have consistent charts and definitions.

The result was that most provincial level programming was been done on the basis of the previous program for Repelita IV. This effect weakened the impact of the earlier situational analysis and policy statements, which were developing new areas of emphasis (finance and administration, and Posyandu).

Many of the provinces also appear not to have accepted the Pusat determination not to plan new hospitals. Several included plans for new hospitals and appeared to still be pressing Pusat on this issue. Some provinces emphasized unrealistic objectives for hospital upgrading: projecting more specialists and more beds than could be supported by available manpower and budgets.

Nevertheless, there were many incremental improvements that make the programs for Repelita V a significant advance over Repelita IV. The central programs of community services, medical referral services, communicable disease control, nutrition, food and drug, and water and sanitation utilized the situation analysis and policy analysis to refine their targets, introduce new activities and give new priorities to established programs.

The medical services referral program was particularly well developed. It included new and more appropriate indicators for targets and it emphasized increasing efficiency through financial and management programs. Targets reflected increased attention to monitoring and evaluation.

In addition, the community health services, CDC, food and drug, nutrition, and water and sanitation programs reflected significant advances over the Repelita IV programs. They developed appropriate new indicators and targets, modified the pre-existing programs to reflect the current policy analysis, and developed new norms for estimating targets.

The manpower planning and health education and training programs were also developed in a more realistic manner than in earlier plans. The focus of this effort combined estimates of the supply of personnel -- based on the current training capability of health education and training institutions -- and a modest 6% annual growth in the government positions available for newly trained people (the previous growth had been 12%) with estimates that reflected the expected "need" for manpower to carry-out program objectives (e.g. number of specialists needed to upgrade a hospital from "D" to "C").

However, estimates of manpower needs did not make sufficient use of the recently developed system of estimating institutional manpower needs (ISN). This system has established needs on the basis of workloads for different job positions. Some of the programs based their manpower needs in part on the ISN, however, it was not used as a general tool to achieve rational distribution of manpower, even though the policy analysis gave priority to redistribution of manpower according to rationally established needs.

#### F. Final Stages of the Repelita V Planning Process

The rest of the process will involve the adjusting of provincial and Pusat working group estimates in an attempt to make the whole plan consistent in terms of program activities and targets. This process will take place in a workshop the week of September 5-9, in Cimacan in which the working group heads will present their final analysis. This report will be presented to Eschelon 1 and then to BAPPENAS.

At this time BAPPENAS has also asked for three estimates of overall program budgets (optimistic, normal, pessimistic) and specifically for operations and maintenance budgets (e.g. how much will it cost to continue operations with existing facilities?) While the planning bureau will present rough estimates to Bappenas, it plans to develop the five year budget

only after the programs have been finally decided. Current expectations are that the final budget analysis will be presented in November.

In addition, short summaries of the provincial health plans which were presented a Ciloto in August will be prepared for inclusion in the global provincial plans that are presented in the final volume of the "Red and White Book" -- the published National Five Year Plan.

By the time the Five Year Plan is completed there will be the national published volume and each province will have its own detailed five year plan, as will each directorate general at Pusat.

### III. STRENGTHS AND WEAKNESSES OF THE PROCESS

The analysis offered in this report has focused specifically on the planning process itself. It is beyond the scope of this review to evaluate the impact of the planning process on actual implementation of programs. No planning process can be held completely responsible for implementation, however, based on an unsystematic review of the past processes and the current system, it appears that the planning process in Indonesia does have some influence on actual implementation, but that decisions are also often made without regard to the plans. The current process appears to be designed to enhance the impact of planning on implementation. Future evaluations might be designed to evaluate this impact.

The following comments are observations and suggestions which reflect judgements based on this consultant's experience and research; however, very little is not also based on the observations and evaluations offered to me by Indonesian officials who work in the health sector. It is important to recognize that these officials understand their system well and are able to evaluate it fairly. The role of the outside consultant is often to crystalize these evaluations and to put these problems onto the agenda for action. I hope that my observations demonstrate the strengths of the health planning process and also provide a basis for the discussion of measures to improve the process further.

## A. Strengths

It should be emphasized here that the Indonesian Health Planning Process is one of the strongest that this consultant has known. It should be publicized as an extremely effective model of how health planning should be done.

Indonesia has a history of increasingly effective health planning which is responsible for the creation of a health planning "mind set" within the Ministry, as well as the development of effective routines, skills and expectations about health planning throughout the Ministry (Schaefer)

One of the central strengths is the high quality of the staff most responsible for developing and implementing the planning process: the Bureau of Planning. The skills, motivation, dedication and leadership of this Bureau were crucial to the effectiveness of the process. There is a genuine commitment in the current staff to development of a high quality plan that involves real participation of the significant inter- and intra- ministerial actors as well as a genuine use of "bottom-up" planning. The Bureau has also benefitted from on-going support from international donors, in particular WHO and USAID which have provided financial support and long-term technical assistance to the planning process. The Bureau has been particularly effective in its utilization of this support and technical assistance.

In addition, in several key provinces especially, there is significant health planning strength at the provincial level. The current process has made good use of these resources and has made a genuine effort to develop more planning experience at the lower administrative levels.

Returning to the analytical framework defined at the outset of this report, here I will discuss the strengths of the process in terms of the rational planning model and the educative, bureaucratic politics and implementation functions of health planning.

### 1. Rational Model

Using pre-established broad goals and objectives defined in various planning documents (from Pancasila to GBHN) the process has been defined effectively to follow a sequence that approximates the rational model: 1) the situational analysis; 2) definition of problem priorities; 3) policy analysis and definition of broad policy objectives, strategies and targets; 4) specific targets and programs.

In terms of the rational ideal model for health planning, it is clear that the current process has made effective use of

the key available data that is crucial for developing the situational analysis. Data for health planning in general has been steadily improving over the previous Repelita periods. This process is utilizing several sources of data -- in particular, the census data, surveys, and health service data in effective ways at all levels. It should be noted, however, that there continue to be problems in data collection, consistency, and uniformity which will be discussed in a later section.

In addition, particularly for the health financing issue, the ministry has made good use of relevant consultants' reports, which in many other health planning processes tend to be ignored.

The situational analysis that emerged formed a good basis for the establishment of problem priorities. In large measure the problem priorities were rationally justified by the situation analysis and the goal guidelines. However, it is clear that more work could be done, especially at the provincial level to begin the development of problem priorities more in line with the data presented in the situation analysis. In particular, several provinces identified the need for hospital construction and upgrading and for additional health manpower, especially for specialists, when their situation analysis suggested that other priorities in primary health care would be more appropriate.

The policy analysis formed the basis for the development of programs and targets; however, there were several areas where this linkage was not as strong as it could have been (as will be discussed below).

In the program and targeting stage major weaknesses occurred partly due to the acceleration of the process at this crucial stage. Nevertheless some of the central programs (medical services, community health services, communicable disease control, nutrition, water and sanitation) showed significant progress in the development of appropriate targets and programs and began modifying the previous programs according to the policy analysis directives.

In addition, some provinces were well prepared and did present well designed and consistent provincial programs and targets, despite the acceleration of the process.

## 2) Education, Bureaucratic Politics and Implementation Functions

The planning process in Indonesia can best be described as lengthy, integrative, and iterative. These qualities make the process particularly effective in providing for the three functions of education, bureaucratic politics, and implementation.

At all levels there have been attempts to integrate different interests and agencies in the process. The process effectively utilized funds available for working groups, workshops and seminars that were important forums for discussions, brainstorming and for hammering out consensus. At Pusat the working groups that developed the situational analyses and the policy analysis involved representatives of the appropriate DEPKES offices, other ministries and the private sector. At the provincial level, many of the provinces involved similar integration both within the Kanwil and Dinas, as well as other provincial offices (Bappeda, public works, PKK, etc.).

The process is also integrative in a vertical sense -- between "top" and "bottom". As noted above, the involvement of provincial levels and, in some cases, the kabupaten level has involved genuine interaction in which both levels influence each other. This process is in marked contrast to the usual "top down" process in many countries.

This integrative emphasis provided a forum for the education of relevant actors in both the methodology of rational health planning and the important substantive issues in the health sector. It also provided a means of generating consensus in which the different bureaucratic interests are respected, although it was not completely effective in breaking down the rivalry among the Directorates General and between DEPKES and other sectoral institutions like BKKBN.

The involvement of many different implementing agencies will also be important for gaining commitment of these institutions to implement the final plan.

The process is also iterative. In each stage planning documents are passed back and forth between center and provincial levels with the input of each level sequentially refining the documents. This iterative process helped establish relatively uniform planning methodology among all provinces (an educative function) and provided a means of hammering out consensus and gaining commitment to implement the plan.

It should be noted, however, that this process began to breakdown in the final programming and targeting stage. Since the programming stage was shortened by two months there was insufficient time to develop the central level consensus and to involve the provinces in as complete a way as they had been in the earlier stages of the process.

## B. Weaknesses

There is room for improvement in even the best health planning processes. The comments below are offered to assist DEPKES in its continuing efforts to improve the quality and effectiveness of health planning in Indonesia. Again it should be noted that many of these ideas come from DEPKES officials themselves, although I take full responsibility for them.

One weakness was apparent throughout the planning process: insufficient development of three new priority areas -- administration and management, health financing and Posyandu. These issues had not been major program areas in the previous plans. They did not have pre-established targets or specific program activities. The situational analysis and policy analysis began to give these issues greater priority, however, they did not become developed in the program and targeting stage. Since they are crucial new issues that are likely to be essential to the achievement of all the other goals and objectives of Repelita V, they needed greater attention in all stages of the planning process.

This weakness emerges first in the development of priorities from the situation analysis. Part of the problem comes from the lack of clear indicators for the management, administrative, financial, quality and efficiency issues that have become important objectives and goals. This lack of indicators biased the situation analysis toward the traditional measures of health status, manpower and facilities which do have well understood indicators.

The lack of sufficient attention to management, financing, and Posyandu also appeared in the program and targeting stage. There were no targets established for these activities, except for a single target for social insurance -- a target which did not have a specific program for its achievement.

A second problem is the lack of clarity in defining the process of formulating policy based on the situation analysis and the goals established by core documents (SKN, Long Term Plan, GBHN 1988).

Third, the programming and targeting stage needs to be given more time and more clearly established guidelines. It is a crucial period in any planning process since the programs and targets are likely to have more impact on actual implementation than any other guidance in the plan.

Fourth, cost analysis and program budgeting should be made a part of the program and targeting stage.

Fifth, greater utilization of workload estimates should be made a priority for determining manpower needs and distribution.

Sixth, while the process of involving the provinces and kabupaten has become more effective than in previous plans, the process has not been systematically and uniformly developed for all provinces.

Seventh, there is insufficient involvement of key ministries and the private sector in the process. The participation of BAPPENAS and the Ministry of Finance should be more systematic and continuous throughout the process. In addition, the participation of representatives of the private sector should be expanded and made more systematic since the role of the private sector will be more important in Repelita V than it has been in the past.

Eight, the continuing lack of integration of key activities of different administrative units at Pusat -- as most clearly indicated by the failure of the General Directorates of Medical Services and Community Health to come to a consensus on a situation analysis of health services -- suggests a more profound administrative problem that would require a major administrative reform to address.

Ninth, although there has been significant effort to discuss key issues through seminars, such as the financing seminar and the seminar on Yogyakarta, it is clear that there needs to be additional discussion of the keystone to the primary health care system: the Posyandu. It might also be useful to hold additional seminars on several other key issues -- management and administrative reform, water and sanitation, malaria, role of the private sector, and specific programs for increasing productivity of workers. These seminars should be held early in the process of developing programs and targets in order to have most effective impact on the development of the plan.

Other problems are more traditional: 1) continuing weakness in the data utilized for the situation analysis, and 2) dependence on foreign sources of funding for key elements of the process.

Each of these issues will be discussed in more detail in the following section.

#### 1) Guidelines for Situation Analysis

Guidelines which the Bureau of Planning prepared for the provinces to utilize in their development of provincial situational analysis were an important step in creating consistent and systematic plans that collect the relevant information both for developing more complete provincial plans and to provide systematic information for the national plan.

These guidelines set the agenda for the provinces and focus provincial health planning on priority issues derived from the GBHN and other documents. They also required the collection and analysis of specific indicators -- IMR, BOR, LOS, etc. -- which are important for complete health planning.

The guidelines that were distributed in October and November 1987 were appropriate in many respects, however, they could have been more developed in several priority areas -- especially in management, efficiency and financial issues. While the provinces were able to develop fairly complete and complex analyses of health service facilities, coverage, IMR, and manpower, the analysis and description of management, efficiency and financial issues were not particularly well developed.

In most cases the provincial plans would mention traditional management problems, call for efforts to improve efficiency, and mention the need to develop social financing mechanisms. They did not discuss the magnitude, depth or elements of the management problem. Few discussed the actual provincial experience in social financing (DUKM, etc.). Except for BOR there was little discussion of efficiency of health services.

By contrast, the provincial analysis of IMR, health service coverage, and manpower was more developed, with specific description of the provincial situation, and clearer analysis of the problem priorities in these areas.

It was clear that the lack of specific measures and concepts for which provincial and kabupaten officials could collect and analyze data, contributed to the weakness of the analysis of the three factors. Greater specification of measures and issues of management, efficiency, and financing would not only produce better provincial situational analysis but also provide tools for implementation and monitoring of progress along these dimensions.

It is perhaps in the area of improving implementation and monitoring that these specific measures can be most immediately effective. They can provide guidelines and targets that will require improved management information, base-line data, development of supervisory forms for these issues

RECOMMENDATIONS:

1) The Bureau of Planning should establish a working group for the development of management, efficiency and finance concepts and indicators to be incorporated in guidelines for future planning, programming, and monitoring activities.

2) This working group should focus on the development of objective measurable indicators that can be used as more complete planning, monitoring and management tools and can focus the planning efforts more in these directions.

3) Financing indicators should be included in all analysis so that provincial levels have incentives to analyze unit costs of all activities to identify areas which require more efficiency.

2) Policy Analysis

There was much confusion in DEPKES over the precise activities that were expected in the phase of policy analysis. The term "policy analysis" has a variety of meanings. It can describe a broad attempt to impose intuition and general logic to the development of guidelines for activities designed to achieve unmeasurable goals. It can also be a very specific quantitative methodology for choosing among a variety of alternative programs for achieving specific goals.

While there was a general understanding that the "policy analysis phase" was to develop broad guidelines for achieving health goals as defined by the GBHN and other documents, there was no clear definition of the terms, activities and methodology to be used by the various actors involved in the policy analysis phase.

The problem is not that officials do not have a general understanding of what is needed to do policy analysis. The problem is that there are a variety of ideas about what is expected in this phase. A more explicit methodology for this phase would allow the separate working groups and the provinces to follow a systematic and consistent approach that could be more easily coordinated into a single national planning statement.

## RECOMMENDATIONS:

1) To reduce confusion it is probably more accurate to refer to this phase as "policy formulation" -- the activities of this phase are really designed to turn the previous analysis of goals, situation and problems into a general policy statement. While policy analytical methodologies may be used to formulate policy, the objective of the phase is to achieve a policy statement which is to be utilized in the subsequent phase for the development of specific programs and program targets.

2) In future planning exercises (Repelita VI, annual plans), the Bureau of Planning should hold workshops for the development of a consensus on the appropriate methodology for policy formulation. This methodology should specify the definitions of policy and programs, develop an understanding of the logical and rational sequence of analysis that moves from broad goals and problem priorities to the establishment of policy objectives, general strategies, and broad targets. Clearer definitions of these concepts (objectives, strategies, targets) should be developed and perhaps best be presented through the use of examples.

### 3) Programming and Targeting Emphasis

There were clear detrimental effects of changing the planned schedule so quickly and so late in the process. Acceleration of the process by two months left only one month to develop the crucial programs. Since the programs are the closest to the operational activities that are necessary to implement the broad policy of the plan, more time should be given to this phase than to previous stages in the planning process. One month was insufficient for a complex process of consensus building, decentralization, and careful development of a rational and consistent plan.

Acceleration of the process at this stage weakened the consistency of the process. Disjunctions between policy analysis and programs, as well as inconsistencies among programs were not easily resolved in such a short period.

Acceleration of the process also weakened the participation and development of planning capability at the provincial and kabupaten levels.

It is also at the program and targeting stage that the development of the key new areas -- Posyandu, management, and finance -- was not sufficiently achieved. Each of these areas needed to have priority activities and targets established so

that they would receive sufficient attention during the implementation of the plan.

Several reasons were given for not developing targets and activities for these issues. It was felt that Posyandu was a community activity that only received support from DEPKES and therefore DEPKES should not be setting targets for communities -- rather DEPKES should respond to community initiatives. However, DEPKES needs to plan on the basis of anticipated demand and needs at the community level. The situational analysis and the special studies of the Posyandu showed that major efforts are necessary at this level in order for DEPKES to achieve its goals and targets for community health and communicable disease control programs. The division of activities between Puskesmas and Posyandu requires different planning and programming and the five year plan should offer guidelines and targets for these different levels of activities. Since community level activities are major priorities in the policy analysis of this plan, it is appropriate -- indeed, essential -- that this priority be as specifically developed in targets and activities as is possible. Explicit estimates of manpower needs, vaccinations and other logistics and supplies, and transportation needs at the Posyandu level should assist and guide yearly operational planning and budgeting over the next five years. Targets for upgrading the training and effectiveness of kader should also help guide activities at this level so as to improve the quality of service.

It was also argued that management issues should not have explicit targets because it is difficult to quantify these objectives and DEPKES should not establish unrealistic targets that it would be held responsible for achieving. As I argue above, I think it is crucial to develop some targets for management objectives so that indeed, officials are held responsible for achieving improvements in this area. All plans call for "strengthening" management, but these objectives often remain unachieved because there is no explicit measure for achieving "stronger" administration. This problem becomes particularly important when the program for management includes broad goals to significantly improve management training. Without a target for more management training (based on estimates of need) there will be no attempt to adjust the supply of management training to these needs.

One of the central weaknesses in the management program is the lack of explicit attention to the policy objective of decentralization. Decentralization is a difficult objective to achieve in any centralized administration. Specific program activities that clarify the new responsibilities and roles at different administrative levels, as well as specific activities for strengthening capabilities at provincial and kabupaten

levels need to be established -- along with targets -- in order to guide implementation of decentralization objectives.

The lack of a program for achieving health financing objectives may result from the fact that health financing is a relatively recent priority and there has not been sufficient study to develop a specific program for these goals. It would, however, be appropriate for the plan to give guidance, especially to provinces and other implementing institutions, about the general direction such programs might take. Since there are major new efforts in health financing -- funded through AID and World Bank -- these activities should form a guide for anticipated program activity in this priority area. Even though the policy analysis established health financing as a major new priority, the lack of a specific program raises questions about how serious a priority this activity is for DEPKES.

Although each of the major programs included some discussion of both management and financing activities and objectives none of the programs was as well developed as they could have been. In all programs, more attention to specifying management and financing activities and establishing targets is necessary.

#### RECOMMENDATIONS

1) Future planning schedules should make every effort to assure sufficient time for the development of the program and targeting stage.

2) Greater priority should be given to the development of targets and specific program activities for the Posyandu, management and financing issues.

#### 4) Lack of Cost Analysis in the Planning Process

Planning in many other countries has utilized cost analysis and program budgeting in the process of developing long term plans. Planning primarily on the basis of estimates of need without including an analysis of costs for facilities, human resources, activities, etc. fails to provide realistic means of determining priorities and trade-offs among policy and program choices.

Since the skills for cost analysis for many activities is well established at Pusat and provincial levels -- program budgeting is utilized for the annual operational proposals and

plans (DUP and DIP) -- it would be possible to develop guidelines for estimates to accompany many of the targets established in the plan. For instance, costs for hospital upgrading could be estimated on the basis of specialists salaries, additional beds, reconstruction costs, etc. Costs for immunizations could also be calculated. Indeed, some of the program working groups (e.g. Community Health Services and Research and Development) presented partial cost analysis of their program activities.

In the current process the financial constraint was established in a general ceiling -- the assumption that there would not be any significant increase in national government resources for health during the next five years. This constraint was interpreted to mean that no new construction would be planned and that no significant redistribution among programs within the health sector would occur.

The result of this process is extremely conservative planning. With no costing analysis, it is difficult to evaluate alternative program choices and different strategies for training and distribution of manpower. It often makes sense to shift resources from one program to another even if the overall ceiling is to be maintained. It may also be advisable to change priorities for training and education so that the same total manpower costs can be achieved with a different manpower mix and a different distribution of manpower.

Planning should provide realistic means of making clear priorities among programs and to achieve goals within budgetary constraints. To plan with no clear mechanism for adjusting "needs" analysis to available resources is to invite unrealistic programming and targeting. It also makes it difficult to establish clear means for evaluating the choices for trade-offs among alternatives for achieving the same objectives.

#### RECOMMENDATION

Costing analysis should be introduced in the programming stage of the planning process so that each program and target for which costing data is appropriate can be evaluated in terms of its budgetary implications allowing rational choice based on analysis of trade-offs among alternative programs.

#### 5) Manpower Programming

The major program working groups built their estimates on a calculation of manpower "needs" to achieve other program objectives. These needs estimates were often based on standard

personnel requirements -- for instance, upgrading hospitals often requires additional staff, especially specialists. Other estimates were based on some measure of workload -- for instance, manpower needs for each Puskesmas with standard numbers of Posyandu.

In some cases, the recently developed ISN system for estimating manpower needs based on workload analysis was utilized; however, this method has not been as fully utilized as it should because it often shows a significant surplus of personnel already exists at some administrative and service levels. Few officials are ready at this time to call for the reduction of manpower in any one level in order to achieve a more rational distribution. However, since a more rational distribution of manpower is a major policy objective, it is clear that the planning processes should attempt to estimate need on the basis of workload estimates. If the ISN guidelines force a rethinking of current patterns of manpower distribution, this issue should be addressed directly and be reflected in the planning process.

#### RECOMMENDATION:

Manpower estimates should make greater use of the ISN system which encourages a more rational distribution of manpower based on work loads.

#### 6) Uniform Involvement of Provinces and Kabupaten

The process of Repelita V has been an effort to improve the participation of provinces and kabupaten in a more interactive role in health planning. This effort to make the planning process more responsive to "bottom-up" planning has made significant strides.

It was also useful for the current planning effort to use the nine provinces that had the most advanced health planning capabilities as the major participants in Ciloto and in the policy analysis questionnaire. Their experience and ideas clearly had a significant impact on the national process.

However, in the interest of creating a more uniform health planning capacity in all provinces and for developing a more representative systematic process of developing consensus, a major effort to bring all provinces up to the same level of capability should be made.

It is clear that only the more capable provinces were able to involve kabupaten level as active participants in the development of the provincial situation analysis. Greater

efforts should be made to assure that all provinces gain full involvement of kabupaten health officials.

It might be useful to utilize more structured and quantifiable questionnaires for the provincial levels so that the planning process can develop a basis for more quantified policy analysis. While quantification should never be the sole basis for developing an analysis, it can provide a systematic way to present the values and judgements of a large number of participants. This process can supplement the qualitative judgements of those responsible for making a synthesis of provincial responses. This method might have assisted in a more rational synthesis of Rakerkesnas and the provincial questionnaire.

#### RECOMMENDATIONS:

1) Future planning exercises should provide additional training and technical assistance to those provinces which have not yet developed full planning capacities. Priority should be given to developing uniform planning capabilities in all provinces. The Bureau of Planning should provide additional "local technical assistance" to the provinces which have the least planning capacities. Manpower decisions should encourage additional training for planners in weaker provinces. Additional budgetary support should be given for transportation and workshops in the weaker provinces.

2) More uniform involvement of kabupaten level in the development of provincial plans should be encouraged for all provinces. Modules should be developed for training in district level planning.

3) The Planning Bureau should consider developing methodologies (questionnaires) for quantifying provincial input into the national plan as one means of synthesizing provincial level ideas and values.

#### 7) Intersectoral Participation

There has been considerable involvement of representatives of different institutions that participate in the health sector. BKKBN, Ministry of Home Affairs, Bappeda, PKK, and representatives of private sector organizations like the Physicians Association, have participated in various workshops, seminars and working groups at pusat and provincial levels.

However, this participation has not been systematic and there are several important institutions that have not fully participated, especially at Pusat level. While there is

reportedly considerable informal contact between the Planning Bureau and BAPPENAS, there should be more active involvement of the Planning Ministry in the process. There is even less participation of the Ministry of Finance. Both the Planning and the Finance Ministries should be able to introduce their broader perspective into the process of analysis and formulation, and DEPKES should have greater opportunities to inform BAPPENAS and the Ministry of Finance of its concerns. Had there been more active participation of BAPPENAS throughout the process, the acceleration of the programming and targeting stage might have been anticipated earlier.

Since the role of the private sector is anticipated to be even more important in Repelita V, there should be involvement of more private institutions in the development of the plan. Representatives of the Physicians Association, the insurance industry, and others have been involved. More involvement of private voluntary organizations, private hospitals and clinics, pharmaceutical industry, etc. should be encouraged.

As noted above, the participation of other sectors significantly declined in the programming and targeting stage. Since programming and targeting are likely to be particularly important times for input from other sectors if they are to be included in the implementation of programs, it is extremely important that they participate in this stage.

#### RECOMMENDATION:

BAPPENAS, the Ministry of Finance, and representatives of the private sector should be more strongly encouraged to participate systematically in all stages of the health planning process.

#### 8) Administrative Fragmentation of Pusat

Like many ministries of health, DEPKES suffers from an institutional pathology which fragments its institutional structure into competing vertical hierarchies that often fail to cooperate on program activities that require integration to be effectively and efficiently administered. In DEPKES, although the Secretary General is responsible for coordinating all activities of the implementing units, the Directorates General (Community Health, Medical Services, Communicable Disease Control, Food and Drugs, and Research and Development), it is these units that ultimately carry out their own activities. The failure to integrate activities, and the institutional rivalry among the General Directorates has had serious consequences which inhibit efficient management of program implementation. Without integration at the higher

levels of the ministry, the burden of integrating program activities falls on the lowest levels, the ones with the least administrative capacity. The lower levels then become an administrative bottleneck which weakens implementation. (see Shaefer, Wheeler, USAID Strategy Statement, among others)

There are a variety of reasons for the lack of functional integration -- legal, structural organization of all governmental institutions, traditional rivalries among administrative units, etc. The planning process cannot be expected to overcome all of these problem areas, however it can make reorganization a priority issue and seek to modify legal, structural and traditional constraints.

While health planning exercises may have been more effective than other activities in promoting integration, the dramatic lack of cooperation between the Community Medicine and Medical Services General Directorates, suggests that much more should be done to assure the development of a consensus in the planning process that could later assist in the implementation of integrated programs.

#### RECOMMENDATIONS:

1) The serious fragmentation of DEPKES administration suggests the need for a major administrative reorganization that should become an objective in Repelita V.

2) The Secretariat should take a more active role in assuring coordination and cooperation among the Directorates General in the development of subsequent stages in the planning process. The development of targets and programs should emphasize collaboration in program activities in all areas where integration of implementation would enhance efficiency and effectiveness of activities. Special efforts should be made to develop a consensus among the General Directorates on shared programs and targets.

#### 9) Special Topic Seminars

There are several important priority areas that require additional discussion and evaluation in the planning process before specific programs and targets are developed in the next stage of the planning process. Two priority areas have already received special attention through the seminars on financial issues and on the explanations for low IMR in Yogyakarta. However, there are still several areas where additional discussion and evaluation would provide important inputs into the current planning process.

A central priority should be to evaluate the cornerstone of the primary health care system -- the posyandu system. The relationship between posyandu and puskesmas, the effectiveness of the current model of five tables, the problems of kader drop-outs, evaluation of alternative motivation and incentive programs, the cost-effectiveness of the present program, management and supervision issues, as well as the role of social financing mechanisms in posyandu are all important issues which should be considered in programming posyandu activities for the next five years. Recently there have been a variety of studies with implications for posyandu -- unit cost analysis, WHO evaluation in 1986, CHIPPS projects, KB-Gizi program evaluation -- which could be utilized as background for a special seminar.

A second appropriate topic would be the development of management and administrative reforms to encourage greater coordination and integration among the vertically organized directorates general.

In addition, although situation analyses have suggested that water and sanitation problems should be a major priority, this area has not received sufficient attention in the planning process. Since it is also an intersectoral problem it would be useful to have additional evaluation of alternative options for water and sanitation before programming and targeting decisions are made. Several important water and sanitation programs by pvo's could be evaluated as background for this area.

Since there is also considerable confusion over the role of the private sector a special seminar should be held on policy options for private sector involvement in public health efforts. Issues such as the role of regulation, financial incentives for private participation in public health efforts, role of foreign investment in private health facilities should be evaluated in order to develop appropriate programs for private sector involvement.

Finally, there are other important issues -- the appropriate way to develop programs for increasing productivity, the ISN manpower estimating system, the need to develop more effective health education programs, options for malaria control -- which could also be evaluated before programs and targets are developed.

Until now the seminars have been broad-ranging discussions of background studies. They have not been posed in specific policy terms. In future seminars, discussion should focus on the policy implications of background studies. Seminar preparation should present material in terms of policy options that should be considered for developing program activities and

targets in order to have the most effective impact on the planning process.

**RECOMMENDATION:**

The Bureau of Planning should hold a series of special seminars -- on Posyandu, management and administrative reforms, water and sanitation, private sector, health and productivity, health education and malaria, ISN manpower allocation system -- during subsequent planning processes.

Special priority should be given to the seminar on the Posyandu system since it is the cornerstone of the primary health care system. Several recent studies on unit costs, effectiveness, coverage, and CHIPPS should be used as background material.

These seminars should be designed to consider programming options and targets in these important priority areas. Background materials should be prepared so as to focus discussion on choices among several options, rather than a broad consideration of the topics.

10) Information

Even though the data used for the situation analysis was considerably improved over those used in previous health plans, there is some doubt about the accuracy and consistency of this data. Even in the best provinces there are several conflicting sources of data for vital statistics and for health services. IMR statistics can vary as much as 20% utilizing different methods of estimation and different sources of data. Even data on the number of health facilities can vary. A particular problem arises in determining the number of posyandu since there is often a wide discrepancy between the official number of posyandu and the number that are actually continuing to operate.

In addition, the assumption that some data, such as Bed Occupancy Rates, are uniform from facility to facility is probably not valid. While some attempts to establish uniform methodologies for manpower allocation and for unit-cost analysis are currently being developed and implemented, they have yet to become a systematic part of the planning process.

**RECOMMENDATION:**

Future planning process should develop more systematic methodologies for the collection of appropriate data. This recommendation does not mean that more data needs to be

collected, rather that more uniform and appropriate data become the basis for health planning.

#### 11) Dependence on Foreign Funding

The current process has depended on significant infusion of donor funding from USAID and WHO. Some of this assistance has provided long-term and short-term consultants whose participation would not have to be supported in the future; however, major recurrent operational costs for the planning process have been provided by external donors.

In crucial areas where the current planning process has made significant advances -- in particular, the involvement of the provinces and kabupaten, and the intersectoral participation -- would not have been as extensive without foreign funding. The failure of some provinces to involve the kabupatens because of a delay in the availability of foreign funding suggests the dependence of the process on this input.

This dependence would not be a problem if the donors could indefinitely support the planning process. However, this support cannot be assured and, as in other programs, all donor support should be evaluated in terms of the sustainability of the program if donor funding stops.

One effective measure for sustainability is the phased reduction of donor support for project activities and a simultaneous assumption of these activities by national funding sources.

#### RECOMMENDATION:

A phased increase in government budgetary support be established for planning workshops, working groups and transportation costs that are now supported by foreign sources.

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