PD-AAF-500 R. Ashton

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AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D. C. 20523

PROJECT PAPER

INDONESIA: Health Sector Financing (497-0354)

February 8, 1988

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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) Amendment Number: _____ | DOCUMENT CODE: 3

2. COUNTRY/ENTITY: INDONESIA

3. PROJECT NUMBER: 497-0354

4. BUREAU/OFFICE: Asia/Near East [04]

5. PROJECT TITLE (maximum 40 characters): HEALTH SECTOR FINANCING

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 03 DD 31 YY 95

7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4): A. Initial FY 88 B. Quarter 2 C. Final FY 92

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 88 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	3,590	4,410	8,000	6,650	8,350	15,000
(Grant)	(3,590)	(4,410)	(8,000)	(6,650)	(8,350)	(15,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country	-	1,924	1,924	-	5,515	5,515
Other Donor(s)						
TOTALS	3,590	6,334	9,924	6,650	13,865	20,515

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) HE	532B	510				15,000		15,000	
(2)									
(3)									
(4)									
TOTALS						15,000		15,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 530 520

11. SECONDARY PURPOSE CODE: 520

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	DEL						
B. Amount							

13. PROJECT PURPOSE (maximum 480 characters)

To develop the institutional and policy context needed to ensure the financial sustainability of child survival programs.

14. SCHEDULED EVALUATIONS: Interim MM 03 YY 92 MM YY Final MM 02 YY 95

15. SOURCE/ORIGIN OF GOODS AND SERVICES: [V] 000 [ ] 941 [V] Local [ ] Other (Specify) _____

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ___ page PP Amendment.)

I have reviewed the methods of implementation and financing in this Project Paper

Steven G. Liapis
Controller

17. APPROVED BY

Signature: David N. Merrill

Title: Mission Director

Date Signed: MM 02 DD 08 YY 88

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

AID 1320-2 (8-79)

		Page
1.	Project Authorization	1
2.	Summary	1
3.	Background and Rationale	2
	3.1 Situational Analysis	2
	3.2 Health Sector Financing Analysis	3
	3.3 Policy Implications	7
4.	Project Description	9
	4.1 Project Goal	9
	4.2 Project Purpose	9
	4.3 Project Outputs	11
	4.3.1 Development of Social Financing Schemes	11
	4.3.2 Hospital Sector Reforms	18
	4.3.3 Pharmaceutical Sector Reforms	20
	4.3.4 Health Sector Financing and Policy Analysis Capacity	21
	4.4 Project Inputs	22
	4.4.1 Technical Assistance	22
	4.4.2 Studies/Assessments/Demonstrations	23
	4.4.3 Training	24
	4.4.4 Commodities	25
	4.4.5 Local costs	25
5.	Relationship to AID and GOI Policy and Other Donor Programs	25
	5.5.1 GOI Policy and Priorities	25
	5.5.2 AID Policy and USAID's CDSS	27
	5.5.3 Other Donor Assistance	28
6.	Summary of Project Analyses	28
	6.1 Technical Analysis	28
	6.2 Financial Analysis	29
	6.3 Economic Analysis	31
	6.4 Administrative Analysis	32
	6.5 Social Soundness Analysis	32
	6.6 Impact on Women	33
7.	Implementation Plan	33
	7.1 Administrative Arrangements	33
	7.2 Activity Schedule	39
	7.3 Procurement Plan	42
	7.4 Financial Plan	46
	7.5 Audit Procedures	48
8.	Monitoring and Evaluation Plan	51
	8.1 Monitoring	51
	8.2 Evaluation	55

Page

9. Conditions and Covenants 57
   9.1 Conditions Precedent 57
   9.2 Special Covenants 57
   9.3 Negotiating Status 58

10. Environmental Analysis 58

Annexes

A. PID Facesheet, AID/Approval Cable, Mission Response Cable
B. Project Logical Framework
C. Request for Assistance
D. Statutory Checklist
E. Environmental Analysis
F. Technical Analysis
G. Financial Analysis
H. Economic Analysis
I. Social Soundness Analysis
J. Detailed Scope of Work for Long-Term Advisors
K. Detailed Budget Tables
L. Waiver for Participant Training

PROJECT AUTHORIZATION

INDONESIA

HEALTH SECTOR FINANCING PROJECT
PROJECT NO. 497-0354

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended,and in accordance with the authority delegated to me under Delegation of Authority No. 652, I hereby authorize the Health Sector Financing Project for the Republic of Indonesia (Cooperating Country) involving planned obligations of not to exceed $15,000,000 in grant funds over a seven year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allowance process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the Project is seven years from the date of initial obligation.

2. The Project consists of various efforts designed to promote the development of institutions and policies needed to ensure the financial sustainability of child survival services in Indonesia. Child survival services are the following: immunization, nutrition, diarrheal disease control, family planning, maternal and child health and control of acute respiratory infections. The Project will help institute reforms in the hospital and pharmaceutical sectors in order to reduce the government's financial burden for curative health services and allow for greater resources to be allocated to child survival programs. The Project will also stimulate the development of private and public health insurance in Indonesia to help generate additional resources for both preventive and curative health care.

3. The Project Agreement, which may be negotiated and executed by the officials to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

   a. Source and Origin of Commodities, Nationality of Services.

   Commodities financed by A.I.D. under the Project shall have their source and origin in the Cooperating Country or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the Cooperating Country or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing.

   b. Conditions Precedent

   Prior to the disbursement of any funds to finance the local currency costs of procurement of goods and services directly by the

Cooperating Country, or to the issuance of any commitment documents with respect thereto, the Cooperating Country shall, except as A.I.D. may otherwise agree in writing, provide evidence that:

(1) the Project Management Unit (PMU) and Project Implementation Offices (PIO's) have been formally established, including a description of the positions in each unit, a list of the names of persons assigned on a full-time basis to such positions, and an outline of the general responsibilities of such units with regard to each major component of the project; and

(2) a first year's workplan for the PMU and each PIO.

c. Covenants

(1) The Cooperating Country will develop a yearly detailed implementation plan for the project which will describe the sequence of activities to be undertaken in each fiscal year. Unless otherwise agreed by A.I.D., the implementation plan for each year will be submitted to A.I.D. for review and approval prior to start of the year covered by the plan.

(2) In order to make greater resources available for child survival programs, the Ministry of Health and Bappenas will take unto serious consideration and adopt, as appropriate, the policy recommendations which result from the research and demonstration activities that are central to the project.

(3) The Cooperating Country will agree that, by the end of the project, it will increase government expenditures for child survival programs by 35 percent in real terms over the IFY87 public sector child survival program expenditure level.

(4) The Cooperating Country shall covenant to formally establish a Health Financing and Policy Analysis Unit within the Bureau of Planning, Ministry of Health, within one year of the date of signature of the project grant agreement, unless otherwise agreed by A.I.D.

(5) The Cooperating Country will agree to grant exemptions from existing government regulations and standard procedures to the extent necessary to carry out the pilot activities and large scale demonstrations planned under the project.

(6) The Cooperating Country will covenant to provide sufficient funds to maintain and supply equipment furnished through the project.

4. Based on the justification presented in Annex L of the Project Paper, I hereby approve a waiver of the policy requirement contained in paragraph 15.B.1. of A.I.D. Handbook 10 that the host country finance the international travel costs for participant trainees trained under the project.

David N. Merrill
Director

2/8/88
Date

2. SUMMARY

Cost. Total project costs are as follows:

AID	
Grant	$15,000,000
Loan	-
Sub total	$15,000,000
Host Country	
Government of Indonesia	$ 5,220,000
Indonesian Financial Institutions	$ 295,000
Total	$20,515,000

Purpose. The Government of Indonesia (GOI) has requested USAID assistance in expanding its program of child survival services throughout the country. The purpose of the Health Sector Financing Project is to develop the institutional and policy context needed to ensure the financial sustainability of child survival programs. This will be achieved by improving efficiency and cost recovery for services which consume a large share of the Ministry of Health's budget and by redirecting the savings to child survival programs. The achievement of the purpose is consistent with the CDSS goal for health and population and hence, the goal for this project, which is to reduce fertility and infant and child mortality.

Description. To achieve the purpose, four major outputs are expected:

1. The first output will be the proliferation of socially financed health insurance programs in both the public and private sectors. Project inputs will facilitate improvements of government operated health insurance programs. Assistance will also be provided to private groups seeking to establish health insurance plans in the private sector. The GOI will be assisted to institutionalize the capacity to coordinate the development of health insurance plans and to enact enabling legislation which formalizes and supports growth of such plans.

2. The second output will be a system for improved management and fundamental structural reforms in government hospitals that will result in greater operational efficiency, increased cost recovery, and less public subsidy to government hospitals. A thorough diagnosis of hospital operations will be conducted to achieve a genuine understanding of the performance and management problems which impede efficiency and cost recovery. A program of interventions will be designed and demonstrated in hospitals in three provinces. The three demonstration areas will be evaluated to determine whether the program of improved efficiency and increased cost recovery has resulted in reduced government subsidy to these hospitals.

3. The third output will be improved efficiency in the procurement, distribution, and use of pharmaceuticals making more resources available for essential drugs which affect child survival.

   A focused assessment of the pharmaceutical sector will be conducted to identify problems impeding the efficient use of the present pharmaceutical budget. Data from the assessment will be used to formulate and test management, training, and communications interventions for more rational drug use. A comprehensive group of interventions will be demonstrated in a representative sample of districts, and evaluated for their impact upon prescribing patterns, internal allocative shifts within the pharmaceutical budget, and magnitude of expenditures on pharmaceuticals which directly support child survival programs.

4. The fourth output will be the further development of health policy analysis capacity within the Bureau of Planning, Ministry of Health (MOH) so that staff can better analyze the policy implications of demonstration activities and provide the linkage between project activities and decision makers.

Summary of Project Analyses. The project paper analyses conclude that the project is technically, socially, economically and financially feasible. The financial analysis identifies the source and magnitude of funds that can be diverted to child survival. The economic analysis quantifies the costs/benefit of this approach versus direct investment in child survival and concludes that greater benefit will accrue using the approach embodied in this project. The implementation plan presents practical and efficient administrative, procurement and financial arrangements to manage the project effectively.

Waivers. A waiver allowing project funds to pay for international airfare and per diem for participants has been approved.

Statutory Requirements. All statutory requirements have been met. See Annex D for the statutory checklist.

3. BACKGROUND AND RATIONALE

3.1 Situational Analysis

Indonesia's health sector is now at a critical juncture. During the past 15 years, substantial progress has been made in reducing rates of fertility, and infant, child and maternal mortality. Progress has been possible because of an expanding economy which allowed for large public sector allocations to the health budget. At the same time, however, Indonesia's rates of infant and child mortality remain high compared to other ASEAN countries. Infant mortality is estimated at 70 per 1000 live births and child mortality at 17.8 per 1000 children aged 1-4, with substantial variation among regions of the country. Nearly 50% of all

deaths in Indonesia occur among infants and children, with tetanus, diarrhea, and respiratory infections as the primary causes of death and malnutrition acting as a serious underlying factor.

In 1985, falling world oil prices severely curtailed revenues from Indonesia's largest source of income and foreign exchange. The austerity measures imposed on all government sectors as a result have profoundly and disproportionately affected health budgets, especially the MOH's ability to provide the preventive and promotive health service which most directly influence child survival. Furthermore, projections for future growth in the Indonesian economy are not encouraging. Economic growth is estimated at only 2.6% per year for the period 1986-1988, and 3.4% for the period 1988-1990. Debt service will consume 30% of the 1987/88 budget, squeezing the development budget further. This economic scenario bodes poorly for future public sector allocations for health. The MOH must thus maintain the momentum of its assault upon infant and child mortality in an atmosphere of dwindling public sector financing for health.

Based upon analyses of the country's major health problems, the MOH has concluded that government resources should be focused on programs which directly impact infant and child mortality and promote child survival. The Ministry of Health has designated the Expanded Program for Immunizations, Nutrition, Diarrheal Disease Control, Family Planning, Maternal Child Health, and Control of Acute Respiratory Infections as child survival programs. However, programmatic priority has not been translated into budgetary support. As public sector health budgets have dwindled, child survival programs have borne the brunt of the budgetary axe. The recurrent cost mortgage of fixed facilities and drugs for curative care poses practical difficulties in shifting budgetary allocations to child survival. Budgetary analyses done by the MOH over the past year have illustrated these fiscal disparities quantitatively. These are summarized in the following section.

3.2 Health Sector Financing Analysis

Public sector expenditures for health are derived from five sources: (1) the MOH central government budget, by far the single largest source of funds; (2) the non-MOH central government budget, primarily from the Ministry of Education and Culture for training; (3) state enterprises such as Bio Farma and Kimia Farma for the production of pharmaceuticals; (4) provincial government budgets, both capital and recurrent; (5) and district government budgets for both capital and recurrent expenditures. Funds from the provincial and district government budgets are primarily devoted to hospitals, health centers, and administrative support costs for personnel and facilities.

The MOH central government budget is the largest and most flexible source of public financing in the health sector, and generally reflects allocative trends and priorities for the health sector in general. This single budgetary source provides a useful microcosm for public sector health expenditures and general directions in health financing.

There are four components to the MOH central government budget: (1) The development budget (DIP) is used for hospital construction, purchasing equipment and supplies, training, research, and supervision. The central budget is also the source for all capital and routine costs for Indonesia's Expanded Program on Immunization (EPI), the diarrheal disease control program (CDD), the national nutrition program, and the maternal/child health program. (2) The routine budget (DIK) supports maintenance, salaries, travel, and purchases of expendable supplies. (3) The InPres budget, is a special fund from the President. It provides funds for health centers and the majority of all pharmaceutical supplies. (4) The SBBO budget is a special central government subsidy for hospital operations and maintenance.

Table 1. MOH Central Government Health Expenditures in Indonesia
1982/83 - 1987/88
(in '000 Rupiah)

Source	1982/83	1983/84	1984/85	1985/86	1986/87	1987/88*
1. Development (DIP)	111,541	108,442	101,720	94,759	65,244	22,900
2. Routine (DIK)	78,727	82,428	93,527	116,767	138,823	140,200
3. InPres	98,450	98,450	98,450	114,552	114,552	76,200
4. SBBO	6,452	8,143	8,200	9,483	9,787	8,000
Total:	294,970	297,463	301,897	335,561	328,406	247,300

*1987/88 figures represent budget allocations and not expenditures.
(all figures in nominal terms)

MOH central government health expenditures have declined 26% in nominal terms since 1985/86. The Development (DIP) budget, from which the overwhelming majority of preventive health and child survival programs are funded, has sustained the most draconian reductions, falling 75% in nominal Rupiah terms since 1985/86. As a result, the GOI's ability to provide capital and recurrent costs for child survival programs has been severely compromised. By comparison, all other sectors combined sustained an average 8% reduction in nominal rupiah terms in their central government allocations since 1985/86.

The Bureau of Planning in the MOH has broken down price adjusted absolute central health expenditures by types of programs funded by the government over the period 1982/83 to 1986/87. Total government outlays for health have declined slightly even though both population and GNP continue

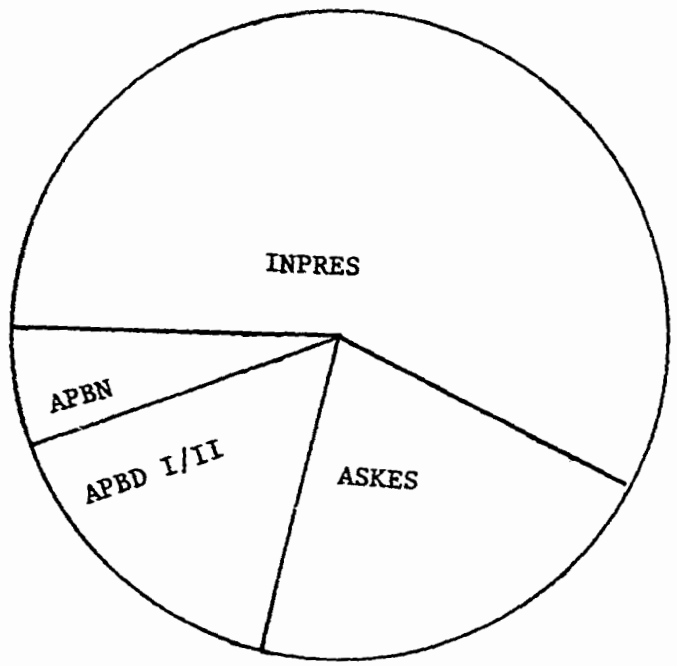
to grow. Hospitals have sustained only a modest decline in real terms, consuming about 35% of total public sector health expenditures, with trends showing a shift in expenditures to more peripheral administrative levels. Most significantly, as a percentage of total government spending, child survival has declined from 13.5% to 11.1% in real terms, a relative percentage decrease of nearly 18%. These analyses indicate that although rates of infant and child mortality remain persistently high and the MOH has made their reduction its highest priority in both its National Health System (SKN) and the Long Range Plan for Health, relatively small portions of the public sector budget are allocated toward those programs and services.

The hospital and pharmaceutical sectors, which alone consume 50% of the GOI's annual expenditures on health, contribute only incidentally to reducing infant and child mortality. There are 1,367 hospitals in Indonesia of which 733 are privately owned and operated, and 634 are publicly financed and operated. However, of the 110,426 beds, 69% are in the public sector. Recurrent costs for government hospitals have risen marginally yet incrementally since 1984, at the expense of the communicable disease control and training budgets. An estimated 33% of all government hospital utilization is by civil service employees through the government health insurance program (ASKES). Revenues from these patients constitute only about 7-8% of costs recovered from government hospitals.

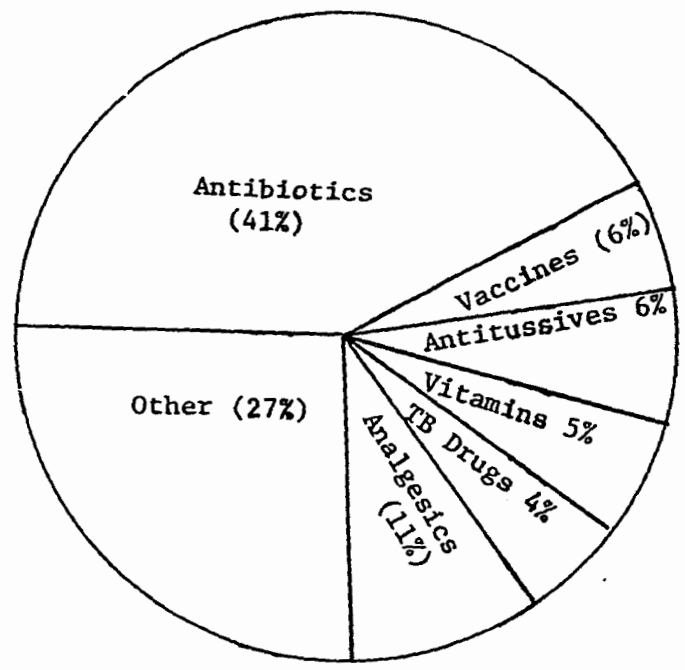
In 1985/86, the recurrent budget for hospitals represented 35% of all recurrent budgets for health, and the hospital investment budget represented 25% of total investment in health. Approximately 45% of the total recurrent budget for hospitals is for salaries, 46% for drugs, supplies, and other materials, 7% for maintenance, and 2% for transport. Between 1984/85 and 1986/87 hospital investment has decline in real terms by 65%, while the recurrent budget has remained constant at about Rp. 110 billion. This pattern of declining investment and constant recurrent expenditures would indicate the need for a sound policy to cut hospital investment in the face of falling government revenues, and to protect the operation of existing facilities through support for recurrent expenditures. However, with the existing mortgage in government hospitals, it is doubtful whether recurrent budgets can sustain the recurrent cost implications of these facilities.

In 1986/87 the MOH spent Rp. 109 billion on pharmaceuticals. The source of these expenditures and the leading therapeutic categories procured via the public sector pharmaceuticals budget are depicted in Figure 1. Most drugs are procured from the InPres and AsKes accounts. Antibiotics are procured far in excess of any other therapeutic category. Public expenditures for cough preparations equalled those for vaccines. The leading product, tetracyline, accounted for over 7% of public expenditures on drugs - more than was spent on vaccines.

Figure 1. The Public Sector Pharmaceutical Budget by source of revenue and therapeutic categories procured 1986.



Source of Revenue



Therapeutic Categories

APBN - Central Routine and Development Budget
APBD - I, II. Provincial and District Routine and Development Budgets

Information from this and other studies indicates that structural problems impede the attainment of maximum therapeutic benefit from pharmaceuticals procured by the public sector. Some of these factors are: (1) Antibiotics are grossly overprescribed relative to their therapeutic need and represent the single most costly drain on the pharmaceutical budget. Specifically, two of the top five drugs purchased in 1984/85, oxytetracycline injection and kanamycin, were antibiotics which did not appear once on nationally developed standard treatment regimens. Nearly as much was spent on oxytetracycline injections as was spent on all vaccines combined. (2) Regulations which limit dispensing quantities to 3 days supply encourage sub-therapeutic doses, particularly for antibiotics. (3) There is little association between epidemiologic need and quantities of drugs procured. Drugs are usually ordered incrementally, based upon the previous year's utilization. (4) Restrictions or exclusions of products which have limited therapeutic benefit (e.g., kanamycin, oxytetracycline injection, chloramphenical) or no impact on public health (antitussives and most injectable vitamin preparations) could conserve large portions of the pharmaceutical budget. (5) There is an over-reliance on more expensive injectable drugs regardless of therapeutic justification, either because of provider preference or patient demand.

3.3 Policy Implications

The budgetary realities described above have forced MOH planners to make critical assessments of resource mobilization potential, cost efficiency, and allocative efficiency. And most important, these realities have created a policy environment in which the MOH is receptive and, in fact, eager to search for practical alternatives to the traditional methods of organizing and financing health care delivery. It is no longer reasonable to expect incrementally larger public allocations for health each year. Allocative priorities must shift such that increased resources for child survival programs come from other health budget line items, and non-government sources of financing must be generated for curative and personal health care. Based on analyses by the MOH's Bureau of Planning, the most promising sources from which public funds can be diverted are the hospital and pharmaceutical budgets. The MOH wants to explore means for reducing allocations for curative care and diverting more resources to child survival recognizing that such reallocations are the key to the sustainability of child survival programs over the long run.

Concrete evidence of MOH commitment to this allocative shift is demonstrated in the MOH central development budget over time over which the MOH has most control. Hospital investment has declined since 1979, while investment in community health and communicable disease control has risen steadily. In 1979, hospitals received 48% of the development budget while the Directorate Generals for Community Health and Communicable Disease Control (CDC) received only 36% combined. By 1986 allocations had reversed entirely, with medical services receiving only 20% and community health and CDC receiving 44%. For the MOH's central development budget, although the pie is getting smaller, child survival is receiving a larger piece.

USAID, on the other hand, has been providing support for capital investment into Indonesia's child survival programs for the past 15 years. While the sustainability of such programs has always been a concern, USAID has never helped the GOI in any systematic way to solve the persistent problem of recurrent cost financing. Analytical work undertaken over the last 18 months has convinced the Mission that further investments in child survival will not provide sustainable, long-term returns until the issue of financial sustainability is addressed.

MOH planners have developed several policy options for financing the need and demand for health services and guaranteeing continued investment and recurrent costs for child survival programs. These are:

1. Obtain greater government allocations to the health sector commensurate with its integral importance to national development. In view of the fierce competition for dwindling resources among the various development sectors, this option holds limited potential in the current environment.

2. Effect greater efficiences in existing government services, focusing priority upon the hospital and pharmaceutical sectors because of their large proportional allocation and perceived opportunities for efficiency. Savings achieved in the hospital sector could then be reallocated toward programs directly supporting the GOI's child survival program. Internal allocative shifts within the pharmaceutical sector could result in substantial support for child survival programs.

3. Increase cost recovery for government sponsored curative health care services with a view toward decreasing the government's subsidy for curative care.

4. Elicit greater non-government involvement in financing and delivering health care to fill the gap created by diminished public resources for health.

5. Promote prepaid capitated health insurance to introduce greater equity in financing the demand for health care.

Economic exigencies demand that the MOH does more with fewer resources, hence, the emphasis upon efficiency and cost recovery. More non-government resources must be mobilized, both to relieve the government of some of its burden for curative care and to make more resources available for child survival. The private sector has traditionally played a prominent role in providing health and medical care in Indonesia. The MOH's Bureau of Planning has estimated that for 1985/86, 63% of all expenditures on health in Indonesia were in the private sector. However, evidence indicates that the private sector's actual contribution toward improving rates of child survival is probably negligible at present, but could be increased.

In summary, the timing is excellent for some fundamental allocative and structural changes within the MOH which will help assure that national

health development objectives can be achieved through better marshalling private sector resources and shifting public sector budgetary allocations to favor child survival programs. USAID and the World Bank have collaborated with the MOH in much of the analytical work which has led to the current policy environment. USAID, through this project, has the opportunity to support the MOH in providing the technical assistance, analytical work and experimentation that will make these policy changes a reality.

4. PROJECT DESCRIPTION

4.1 Project Goal

The goal of this project, as well as the goal for USAID's health and population program in general, is to reduce fertility and infant and child mortality. This goal is based on a detailed health and population sector assessment, conducted in preparation for the 1989-93 CDSS, which demonstrated that decreasing fertility and improving rates of child survival should remain the principal development concern in this sector.

This sectoral goal, in turn, is supportive of the Mission's overall goal which seeks to increase employment and incomes by making important investments in the quality and productivity of Indonesia's human capital. While methodologically sound studies on the relationship between health and economic productivity are currently not available, the Agency's policy paper on health assistance supports the view that a healthy population is an important ingredient in economic growth and productivity and that improving rates of child survival is one of the Agency's most important goals.

Four objectives support the sectoral goal. These are: (1) to encourage greater private sector involvement in health and family planning, (2) to ensure sustained levels of recurrent financing for child survival and family planning programs, (3) to improve public sector efficiency in child survival and family planning, and (4) to develop human resources for health and family planning programs in the public and private sectors. The Health Sector Financing (HSF) Project will inaugurate the new Mission health strategy by developing health financing policies which favor a strong private sector role and the diversion of public resources gained through enhanced efficiency and greater cost recovery toward child survival programs to ensure their sustainability.

4.2 Project Purpose

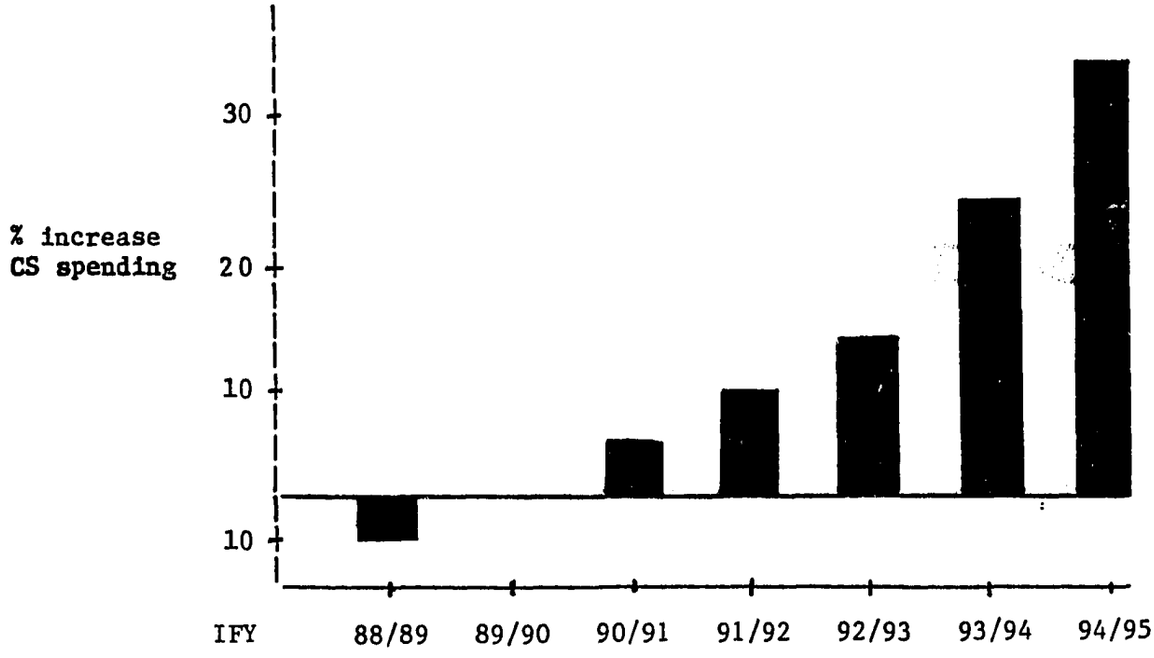
The purpose of the project is to develop the institutional and policy context needed to ensure the financial sustainability of child survival programs. The project purpose addresses the first two Mission objectives listed above. It will encourage a larger role for non-government entities in the provision and financing of personal health care and helps the GOI begin to reallocate its resources to favor child survival programs, many of which are difficult to finance privately. The budgetary crisis has seriously jeopardized the availability of the recurrent cost financing

needed to sustain essential child survival services in the long term. Short of significant increases in overall government health budgets, considered highly unlikely for the forseeable future, additional resources for child survival must be diverted from other public sector health programs. The project addresses the practical issues of how to reduce the GOI subsidy to hospitals and effect efficiencies in both hospital and pharmaceutical operations in order to decrease the need for public financing of curative care and reallocate those resources to child survival. Reallocating resources in this fashion has far reaching ramifications, and thus requires careful analysis, experimentation, and convincing evidence of feasibility to support the MOH's current determination to make difficult but necessary policy and allocative decisions in this area.

The linkage between the purpose and goal of this project is direct. Continued progress in reducing rates of infant and child mortality will depend on the sustainability of child survival programs. The total amount of resources for health must be expanded by harnessing private sector dynamism to finance curative care, allowing the government to focus its efforts on child survival.

The end-of-project status, which will allow the GOI and USAID to measure whether the project has accomplished its purpose, will be a 35% increase in total government spending on child survival programs in real terms compared to total government spending on child survival in 1987. The project yearly increases in child survival spending in real terms during the life of project is presented in Figure 2.

Figure 2. Percentage Increase in Real Government Expenditures on Child Survival Compared with Base Year IFY 1987/88.



Real GOI expenditures on child survival have been declining since 1982. (see Financial Analysis). The project projects that this trend will probably continue in 1988, but with the percent decrease in real child survival spending moderating to only 5% when compared with 1987. By 1989, with project activities coming on line and data reaching policy makers, the forecast is for a reversal of the declining trend. A real increase in child survival spending of 5% per year is projected between 1989 and 1992. During the final two years of the project, by which time efficiency and health financing reforms pioneered through the project should begin affecting the system, a real increase of 10% per year in child survival spending can be expected.

This allocative shift will be supported by the following conditions: (1) viable, self-financing social insurance schemes will be functioning which demonstrate the value of a pluralistic health care financing system, (2) fundamental policies will have been adopted with respect to hospitals which will lead to a decrease in the GOI subsidy to public hospitals, (3) policies and procedures governing pharmaceutical procurement, distribution, and use will be in place to improve the therapeutic impact of GOI drug expenditures, and (4) a data base and analytical capacity needed by MOH policy makers to make rational allocative decisions will be in place.

The HSF Project represents a departure from traditional AID child survival projects which establish performance targets, e.g., number of children immunized, number of health workers trained, to achieve the goal and purpose of the project. This project seeks to improve performance in the health sector through structural changes in the organizational format of hospitals; in the procurement, selection, distribution and use of pharmaceuticals; and in strategies to finance the demand for curative care.

The planning approach embodied by this project features a number of structural interventions and policy changes needed to improve performance in the health sector in general, and in particular with relation to child survival. It avoids preconceived notions of what those structural interventions should be, seeking instead to conduct a thorough analysis of problems that hinder efficiency in the public hospital and pharmaceutical sectors, and then designing, testing, and evaluating the structural interventions that can have the greatest impact. The ultimate objective is to develop a policy framework that can institutionalize the structural interventions, eventually resulting in greater recurrent cost financing for child survival. Mechanisms are in place to channel findings generated by this project to decision makers at appropriate levels within both the MOH and other government agencies who make public policy as it concerns financing the GOI's health program.

4.3 Project Outputs

4.3.1 Development of Social Financing Schemes

Social financing is defined as the spreading of risk for incurring out-of-pocket costs for health services. It is generally synonymous with health insurance. Health insurance programs mobilize resources for the

health sector and protect households from large financial losses. They can also relieve the government budget of the high cost of expensive curative care, and reduce the government's burden of financing and providing curative health services to those who can afford to pay.

A convergence of economic, social and political factors makes this an opportune time to foster the expansion of the pre-paid health insurance sector in Indonesia. This project will facilitate that expansion by (1) providing the technical assistance, feasibility studies and other costs associated with initiating or improving a variety of social financing schemes for health and (2) developing the GOI's capacity to guide the development of social financing schemes.

Currrently there is a small but expanding segment of the population covered by socially financed insurance programs. The largest of these is the public employees health insurance program called ASKES, which purchases care for Indonesia's 3 million civil servants and their dependants (a total enrolled population of 15 million members) through a 2% payroll deduction. A similar program, called ASABRI, provides care for military personnel and their dependants. The government has also introduced a health insurance plan for private salaried employees called PKTK, which has launched pilot projects in Jakarta and several other cities. In the private sector, several large life insurance companies have diversified into health insurance, and groups of providers have organized group practices which offer care on a capitated, pre-paid basis.

Growth in this sector has been random and unfocused, and has largely resulted in indemnity-type, private sector health insurance plans for the wealthy. In order to expand health insurance coverage to other income groups and to avoid the negative consequences which have accompanied the uncontrolled growth of health insurance in other settings, the MOH has developed guiding principles for health insurance called DUKM. Through this project, the MOH will develop the capacity to act as a catalyst for the development of a variety of public and private social financing schemes that emphasize health maintenance and cost containment, and at the same time provide consumer protection by regulating quality and setting standards for care.

Expansion of health insurance. This component will improve publicly owned and managed health insurance programs and stimulate the growth of private health insurance schemes. Two public sector programs will receive assistance through this project:

(1) ASKES: This program generated Rp. 67 billion in revenues for the government in 1986/87, and its members were responsible for about 33% of health service utilization at government health facilites. However, ASKES operates essentially as an indemnity insurer, and continues to suffer from high utilization and uncontrolled cost inflation. Inadequate data exist at present to evaluate the program's financial performance and prospects for fiscal solvency. The project will assist ASKES to undertake a critical review of its program with a view toward

improved efficiency, reforms in the delivery and financing of care, and eventual self-sufficiency.

With project funds ASKES will actuarially assess its present benefit package and premium structure with a view toward designing the necessary reforms. The project will also explore and evaluate new financing and delivery mechanisms, e.g., capitated payment to both public and private providers, which incorporate providers into the risk sharing arrangement to replace the present fee-for-service reimbursement system. These financing arrangements will be pilot tested and evaluated in a circumscribed geographic area.

The project will also assist ASKES to improve its management information system to better monitor service utilization, personnel, inventory and financing, and will provide training for ASKES staff in actuarial analysis, claims processing, financial control, and utilization review. These are areas in which ASKES staff are inadequately trained, but they are essential functions for improving the management of the ASKES program.

(2) PKTK: This is a joint program sponsored by the Ministry of Health and Ministry of Manpower to provide a comprehensive range of preventive and curative health services for the wage-based population. The Ministry of Manpower's Workmen's Compensation Program (AsTek) is responsible for the insurance aspect of the scheme (i.e., marketing, enrollment, collection of premiums, and reimbursement for services), and the Ministry of Health is responsible for providing primary and secondary care.

A PKTK pilot scheme was inaugurated in Jakarta in 1985. The program expanded to eleven additional cities in September 1987 with further expansion scheduled for four additional cities. The pilot project has faced problems in recruiting sufficient numbers of enrollees to make the program viable.

The HSF project will begin with a comprehensive review of all PKTK pilot activities in six cities, focusing upon management, cost recovery, benefit packages, premium rates, and marketing and enrollment strategies. This assessment will lead to the design of a model for PKTK which will be used to make program improvements in the six cities. This model should contain criteria for developing premium rates and benefit packages; a marketing strategy; design of administration, management, and information systems; and a training plan. The project will support development costs for replicating this model in the six cities, and will evaluate these programs at year 3 of the project. Using its own resources, PKTK will use the model for expansion into the remaining cities, which will be completed by the end of this project. The UNDP will also provide a $350,000 grant to support improved management of the AsTek program to help institutionalize the reforms made through this project.

The project will also encourage the growth of non-government health insurance schemes through wage-based groups, community groups, small and large scale enterprises, and other organizations which provide the opportunity to expand social financing of health care and experiment with different organizational models. This will include an analysis of non-government and private service providers and how their roles can be enchanced. Assistance provided will fall into two categories as follows:

(1) Dana Sehat: These are voluntary health care purchasing cooperatives at the village level which arise through spontaneous initiatives by villagers. The Dana Sehat collect contributions monthly, which are then used to purchase medicines, finance a water system, or purchase care at a health center. The Dana Sehat represent an organized focus for reaching the rural community groups.

The project will attempt to link government health services to community groups by experimenting with pre-paid socially financed health schemes organized through the Dana Sehat. The Dana Sehat in a subdistrict will be organized into a pooled-risk, pre-paid health insurance scheme with primary care provided through local providers and the health center, and secondary care provided by the district hospital.

The concept of Dana Sehat confederations will be tried in five subdistricts chosen because of the existence of functioning Dana Sehat, the progressive nature of their health and development programs, and the existence of religious groups or cooperatives that can provide the organizational focus for managing a prepaid health insurance program. The Dana Sehat in these areas will have either a geographical focus, or can be organized around units of similar productive enterprise such as farmers, fisherman, etc.

(2) Privately managed health insurance programs: There is clearly great interest and potential for developing socially financed health insurance programs which are owned and managed by private groups. The project will provide a focal point for information, technical assistance, and other resources which can be accessed by private groups interested in starting health insurance programs. This will allow the government to stimulate and coordinate the development of these programs.

A Private Health Insurance Unit which is solely responsible for this task will be developed by the MOH through this project. The unit will actively promote the concept of health insurance and seek to identify groups interested in exploring the development of prepaid health insurance programs. There are four major target groups with whom this unit will probably interact to stimulate interest. These are: (1) large life insurance companies which have capital and are interested in diversifying into health insurance, (2) groups of providers or hospitals interested in developing group practices which can offer care on a capitated, prepaid basis, (3) industrial companies with large numbers of employees and possibly existing self-financed health

programs for their employees who are interested in converting existing health financing structures into a capitated, premium-based system which shares risk among clients and providers, and (4) organized community groups such as farming or dairy cooperatives which would like to provide health care to their members on a capitated prepaid basis.

The unit will proactively canvass organizations among the target groups to identify those interested in exploring the feasibility of starting a health insurance plan. Interested groups will be able to access the project's resources on a selective basis using criteria of eligibility. The following types of assistance will be made available to them by the unit: information about different configurations for capitated prepaid health insurance programs; development of feasibility studies and business plans; identification of suitable consultants and, where indicated, funding for technical assistance; provision of commodities, particularly for information management; identification of capital requirements; and brokering access to capital. This unit will develop specific criteria to determine which groups would be eligible for project assistance, and the types of assistance which will be provided. Once eligibility has been established, it is anticipated that assistance for feasibility studies will be available for all groups. Other types of assistance will be dependent upon the eligibility criteria which the health insurance unit will establish once the project has commenced.

Additional technical assistance will be accessed through the Private Enterprise Development Services (PEDS) project, a centrally funded project of the Private Enterprise (PRE) Bureau and the Mission's planned, FY 88 Financial Markets Project. PEDS can make TA available either for feasibility studies or for technology transfer. Where indicated, project funds can be used to obtain technical assistance through the PEDS project.

Several venues will be explored to access capital. Promising ventures with viable business plans will be referred to Bank Niaga, a foreign exchange local bank which has been established in Jakarta as a PRE financial intermediary making loans to small and medium sized business ventures. Existing PRE loan guarantee facilities allow this institution to assume the risk associated with lending to smaller business ventures. Equity investment for promising business enterprises might also be accessed through the PRE Non-Bank Financial Institutions program should such a facility be established in Indonesia. In this instance, PRE loans capital to local non-bank investment companies which function as venture capital firms and make equity investments into promising business opportunities.

A final source of venture capital which will be explored through the project is existing special interest groups possessing capital pools which might realize some economic benefit from the proliferation of pre-paid health insurance plans in the private sector. Examples of such groups are life insurance companies, medical equipment and supply

companies, and pharmaceutical companies. The Private Health Insurance Unit will actively seek to identify groups who might be interested in providing capital to fledgling insurance companies, and refer potential health insurance schemes with promising business plans to these sources.

With respect to the non-government health insurance schemes, it is important to note that schemes have not been pre-designed. The project will provide a mechanism for seeking out interested organizations and making available the technical assistance or start-up costs necessary to initiate and monitor the performance of such schemes. The specific construct of each scheme will depend on the nature of the institutions involved, the nature of the client group, the availability of health care providers in the area and so on. Some may be fairly simple, and others highly sophisticated. The idea is to find out what works in a variety of circumstances and how the government can continue to provide the support and encouragement for continued growth in this area.

Development of GOI capacity to coordinate and foster health insurance. There are two aspects to developing the GOI's capacity to coordinate the development of health insurance for which this project will provide assistance. The first is the ability to monitor and evaluate health insurance plans in order to make sure that benefit packages, quality of care, and internal management, information and reporting capacities meet a set of minimum standards. The second is developing the legislative framework to ensure that the government is able to coordinate and influence the shape of health insurance in Indonesia.

It is important, at this point, to understand the major principles of the MOH's concept of health insurance (called DUKM). DUKM is an evolving concept but also one which seeks to stimulate diversity and increase general access to health insurance. These principles are:

- Health insurance should be encouraged in both the public and private sectors.
- Services provided via health insurance programs should be oriented to health maintenance and therefore include, whenever possible, preventive, promotive and curative services.
- Services should be provided according to need and should meet minimum standards of quality.
- Health insurance programs should support the GOI's national objectives in health so that they can eventually relieve the government of its burden for providing personal health services to the public at large.
- Health insurance programs should be funded on a pre-paid capitated premium basis.

- o Health insurance should promote more equitable access to health services with healthy as well as sick persons contributing toward support of the health system.

- o Coverage of health insurance should eventually be national in scope. At some point, every person in Indonesia should have access to health services through some form of health insurance.

- o Health insurance programs should be coordinated under the auspices of government to guarantee standards of quality and cost.

- o There should be enabling legislation which formalizes the principles of DUKM and a coordinating body which can oversee adherence to these principles.

The project will support the development of a multidisciplinary board which can oversee and coordinate developments in the health insurance sector according to the principles of DUKM. The MOH anticipates establishing the board in three phases: (1) Phase I: formation of a Task Force responsible to the Secretary General in the Ministry of Health. The Task Force will design the organizational structure, staffing, internal administration and functional operating mechanisms for the board. (2) Phase II: formation of an intersectoral coordinating body, by Presidential Decree, which will function as determined in Phase I. Membership will comprise representatives from the MOH, Bappenas (the national planning board), other government departments, and private organizations active in health insurance. This body will serve an interim role as provided by the Presidential Decree in anticipation of a permanent structural body during Phase III. (3) Phase III: formation of a permanent Health Insurance Coordinating Board which retains the multidisciplinary composition of the Phase II board and which is entrusted, by law, with accrediting and certifying health insurance plans. The project will provide the technical assistance, some training, and other local costs designed to support the activities of the task force as it evolves toward the stage of becoming a permanent board.

To help develop the enabling legislation for DUKM, the project will provide the MOH with analytical and technical assistance needed to draft this legislation. A preliminary concept paper which describes the legislation has been submitted to the MOH. The project will support the MOH legal team which has been assembled to transform the preliminary concept paper into a legislative proposal for submission to the President and Parliment. Enactment of this legislation will be a prerequisite for the formation of the structural Health Insurance Coordinating Board. While in terms of cost, these inputs are small in the overall project budget, they represent important measures for developing the structural changes which will serve to stimulate the proliferation of health insurance in Indonesia.

4.3.2 Hospital Sector Reforms

The second output of this project will be a system for improved management and fundamental structural reforms in government hospitals that will result in greater operational efficiency, increased cost recovery and less government subsidy to public hospitals. Unless reforms are introduced in the hospital sector, rising hospital costs will continue to squeeze the GOI's already compromised ability to allocate funds for preventive and promotive child survival services. This component of the project will initiate the process of identifying ways to check the inexorable increase in public sector allocations to hospitals by exploring ways to increase efficiencies and recover a greater percentage of costs. The project will also investigate the private sector's potential for relieving the government of some of its burden to provide secondary and tertiary care. The Ministry of Health will explore ways to improve efficiency and cost recovery in public hospitals, and an expanded role for private hospitals, all with the objective of reducing the GOI's subsidy for hospitals, a hallmark of its proposed Repelita V (the fifth five-year national development plan) strategy in the hospital sector.

A substantial body of evidence exists which documents hospital inefficiency, however, the reasons are less clear. Several causes can be deduced: over staffing, absence of appropriate management and information systems, and inadequate training. There may be less apparent impediments to efficient performance such as restrictive regulations, lack of discretionary budget resources, or no effective incentive structure.

It is clear that effective remedies for hospital inefficiency cannot be prescribed until the causes have been diagnosed. Consequently, the project will conduct a thorough diagnosis of hospital operations as a precursor to designing any interventions. The subject of this diagnosis will be "secondary care systems" in three provinces, each system consisting of a class B hospital at the provincial level, a private hospital at the provincial level, and a class C and class D hospital at more peripheral administrative levels, all of them linked geographically. The diagnosis will concentrate upon a "secondary care system" rather than individual hospitals because of the interdependence and referral linkages among hospitals in the same geographic area. Inefficiencies in a single hospital may only be apparent when viewed in the context of that hospital's role in the system.

Experienced hospital administrators will be placed as observers/counterparts to hospital management staff in the facilities in each of the three systems for a period sufficient to achieve a genuine understanding of the performance and management/administration problems in these institutions. This diagnosis will be similar to a hospital audit which at a minimum will focus upon the following features of hospital operations:

- o the hospital's organizational structure, responsibilities, and standard operating procedures.

- o a cost accounting analysis which determines the real costs for providing specific services.
- o the hospital's potential to recover costs based upon an economic profile of its client pool.
- o staffing patterns and practices.
- o medical and pharmaceutical services and standards of care.
- o support services such as food services, maintenance, transportation, linen, etc.
- o hospital management systems and managerial capacities.
- o regulations and policies, both from the MOH and the local government, which govern hospital operations.

Following this intensive diagnostic work, the consultant teams, along with counterparts from the MOH, will design a program of pragmatic interventions which apply to the "secondary care systems" being studied, and hence may apply to both public and private hospitals. These interventions will be aimed both at improving efficiency and increasing cost recovery. Once a comprehensive packet of interventions has been designed, they will be pretested, evaluated, and then demonstrated in the three secondary care systems which have been chosen as intervention areas for this project.

To date government hospitals have enhanced cost recovery by opening special private wings which cater to wealthy clientele or by adjusting fee structures for more affluent patients. Prospects for successful cost recovery in government hospitals will be vastly improved if a large part of the demand for services by these hospitals can be socially financed. Health insurance obviates the need for single, large, out-of-pocket payments, provides wider and more equitable access to services, and greatly facilitates the collection of fees. It is likely that a hospital-based social financing scheme will be one intervention proposed to improve cost recovery. This activity will be closely coordinated with the social financing component of this project.

There is an intrinsic interdependence between efficiency and cost recovery. It is likely that an efficient hospital providing a high quality of service is a prerequisite for greater cost recovery. Increased efficiency is difficult unless an organizational format exists such that there is some incentive for management to perform in ways which improve efficiency. A motivated management which improves efficiency and recovers more of its costs must have some mechanism to benefit from the success of its endeavors.

Recovering more of its costs allows a hospital to generate greater resources which it can reinvest into more efficient and higher quality services only if it is allowed to retain its revenues. Current regulations

do not allow hospitals to retain their revenues, although this is being done by hospital administrators in Jakarta and Surabaya with a very favorable impact upon hospital efficiency. In order for this project to experiment with different efficiency and cost recovery modalities, the hospitals which have been included within the study areas of this project must have flexibility to experiment with different fee schedules and retain revenues generated in this fashion. For the hospitals participating in this study an exemption will be obtained from existing fee structures and regulations which prohibit retaining revenues. In this way the project will be able to simulate organizational formats in these hospitals such that appropriate incentive structures which reward efficiency will be developed.

The three demonstration areas will be evaluated to observe whether the efficiencies and improved cost recovery have resulted in reduced government subsidy to these hospitals. These findings will be reported through appropriate policy channels for consideration of their long-term policy impact.

4.3.3 Pharmaceutical Sector Reforms

The third output will be reforms in the way pharmaceuticals are ordered, managed, perscribed, and distributed, which will result in improved efficiency (greater therapeutic impact for money invested) and more resources available for essential drugs which have an impact on child survival. WHO estimates that reforms in the pharmaceutical sector in developing countries, which are centered upon rational prescribing of essential drugs could save up to 70% of a country's pharmaceutical budget. Preliminary analyses in Indonesia indicate that substantial operational efficiencies could be effected to maximize therapeutic benefit of the pharmaceutical budget and reduce costs. Similar to the hospital sector, there is considerable speculation regarding reasons for inefficient drug use, but little hard evidence upon which successful interventions can be planned.

The project will seek to obtain this hard evidence through a focused assessment of the public pharmaceutical sector. The assessment will, at a minimum, cover the following areas:

- o product selection and procurement planning at the provincial and district administrative levels.
- o storage and distribution at the district level, the district hospitals, and health center levels.
- o Prescribing and dispensing practices in hospitals and health centers, especially their relationship to diagnosis and conformity with standard treatment protocols.
- o factors influencing the prescribing patterns of providers.
- o factors influencing community expectations for prescribing drugs at hospitals and health centers.

The focused assessment will be designed to identify problems which impede efficient use of the present pharmaceutical budget. For example, an excessive amount of money is being spent for antibiotics which does not appear on any national standard treatment protocols, and on non-essential drugs such as vitamins and antitussives which have little or no therapeutic benefit. Conversely, very little is being spent on vaccines, ORT, Vitamin A, and iron supplements. The reasons for this dichotomy will be investigated to determine whether they relate to selection, procurement, distribution, or use.

Based upon these data the project will formulate and test management, training and communications interventions that will overcome these problems and lead to more rational drug use. For example, if research reveals that providers are not well informed about MOH standard norms of treatment, a newsletter may be developed to communicate with them directly about rational prescribing. Or if the research reveals that overprescription of antibiotics responds to patient expectations rather than good medical practice, communications programs might be designed to better inform and educate the public about appropriate pharmaceutical consumption and use patterns.

There is no single intervention that can address the constellation of causes that affect rational drug use. The project will design a range of interventions and test and evaluate these on a small scale. Interventions will include workshops and training packages for physicians, use of modern marketing and communications techniques to change patient expectations, improved drug supply management and so on. These packages will be demonstrated in a representative sample of six districts. The composition and timing of demonstration packages will have to be carefully worked out on the basis of experience gained in developing and testing the various packages.

The packages of interventions in these demonstration areas will be evaluated to determine whether drugs are being more rationally prescribed, whether expenditures for the different therapeutic categories of drugs have been changed to reflect internal reallocative shifts within the drug budget, and whether larger expenditures are being made on pharmaceuticals which directly support child survival programs. Results of the demonstrations will be presented to decision makers through appropriate policy channels for consideration of their long-term policy impact.

4.3.4 Health Sector Financing and Policy Analysis Capacity

There is a substantial research, development, and policy emphasis in this project which will require oversight, coordination, monitoring, and analysis. The Bureau of Planning has assembled a Health Sector Financing Working group which conducted the in-depth analysis of public and private financing for health and coordinated all preliminary assessments undertaken preparatory to this project. The Faculty of Public Health (FKM/UI) and Faculty of Economics (LD/UI) from the University of Indonesia, the

Indonesian Medical Association (IDI), and the Indonesian Public Health Association (IAKMI) have all participated in this working group.

The project will build upon the proven analytical capacity of this group to develop a health economics analysis capacity within the Bureau of Planning, which the following responsibilities:

- o maintain an on-line data base which can, on an annual basis, track all public and private revenues and expenditures for health by source and administrative level, geographic area, type of service, and type of expenditure.
- o conduct independent studies to determine service utilization levels in both the public and private sectors, average unit costs of service outputs, and household level and pattern of service use and expenditure.
- o oversee all studies, assessments, pilot tests, and demonstration projects which have been proposed under this project.
- o analyze the policy impact of activities and demonstrations conducted under the project.
- o make policy recommendations based upon data generated from this project to appropriate persons in the MOH, Bappenas, the Ministry of Finance, and other agencies which make public policy as it relates to health.

Project inputs will strengthen the Bureau of Planning's present analytical capacity. Resources will be provided to train personnel in data collection and analysis techniques, both on a long- and short-term basis. Funds will be made available for primary and secondary data analysis to collect the information needed to maintain health financing data bases. Technical assistance will be provided to the Bureau of Planning to assist with data analyses, data management, and policy analysis.

4.4 Project Inputs

The project will have six major inputs which are described below:

4.4.1 Technical Assistance ($5,815,000)

Because of the nature of this project and its emphasis upon research, development, and policy, a substantial technical assistance input is essential. In addition, health financing is a relatively new emphasis area for the MOH for which experienced and qualified in-house capacity does not yet exist. The expertise of domestic and international consultants will be utilized to assist the MOH to clarify and define problem areas, identify and test interventions which result in the changes proposed under this project, demonstrate and evaluate these interventions in large geographical areas, and analyze the policy implications of the results.

The project will provide four long-term international advisors for a total of 16 person years, and four-long term domestic advisors for a total of 19 person years. An expatriate Project Technical Coordinator will be assigned to the project's Central Secretariat to assist the MOH Project Director to oversee all aspects of this project. A long-term expatriate and domestic advisor, functioning as a team, will be assigned to both the hospital and social financing components of the project. An expatriate long term advisor and two domestic long-term advisors will be assigned to the pharmaceutical management component of the project.

The project will also provide 135 person months of short-term domestic technical assistance, and 66 person months of short term international technical assistance. The short-term technical assistance will support the activities of the long-term advisors, expatriate and domestic, by providing specialized expertise in technical areas related to social financing, hospital management, cost recovery, pharmaceutical supply management, and health sector financing statistics and data management.

4.4.2 Studies/Assessment/Demonstrations ($3,950,000)

The project will provide the funds necessary to conduct all analyses, field tests, demonstrations and evaluations required to achieve stated outputs. This will include:

- all analytical work needed to design, test, and demonstrate new approaches under consideration for ASKES, PKTK, and Dana Sehat.
- feasibility studies and business plans needed to develop new health insurance schemes.
- development activities of the Health Insurance Coordinating Board and enabling legislation for DUKM.
- local support for the diagnostic phase in hospitals.
- design, testing, and demonstration of interventions in the hospital sector.
- an inventory of non-government health organization, and analyses of how the MOH can improve its ability to achieve national health goals through these organizations.
- start-up costs necessary to demonstrate or initiate a health insurance scheme associated with a rural cooperative or enterprise.
- focused assessments of pharmaceutical management system.
- design, testing, and demonstration of interventions in pharmaceutical supply management.

- o support costs for data collection, management, and analysis by the health economics policy unit in the Bureau of Planning, MOH.

- o costs for training when it is an integral component of an intervention designed through this project.

- o workshop costs which support the analysis, design, testing, and demonstration of interventions through this project.

4.4.3 Training ($1,555,000)

The activities in this project will, in many cases, require skills and expertise that are still under development in Indonesia. The training input will prepare personnel with the skills in social financing, hospital management, pharmaceutical supply management, information management, and marketing that this project will require. The following training inputs are expected under the project:

(1) Long-term training. This will be done both overseas and in Indonesia. Two persons will receive masters degrees in hospital administration overseas to support activities in the hospital sector. In order to develop the Bureau of Planning's capacity in health economics policy and analysis, two Masters degree fellowships will be provided in the U.S. and three masters degree fellowships in Indonesia.

(2) Short-term training. As organized courses of study exist for only very few of the skills needed for this project, there will be a greater emphasis on short-term training. Funds from this project will support two types of activities:

- o overseas training: participants will attend organized courses or work externships. The work externship will place participants into actual work situations in health insurance plans, health maintenance organizations, insurance accreditation bodies, or hospitals for on-the-job training.

- o in-country training: where sufficient need exists, the project will organize special in-country training programs to support elements of this project. A program of project support training will be organized for the pharmaceutical supply management component to create a core group of staff from the different involved Directorates who can work productively over the life of the project. The training program will focus upon operations research and computer skills for pharmaceutical management. A similar project support training program will be developed to train ASKES personnel in information management and claims processing techniques for health insurance plans.

(3) Study tours. Many of the activities proposed in this project are already being done in other settings. Funds will be provided for study tours which observe health insurance coordinating bodies and their legal basis, hospital management, pharmaceutical management, health insurance, and health policy analysis capacity.

4.4.4 Commodities ($860,000)

Funds will be available for computers to support the information management needs of this project and office equipment for administration. Given the research and development nature of this project, there must be a strong data analysis and information management component to this project. Computers will be needed at all hospitals included in the three study sites; for the districts where demonstrations in pharmaceutical management will be conducted; for ASKES, PKTK and the Health Insurance Coordinating Board; and for the Bureau of Planning Health Financing and Policy Analysis Unit. Office equipment consisting of a computer, typewriter, photocopy machines, and ancillary office equipment will be provided to the Project Management Unit (PMU) and the three Project Implementation Offices (PIO) that will oversee the social financing, hospital, and pharmaceutical components of this project.

4.4.5 Local Costs: ($1,550,000)

Funds will be available for salaries, travel, communications, and supervision costs for the central Project Management Unit and the three Project Implementation Offices. All personnel receiving salaries will over the life of the project be full time project staff. The central PMU will have a director, two assistant directors, a financial officer and two secretaries. Each PIO will have a director and two administrative staff. The project will have yearly seminars to present data generated through this project. These seminars will provide a channel for disseminating information to decision makers in the MOH and other government agencies.

Annual implementation workshops will also be held to plan activities for each year.

5. RELATIONSHIP TO AID AND GOI POLICY AND OTHER DONOR PROGRAMS

5.1 GOI Policy and Priorities

The National Health System (SKN), which is the constitutional basis for all health activities, recognizes that government alone cannot meet the total health needs of the Indonesian population. In the delivery and financing of health services, the SKN clearly identifies the private sector as an important participant in the effort to achieve national health goals. In more recent policy pronouncements, the MOH has declared the importance of mobilizing resources for health and focusing the use of government resources on the most critical goals of reducing infant and child mortality.

Throughout the development of this project, it has been clear that the MOH, particularly senior policy makers, are committed to the principles embodied in this project.

A graphic example of the GOI's commitment to policy reform, which supports the principles of this project, was the MOH's recent decision to fund all vaccines from the InPres budget rather than the central development budget (APBN-DIP). As stated in Section 3.2 of this paper, it is this budget which has been cut most drastically since 1985/86. Because vaccines and other child survival pharmaceuticals are funded from the APBN-DIP, the MOH's ability to purchase them has been severely compromised. The InPres budget, from which most non-child survival pharmaceuticals are purchased, fared much better. With the MOH's recent decision to shift vaccine procurement to the InPres budget, it will simplify resource reallocation shifts from antibiotics, vitamins and antitussives to vaccines and ORT, since all procurement will now originate from the same budget source.

The later stages of project development have coincided with the planning activities for the next five-year National Development Plan (Repelita V). In order to ensure that the details of this project truly reflect the policy intentions and future program directions of the MOH, USAID and MOH staff set up working groups to develop various elements of the project. Issues were debated, plans and ideas drawn up, feedback solicited from policy makers, and finally, specific elements negotiated over a three-month period after the PID was made final. This highly iterative and collaborative project development process resulted in confidence on both sides that goals and project objectives were shared, which is of critical importance in a project of this nature. The MOH has made it clear that they intend to use this project as a means for accomplishing specific objectives during Repelita V, which begins in 1989. At this juncture it appears highly likely that the plan will refer to the MOH's determination to have public hospitals function with less GOI subsidy through increased cost recovery, primarily through social financing. The plan will most likely explain the principles of DUKM and the government's desire to use health insurance as a means for making health care more affordable and more accessible for greater numbers of people. And finally, the MOH will be setting forth plans outlining how it will continue its allocative trend in favor of programs that reduce infant and child mortality.

The National Development Planning Board (Bappenas) was brought into the project development process early, and has been supportive of both its content and direction. Bappenas recognizes that policies within the MOH and other ministries, Finance and Home Affairs in particular, hamper more rational resource allocation. It has also been vocal in support of budget and policy reform, especially in the hospital and pharmaceutical sectors. The MOH and Bappenas view this project as the first phase in their efforts to reform restrictive policies that impede hospital efficiency, cost recovery, fee retention, and rational selection, procurement, distribution and use of pharmaceuticals. They are using the Health Sector Financing Project and the upcoming (1989) World Bank project complementarily to achieve the desired policy reform. The HSF Project will be used for the

up-front analytical work needed to identify problems and design interventions. Both projects will demonstrate interventions designed in the HSF project in large geographical areas. Bappenas has already obtained agreement from the Ministries of Finance and Home Affairs to relax existing regulations and grant exemptions to established procedures in the provinces where the large-scale demonstrations funded by the HSF Project and the World Bank projects will be conducted, so that interventions requiring policy change can be demonstrated in a real setting. Bappenas involvement and strong support for this project provide an additional guarantee that findings from the HSF Project will reach the appropriate policy makers in the MOH and other ministries, and that the policy implications will be considered in the appropriate GOI forum.

While the resources represented by this project are quite small, the objectives of the project address what the MOH considers to be the priority problems facing the sector during the next decade. The Ministry of Health and other relevant GOI agencies are unusually progressive in their willingness to tackle these complex health sector financing issues head-on and make the difficult policy and budgetary allocation decisions to ensure the wise use of scarce resources.

5.2 AID Policy and USAID's CDSS

While AID's health policy emphasizes child survival as the primary focus for its health programs, both the AID health policy and strategy documents emphasize the importance of developing and supporting programs which are sustainable. The issue of sustainability in child survival programs is crucial because progress made in improving rates of child survival will not be maintained unless programs can become institutionalized and reliable methods found for supporting the recurrent costs of such programs. The 1986 Health Sector Policy Paper places particular emphasis on "improved allocation of resources, cost containment and organization in the sector to ensure sustained levels of recurrent financing of child survival services".

In the USAID draft CDSS for 1989-1993, increasing employment and incomes is the overall goal. Within that goal, USAID recognizes the importance of investments in improving the quality of Indonesia's human capital, including health status, given the experience of neighboring countries. In the new health sector strategy, child survival will be a key objective. However, instead of solely continuing to fund child survival programs directly as the Mission has been doing in the past, the new strategy recognizes the critical issue of the financial sustainability of child survival programs. Furthermore, the strategy states that additional investments in child survival programs will not have substantial, long-term development impact unless the sustainability issue is addressed first. The Health Sector Financing Project begins the new Mission health strategy to develop health financing policies that favor a strong private sector role and the reallocation of budgetary resources in favor of child survival.

5.3 Other Donor Assistance

Two other donors are currently active in supporting activities related to this project. The World Health Organization has provided funding for health care cost and utilization studies as well as some technical assistance for the studies. The World Bank, however, has been a prime mover behind efforts to obtain hard data on health expenditures in Indonesia. The Bank has also been very active in encouraging the expansion of health insurance and improved cost recovery in hospitals. USAID has provided World Bank representatives with copies of much of the analytical work the MOH and USAID have undertaken for this project and provided periodic updates on plans and progress.

As stated in Section 5.1, the World Bank has a policy reform project scheduled for commencement in 1989. In the area of health financing the project will look at operational and policy issues which affect recurrent cost financing of provincial hospitals, and will be implemented in two provinces East Kalimantan and West Nusa Tenggara. The project investigators have begun preliminary analyses of hospital expenditures and revenues. However, the project does not have the mandate to adequately analyze and assess efficiency and cost recovery issues to design potential interventions, but does have resources to test interventions on a province wide basis. For this reason Bappenas and the MOH have planned the IBRD and the HSF project in tandem to address policy reform issues in the health sector. The HSF Project will be used by the GOI to do the research and developmental work for policy reform in hospitals, pharmaceuticals, and health insurance. Both the World Bank project and the HSF Project will provide field laboratories to demonstrate interventions on a wide scale. While the HSF Project focuses on hospitals, pharmaceuticals, and health insurance, the IBRD project will look at policy reform in manpower, training, and information management as well. Bank representatives have been interested in and supportive of the activities proposed for the project and agree with the importance of sharing information and collaborating on specific activities as their plans for 1989 are further defined.

6. SUMMARY OF PROJECT ANALYSES

6.1 Technical Analysis

The full technical analysis found in Annex F presents the technical feasibility issues which were analyzed during the design of the project and provides more information on the background studies which were used to construct the components of the project itself. It also explains the inter-relationship among the major project components and the rationale for selecting the kinds of "structural" interventions which are so central to the design of the project.

In summary, the key findings of the full technical analysis are: (1) The baseline situation with respect to social financing in Indonesia demonstrates that a rapid growth in health insurance is possible if the

government can develop its ability to encourage and guide such growth and if funds are available to undertake the feasibility studies and provide the technical assistance necessary to stimulate the private sector. In the long run, it is anticipated that growth in pre-paid health insurance, especially in the private sector, will help dramatically lessen the investment the GOI must make in providing subsidized personal health services and allow the MOH to focus its scarce resources on child survival programs. (2) Analyses of the country's hospital system have led experts to conclude that certain important structural reforms are necessary in order to increase efficiency and improve cost recovery in public hospitals. The GOI would like to find a way to decrease the public subsidy for hospitals in order to free up resources for child survival. The project offers an excellent opportunity for the GOI to pilot test new policies which seek to make hospitals more self-sufficient. (3) Pharmaceuticals consume a large portion of the MOH budget each year and yet expenditures are far from cost-effective. Modest changes in public sector drug procurement and management practices could redirect substantial resources toward drugs such as vaccines and ORT which have an impact on child survival. (4) The project components are integrally linked and cannot be undertaken in isolation. The component devoted to building the health financing and policy analysis capacity of the MOH is the glue which holds the other three components together in terms of national policy. The development of MOH capacity to do this kind of analysis will also help it compete more effectively for increased shares of the national development budget.

In conclusion, while the project may be one involving slightly higher risk than more traditional projects, the potential impact on the nation's health system is such that the risk is well worth the investment. Project design was preceeded by two years of preparatory studies and analyses which have laid a solid foundation for project activities, both technically and from the policy perspective.

6.2 Financial Analysis

The financial analysis (Annex G) documents the budget crisis in the health sector since 1982/1983 and quantifies its impact upon public resources availability for child survival. The analysis also projects the annual shortfall in child survival funding, and estimates the extent to which either reallocations can be made from the hospital and pharmaceutical budget to child survival or additional funds can be raised from non-government sources through social financing to augment the child survival budget.

Following brisk growth during the 1970s, Indonesia's economic growth has slowed to 2-3% during the 1980s. In real terms, total central government expenditures have stagnated during the period, declining substantially in 1986/87 following the fall in oil prices. Total nominal expenditures on health have risen marginally during this time, but have fallen from 2.7% of GNP in 1982 to 2.2% of GNP in 1986. Current data suggest that Indonesia spends much less on health care as a percent of GNP than any country in South East Asia (see Attachment I, Annex G). Indonesia

spends about $8.88 per capita on health annually. Of this amount, 63.7% was funded through private sources, and 36.3% through the public sector. The GOI spends about $3.22 per capita on health per year, or about .68% of GNP. The analysis concludes that Indonesia as a whole spends relatively little on health, with government expenditures being particularly lean.

The distribution of public sector health expenditures among administrative levels reveals that central expenditures account for 70% of all spending, with the provincial and district governments contributing the remainder, mainly for routine expenditures. Central health expenditures, consisting of the development budget, routine budget and special presidential account, declined by 33% over the interval 1982/83 - 1986/87, with a sizable portion of the decline occurring in the most recent year when expenditures in real terms declined by 19% from levels in 1985/86. The development budget, which provides the largest source of discretionary health spending and which serves as a major source for both capital and recurrent spending for child survival, declined by 62% in real terms over the entire period, and suffered a decline of nearly 50% in real terms between 1985/86 and 1986/87.

Price adjusted central government health expenditures by type of program between 1982/83 and 1986/87 reveal a modest decline in total hospital expenditures accompanied by a substantial shift away from central-level expenditures to the provincial and district levels. This analysis asserts that there is less to squeeze out of the central hospital budgets than originally envisioned; however, provincial and district hospital budgets offer opportunities for savings. Spending on child survival in constant prices has declined by 20% over this interval. As a percentage of government spending, child survival has declined from 13.5% to 11.1%, a relative percentage decrease of 18% during the period studied.

The financial analysis estimates that a 35% increase in real child survival spending will be needed during the seven-year life of the project to reach child survival coverage targets set by the GOI for 1994/95. This will require revenue enhancement of the child survival budget by Rp. 55 billion per year. The analysis projects that as a result interventions introduced through the project, extra funding for child survival will originate from:

- 16-24 billion Rupiah per year as a result of increased efficiency and cost recovery for hospital services;
- 2-4 billion Rupiah per year as a result of greater efficiency in drug procurement, distribution, and use, and;
- 22-49 billion Rupiah per year as a result of social financing of the demand for health care.

6.3 Economic Analysis

Because the Health Sector Financing Project is not a typical direct "performance" intervention project but instead involves "structural" changes which will effect efficiency and resource flows within the health care system, the usual human-capital type cost/benefit or cost effective analyses are not as directly applicable. The other unique feature of this project is that there are two levels of benefits which must be considered in analyzing costs and potential benefits. At the most important level, project designers looked at the cost-benefit implications of choosing a structural intervention type of project and evaluated the cost-benefit of the strategy which aims to increase government spending for child survival programs. The second level analysis examines the broader impact of the project, i.e., its implications for the longer-run benefits on the nation's health services sector in relation to the project investment. The following paragraphs provide a brief summary of the findings of each of these analyses. Annex H presents the economic analysis, including the rationale for the kind of tests applied and the assumptions made.

The first round analysis examines the cost-benefit implications of reallocating resources in favor of child survival programs. It examines the additional investment to child survival from the perspective of deaths averted, using the immunization program (EPI) as an example because of the availability of reliable data on this program's coverage and impact. Taking into consideration the cost and performance of the EPI program, the calculation reveals an equivalent benefit value of $0.45 per year for each death averted from childhood disease. An internal rate of return (IRR) calculation produced a 97.5% IRR if the project is fully successful in the resource reallocation levels projected in the financial analysis and a 58% IRR if the success rate is only 50%. An alternative analysis was also done to simulate clients, willingness to pay should 100% of the program costs be borne privately, as a proxy measure of cost-worthiness. Again, based on average incomes, the gross burden would amount to about 0.62% or less of annual household income. By any of these calculations, the project is judged to be well worth the investment.

In the second round analysis of the costs and expected benefits, similar cost-worthiness tests were applied to the hospital and social financing components to gauge the broader benefits for the population groups affected by project activities. For the hospital component, the net present value (NPV) calculation was about Rp. 55.0 billion with a large IRR of about 88.7%, or if extremely conservative assumptions are made about the net savings in the hospital sector, an IRR of about 66%. For the social financing component it is more difficult to produce absolute figures; however, the cost-worthiness of each insurance scheme will undergo the least theoretical and most practical test in its attempt to attract and maintain members who must decide on an individual basis whether the costs are worth the benefits.

6.4 Administrative Analysis

The administrative analysis is incorporated into the Implementation Plan, Section 7.1 Administrative Arrangements and Analysis. That section discusses the administrative mechanisms which have been chosen, their feasibility, and the administrative capability of the structural and functional units which will manage the project.

6.5 Social Soundness Analysis

The findings of the social soundness analysis (Annex I) are only summarized in this section. In Annex I, the project beneficiaries are described, social feasibility issues are discussed, the likelihood of project innovations spreading are considered, and the social impact anticipated.

The primary project beneficiaries will be the infants and young children of Indonesia and to a secondary degree their mothers. It is this group of people who suffer a disproportionately high risk of disease and death in large part, due to difficulties the government experiences in providing high quality curative and preventive care to everyone. By redirecting government expenditures to support for child survival programs and by providing alternative ways for families to receive dependable, sustainable and managed health services, the quality of life of the young children of Indonesia should be improved and their chances of surviving childhood increased substantially. The secondary beneficiaries will be the rural and urban poor, who waste a significant proportion of their resources on purchasing health care services on an unplanned, fee-for-service basis and on services or products which have minimal long-term effects on their health status.

The social feasibility issues are most prominant in the social financing component of the project. While the notion of pre-payment for health care is not widely accepted yet in Indonesia, there is some evidence from studies undertaken that current health seeking behavior does not rule out the feasibility of introducing the concept (see Annex I). These studies show that there is an active rural medical marketplace characterized by significant decision making by households regarding various providers and how to use them. Some pre-payment schemes on a small scale are flourishing and show potential. Pre-payment and installment payments for other consumer goods and services are widely practiced.

Project innovations, again primarily with respect to social financing, are likely to spread beyond the original sites if new schemes are successful at attracting and maintaining membership. Because of the emphasis on self-reliance and beneficiary participation, the continuity of the schemes beyond the life of the project is much more highly likely than with more traditional health care projects.

And finally, increased investments in child survival throughout the life of the project will directly effect on the population group which is

generally at highest risk for mortality due to childhood illnesses and who suffer most from lack of access to immunization services and diarrheal disease control programs. The other project analyses have dealt with the increased child survival program coverage which can be anticipated given the higher level of GOI (and private) investment in this area.

6.6 Project Impact on Women

The HSF will have a highly favorable impact on women, both because women and their children are among the primary beneficiaries and because women in the Ministry of Health occupy some of the key managerial positions in the project at the central level. In the field, it is anticipated that women will be active participants in managing project related activities.

The social soundness analysis deals with the way in which women and their families benefit from pre-paid health care and the protection from having to pay unanticipated, large bills for curative care. Because small children are so frequently ill and the mothers normally bear the burden of child care, being covered by health insurance is both a financial and psychological benefit. The overall assessment for the impact of the project on women in Indonesia is very favorable.

7. IMPLEMENTATION PLAN

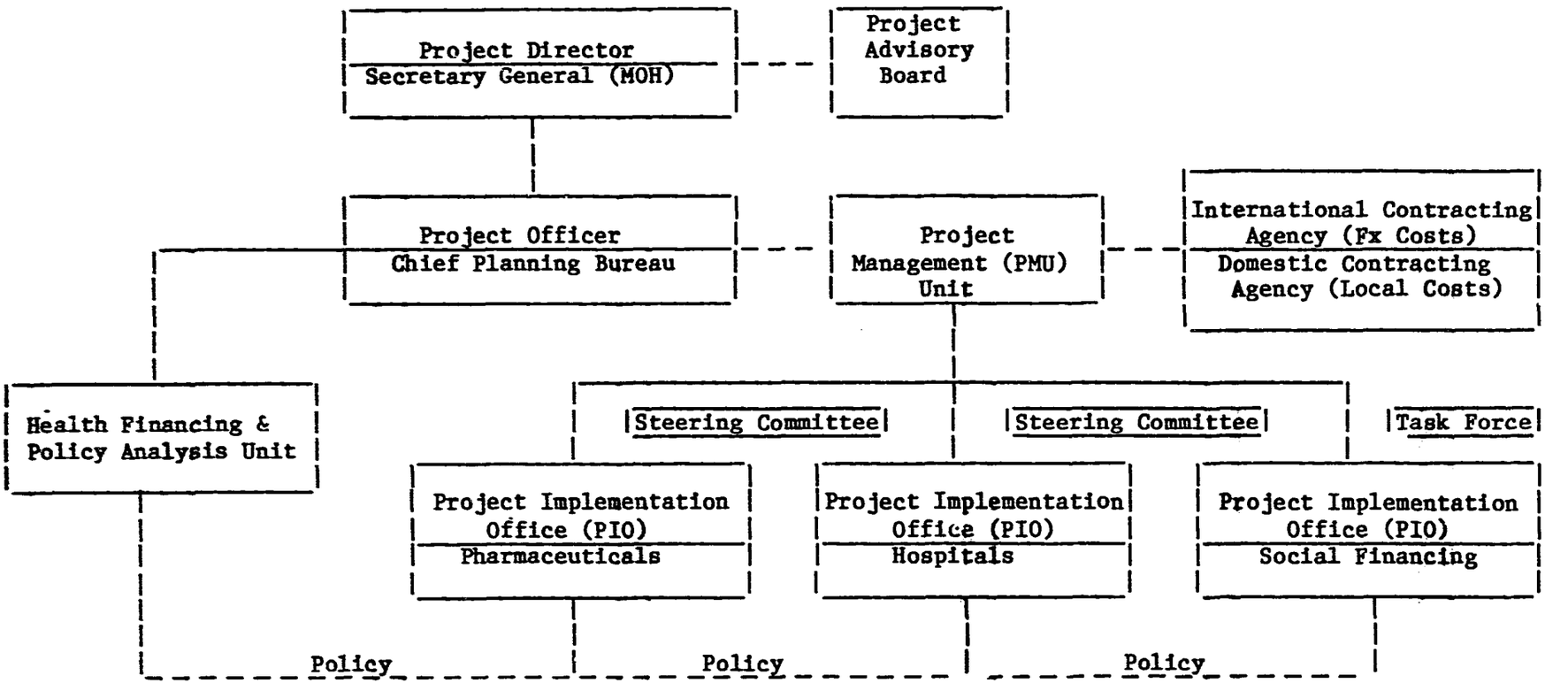
7.1 Administrative Arrangements and Analysis

This project will be administered through the Office of the Secretary General, Ministry of Health. An organizational chart is presented in Figure 3.

The Secretary General of the MOH, acting as the Project Director, will have overall responsibility for this project. He will be assisted by a Project Advisory Board whose membership will consist of the Director General for Medical Services, the Director General for Community Health, the Director General for Food and Drugs, and appropriate representatives from the Ministries of Home Affairs and Finance, and Bappenas. The Advisory Board will set policy guidelines for the project, periodically review the pace and quality of project implementation, review policy implications of findings from the different elements in the project, and make policy recommendations to the Project Director and Minister of Health based upon the results of the project.

The Chief, MOH Bureau of Planning, in his capacity as Project Officer, will supervise routine implementation of the project. All project actions will be initiated and undertaken through his auspices. He will be assisted by a Project Management Unit (PMU) which will coordinate all project inputs. The PMU's specific responsibilities will be:

Figure 3. Organizational Chart for Health Sector Financing Project



- o to develop yearly workplans for each component of the project
- o to assure timely commitment of USAID and GOI funds in accordance with yearly workplans
- o to develop scopes of work for short term domestic and overseas technical assistance needed by each component of the project
- o to coordinate procurement of all commodities
- o to determine training needs and identify suitable training opportunities to support each component of the project
- o to coordinate design and implementation of project related research
- o to oversee financial management and control
- o to monitor project implementation
- o to report the progress of project implementation to the Project Officer and the Project Advisory Board on a regular basis.

The PMU will be staffed by full time personnel and will include a Director, two Assistant Directors, a Finance Officer and a secretary. A long-term international advisor (the Project Technical Coordinator) will be placed in this unit to assist the Director. The PMU will interface with the international and domestic contracting agencies which will provide all technical assistance, procure commodities, arrange all overseas training opportunities, and provide funding for research.

For the first three project components, the MOH will establish a Project Implementation Office (PIO), responsible directly to the Project Management Unit, which will supervise project implementation in each project component. Each office will contain a Director and a secretary, and will be assisted by a long-term expatriate advisor, a long-term domestic advisor, and both international and domestic short-term technical assistance as needed. Discrete activities in each project component will be supervised by an Activity Coordinator whose service will terminate when individual activities have been completed.

The Project Implementation Office will have the following responsibilities:

- o develop yearly workplans for the individual project components
- o make yearly funding and equipment requests to the PMU
- o supervise implementation of all activities in the individual project components

- o submit finance and activity reports to the PMU
- o monitor the progress of project implementation.

Project funds will be used to pay for salaries of full time personnel in the PMU and PIOs. In cases where such personnel are MOH employees, and their employment would result in their receipt of salary supplements, such employment will not be approved by AID until the appropriateness of such supplements is specifically approved in accordance with Mission Order 1900.2 dated July 10, 1987. Salaries will be determined in accordance with established Bappenas regulations. There are MOH procedures which must be followed to make such project secondments official. GOI officials and all project personnel will receive project funded travel and per diem, again in accordance with guidelines established by Bappenas for ministries.

The Project Implementation Offices for Hospitals and Pharmaceuticals will each be assisted by a Steering Committee comprising recognized technical experts in the respective fields. The Steering Committees will provide technical guidance to the Project Implementation Director, review yearly workplans, and assist with the development of research agendas.

The Project Implementation Office for Social Financing will be assisted by a Task Force with representation from various functional units in MOH formed by decree of the Secretary General for Health. In addition to providing technical guidance to the Project Implementation Office, the Social Financing Task Force will play an active operational role in three elements of the social financing component of the project. The three elements and the Social Financing Task Force's role in each are described below:

1. Development of a Health Insurance Coordinating Mechanism: the Task Force will be entrusted with much of the developmental and analytical work of institutionalizing this capacity within the GOI. Specifically, it will:
   - o design the organizational structure, staffing, internal administration, and operating systems for the Health Insurance Coordinating Board.
   - o serve as a Secretariat for the Intersectoral Coordinating Body established by Presidential Decree to function as an interim Coordinating Board during Phase II.
2. Enactment of Enabling Legislation for DUKM: the Task Force will directly oversee this activity, and provide the linkage between the Coordinating Mechanism for Health Insurance and the development of the enabling legislation which authorizes its existence.
3. Development of Privately Managed Health Insurance Plans: A special unit will be established within the Project Implementation Office for Social Financing with sole responsibility for this task. Its charge will be

to promote the concept of health insurance and to identify groups interested in developing health insurance plans. When private groups approach the unit with proposals for developing capitated pre-paid health care plans, these proposals will be screened by the Task Force to ascertain eligibility and types of assistance which can be provided.

A Health Financing and Policy Analysis Unit will be established by the MOH as a functional unit responsible to the Chief, Bureau of Planning. This unit will be an outgrowth from the Health Sector Financing Working Group in the Bureau of Planning, an ad-hoc group organized to analyze secondary data on health financing and coordinate the collection of primary data. Its Director and staff will be drawn from existing staff in the Bureau of Planning. The Health Sector Financing and Policy Analysis Unit will assist the Bureau of Planning to fulfill its organizational responsibility to analyze data and formulate policy in the health sector. Its specific tasks will be:

- o to conduct an in-depth review of health financing policy in the MOH, with particular emphasis on its conformity with national policy and adherence within MOH.
- o to maintain an on-line data base which can, on an annual basis, track all public and private revenues and expenditures for health in Indonesia.
- o to develop an annual research agenda and terms of reference for the collection of additional primary data relating to health sector financing.
- o to tender research studies funded directly by the Health Financing and Policy Analysis unit to collaborating research institutes and oversee their implementation.
- o to monitor all studies, trials, and demonstrations conducted under the Health Sector Financing Project.
- o to make policy recommendations based upon data generated from the Health Sector Financing Project to the Project Officer and Project Advisory Board.
- o to assess findings from projects supported through other funding sources for their policy implications and advise the Chief, Bureau of Planning accordingly.
- o to publish and disseminate data on health sector financing through appropriate channels.
- o to conduct an annual national workshop which presents health sector financing data to an intersectoral and national audience.

Although not functionally responsible to the PMU, the Health Financing and Policy Analysis Unit will coordinate the development of annual project implementation plans and make funding requests through the PMU for purposes of project coherence and coordination.

Several factors were considered in designing the organizational structure and administrative arrangements for this project. The scope of the project requires diverse organizational involvement from the Ministry of Health. First, bureaus and Directorates from three Director Generals and the Office of the Secretary General for Health have functional responsibility for activities in the hospital, pharmaceutical, and health insurance sectors; the project must be able to access resources from all of them. Second, the policy implications of the structural interventions proposed via the project require access to the policy making process.

The Office of the Secretary General in the Ministry of Health is ideally situated organizationally to fulfill both requirements. His functional responsibility to oversee the activities of the five Director Generals provides the mandate to coordinate the requisite involvement from the various bureaus and directorates. His direct access to the Minister of Health will provide a linkage to the policy making process that is critical to the success of the project.

With responsibility for short- and long-term planning, resource allocation and budgeting, the Bureau of Planning must work across Director Generals and Directorates. Hence, it is also ideally situated to coordinate the various elements of this project. Impetus for this project arose from the Bureau of Planning. It has had to reorganize allocative priorities subsequent to the severe budgetary curtailment of 1985/86, and undertook all of the preliminary analyses which led to the development of this project. The information generated by the HSF Project will be used by the Bureau of Planning to inform decision makers of allocative alternatives which equitably support the objectives of the MOH.

The Project Management Unit has been chosen as the administrative construct for several reasons. First, existing structural divisions within the Bureau of Planning have neither the organizational mandate nor the staff to coordinate the implementation of this project. The formation of a functional unit with responsibilities confined to the management of this project will guarantee that the Bureau of Planning can provide adequate oversight and management control. Second, the tasks of the Project Management Unit extend through the life of project only; hence, their placement in a functional unit which will disband upon project termination is a reasonable and practical management strategy. Third, the PMU/PIO format provides a flexible mechanism for managing project activities that must necessarily span Directorates, Bureaus, and Director Generals. Finally, the PMU/PIO format, coupled with the technical assistance and fund disbursement strategies proposed for this project, will allow the MOH to assume a greater administrative and management responsibilities, and will relieve USAID's administrative and management burden at a time of impending staff reductions.

Although policy analysis is the functional responsibility of the Bureau of Planning, this capacity does not exist at present within existing structural divisions. The health sector work pioneered by the Bureau of Planning was an ad hoc collective effort to analyze existing data on health financing to ascertain implications for resource allocation. The Health Finance and Policy Analysis Unit will build upon this embryo. The research and development nature of this project and the impact that the structural interventions can have upon health financing policy require the special attention to monitoring and policy analysis that this unit will provide.

There is adequate assurance that the administrative arrangements will function as envisioned. The Bureau of Planning has served as the MOH counterpart during project development. It has established ad hoc committees which mirror the PMU and PIO to develop details of each component of the project. These committees have managed to attract technical resources from the various Director Generals to formulate comprehensive plans of action and to coordinate their participation in the project development process. The Bureau of Planning's Health Sector ad hoc Working Group has accumulated and analyzed an impressive array of data on health sector financing in Indonesia. These groups are precursors to the functional units which the MOH will establish to manage this project. Their performance to date provides sufficient assurance of the feasibility of the administrative arrangements proposed for this project.

USAID has assigned a Project Officer who will spend an estimated 35% of her time managing this project. Because of the PMU structure that has been created and because of the presence of the TA contractor with broad responsibilities, this project will be less staff-intensive from USAID's point of view than more traditional health and population projects. The use of a PMU with functions which include developing draft PILs, establishing project implementation schedules, drafting scopes of work for consultants and so on, has been used very successfully in another USAID-funded project. The HSF Project is benefiting from and building on this experience. There are also plans to hire locally a Project Implementation Assistant using project technical assistance funds to assist with the heavy workload during the first few years of the project. This will free up the USDH Project Officer to focus on the technical and managerial issues in the project and will help accelerate implementation.

7.2 Activity Schedule

All project planning, activities and funding will operate on yearly cycles which coincide with the Indonesian fiscal year to facilitate coordination of AID and GOI funds for this project. Project funding will be disbursed on a yearly basis subsequent to GOI and USAID approval of annual implementation plans and budgets. The sequence of events for an illustrative year, IFY 1989/90, the first year in which the project and GOI planning and funding cycles will coincide, is presented in Figure 4.

Project activities, however, are expected to commence during IFY 1988/89. The schedule of major actions, estimated completion dates, and the responsible party for all activities planned during that period is presented in Table 2.

Figure 4. Annual Project Planning Cycle for FY 1989/90

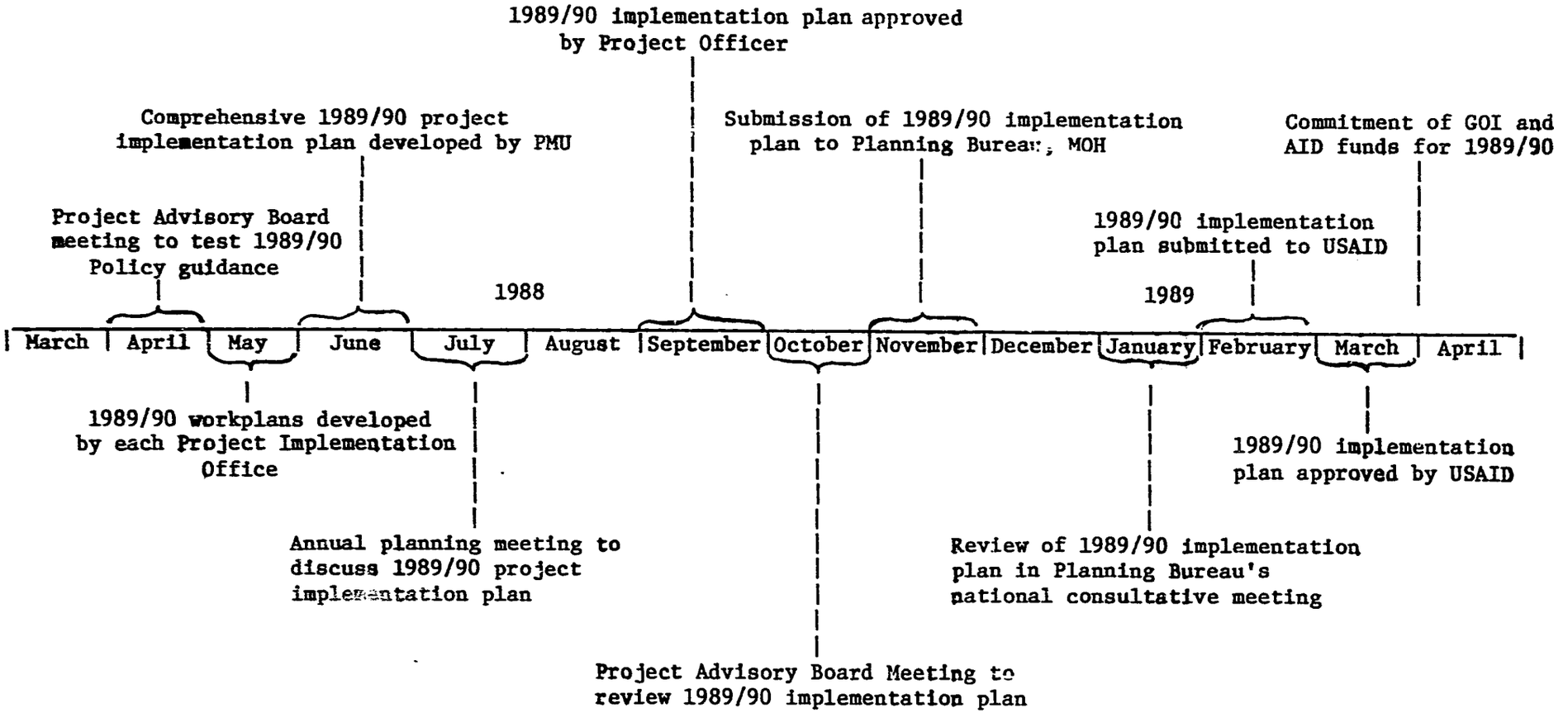
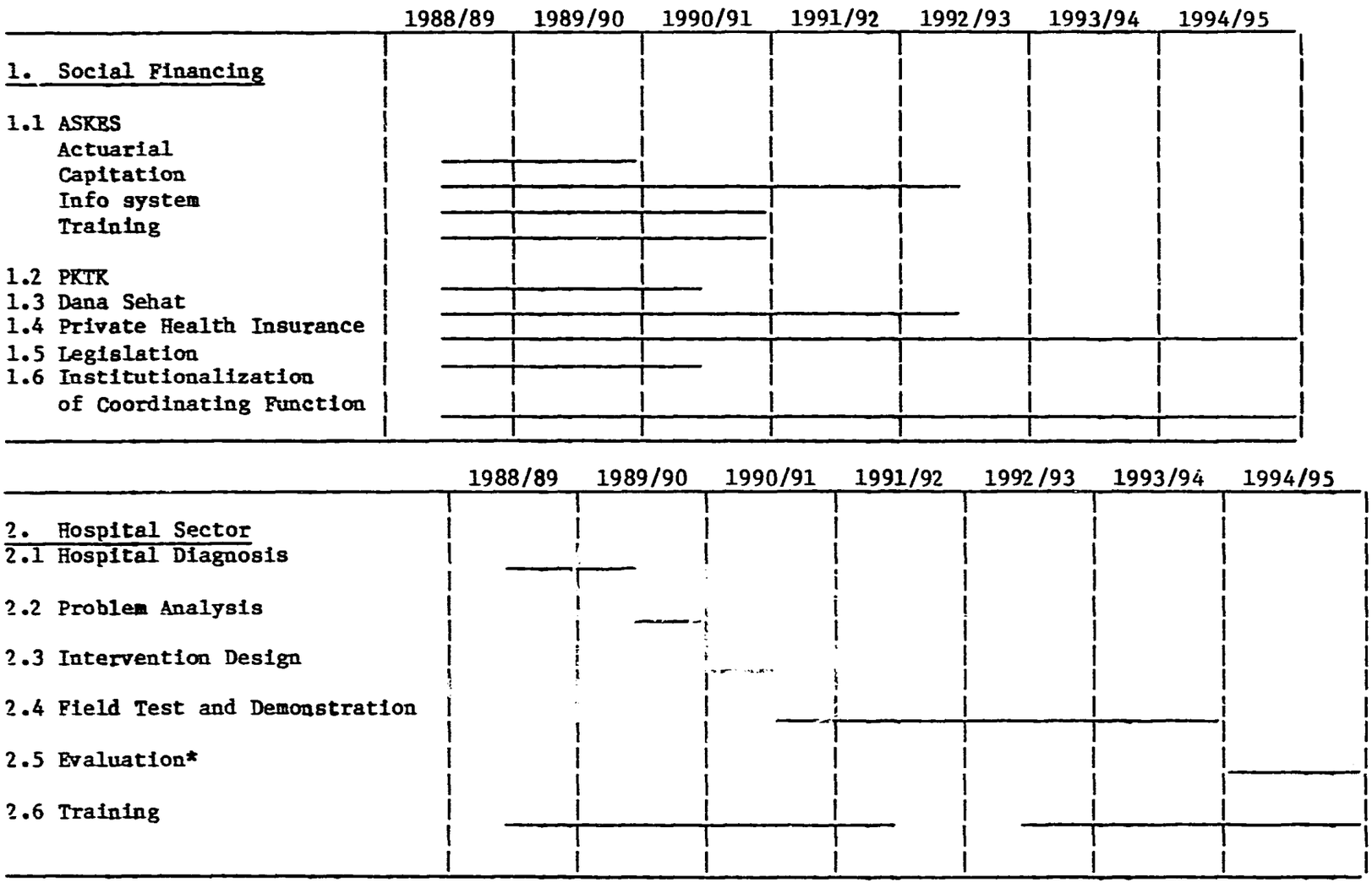


Table 2. Schedule of Major Actions, IFY 1988/89

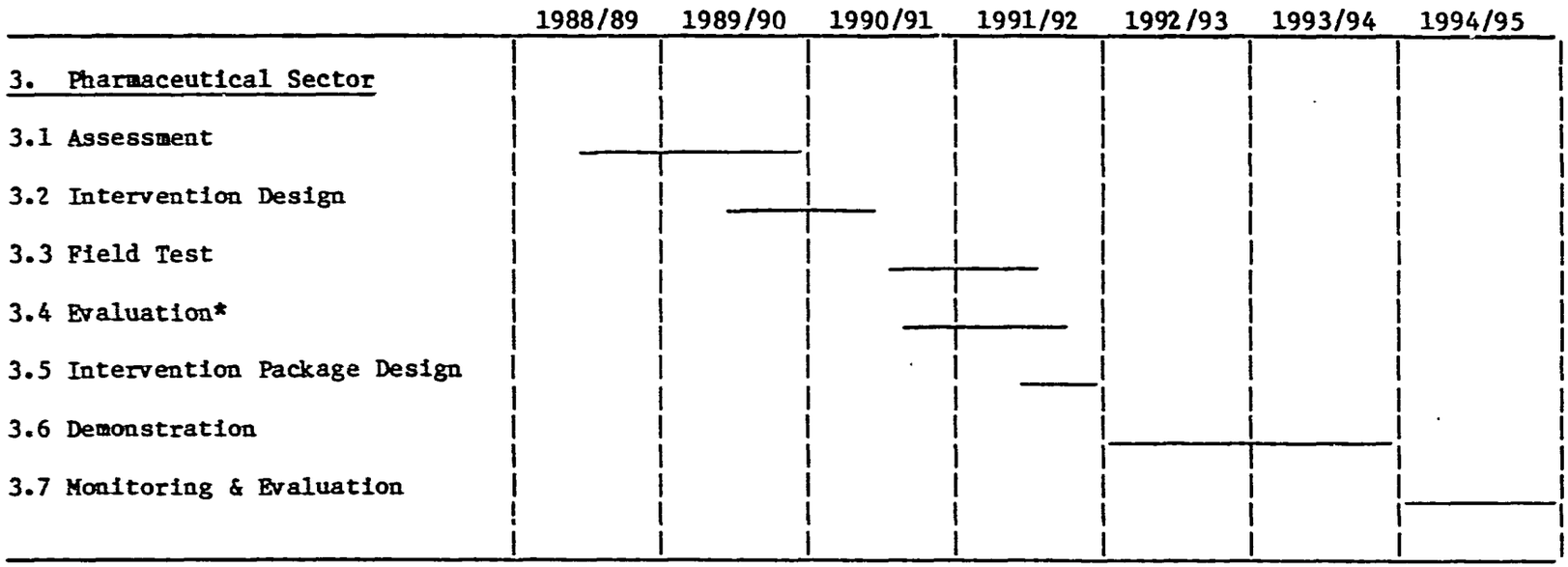
	Action	Estimated Completion Date		Responsibility
1.	Project Agreement signed	February	1988	AID/GOI
2.	Initial conditions precedent satisfied	March	1988	GOI
3.	Domestic and external technical assistance contracting completed	June*	1988	AID/GOI
4.	Long-term consultants in place	July	1988	GOI
5.	Project Officer, Advisory Boards and Policy Analysis Unit established via ministerial decree	March	1988	GOI
6.	First meeting of Project Advisory Board	April	1988	GOI
7.	Project Implementation Office and Policy Analysis Unit formulate 1988/89 and 1989/90 Workplans and budgets and submit to PMU	May	1989	GOI
8.	Formulation of comprehensive project implementation plan for 1988/89 and 1989/90 by PMU	June	1988	GOI
9.	Project Planning Meeting to finalize 1988/89 project implementation plan and review 1989/90 comprehensive implementation plan	July	1988	GOI
10.	Submit 1988/89 implementation plan to USAID	July	1988	GOI
11.	Approval of 1988/89 implementation plan	August	1988	AID
12.	Commitment of 1988/89 project funds	August	1988	AID
13.	1989/90 project implementation plan approved by Project Officer	September	1988	AID
14.	Project Advisory Board meeting to review 1989/90 implementation plan	October	1988	GOI
15.	Comprehensive project implementation plan submitted to Planning Bureau, MOH	November	1988	GOI
16.	Review of 1989/90 project implementation plan at Bureau of Planning annual planning meeting (Konsultasi Perencanaan Pusat-Daerah)	January	1989	GOI
17.	Submission of 1989/90 implementation plan to USAID	February	1989	GOI
18.	Approval of 1989/90 implementation plan by USAID	March	1989	AID
19.	Commitment of all 1989/90 project funds	April	1989	AID/GOI

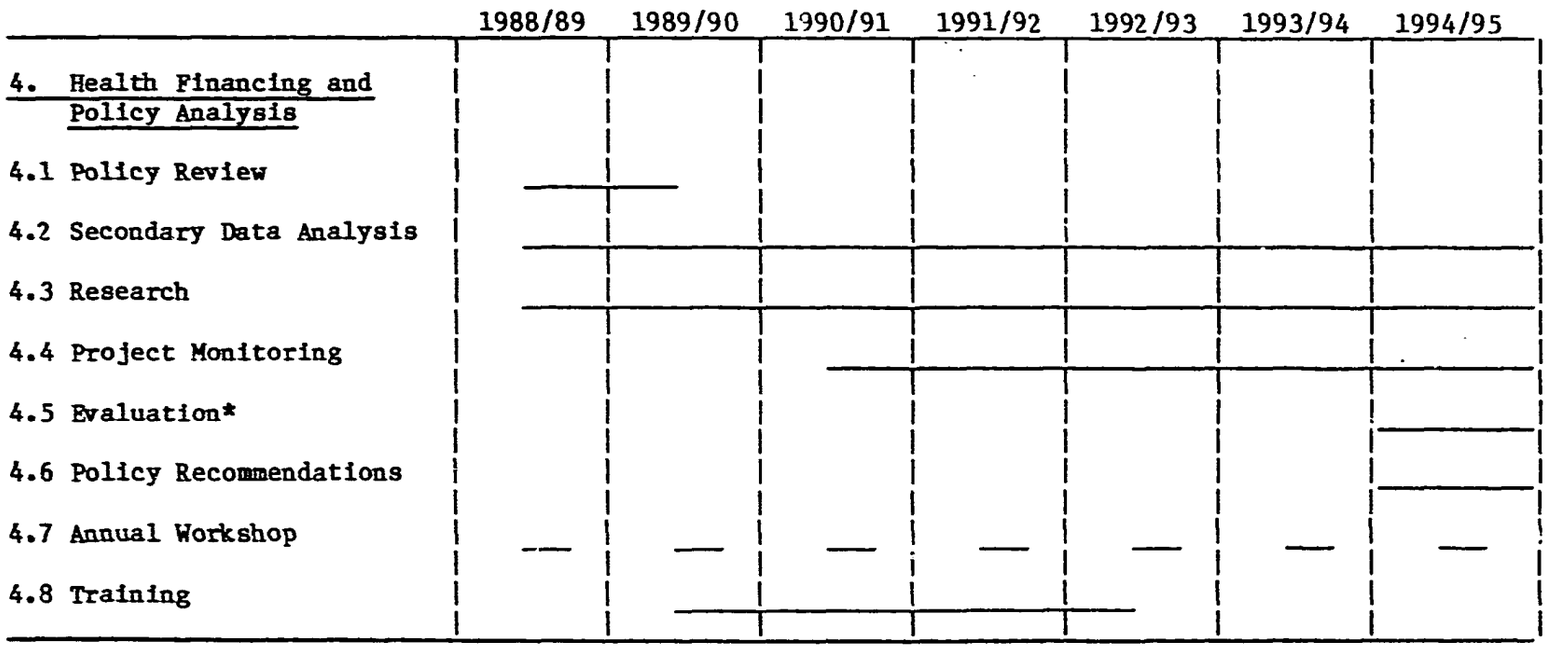
*A delay of six months for competitive selection is anticipated if an 8-A firm capable of undertaking the scope of work is not available.

Figure 5. Planned Implementation Schedule

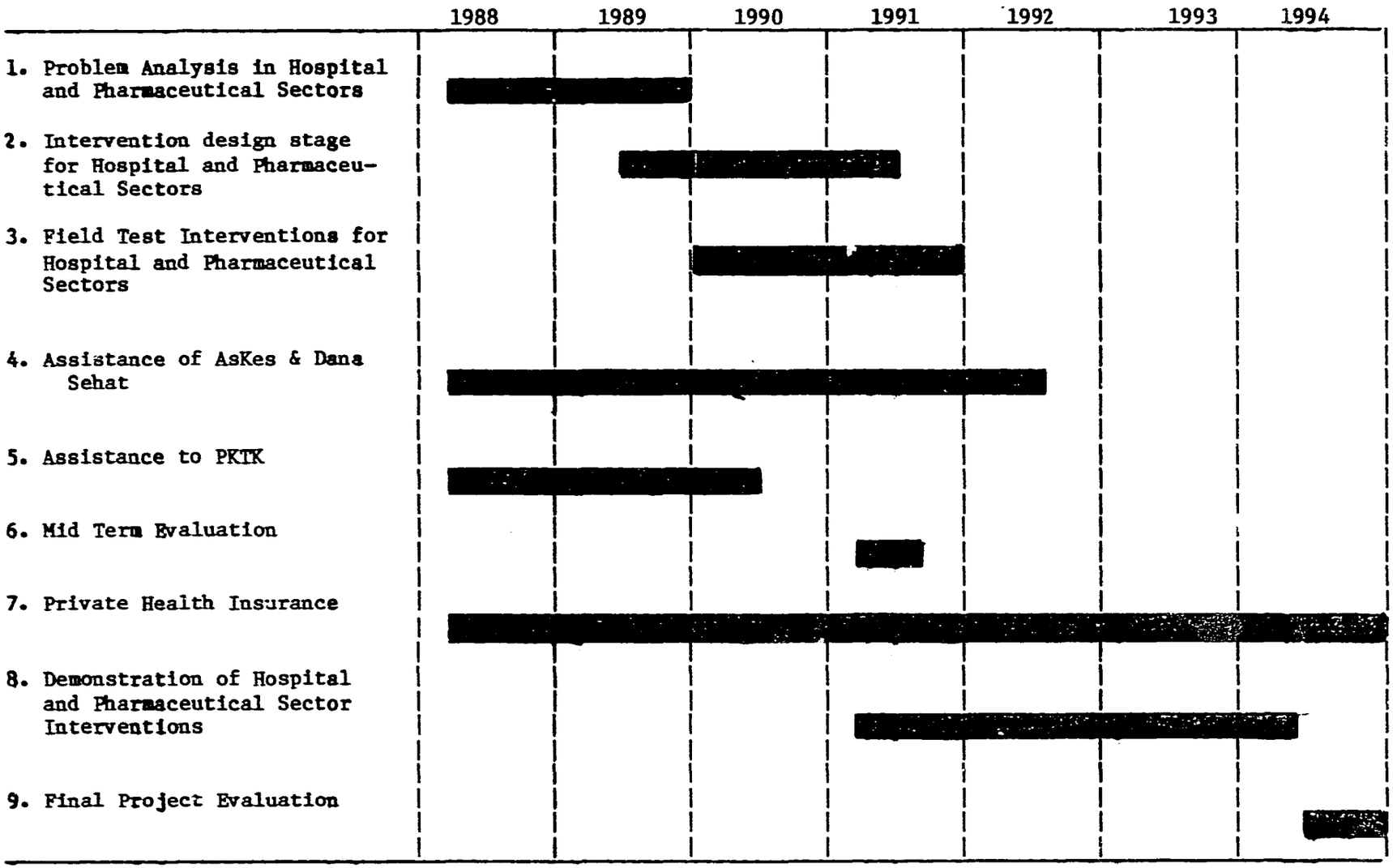


*Evaluation here refers to evaluation of activities in each component. Major overall project evaluations (mid-term and final) are described in Section 8.


1988/89
1989/90
1990/91
1991/92
1992/93
1993/94
1994/95
3. Pharmaceutical Sector
3.1 Assessment
3.2 Intervention Design
3.3 Field Test
3.4 Evaluation*
3.5 Intervention Package Design
3.6 Demonstration
3.7 Monitoring & Evaluation


1988/89
1989/90
1990/91
1991/92
1992/93
1993/94
1994/95
4. Health Financing and Policy Analysis
4.1 Policy Review
4.2 Secondary Data Analysis
4.3 Research
4.4 Project Monitoring
4.5 Evaluation*
4.6 Policy Recommendations
4.7 Annual Workshop
4.8 Training

Major Implementation
Events for Life of the Project



Project activities in the four major components of the project are projected to commence in August 1988. The planned implementation schedule for all project activities in each project component during the life of project is presented in Figure 5.

7.3 Procurement Plan

In order to minimize the amount of USAID and MOH staff time required to manage project activities, a major USAID direct technical assistance contract will be utilized for the procurement of most of the commodities and services required for the project. Currently, it is envisioned that the prime contract would involve two sub-contracts to one US and one Indonesian organization. The contractor would be responsible for providing all long- and short-term technical assistance personnel for the project, both Indonesian and external consultants; placing participants in overseas training programs and externships and arranging for study tours; arranging for special studies and project assessments; procurement of most project commodities; and undertaking in-country training sessions, and other activities related to information dissemination. The contractor will work under the direct supervision and guidance of USAID and the Chief of the MOH Bureau of Planning. Personnel provided through the contract will be placed in the relevant directorates in the MOH; however, all components of the project will be coordinated by the Project Management Unit located in the Planning Bureau. All major implementation actions taken by the contractor (e.g., recruting project personnel, releasing funds for studies, arranging for training, etc.) will be cleared in advance by the Chief of the Bureau of Planning and USAID. The contractor will also be responsible for submitting technical progress and quarterly financial reports to USAID and the MOH.

It is anticipated that the contract will be negotiated on a non-competitive basis under the 8(A) program with a qualified Grey Amendment firm, after a review of the capabilities of a number of eligible Grey Amendment firms. AID/Washington has been asked to assist in a market search for such qualified firms. If no qualified Grey Amendment firms are identified, the contractor will be competitively selected under the FAR procedures. Whether or not the contractor is a Grey Amendment firm, it is anticipated that sub-contracts will need to be arranged to handle specific elements of the project. It is also essential to involve one or more Indonesian non-government organizations with strong administrative and financial capabilities to work with the US firm to manage local costs, prepare financial reports and identify and hire local consultants. The performance of the contractor will be assessed periodically during the project life to determine if changes are required. Preparation of a detailed PIO/T describing the requirements is underway and will be issued shortly after the project is obligated and the initial condition precedent met.

The Project Implementation Assistant position described in Section 7.1 will be recruited and hired locally on a direct personal services contract for a two year period. This will be outside of the TA contract to permit

direct supervision by the Project Officer. Project evaluations will also be contracted directly by the USAID Mission on a competitive basis independently of the prime TA contractor.

Goods and services procured through this project will conform to Geographic Code 000 (U.S.) or Indonesian source and origin. It is anticipated that the contractor will procure most of the commodities on behalf of the MOH, including the personal computers, off-the-shelf in Indonesia. The computers will be procured in two batches. The first set of about 10 PCs will be purchased in advance of the others because they will be needed immediately for activities which are scheduled to begin in July. The others will be purchased after a detailed procurement plan is developed which analyzes the specific kinds of computers and software needed, when they should be procured, the training programs required and so on. It is planned that all commodities and equipment, except perhaps vehicles, will be procured under AID Handbook 11, Chapter 3, host country procurement procedures. In keeping with USAID's normal practice, vehicles will likely be procured directly by USAID on a competitive basis in the local market under the anticipated renewal of the blanket waiver authority from AID/W.

7.4 Financial Plan

Methods of Implementation

Method of Implementation	Method of Financing	Approximate Amount ($000)
Technical Assistance (Institutional contract)	Direct Pay	5,515
TA AID - PSC	Direct Pay	100
TA Evaluation/Audits (Institutional contract)	Direct Pay	200
Commodities (Institutional contract)	Direct Pay	860
Studies/Assessments (Institutional contract)	Direct Pay	3,950
Training (Institutional contract)	Direct Pay	1,555
Local Cost	HC Reimbursement	1,550
Contingency	Direct Pay/ HC Reimbursement	1,270
		15,000

The disbursement methods and financial management systems for this project will follow normal procedures employed by the GOI and USAID.

Because of the need for quick disbursement, some of the local procurement will be included in the technical assistance contract. As described in Section 7.3, one large technical assistance contract will be developed which will cover activities ranging from the provision of all technical assistance personnel to commodity procurement. Two sub-contracts are envisioned; one with a U.S. firm with experience in pharmaceutical supply management and another with an Indonesian firm with strong financial management capabilities. The contractor will be reimbursed for the cost of activities approved in advance by the MOH and USAID. On a quarterly basis, consolidated financial reports will be submitted by the prime contractor to be reviewed by the USAID Project Officer before review, certification and payment by USAID's Office of Finance.

Financing for other local costs will be made available through Project Implementation Letters (PILs) to be issued on an annual basis and providing funding for reimbursement to the GOI for its expenditures for local procurement of goods and services and other local costs (with the provision of advances not to exceed 90-day requirements, if needed). The kind of activities which will be included in the annual PILs will be the following: operating expenses for the PMU and PIOs including office materials, supplies and communications; workshops for developing annual implementation plans, policy formulation or dissemination, presentation of data or findings from project activities, and travel and per diem expenses for GOI staff and officials who are making regular supervision or monitoring trips to field sites.

The project audits and evaluations will be undertaken through independant firms accessed through an IQC mechanism or a buy-in to a centrally funded project. In addition, one direct personal services contract with an individual recruited hired locally is envisioned to function as a Project Implementation Assistant as described in Section 7.1.

In order to ensure that the financial personnel involved, both contractual personnel and MOH regular financial staff, are familiar with the financial management system for this project, a two-day workshop will be held as soon as possible after the contractor is on board to review the procedures involved and make sure that all staff understand the requirements.

O/PH has a full time financial analyst on its staff who will provide periodic reviews of how well the project is being managed financially and will make sure that any new staff are adequately briefed on the requirements.

The budget summary, cost estimate, and yearly projections of expenditures are shown in the budget tables. (Please refer to Annex K for detailed budget tables). AID funds will be used in accordance with project inputs (described in Section 4.4). Counterpart costs provided by the GOI will be for ancillary supplies for use with all commodities purchased

through this project; salaries for all long- and short-term training participants during their training; funding for the continuation of training programs developed through this project especially for ASKES, PKTK, and hospitals; provision of facilities to house the PMU and each PIO; counterpart contributions in the form of staff, facilities, transportation and utilities for studies and assessments conducted through the project; a counterpart contribution for staff, technical assistance, and training for the expansion of the PKTK program into 13 cities; and capital which will be raised in Indonesia to launch new health insurance programs.

7.5 Audit Procedures

Assistance financed by AID is subject to audit. In order to minimize vulnerability, the Mission Controller will conduct periodic examinations of records, and as part of its voucher examination program, will review GOI accounting procedures and documentation relating to their direct procurement financed under the project. Project funding is also available for audit of host country and AID direct contracts, following guidelines from the AID Inspector General's Office. This audit coverage will be performed by auditors through local representatives of U.S. certified public accountant firms, with assistance from the Regional Inspector General - Audit Division in Manila. These services will be procured with project funds by AID direct contract following direct payment procedures.

Table 3. Summary Budget - Health Sector Financing Project
(U.S.$'000)

		Social Financing	Hospitals	Pharma-ceutical	Financial and Policy Analysis	Project Administration	Evaluation & Audit	Total
1.	Technical Assistance	2,250	1,035	1,020	310	1,000	200	5,815
2.	Commodities	550	105	150	25	30		860
3.	Studies/Assessments/ Demonstrations	1,150	1,000	1,300	500	0		3,950
4.	Training	700	375	300	180	0		1,555
5.	Local Cost	250	250	250	200	600		1,550
6.	Contingency	400	275	300	130	165		1,270
	Total	5,300	3,040	3,320	1,345	1,795	200	15,000

Table 4. Summary Cost Estimate and Financial Plan
(U.S.$'000)

SOURCE	AID GRANT		HOST COUNTRY		TOTAL
	FX	LC	FX	LC	
1. Technical Assistance	4,980	835		-	5,815
2. Commodities	-	860		172	1,032
3. Studies	-	3,950		3,460	7,410
4. Training	1,035	520		1,245	2,800
5. Local Costs	-	1,550		638	2,188
6. Contingency	635	635		-	1,270
	6,650	8,350		5,515	20,515

Table 5. Projection of Expenditures by U.S. Fiscal Year
(U.S.$'000)

	AID Grant	GOI	TOTAL
1. U.S. FY 1988	910	98	1,008
2. U.S. FY 1989	1,650	395	2,045
3. U.S. FY 1990	2,500	505	3,005
4. U.S. FY 1991	2,930	926	3,856
5. U.S. FY 1992	3,200	1,241	4,441
6. U.S. FY 1993	1,615	1,200	2,815
7. U.S. FY 1994	1,255	950	2,205
8. U.S. FY 1995	940	200	1,140
Total:	15,000	5,515	20,515

8. MONITORING AND EVALUATION PLAN

8.1 Monitoring

Responsibility for project monitoring rests with the Project Management Unit under the direction of the GOI Project Officer. The PMU will have access to information from all project components through its Project Implementation Offices; hence, it will be in the most advantageous position to collect, analyze, and report this information.

A project monitoring system will be established by the PMU. The system will provide a regular flow of data to monitor progress of project implementation in achieving the desired outputs. Each separate activity will be monitored through a tracking system which will specify dates by which specific benchmarks are expected to be achieved. While the project will need to be somewhat flexible in its assignment of temporal parameters within which benchmarks are to be accomplished, the Director of the PMU and those persons responsible for individual activities will need to maintain a regular exchange of information on progress toward the completion of each activity. While the PMU will monitor progress toward achieving project outputs, the Health Financing and Policy Analysis Unit will monitor results of individual studies and demonstration project to assess their policy implications.

The focus of the project monitoring system will be the four project outputs. For monitoring purposes, indicators of progress and benchmarks have been developed for each output. These are shown in Table 6. The benchmarks for monitoring the project's success in progressing toward the end-of-project status of a real increase of 35% in Child Survival spending is shown in Table 7.

Table 6. Indicators of Progress and Benchmarks to Monitor Progress Toward Achieving Project Outputs

OUTPUTS	INDICATORS OF PROGRESS	BENCHMARKS
1. Development of social financing schemes	1.1 ASKES program has been assessed and proposals have been tested to improve training, information management, and fee collection.	1.1.1 Assessment of benefit/premium package completed 1.1.2 New financing and delivery mechanisms tested 1.1.3 Management information system developed 1.1.4 Training programs for ASKES staff completed
	1.2 Model for PKTK expansion tested in six cities and expanded to 11 cities.	1.2.1 PKTK pilot scheme in Jakarta reviewed and evaluated 1.2.2 Marketing strategy designed 1.2.3 Management systems designed 1.2.4 Training plan designed 1.2.5 Premium/benefit package designed
	1.3 Health financing scheme has been tested in five sub-districts which link a confederaton of Dana Sehat to primary and secondary care facilities.	1.3.1 Health financing package designed 1.3.2 Dana Sehat groups identified and organized 1.3.3 Training package designed 1.3.4 Management systems designed 1.3.5 Confederation of Dana Sehat model tried in one district
	1.4 Privately owned health insurance plans which conform to the principles of DUKM are providing health care to consumers.	1.4.1 Unit established within PIO for Social Financing to stimulate development of private health insurance plans 1.4.2 Private groups interested in developing health insurance plans identified 1.4.3 Feasibility studies done on promising plans to determine business viability 1.4.4 Start-up assistance provided for promising business ventures
	1.5 Multidisciplinary board has been established which can coordinate developments in the health insurance sector.	1.5.1 Task Force responsible to Secretary General, Ministry of Health formed 1.5.2 Organizational structure, staffing requirements, internal administration, and operating mechanisms of the intersectoral board designed 1.5.3 Intersectoral board formed by Presidential decree 1.5.4 Health Insurance Coordinating Board with structural status established

OUTPUTS	INDICATORS OF PROGRESS	BENCHMARKS (2)
	1.6 Enabling legislation has been enacted which legitimizes DUKM and provides the legal basis for the Health Insurance Coordinating Board.	1.6.1 Preliminary concept paper transformed into a legislative proposal 1.6.2 Legislative proposal submitted to the President and Parliament 1.6.3 Legislation passed by Parliament and signed by President
2. A system for improved management and fundamental structural reform in government hospitals resulting in greater operational efficiency, increased cost recovery, and less government subsidy to government hospitals	2.1 Diagnosis of hospital systems in three provinces will be completed.	2.1.1 Provinces where diagnosis will be conducted determined 2.1.2 Diagnosis instrument developed 2.1.3 Team of experts deployed for hospital diagnosis
	2.2 Analysis of problems impeding efficiency and cost recovery completed.	2.2.1 Data from hospital diagnosis analyzed and interpreted 2.2.2 Workshop held to discuss fundings from hospital diagnosis 2.2.3 Report on major problems affecting efficiency and cost recovery submitted to PIO for hospitals and steering committee
	2.3 Comprehensive intervention package has been designed to address efficiency and cost recovery problems encountered in the problem analysis phase.	2.3.1 Activity coordinator assisted by ad hoc committee designs comprehensive intervention package 2.3.2 Comprehensive intervention package approved by PIO for hospitals and steering committee
	2.4 Field test and demonstration have been conducted in three provinces which incorporate all elements of the comprehensive intervention package.	2.4.1 Provincial teams organized 2.4.2 Necessary regulatory exemptions obtained from MOH and provincial authorities 2.4.3 Prerequisite training programs completed 2.4.4 Intervention packages instituted
3. Reforms in pharmaceutical management and distribution which will result in improved efficiency and more resources for essential drugs which have an impact on child survival.	3.1 A focused assessment of the public pharmaceutical sector has been completed which analyzes procurement, storage, distribution, and use factors.	3.1.1 Review of secondary data on pharmaceutical supply management completed 3.1.2 Workshop held to finalize research agenda for focused assessment 3.1.3 Study areas determined 3.1.4 Individual studies commissioned either to provincial health authorities or research institutions

OUTPUTS	INDICATORS OF PROGRESS	BENCHMARKS (3)
	3.2 Management and communications interventions have been designed and tested to address problems identified during the focused assessment.	3.2.1 Individual interventions chosen to address problem areas identified during focused assessment 3.2.2 Interventions field tested in selected rural areas 3.2.3 Field tests evaluated to determine most effective interventions 3.2.4 Comprehensive packet of interventions formulated for large-scale demonstration
	3.3 Comprehensive package of interventions has been demonstrated in six districts.	3.3.1 Demonstration sites chosen 3.3.2 Provincial and district teams formed 3.3.3 Requisite training completed 3.3.4 Demonstrations commenced
4. Development of a health financing and policy analysis capacity within the Bureau of Planning, MOH	4.1 Formation of Health Financing and Policy Analysis Unit as functional unit in the Bureau of Planning.	4.1.1 Decree promulgated by the Secretary General, Ministry of Health, establishing Health Financing and Policy Analysis Unit
	4.2 An on-line data base has been established which can track all public and private expenditures for health on a yearly basis.	4.2.1 Information system developed which can track public expenditures from APBN, InPres, APBD I, and APBD II 4.2.2 Annual research agendas formulated to complement secondary data 4.2.3 Research commissioned and completed 4.2.4 Annual workshop held to disseminate findings
	4.3 Policy recommendations have been made to the Project Advisory Board based upon data generated from this project.	4.3.1 A review of existing MOH policy as it concerns health financing has been completed 4.3.2 Findings from individual studies monitored continously for policy implications 4.3.3 Evaluation design for hospital, pharmaceutical, and social financing components of the project have been completed 4.3.4 Project evaluation completed

Table 7. Benchmark to Monitor Progress Toward Achieving End of Project Status (U.S.$'000)

End of Project Status	Benchmark	
	CUMULATIVE REAL INCREASE (%) OVER 1987 EXPENDITURES ON CHILD SURVIVAL	
35% real increase in total government spending on child survival compared to total government spending on child survival in 1987	1988	5% Decrease
	1989	Equal to 1987
	1990	5% Increase
	1991	10% Increase
	1992	15% Increase
	1993	25% Increase
	1994	35% Increase

8.2 Evaluation

The Health Financing and Policy Analysis Unit will oversee the overall evaluation of this project. There will be a mid-term formative evaluation which will assess progress toward achieving outputs and benchmarks, and a final summative evaluation. Both evaluations will be conducted by an experienced team of international and domestic consultants, none of whom have had a direct association with project implementation.

Mid-term Evaluation. This evaluation will take place in FY 1991/92. Its primary focus will be the degree of progress the project has made toward meeting established benchmarks in each of the components. The evaluation will also assess the administrative arrangements established for this project, the project management systems established by the PMU, and the expenditure rates for different project elements. Recommendations will be made to the Project Director and his Advisory Board on the process of planning, executing and monitoring project activities.

Final Evaluation. The final evaluation will be carried out during the last year of project implementation. The final evaluation will be coordinated by the Health Financing and Policy Analysis Unit of the Bureau

of Planning. It will focus on the degree to which policy recommendations have been accepted, new ideas institutionalized and the degree to which individual project outputs have been achieved.

An evaluation component has been included in all elements of this project. Its purpose will be to assess the impact achieved through all demonstration projects with respect to intended project outputs. The evaluation indicators which will be used for each component are:

1) Social Financing: the evaluation will ascertain the number of members who have been enrolled in third party pre-paid health insurance plans which conform to the principles of DUKM. The evaluation will also assess the degree to which the Health Insurance Coordinating Board is operating as an intersectoral body to accredit health insurance plans which conform to the principles of DUKM.

2) Hospitals: the evaluation will measure the extent to which public sector subsidies to the government hospitals in demonstration areas have been reduced through the efficiency and cost recovery measures introduced through the project. Baseline measurements of public sector subsidies to the hospitals in three study provinces will be made prior to the demonstration of project efficiency and cost recovery measures. The final evaluation will compare post-intervention subsidies to pre-intervention subsidies in the three demonstration provinces.

3) Pharmaceuticals: the evaluation will measure the internal allocative efficiency of public pharmaceutical expenditures in study districts to ascertain whether:

   - o pharmaceuticals are being more rationally prescribed,
   - o expenditures for the different therapeutic categories have been changed to reflect internal allocative shifts within the drug budget,
   - o whether larger expenditures are being made on pharmaceutics such as vaccines, ORT, Vitamin A and iron folate which directly support child survival programs.

A pre-test/post-test evaluation design will be used in the study areas where project interventions will be demonstrated.

Results of the final evaluation will be analyzed and interpreted by the Health Finance and Policy Analysis Unit for their relevance to health financing policy. A list of policy recommendations will be drawn up and presented to the Project Advisory Board for its consideration. The Project Advisory Board will review these recommendations and present them to the Project Director and Ministry of Health.

9. CONDITIONS AND COVENANTS

9.1 Conditions Precedent

Prior to disbursement of any funds to finance the local currency costs of procurement of goods and services directly by the Cooperating Country, or to the issuance of any commitment documents with respect thereto, the Cooperating Country shall, except as A.I.D. may otherwise agree in writing, provide evidence that:

(1) the Project Management Unit (PMU) and Project Implementation Offices (PIO's) have been formally established, including a description of the positions in each unit, a list of the names of persons assigned on a full-time basis to such positions, and an outline of the general responsibilities of such units with regard to each major component of the project; and

(2) a first year's workplan for the PMU and each PIO.

9.2 Special Covenants

(1) The Cooperating Country will develop a yearly detailed implementation plan for the project which will described the sequence of activities to be undertaken in each fiscal year. Unless otherwise agreed by A.I.D., the implementation plan for each year will be submitted to A.I.D. for review and approval prior to start of the year covered by the plan.

(2) In order to make greater resources available for child survival programs, the Ministry of Health and Bappenas will take unto serious consideration and adopt, as appropriate, the policy recommendations which result from the research and demonstration activities that are central to the project.

(3) The Cooperating Country will agree that, by the end of the project, it will increase government expenditures for child survival programs by 35 percent in real terms over the IFY87 public sector child survival program expenditure level.

(4) The Cooperating Country shall covenant to formally establish a Health Financing and Policy Analysis Unit within the Bureau of Planning, Ministry of Health, within one year of the date of signature of the project grant agreement, unless otherwise agreed by A.I.D.

(5) The Cooperating Country will agree to grant exemptions from existing government regulations and standard procedures to the extent necessary to carry out the pilot activities and large scale demonstrations planned under the project.

(6) The Cooperating Country will covenant to provide sufficient funds to maintain and supply equipment furnished through the project.

9.3 Negotiating Status

Except for the writing of this Project Paper to conform with the prescribed AID documentation system, the design of this project has been undertaken by the Indonesian Government. Three Task Forces, representing various relevant Directorates within the Ministry of Health, were convened to agree on the three major project components and to design the detailed activities to be undertaken in each. These Task Forces were guided by their respective Director Generals and by the Secretary General for Health. The Bureau of Planning served as the design secretariat and chief liaison unit with USAID.

Given that the project was designed in a highly collaborative manner and with maximum participation by both senior and mid-level officials within the Govenment of Indonesia, we anticipate no difficulties in concluding an agreement as soon as this project is authorized.

10.0 Environmental Analysis

During the preparation of the PID it was determined and approved by the Mission Director that an Initial Environmental Examination was not required in accordance with 22 CFR Part 216.2 (c)(2)(viii) and 216.3(a)(1). While the HSF Project has changed slightly since the PID, it does not have an effect on the natural or physical environment and it is a program involving nutrition, health care or population and family planning services which does not directly affect the environment. Therefore, it still meets the criteria for categorical exclusion under 22 CFR Part 216.2 (c)(2)(i) and (viii) and no Initial Environmental Examination, Environmental Assessment, or Environmental Impact Analysis is required.

ANNEXES

A. PID Facesheet, AID/Approval Cable, Mission Response Cable

B. Project Logical Framework

C. Request for Assistance

D. Statutory Checklist

E. Environmental Analysis

F. Technical Analysis

G. Financial Analysis

H. Economic Analysis

I. Social Soundness Analysis

J. Scopes of Work for Long-Term Advisors

K. Detailed Financial Tables

L. Waiver for Participant Training

ANNE

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT IDENTIFICATION DOCUMENT
FACESHEET (PID)

1. TRANSACTION CODE: A = Add, C = Change, D = Delete — [A] — Amendment No. — DOCUMENT

2. COUNTRY/ENTITY: Indonesia

3. PROJECT NUMBER: 497-0354

4. BUREAU/OFFICE: Asia Near East — A. Symbol — B. Code: 04

5. PROJECT TITLE (maximum 40 characters): Health Sector Financing

6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION
A. Initial FY: 88
B. Final FY: 91
C. PACD: 95

7. ESTIMATED COSTS ($000 OR EQUIVALENT, $1 = 1640)

FUNDING SOURCE	LIFE OF PROJECT
A. AID	15,000
B. Other U.S. 1.	
B. Other U.S. 2.	
C. Host Country	7,000
D. Other Donor(s)	
TOTAL	22,000

8. PROPOSED BUDGET AID FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	C. PRIMARY TECH. CODE 2. Loan	D. 1ST FY 88 1. Grant	D. 1ST FY 88 2. Loan	E. LIFE OF PROJECT 1. Grant	E. LIFE OF PROJECT 2. Loan
(1) HE	532 B	510	560	5000	2000	10,000	5,000
(2)							
(3)							
(4)							
TOTALS				5000	2000	10,000	5,000

9. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 530, 520

10. SECONDARY PURPOSE CODE: 520

11. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	DEL						
B. Amount							

12. PROJECT PURPOSE (maximum 480 characters)

To create the experiential base and policy context needed to initiate and sustain the process of shifting greater GOI resources toward child survival programs.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff: Joy Riggs-Perla, OPH Project Officer
Thomas R. D'Agnes, Consultant
Dr. Paramita, MOH
Dr. E. Voulgaropoulos, Chief, OPH

Funds: Reach Project, ST/Health
PD&S Funds

14. ORIGINATING OFFICE CLEARANCE
Signature: James M. Anderson
Title: Acting Director
Date Signed: MM 07 DD 07 YY 87

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

16. PROJECT DOCUMENT ACTION TAKEN
S = Suspended
A = Approved
D = Disapproved
CA = Conditionally Approved
DD = Decision Deferred

17. COMMENTS

18. ACTION APPROVED BY
Signature
Title

19. ACTION REFERENCE

20. ACTION DATE: MM DD YY

AID 1330-2 (8-79)

60

UNCLASSIFIED STAT 388770/01

ACTION AID 3 INFO DCM ECON CHRON

NVZCZCNRC002
PP RUEHJA
DE RUEKC #8770/01 3540321
ZNR UUUUU ZZH
P 1803172 DEC 87
FM SECSTATE WASHDC
TO AMEMBASSY JAKARTA PRIORITY 0398
BT
UNCLAS SECTION 01 OF 02 STATE 388770

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LOC: DISK 220 533
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CN: 33141
CHRG: AID
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IMMEDIATE

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USAID	ROUTING	
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DMC		
GSO		
ORR		

E.O. 12356: N/A
TAGS: N/A
SUBJECT: HEALTH SECTOR FINANCING PROJECT (497-0354) PID REVIEW

REFS: (A) JAKARTA 17170:(B) STATE 262149

1. SUMMARY: BUREAU PROJECT REVIEW COMMITTEE (PRC) MET NOVEMBER 17, 1987 TO REVIEW REF. A RESPONSE TO ISSUES AND CONCERNS DESCRIBED REF B. PRC RECOMMENDED APPROVAL AND AA/ANE APPROVED THE PID. BUREAU COMMENDS MISSION ON THIS INNOVATIVE EXPERIMENT AIMED AT IMPROVING THE FINANCIAL SUSTAINABILITY OF CHILD SURVIVAL PROGRAMS. BUREAU APPRECIATES USAID'S CLARIFICATION ON HOW THIS PROJECT FITS WITHIN YOUR NEW DRAFT HEALTH SECTOR CDSS AND YOUR EXTENSIVE DISCUSSION OF RELATED PROJECT ISSUES. WE DO, HOWEVER, EXPECT THAT THE PP WILL CONTAIN MEASURABLE PERFORMANCE INDICATORS FOR EXPECTED RESOURCE SHIFTS FOR CHILD SURVIVAL AND FOR RELATED POLICY SHIFTS. WE ARE ALSO CONCERNED ABOUT THE PIPELINE IMPLICATIONS OF THIS MULTI-COMPONENT PROJECT THAT WILL LIKELY BE SLOW DISBURSING. OTHER ISSUES OF CONCERN TO THE PRC ARE NOTED BELOW FOR USAID'S CONSIDERATION IN PREPARING THE PP. END SUMMARY.

2. THE PRC RECOMMENDED APPROVAL, AND THE AA/ANE APPROVED HE PID. THE MISSION MAY NOW PROCEED WITH THE COMPLETION AND APPROVAL OF THE PROJECT PAPER AT POST.

3. THE BUREAU APPLAUDS GOI AND USAID'S EFFORTS AND FORESIGHT IN DESIGNING A PROJECT THAT BREAKS NEW GROUND TO ENHANCE THE LONG-TERM FINANCIAL VIABILITY OF CHILD SURVIVAL PROGRAMS. THE BUREAU AGREES WITH THE IDENTIFICATION OF THREE TARGET AREAS IN THE CDSS FOR POLICY REFORM IN THE HEALTH AND POPULATION SECTOR: THE PRIVATIZATION OF AS MANY FUNCTIONS AS POSSIBLE, GREATER PUBLIC RESOURCE ALLOCATION TOWARDS CHILD SURVIVAL PROGRAMS, AND INCREASED OPERATIONAL EFFICIENCIES IN PUBLIC HEALTH AND FAMILY PLANNING PROGRAMS. TO THESE ENDS, THE BUREAU WELCOMES THE THRUST AND DIRECTION OF THE PROPOSED PROJECT AS A POSITIVE INITIATIVE IN THE HEALTH POLICY DIALOGUE ARENA. WE RECOGNIZE THE PROJECT TO BE AN IMPORTANT GOI DRIVEN EXPERIMENT IN SYSTEMIC STRUCTURAL

ADJUSTMENTS INTENDED TO IMPROVE THE PERFORMANCE OF THE HEALTH MARKET BY ENHANCING THE INCENTIVES AND OPPORTUNITIES WITHIN THE SAME MARKET. WE ALSO APPLAUD YOUR PROPOSAL TO USE PL 480 TITLE I RESOURCES TO SUPPLEMENT MOH CHILD SURVIVAL PROGRAMS WHILE THIS PROJECT BUILDS A MORE SUSTAINABLE STRUCTURAL BASE IN THE BUDGET.

4. THE PRC NOTED THAT USAID HAS NOT YET IDENTIFIED APPROPRIATE PERFORMANCE INDICATORS TO MEASURE PROGRESS TOWARDS ACHIEVING POLICY OBJECTIVES. OF PARTICULAR CONCERN IN THIS REGARD IS MONITORING THE SHIFTS OF RESOURCES IN FAVOR OF CHILD SURVIVAL PROGRAMS AS WELL AS INTERMEDIATE PROGRESS MADE TOWARDS THESE SHIFTS. WE ALSO NOTED THAT THE OUTPUTS RELATING TO POSSIBLY SUBSTANTIAL ECONOMIC (AND THERAPEUTIC) EFFICIENCIES IN THE MANAGEMENT OF PHARMACEUTICALS IN PUBLIC HEALTH ALSO LACK MEASURABLE INDICATORS AND TARGETS. WE EXPECT THAT SUCH INDICATORS OF STRUCTURAL CHANGE WILL BE IDENTIFIED DURING PREPARATION OF THE PP, ALONG WITH A CLEAR METHODOLOGY ON HOW SUCH PERFORMANCE WILL BE MONITORED. THE BUREAU ALSO EXPECTS THAT APPROPRIATE EVALUATION PLANS FOR MID-COURSE REVIEW OF PROGRESS WILL BE CLEARLY FORMULATED. REGULAR MONITORING REVIEWS OF PERFORMANCE INDICATORS WILL ALSO BE IMPORTANT. WE ASSUME THAT SHOULD ADEQUATE PERFORMANCE TOWARDS ACHIEVING OBJECTIVES NOT BE ACHIEVED AT SPECIFIED INTERVALS DURING THE LIFE OF THE PROJECT, THE MISSION AND GOI WILL DISCUSS REVISION OF THE PROJECT AS APPROPRIATE.

5. FROM THE POINT OF VIEW OF MINIMIZING PIPELINE LEVELS, THE BUREAU CONSIDERS IT DESIRABLE TO PROVIDE A SENSIBLE QUOTE BREAK UNQUOTE IN PROJECT PHASING, FOR EXAMPLE, BETWEEN AN INITIAL 2-3 YEAR PERIOD OF

ANALYSIS/DEMONSTRATION AND A LATER ONE OF APPLYING THESE RESULTS TO IMPROVING PUBLIC HOSPITAL EFFICIENCY, PHARMACEUTICAL MANAGEMENT AND EXPANSION OF HEALTH CARE FINANCING SCHEMES. WE BELIEVE OBLIGATION LEVELS SHOULD NOT EXCEED THE FUNDING REQUIREMENTS WHICH THE FINANCIAL PLAN OF THE PP JUSTIFIES FOR THIS INITIAL PERIOD (SAY NO MORE THAN DOLS 7-8 MILLION) AND THAT AN EVALUATION OF INITIAL ACTIVITIES AND GOI COMMITMENT TO APPLYING EVALUATION RESULTS SHOULD BE REQUIRED BEFORE OBLIGATING ADDITIONAL FUNDS. HOWEVER, IF AT ANY TIME IT CAN BE SHOWN THAT GOI READINESS TO BROADLY IMPLEMENT STRUCTURAL CHANGE IN THE HEALTH SECTOR IS PROCEEDING FASTER THAN ANTICIPATED, THEN OBLIGATION LEVELS COULD BE ACCELERATED COMMENSURATELY TO SUPPORT SUCH CHANGES. WE ANTICIPATE THAT THE PP FINANCIAL PLAN WILL PROVIDE AN APPROPRIATE FRAMEWORK CONSISTENT WITH PRUDENT FINANCIAL MANAGEMENT AND FAA SECTION 611 A CONCERNS.

6. OTHER ISSUES OF CONCERN NOTED AT THE PRC FOR USAID
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CONSIDERATION IN FINALIZING THE PP ARE THE FOLLOWING:

A) WHAT IS THE ROLE WHICH THE PRIVATE SECTOR PLAYS IN THE PROCUREMENT, MARKETING, WHOLESALE AND RETAIL SALES OF PHARMACEUTICALS? A STUDY TO EXPLORE THE PUBLIC-PRIVATE LINKAGES IN THIS REGARD WAS SUGGESTED AS BEING HIGHLY BENEFICIAL TO THE OBJECTIVES OF THE PROJECT.

B) HOW WILL GOI ENCOURAGE PUBLIC HOSPITALS TO MOVE TOWARD PRIVATIZATION OF FUNCTIONS APPROPRIATELY MANAGED WITHIN THE PRIVATE SECTOR? FOR EXAMPLE, ARE THERE OPPORTUNITIES TO CONTRACT OUT CATERING OR HOUSEKEEPING OPERATIONS AS A WAY TO IMPROVE PUBLIC HOSPITAL EFFICIENCIES?

C) WHAT IS THE AMOUNT, AVAILABILITY AND POTENTIAL SOURCES OF CAPITAL THAT WILL BE REQUIRED FOR ESTABLISHMENT AND EXPANSION OF PRIVATE HEALTH CARE FINANCING PLANS? WHAT IS THE LIKELIHOOD THAT THE REGULATORY MECHANISM TO BE ESTABLISHED WILL PERMIT PARTICIPATION OF EXISTING INSURANCE INSTITUTIONS AND INVESTMENT OF SURPLUS HEALTH PLAN FUNDS IN PRIVATE SECTOR?

D) CAN PUBLIC EMPLOYEES' HEALTH PLANS BE WEANED FROM PUBLIC HOSPITAL SUBSIDY AND PLACED ON A EQUAL FOOTING WITH PRIVATE PLANS BY BEING CHARGED ON A FULL FEE-FOR-SERVICE BASIS? TO WHAT EXTENT CAN PUBLIC EMPLOYEES' HEALTH NEEDS BE MET THROUGH PRIVATE INSURANCE PLANS? WHITEHEAD
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CLASS: UNCLASSIFIED
CHRGE: AID 01/29/87
APPRV: DIR:DNMERRILL
DRFTD: OPH:JRIGGS-PERLA:
CLEAR: 1.OPH:EVOULGAROPOULOS; 2.PPS:MBONNER;
DISTR: AID-8 DCM CHRON ECON

AIDAC FOR ANE/PD, R. VENEZIA AND ANE/TR, B. TURNER

E. O. 12356: N/A

WORKING COPY

SUBJECT: HEALTH SECTOR FINANCING PROJECT (497-0354)

REF: (A) 87 STATE 388770; (B) ACTION MEMORANDUM TO AA/ANE ON SUBJECT PID

1. MISSION COMPLETED THE EXECUTIVE COMMITTEE REVIEW OF SUBJECT PP ON JANUARY 19 AND APPROVED THE PP AND AUTHORIZED THE PROJECT ON FEBRUARY 9. COPIES OF THE PP INCLUDING THE ANNEXES WILL BE POUCHED TO AID/W AS SOON AS POSSIBLE. WE WILL CABLE ADVICE WHEN SENT.

USAID ROUTING TO	ACT.	INFO
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2. THE PURPOSE OF THIS CABLE IS TO RESPOND TO THE ISSUES RAISED BY AID/W IN REFTEL A PARAGRAPHS 4, 5 AND 6 AND TO EXPLAIN HOW THEY WERE HANDLED IN THE PP.

- A. APPROPRIATE PERFORMANCE INDICATORS: DURING THE COURSE OF THE PP DESIGN, SPECIFIC PERFORMANCE INDICATORS WERE DEVELOPED AND AGREED UPON BY USAID AND THE GOI. THE PROJECT OUTPUTS, INDICATORS OF PROGRESS AND BENCHMARKS FOR EACH OF THE PROJECT COMPONENTS ARE LISTED IN THE MONITORING AND EVALUATION PLAN OF THE PP. AT THE PROJECT PURPOSE LEVEL, BASED ON DETAILED FINANCIAL AND ECONOMIC ANALYSES, A 35 PERCENT REAL INCREASE IN CHILD SURVIVAL SPENDING BY THE MOH HAS BEEN ESTABLISHED AS THE TARGET. AS A RESULT OF THE EXECUTIVE COMMITTEE REVIEW, INTERMEDIATE INDICATORS TO MEASURE PROGRESS TOWARD ACHIEVING THIS RESOURCE SHIFT WERE NEGOTIATED AND ARE EXPLAINED IN DETAIL IN THE PP.

USAID IS ALSO CURRENTLY RECRUITING A FULL TIME HEALTH ECONOMIST TO WORK WITH US ON POLICY AND ECONOMIC ISSUES ON OUR NEW HEALTH AND POPULATION ACTIVITIES. ONE OF HIS/HER DUTIES WILL BE MONITORING THE RESOURCE REALLOCATION PROGRESS ON THE HSF PROJECT AND ADVISING US IF THE MOH IS NOT LIVING UP TO ITS END OF THIS BARGAIN. IF AT ANY POINT DURING PROJECT IMPLEMENTATION, BUT ESPECIALLY AFTER THE FIRST MAJOR EVALUATION SCHEDULED FOR 1991, THE PROJECT IS NOT ACHIEVING THE RESOURCE REALLOCATION TARGETS, A RESTRUCTURING OF THE PROJECT WILL BE CONSIDERED OR A DISCONTINUATION IF WARRANTED.

- B. PIPELINE LEVELS AND PROJECT PHASING: THE MISSION IS PLANNING ON OBLIGATING DOLS. 5.1 MILLION IN FY

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PB WHICH WILL BE COMMITTED IN THE FIRST 18-MONTHS OF THE PROJECT. WE WOULD EXPECT TO BRING THIS UP TO DOLS. 9 MILLION BY 1991 TO MEET REQUIREMENTS UNTIL THE FIRST EVALUATION. EVERY EFFORT HAS BEEN TAKEN TO EXPEDITE EXPENDITURES IN THE PROJECT AND AVOID ANY "DOWNTIME" AFTER THE INITIAL OBLIGATION. THE MOH IS CURRENTLY WELL ORGANIZED TO BEGIN IMPLEMENTATION AND IN FACT HAVE BEEN IMPATIENTLY AWAITING USAID APPROVAL OF THE PROJECT. THE PROJECT GRANT AGREEMENT IS BEING DRAFTED AND WILL SOON BE CLEARED THROUGH THE MISSION. THE FIRST PIO/T FOR THE CONTRACT HAS BEEN DRAFTED AND IS AWAITING SIGNATURE OF THE PROAG. LETTERS TO MEET THE FIRST CONDITION PRECEDENT ARE DRAFTED AND WAITING THE PROAG FOR SIGNATURE.

OBLIGATION OF FUNDS BEYOND THE DOLS. 8 MILLION IS SCHEDULED FOR FY 92 AFTER THE FIRST MAJOR PROJECT EVALUATION. IN THAT SENSE, THE PROJECT IS PHASED. THERE IS NO PHASING, HOWEVER, OF THE PROJECT IN THE MANNER SUGGESTED IN REF B, I.E., INTO A RESEARCH AND DEMONSTRATION PHASE AND A WIDESPREAD APPLICATION PHASE. THIS SUGGESTION IS INAPPROPRIATE GIVEN THE FACT THAT THE ENTIRE PROJECT IS IN FACT A RESEARCH AND DEVELOPMENT EFFORT. THE ULTIMATE OUTCOMES ARE CHANGES IN POLICY WHICH SET THE STAGE FOR STRUCTURAL REFORMS IN THE ORGANIZATION AND FINANCING OF THE HEALTH CARE SYSTEM. THERE IS NO NATIONAL REPLICATION PHASE FINANCED BY THIS PROJECT NOR IS SUCH FINANCING NECESSARY. THE SCHEDULING OF ACTIVITIES WITHIN EACH COMPONENT FOLLOW A PATTERN OF BEGINNING WITH ANALYTICAL/DIAGNOSTIC STEPS FOLLOWED BY PILOT TESTING/DEMONSTRATION EFFORTS. HOWEVER THE TIMING IS DIFFERENT FOR EACH COMPONENT. THERE IS NO NATURAL BREAKPOINT AT WHICH TO DIVIDE THE PROJECT. DETAILED BUDGETS HAVE BEEN WORKED OUT BY THE MOH DESIGN COMMITTEE IN COLLABORATION WITH USAID STAFF BASED ON THE ACTIVITIES IN EACH COMPONENT. USAID DOES NOT FEEL THAT THERE ARE ANY FAA SECTION 611A CONCERNS REMAINING.

- C. INFORMATION REGARDING THE FOUR ADDITIONAL ISSUES IN PARA 6 OF REFTEL IS AS FOLLOWS:

- - FUNDS ARE ALREADY INCLUDED IN THE PHARMACEUTICAL COMPONENT TO EXPLORE THE ROLE OF THE PRIVATE DRUG SECTOR WITH RESPECT TO IMPROVING EFFICIENCY AND CHILD SURVIVAL IMPACT OF GOI EXPENDITURES.

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-- ANALYSIS OF THE FUNCTIONS OF PUBLIC HOSPITALS WHICH COULD BE CONTRACTED OUT TO PRIVATE INSTITUTIONS TO INCREASE EFFICIENCY WILL BE PART OF THE DIAGNOSTIC STEP IN THE PILOT AREAS AS DESCRIBED IN THE HOSPITAL SECTOR REFORM COMPONENT OF THE PROJECT. THE PROJECT WILL WORK TO CHANGE POLICIES WHICH AFFECT HOSPITAL EFFICIENCY FROM THE FINANCIAL POINT OF VIEW IN ORDER TO ENSURE REDUCED GOVERNMENT SPENDING IN THIS SECTOR. PROJECT FUNDS WILL NOT BE USED TO TRY TO IMPROVE HOSPITAL CATERING OR HOUSEKEEPING OPERATIONS DIRECTLY.

-- THE QUESTION OF ACCESS TO CAPITAL FOR ESTABLISHING AND EXPANDING INSURANCE SCHEMES IS AN ISSUE WHICH USAID HAS BEEN DISCUSSING WITH PRE BUREAU. THE PP DESCRIBES HOW THE PROJECT WILL HELP BROKER ACCESS TO CAPITAL THROUGH THE PRE BUREAU'S PRIVATE ENTERPRISE DEVELOPMENT SERVICES (PEDS) PROJECT AND USAID'S PROPOSED FINANCIAL MARKETS PROJECT. EXISTING PRE LOAN GUARANTEE FACILITIES IN JAKARTA WILL ALSO BE TAPPED AS REQUIRED. FOR MANY INSTITUTIONS, CAPITAL WILL NOT BE A PROBLEM (INSURANCE FIRMS, PLANTATIONS, LARGE CORPORATIONS). WE ANTICIPATE THAT IT MIGHT BE AN ISSUE FOR SMALLER ENTREPRENEURS LIKE PHYSICIANS IN GROUP PRACTICES OR SMALLER COMPANIES AND COOPS.

-- THE PROJECT WILL BE EXPERIMENTING WITH WHAT IS SUGGESTED IN THE FINAL PARAGRAPH OF REFTEL. FOR EXISTING GOVERNMENT HEALTH INSURANCE SCHEMES, THE PROJECT WILL DEVELOP AND TEST ALTERNATIVES WHICH ACCESS PRIVATE PRACTITIONERS INSTEAD OF PUBLIC FACILITIES. CONSUMER DISSATISFACTION WITH THE PUBLIC FACILITIES IS WELL DOCUMENTED AND RECOGNIZED BY THE SCHEME ADMINISTRATORS WHO ARE EAGER TO TEST THE ALTERNATIVES. TECHNICAL ASSISTANCE FROM THE PROJECT WILL BE USED TO PLAN THESE CHANGES. WOLFOWITZ
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PROJECT LOGICAL FRAMEWORK ANNEX B

PROJECT LOGICAL FRAMEWORK

Evaluation for Period:_____ to _____

Date Prepared:_____

Project Title: HEALTH SECTOR FINANCING PROJECT 497-0354

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	IMPORTANT ASSUMPTIONS	MEANS OF VERIFICATIO
Program or Sector Goal: To reduce fertility and infant and child mortality.	Measures of Goal Achievement: Reduction in fertility and infant and child mortality rates.	- an increase in use of child survival services will reduce infant and child mortality.	- Demographic surveys - SKKBN and MOH routine data
Project Purpose: To develop the institutional and policy context needed to ensure the financial sustainability of child survival programs.	Conditions Expected at End of Project: A 35% increase in total government spending on child survival programs.	- The GOI will continue to be receptive to making policy and program changes based on evidence generated by the project to do so. - The GOI will continue to favor a pluralistic health system.	- Project evaluations. - Budget allocation trends.
Outputs: - Proliferation of socially financed health insurance programs. - Program and policy reforms instituted in the hospital sector. - Drug sector reforms instituted to increase child survival proram impact. - GOI capacity developed for health sector financing and policy analysis.	Magnitude of Outputs: - Ten viable, self-financing social insurance schemes in operation by 1995. - Policies adopted to decrease GOI subsidy to public hospitals. - Policies and procedures in place to increase child survival impact of GOI expenditures on drugs. - A data base and analytical capacity needed by MOH policy makers to make rational allocative decisions.	- Economic conditions will remain stable, making consumer participation in financing health care feasible. - Other ministries will support MOH policy changes for cost recovery for hospitals and health care financing schemes.	- Project evaluations. - Project monitoring and eval observation.
Inputs: ($000) Technical Assistance 5,815 Commodities 860 Studies/Demos 3,950 Training 1,555 Local Costs 1,550 Contingency 1,270 15,000	Implementation Schedule (Target Dates): Activity — Date Sign Project Agreement — 2/88 TA Contract signed — 6/88 Hospital diagnostic phase complete — 3/89 Focussed drug assessment complete — 3/90 DUKM legislation in place — 7/90 Final evaluation — 2/95	- Appropriately qualified TA will be available. - Suitable candidates for training will be available. - A local institution can be identified to help with project administration.	- Project documentation. - Evidence of training occurr TA contracts, etc.

ANNEX C

MINISTER OF HEALTH
REPUBLIC OF INDONESIA

Nr : 126/Menkes/II/1988 Jakarta, February 24, 1988
Re : Health Sector Financing
Project.

Mr. David Merrill
Director USAID Mission
c/o American Embassy
Jl. Medan Merdeka Selatan 3-5
JAKARTA.

Dear Mr. Merrill.

The purpose of this letter is to request a grant of up to 15 million United States Dollars (US $ 15.0 million) for the Health Sector Fi - nancing Project which we have developed in collaboration with USAID. The Government of Indonesia and other local organizations will contribute the Rupiah equivalent of US $ 5.515 million in cash and in kind to support this project through the period ending in March of 1995.

The purpose of the Health Sector Financing Project is to develop the institutional and policy context needed to ensure the financial sustainability of child survival programs. The project will help support the Ministry of Health's efforts during the next seven years to improve efficiency and cost recovery of government services and redirect savings to increase support for child survival programs. The outputs of the projects are :

(1) A system for improved management and structural changes in government hospitals resulting in greater operational efficiency, improved cost recovery, and less government subsidy to hospitals.

(2) Modifications in pharmaceutical management and distribution which result in improved efficiency, greater therapeutic benefit, and more resources for essential drugs which impact on child survival.

(3) Development of health insurance schemes which adhere to the principles of DUKM.

MINISTER OF HEALTH
REPUBLIC OF INDONESIA

(4) Development of health financing and policy analysis capacity within the Bureau of Planning of the Ministry of Health.

The project will be implemented by the Ministry of Health.

We look forward to your favorable consideration for this request.

Sincerely,

Dr. Suwardjono Surjaningrat
Minister of Health Republic
of Indonesia.

69

ANNEX D

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; of (B)(2) the Economic Support fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1988 Continuing Resolution Sec. 526. Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? No.

2. FAA Sec. 481(h). (This provision applies to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which

significant sums of drug-related profits are laundered with the knowledge or complicity of the government), has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 30 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, and to prevent and punish drug profit laundering in the country, or that (b) the vital national interests of the United States require the provision of such assistance?

(a) Yes.

(b) N/A.

3. Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec. 481(h)), has the President submitted a report to a Congress listing such country as one (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilities the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened

(a) No.

(b) No.

(c) No.

	with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcemen agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?	(d) No.
4.	FAA Sec. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government?	(a) No. (b) No.
5.	FAA Sec. 620(e)(1). If assistance is to a a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?	No.
6.	FAA Secs. 620(a), 620(f), 620D; FY 1988 Continuing resolution Secs. 512, 554. Is recipient country a Communist country? If so, has the PResident determined that assistance to the country is important to the national interests of the United States? Will assistance be provided to Angola, Cambodia, Cuba, Iraq, Syria, Vietnam, Libya, or South Yemen? WIll assistance be provided to Afghanistan without a certification?	No. N/A. No. No.

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7. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property?

No.

8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC?

Indonesia has an Investment Guarantee Bilateral with the U.S. which entered into force January 7, 1967 (TIAS 6330).

9. FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?

(a) No.

(b) N/A.

10. FAA Sec. 620(q); FY 1988 Continuing Resolution Sec. 518. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1987 Continuing Resolution appropriates funds?

(a) No.

(b) No.

11. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support FUnd, has the Administrator taken into account the percent of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

N/A.

12. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No.

N/A.

13. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operating Year Budget? (Reference may be made to the Taking into Consideration memo.)

Indonesia's U.N. Payments status was taken into consideration by the Administrator in determining the FY88 OYB.

14. FAA Sec. 620A; FY 1988 Continuing Resolution Sec. 576. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism?

No.

15. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?

No.

16. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

No.

17. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

No.

No.

18. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device?

No.

19. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministries of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo.)

Indonesia was represented at the meeting. Its position regarding the communique was considered by the Administrator at the time of approval of the FY88 OYB.

20. FY 1988 Continuing Resolution Sec. 528. Has the recipient country been determined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States?

No.

21. FY 1988 Continuing Resolution Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree?

No.

22. FY 1988 Continuing Resolution, Section 538. Does the country include as part of its population planning programs in voluntary abortion or sterilization? No.

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY.

1. Development Assistance Country Criteria.

FAA Sec. 116; FY 1988 Continuing Resolution, Sec. 511. Has the Department of state determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, No.

can it be demonstrated that contemplated assistance will directly benefit the needy? N/A.

2. Economic Support Fund Country Criteria. Not ESF-funded

FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest? N/A.

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded from Development assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT? Yes.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1988 Continuing Resolution Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project.

   A CN has been prepared. Obligation will occur following expiration of the Congressional notification period without objection.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of $500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

   (a) Yes.

   (b) Yes.

3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

   No further legislative action is required.

4. FAA Sec. 611(b); FY 1988 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent

   N/A.

practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See AID Handbook 3 for new guidelines.)	
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?	N/A.
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project?	No.
If so, why is project not so executed?	N/A.
Information and conclusion whether assistance will encourage regional development programs.	N/A
7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	(a) N/A. (b) and (c) Project will encourage and provide funds for growth of health insurance through private companies, coops, and other organizations. (d), (e) and (f) N/A
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	The Project will finance long and short-term technical assistance from the United States.

9. FAA Sec. 612(b), 636(h); FY 1988 Continuing Resolution Sec. 509. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

The GOI will provide the equivalent of over $5.0 million for the project, mostly for local costs.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

11. FY 1988 Continuing Resolution Sec. 522. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A.

12. FY 1988 Continuing Resolution Sec 552. (as interpreted by conference report). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers?

N/A.

13. FY 1988 Continuing Resolution Sec. 553. Will the assistance (except for programs in Carribbean Basin Initiative countries under U.S. Tariff Schedule: Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets of coin purses worn on the person), work gloves or leather wearing apparel? — No.

14. FAA 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: — Yes. See Annex E.

(a) stress the importance of conserving and sustainably managing forest resources; — (a) N/A.

(b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; — (b) N/A.

(c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; — (c) N/A.

(d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; — (d) N/A.

(e) help conserve forests which have not yet been degraded, by — (e) N/A.

helping to increase production on lands already cleared or degraded ; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

(f) N/A.

(g) N/A.

(h) N/A.

(i) N/A.

(j) N/A.

(k) N/A.

16. FAA Sec. 119(g)(4)-(6). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

(a) N/A.

(b) N/A.

(c) N/A.

(d) N/A.

17. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? — N/A.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(a), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

(a) The poor will benefit from increased GOI expenditures for child survival programs.

(b) N/A.

(c) The project directly addresses the problem of recurrent cost financing of health care to promote self-sufficiency.

(d) Women and their pre-school children are primary project beneficiaries.

(e) N/A.

b. FAA Sec. 103, 103A, 104, 105, 106, 120-21. Does the project fit the criteria for the type of funds (functional account) being used?

Project fully meets the criteria for FAA Section 104.

c. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	N/A
d. FAA Sec. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	Yes.
e. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	Yes.
f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.	The project design is based on 2 years of analytical work which explored local capabilities to carry on the activities within the project; local capabilities will be used to the maximum extent feasible to implement project activities.

g. FY 1988 Continuing Resolution Sec. 538. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? No.

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to under go sterilizations? No.

Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No.

h. FY 1988 Continuing Resolution. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization? No.

If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services? N/A.

i. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow others ? Yes.

j. FY 1988 Continuing Resolution. How much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

It is anticipated that the major technical assistance contract to be signed under the agreement will be with a Gray Amendment entity and potential Gray Amendment contractors are currently being sought.

k. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plan species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A.

l. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

N/A.

m. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance or roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development? N/A.

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Informatio and conclusion on capacity of the country to repay the loan, at a reasonable rate of interest. N/A.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest? N/A.

c.	FY 1988 Continuing Resolution. If for a loan to a private sector institution from funds made available to carry out the provisions of FAA Sections 103 through 106, will loan be provided, to the maximum extent practicable, at or near the prevailing interest rate paid on Treasury obligations of similar maturity at the time of obligating such funds?	N/A.
d.	FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?	N/A.
3.	Economic Support Fund Project Criteria	Not ESF-funded.
a.	FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of part I of the FAA?	N/A.
b.	FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes?	N/A.
c.	ISDCA of 1985 Sec. 207. Will ESF funds be used to finance the construction, operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such country is a party to the Treaty on the Non-Proliferation of Nuclear Weapons or the Treaty for the Prohibition of Nuclear Weapons in Latin America (the "Treaty of Tlatelolco"), cooperates fully with the IAEA, and pursues nonproliferation policies consistent with those of the United States?	N/A.

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?	N/A.

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. PROCUREMENT

1. FAA Sec. 602(a). Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? — Yes.

2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him? — Yes.

3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? — Indonesia does not so discriminate against U.S. marine insurers.

4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.). — N/A.

5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive — N/A.

capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States forms to compete for construction or engineering services financed from assistance programs of these countries.)

6. FAA Sec. 603. Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

No. Section 901(b) applies.

7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

Yes.

8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes.

9. FY 1988 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

All AID direct contracts will so provide.

10. FY 1988 Continuing Resolution Sec. 524. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? — Yes. Any such expenditures will be so available.

B. CONSTRUCTION

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? — N/A.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? — N/A.

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the CP), or does assistance have the express approval of Congress? — N/A.

OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? — N/A.

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? — N/A.

3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes.

4. Will arrangements preclude use of financing:

a. FAA Sec. 104(f); FY 1988 Continuing Resolution Secs. 525, 538. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion?

(1) Yes.
(2) Yes.
(3) Yes.
(4) Yes.

b. FAA Sec. 483. To make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes.

c. FAA Sec. 620(g). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes.

d. FAA Sec. 660. To provide training advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes.

e. FAA Sec. 662. For CIA activities? Yes.

f.	FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?	Yes. A world-wide light weight vehicle waiver applies.
g.	FY 1988 Continuing Resolution Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel?	Yes.
h.	FY 1988 Continuing Resolution Sec. 505. To pay U.N. assessments, arrearages or dues?	Yes.
i.	FY 1988 Continuing Resolution Sec. 506. To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)?	Yes.
j.	FY 1988 Continuing Resolution Sec. 510. To finance the export of nuclear equipment, fuel, or technology?	Yes.
k.	FY 1988 Continuing Resolution Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?	Yes.
l.	FY 1988 Continuing Resolution Sec. 516. To be used for publicity or propaganda purposes within U.S. not authorized by Congress?	Yes.

Annex E

UNITED STATES GOVERNMENT

memorandum

DATE: February 4, 1988

REPLY TO ATTN OF: Joy Riggs-Perla, O/PH

SUBJECT: Environmental Procedures and Analysis for Health Sector Financing Project (HSF)

TO: Ronald Greenberg, Mission Environmental Officer

Thru: Dr. E. Voulgaropoulos, Chief, O/PH

The purpose of this memorandum is to request your concurrence that the proposed project is categorically excluded from the environmental procedures in 22 CFR Part 216.

Background

During the preparation of the PID it was determined and approved by the Mission Director that an Initial Environmental Examination was not required in accordance with 22 CFR Part 216.2 (c)(2)(viii) and 216.3 (a)(1). While the HSF Project has changed slightly since the PID, is still meets the criteria for categorical exclusion as noted below.

Description of the Project

The purpose of the HSF Project is to develop the institutional and policy context needed to ensure the financial sustainability of child survival programs. This will be done primarily through initiatives to increase efficiency in the government hospital and pharmaceutical sectors, and by demonstrating the feasibility of shifting much of the burden of curative care into schemes which are self-financing. Resources which are freed up will then be diverted towards the preventive measures that most directly contribute to child survival.

Environmental Considerations

No Initial Environmental Examination, Environmental Assessment, or Environmental Impact Analysis is required for the HSF Project since the proposed project meets the criteria for exemptions to environmental analysis in 22 CFR Part 216.2 (c)(1) Categorical Exclusions under the Sections (i) and (viii). The HSF Project does not have an effect on the natural or physical environment (Section i) and it is a program involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment. The HSF Project will not be providing any funding for construction of facilities that will directly affect the environment.

Ronald Greenberg

Concur:
Ronald Greenberg
Mission Environmental Officer

Do Not Concur:
Ronald Greenberg
Mission Environmental Officer

cc. Bureau Environmental Coordinator
Steve Lintner, Ane/PD/ENV

OPTIONAL FORM NO. 10
(REV. 1-80)
GSA FPMR (41 CFR) 101-11.6
5010-114
★ U.S.G.P.O.: 1986-491-248/20641

Annex F

TECHNICAL ANALYSIS

F.1 Introduction

Extensive analytical work was undertaken over a two-year period in preparation for the HSF Project. These background analyses were important in helping the GOI and USAID confront the fundamental policy issues arising from the project and develop the methodology for addressing those issues in each of the project components.

This section discusses the technical feasibility issues analyzed during project design and provides a more detailed description of the background information used to construct the project components. It also explains the inter-relationship among the three major project components and the rationale for selecting the kinds of "structural" interventions that are central to the design of the project.

F.2 Social Financing Component

In September 1986 a joint Indonesian and U.S. consultant team conducted an in-depth analysis of Indonesia's health insurance sector[1]. That study assessed the present status of health insurance in Indonesia, both in the government and private sectors, with particular emphasis on existing health insurance plans, their management and administration, benefit packages, enrollment, and potential for further growth and development. The findings are summarized below.

F.2.1 Public Sector Health Insurance Plans

There are three major health insurance plans offered through the government, the ASKES program for civil servants, the PKTK scheme for wage based employees, and ASABRI for the military. Because the ASABRI program is confined to military personnel and not readily accessible, the analysis was limited to the former two schemes.

1. ASKES: ASKES is an acronym for the largest health insurance system in Indonesia, which purchases care for Indonesia's 3 million civil servants and their dependents (a total of 15 million members). ASKES was established in 1968 and has undergone a number of changes since that time. Today the ASKES system is administered by a government enterprise called the Perum Husada Bakti, which is responsible for both revenues and expenditures and has an independent governing board reporting to the Minister of Health and the Minister of Finance. ASKES operates essentially as an indemnity insurer. Premiums are paid by an

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1. H. Hunter and K. Binol, "Health Care Financing in Indonesia", USAID/Jakarta, September 1986.

automatic 2% payroll deduction for all civil service employees. Perum Husada Bakti operates much like a private entity purchasing services, on a fee-for-service basis, from government clinics and hospitals at what many consider subsidized prices. Current problems in the system include: excessive use of, and expenditures for, drugs, an increasing demand for expensive secondary and tertiary care; escalating hospital costs; over-utilization by the covered population; client dissatisfaction with the quality of services provided; inadequate claims control and accounting systems; lack of quality control; and a poorly developed management information system. Introducing improvements in this system represents a good opportunity for providing and improving health care for a large number of people in Indonesia. Reforms in fee structures and revenue retention policies could allow ASKES to serve as a major source of financial resources that can be mobilized for child survival.

2. PKTK: This public sector insurance system is operating on a pilot basis. It is based on voluntary enrollment of private employers in a number of urban areas. It is a joint program between the MOH and the Ministry of Manpower's Workmen's Compensation Program called AsTek. AsTek is responsible for the insurance aspect of the schemes, including premium collection, reimbursement for services and marketing the program. In some of the pilot areas, the MOH is the provider of services. Not all of the schemes are the same and little is currently known about how successful schemes outside of Jakarta have been. There are well recognized problems with the Jakarta-based PKTK pilot scheme, some of which are the same as those encountered by the ASKES system. There is a pressing need to contain costs, improve the quality of care by expanding sources of care to private providers, establish an actuarial basis for premium rates, and improve the premium collection and pricing systems. The analysis concludes that the PKTK scheme could provide a valuable source of socially financed health care to certain market segments, but its growth and expansion will be slow unless certain structural changes are made to improve the quality of service and market the product.

F.2.2 Private Sector Health Insurance Plans

Only four companies in Indonesia now sell group health insurance, all of the indemnity type, with a total coverage of less than 30,000 people. Individual policies probably double that number. Current insurance regulations require that any policy sold by a general insurance company cover only in-patient care to individuals on an indemnity basis. In order for a company to sell health insurance, it must also include life insurance. One company, Timur Jauh/Aetna offered a capitated, prevention oriented package but had difficulties due to providers' and clients' lack of familiarity with the concept. It now provides a group practice fee-for-service package which is more popular, but cost containment, especially for drugs, is a problem. The analysis also found that several individual providers or groups of providers were offering their services on

a capitated pre-paid basis. This phenomenon was most prevalent in urban areas with a surfeit of facilities and providers. However, several entrepreneurial providers were marketing their services on a capitated, pre-paid basis to employers with large numbers of employees looking for ways to control the costs of employee health benefits. Several large organizations with large numbers of employees, such as Pertamina, Mobil, Unilever, and P.T. Tambang Timah, were exploring ways to convert existing self-insurance programs into HMO-like health insurance.

The potential for introducing socially financed health schemes to rural communities was also investigated. Large rural co-ops were identified as one promising avenue because they provide access to large numbers of rural inhabitants, all of whom are engaged in efforts of similar productive enterprise, and they offer an existing administrative entity around which health insurance schemes can be organized.

The analysis also considered the potential of using existing village-level health funds, called Dana Sehat, to introduce socially financed health insurance to rural communities. The Dana Sehat are normally set up to fund supplementary feeding programs for pre-school children, to provide loans to individuals for acute care needs, or to pay for special health projects in a village. Recently there have been reports of Dana Sehat groups using the funds to negotiate pre-paid arrangements with public clinics for consultants and a limited amount of drugs. In their current form, Dana Sehat do not represent a very promising avenue for collectivizing the demand for health care. However, very little information exists about where successful Dana Sehat are operating, whether federations of such schemes could be organized around an existing economic entity (such a rural co-op) to provide opportunities for the administration of social financing schemes. Because of the opportunity for reaching large portions of the rural population in this manner, the project will experiment with expanding the Dana Sehat federation idea if it appears to be feasible after careful investigation.

The analysis concluded that enormous potential exists in Indonesia for expanding capitated, prepaid, managed health care programs in the private sector. The targets of opportunity considered most interested in introducing health insurance in the private sector were:

1. Large life insurance companies possessing adequate capital which are interested in diversifying into health insurance. Health insurance could be offered as a rider on life insurance policies, thus fulfilling existing legal requirements.

2. Groups of providers or hospitals interested in developing group practices on a capitated, pre-paid basis. Opportunities would present themselves initially in urban areas where excess provider and service capacity exists. Large companies possessing a critical mass of employees would be a very attractive potential market for these plans.

3. Industrial companies with large numbers of employees and possibly existing self-financed health infrastructures which are interested in converting their existing health benefit packages into a capitated, premium-based system which shares risk among clients and providers. The risk sharing arrangement inherent in such schemes will control escalating costs, and recent changes in the tax law, which disallow self-insured health expenditures as an income tax deduction, provide strong incentives for such companies to convert to a capitated pre-paid system to provide health benefits.

4. Organized community groups such as farming or dairy cooperatives and Dana Sehat, which would like to provide health care to their members on a capitated basis. Such schemes could provide more equitable access to health services for rural people. Linked to government clinics and hospitals, they could also mobilize more community resources for health.

The strategy of the project for this component is two-fold: (1) assistance will be provided to improve existing public and private schemes which offer a way of making large-scale improvements with relatively small investments in technical assistance and training, and (2) funds will be provided for the initiation of new models of social financing schemes which are expected to emerge as the result of the feasibility work and technical assistance provided through the project. In the process of developing this component, the MOH/USAID working group was cognizant of the importance of the project playing a catalytic role for initiating schemes as well as of the dangers of government involvement. The need for creating an environment which encourages diversity and experimentation and avoids rigidity or excessive public sector interference in private social financing schemes was discussed extensively. This principle remains an underlying philosophy throughout the project. A balance will be sought which allows for the proliferation of social financing schemes to be demand-driven and yet provides guidance to offer alternatives which will help contain costs, offer consumer protection, and that are appropriate to the health and economic conditions found in Indonesia.

The uncontrolled growth of health insurance in other settings has led to the proliferation of predominantly indemnity or casualty type health insurance which does not share risk equitably, favors curative care, and has caused uncontrolled inflation of health care costs. The MOH has recognized this problem, and has established principles, called DUKM, for guiding the development of health insurance in Indonesia. These are described in detail in Section 4.3.1. The analyses recommend that some formal mechanism, preferably with multisectoral representation, be created to coordinate and guide the growth and development of health insurance within both the public and private sectors in accord with these principles, and that this mechanism be authorized legislatively. The project has responded to these recommendations with efforts to develop GOI capacity to foster health insurance.

In the long run, it is anticipated that growth in pre-paid health insurance, especially in the private sector, will help lessen dramatically the investment the GOI must make in providing personal health services and that there will be a gradual shift in favor of the MOH's mandate becoming more oriented to public health problems. Over the next ten years, the emphasis for the MOH will need to be on child survival programs. There should be a parallel growth in the total resources available for health care in general, primarily due to private sector resource mobilization.

F.3 Hospital Sector Reforms

As stated earlier a careful disection of the MOH's budgets revealed the predictable "mortgage" on the available resources represented by the hospital sector (described in greater detail in Annex G). To understand the hospital sector and investigate the possibility of diverting resources away from hospitals and toward child surivival, several detailed studies of hospital expenditures and the organization of hospital services have been undertaken by World Bank[2] and USAID consultants[3] in collaboration with Indonesian experts. The following are some key findings from these studies:

(1) The bed-to-population ratio in Indonesia is lean. For all hospitals, the bed/population ratio is about 0.65 beds per 1000 population. For general hospital beds, it is about 0.50 beds/1000 population. Bed occupancy rates are quite low, running about 52% in the aggregate, indicating that in spite of the relatively low bed-to-population ratio, the hospital sector is over-bedded relative to demand.

(2) Private hospitals provide 31% of total hospital beds and 25% of general hospital beds; the government hospitals are the major factor on the supply side of the market for hospital services. Most bed capacity in the private sector is in the church-related hospitals which provide about 27% of the total beds.

(3) The government hospitals operated by the MOH and local governments are classified as A, B, C or D in descending order by the number and sophistication of services they provide. The A level hospitals are tertiary-level referral centers. The distribution among classes is as follows:

2. H. Barnum, "Hospital Expenditure in Indonesia", World Bank PHN Technical Note 87-17, June 1987.
3. C. Stevens and A. Doodoh, "Increasing the Efficiency of Health Services in Indonesia: A Key Strategy for Child Survival, USAID/Jakarta, September 1986.

Class	No. Hospitals (percent)	No. Beds (percent)
Class A	4 (1 percent)	2918 (7 percent)
Class B	16 (5 percent)	2396 (22 percent)
Class C	79 (25 percent)	15183 (35 percent)
Class D	219 (69 percent)	15505 (36 percent)

Class C and D hospitals provide 71% of the beds and comprise about 94% of the total number of government hospitals.

(4) There are a number of problems with public hospital services which are probably more related to structural and incentive problems than to technical ones. Bed occupancy rates are generally low, especially so for the Class D hospitals, but the reasons are not entirely clear. The quality of care offered is perceived as being sub-standard and there may be problems with respect to affordability of services, particularly because payment for services is on a fee-for-service basis, the most onerous from the client's point of view. Fees collected by public hospitals are remitted back to the general Treasury and therefore few incentives exist for efficiency.

(5) Experts who have examined the hospital sector believe that cost recovery and efficiency could be improved by reforms that put public hospitals at greater risk for failure and success. The solutions are not simple or straightforward and reforms must be implemented carefully. Simply increasing fees may further erode utilization rates. Allowing hospitals to retain revenues without other changes could result in great pressure to collect fees without any real ability to do so. Reforms in the hospital sector must thus be made on a pilot basis and must involve social financing in order to be successful.

The HSF project will provide the opportunity for reforms to be instituted which could make important structural changes in the way hospitals are operated in Indonesia. The MOH recognizes that reallocating more resources for child survival will require shifting public resources away from the hospital sector while trying to increase private resource mobilization. But in order to decrease the public sector subsidy to the hospital sector, basic reforms will need to be instituted which allow for improvements in efficiency and self-sufficiency in public hospitals. MOH planners intend to use this project as a means for conducting the pilot testing and further analysis required to develop the necessary reforms. This intention will be described in the next Five-Year National Development Plan. As with the social financing component, the project will not pre-design all of the interventions. Activities in this component will begin with a diagnostic phase that will provide an opportunity to make an detailed study of the factors which contribute to inefficiency and low cost recovery before attempting to institute changes. This will avoid recommending symptomatic remedies for problems which are systemic in nature.

One of the issues the project faces in this component is the whether or not USAID will be able to locate a long-term technical consultant who has relevant experience in hospital administration in the developing country context and who will be able to take techniques of modern hospital management and apply them in situations dramatically different than those found in industrialized countries. A careful recruitment job thus lies ahead.

F.4 Pharmaceutical Sector Reforms

Over the past year, the MOH, with assistance from USAID through Management Sciences for Health (MSH), has undertaken an extensive seven-province study[4] which has helped to quantify and verify some of the inefficiencies suspected to exist in the area of drug procurement and distribution. The major findings of that study were summarized in Section 3.2 of the project paper. The study also makes suggestions about opportunities for therapeutic and economic efficiency in the drug sector, given its importance to child survival and the proportion of the MOH's resources the sector consumes. These are:

Selection: Improvement in the public sector essential drug list can be made to restrict products which have limited therapeutic value for health center patients and could conserve large portions of the drug budget (e.g., kanamycin, injectable oxytetracycline, chloramphenicol, antitussives and most injectable vitamin preparations). The use of newer, more cost-effective drugs like oral penicillin, folate or folate-iron by physicians should be encouraged.

Financing: Consumer studies are needed to determine willingness to pay in connection with attempts to improve cost recovery and to determine what is feasible and desirable for certain kinds of drugs. Information is needed on reforms that can be instituted to provide positive incentives for drug system managers to increase efficiency and hold down costs. Also planners must choose the kinds of pharmaceuticals the GOI should spend public resources on (e.g., vaccines) versus what consumers should finance directly (e.g. some categories of symptomatic remedies).

Procurement: Procurement too often has been based on historical usage patterns rather than estimates of need based on sound epidemiological information. Experience with trying to change drug procurement patterns at the regency level within another USAID-funded projects provides encouraging evidence that medical officers will make substantial improvements following workshops in which the problems were discussed. This success needs to be expanded.

4. "Analysis of Child Survival Pharmaceuticals in Indonesia," MOH/MSH/YIS, USAID/Jakarta, June 1987.

Distribution: Indonesia has avoided the "central medical store" distribution system which causes problems in other countries. Kegency and health center level drug management practices need to be improved and strengthened.

Use: Much remains to be done in the area of improving drug prescribing patterns and patient expectations. As in other developing countries, there are many practices, both by physicians and patients, which result in inappropriate prescriptions, sub-therapeutic doses of multiple products and much waste via the use of unnecessary drugs . Ways need to be found and tested to change patient demands for inappropriate drugs and standard treatment guidelines need to be developed to help improve therapeutic efficiency.

A Phase II study is now underway which takes a more detailed look at physician prescribing decisions at several levels within the health care system and attempts to determine how changes can be made. This information, in addition to other focused assessments and studies funded through this project, will lead the way to fairly substantial changes throughout the health system. Again, the project takes an operations research approach to the careful identification and resolution of problems within the sector. Results of pilot testing or demonstrating alternate approaches will be presented to decision makers to give concrete evidence of how changes in policies and programs can result in increasing the impact of MOH investments.

F.5 Inter-relationships among Project Components

A brief explanation is in order regarding the nature of the inter-relationships among the project components, including the component which addresses improving health financing and policy analysis capabilities within the MOH. The rationale for choosing the three project components in relation to making more resources available for child survival programs has been covered in the background and rationale section of this paper. There are two important points to be made about the relationships among the components. (1) Social financing is linked with the hospital sector activity because it will eventually be the key to more effective cost recovery in that component of the project. Likewise, activities to increase various forms of social financing will certainly have a impact on the availability and utilization of hospital services. In the Philippines, for instance, the establishment of a national health insurance system resulted in a rapid growth of private hospitals throughout the country. (2) Improvements in the pharmaceutical sector will have an immediate impact on hospital pharmacy operations, which form a significant cost center for hospital operations as well as for the public health insurance systems.

And finally, the minor component (minor in budget terms) is the important glue which holds the other three components together in terms of national policy. The Bureau of Planning within the Ministry of Health is steadily developing a nucleus of expertise in health financing and policy analysis. This nucleus has been stimulated by support provided, principally

technical assistance and money for research, by the World Bank, WHO and USAID. This project takes this development a step further by providing staff training, funds for economic and policy analyses, and further short-term technical assistance to help institutionalize the capacity to continue this kind of work in the future. The policy decisions that have been and will continue to be stimulated by this project need a focal point which is now the Bureau of Planning. The Bureau has demonstrated its ability to raise crucial issues to the appropriate policy levels within the MOH, no matter which functional unit of the Ministry is involved. It is important for this analytical capacity to grow and increase its credibility as the "think tank" for the MOH. While many of the actual studies will be contracted out to private institutions, the core staff of analysts in the Bureau will need to continue improving their ability to know when research is required and to translate this work into concrete policy options for senior policy makers.

Annex G

FINANCIAL ANALYSIS

The financial analysis assesses the extent to which reallocations in favor of child survival programs can be made from projected health budgets, the level of efficiency savings which could be gleaned from expenditures on hospitals and pharmaceuticals, and the volume of additional funds which can be raised from non-government sources such as user fees and social insurance schemes. The analysis consists of the following elements:

- o. An analysis of the trend over the past five to seven years in budget allocations and expenditures for various programs and at various administrative levels,

- o. A description of the various elements of the Ministry of Health (MOH) budgets and how resource allocation decisions are made with respect to each major budget category,

- o. An analysis of trends in the proportion of budgets that can be attributed to child survival program components as compared to those predominately involving the provision of hospital-based (and presumably not strictly child survival) curative medical services,*

- o. An estimation of the percentage of future routine funds that could be shifted away from supporting hospital services in favor of sustaining or even increasing support for child survival services delivery, taking into account the extent to which future MOH routine budgets are already "mortgaged" in the sense that funds already may have been committed irretrievably to supporting services provided by hospitals and other fixed facilities, and

- o. An evaluation of potential savings of funds in hospital services provision and drug supply which could be reallocated to support child survival programs, coupled with an estimation of how much the MOH budget (and presumably delivery) burden could be reduced if a substantial proportion of the population were to receive personal health services through the establishment of viable social health insurance scheme(s).

*It should be noted that some significant portion of child survival services (e.g., treatment of respiratory illnesses) in principle can be provided effectively in hospitals. Presumably this is the case in Indonesia. Thus, the trade-off between hospital and child survival service provision is not entirely clear-cut. But because it is true that the bulk of hospital resources are in fact devoted to the provision of types of curative services other than those identified with child survival, we will not attempt to make any adjustment for the purposes of this analysis.

G.1 Budget Analysis

G.1.1 Analyses of Budget Trends

Table 1 shows the levels of GNP Indonesia has achieved in recent years. Note that neither a reduction in aggregate GNP, measured in constant prices, nor a reduction in nominal spending on the part of the central government was experienced over the interval 1978-1985.

Table 1: Indonesia GNP and Central Government Expenditures over Time
(Rp. Billions, GNP in 1983 Prices)

1978	1979	1980	1981	1982	1983	1984	1985
GNP							
58,190	61,777	66,675	71,613	71,377	73,698	78,214	79,046
Central Government Expenditures in Nominal Terms							
5,029	8,076	11,716	13,916	14,355	18,311	19,380	22,825
Central Government Expenditures in 1983 Prices							
11,139	12,501	15,484	17,143	16,124	18,311	17,768	20,047

Sources: Central Bureau of Statistics for GNP and price index data, and Ministry of Finance for nominal expenditure data.

However, when central government expenditure data are adjusted to a basis of 1983 prices, the data reveal variations in real expenditures between 1981 and 1982 and 1983 and 1984. Moreover, real expenditures show signs of dropping off, particularly with respect to GNP after 1983. Central government expenditures as a share of GNP grew dramatically over the entire interval 1978-1985.

The lower oil prices experienced over fiscal years 1985/86-1986/87 required some remarkable and serious adjustments by the government. Oil and other commodity prices had begun to fall early in the 1980s, but these declines were regarded as transitory. By 1985/86, crude oil prices fell by one half, from US$25/barrel to US$13/barrel in 1986/87. Central government

expenditures declined in 1986 to 21.7 trillion Rupiah in nominal terms, but declined to 17.5 trillion Rupiah in terms of 1983 prices (the latter number was derived by deflating nominal central government expenditure data for 1986).

The speed and the extent of the decline in oil prices were not anticipated by GOI officials. The loss in revenue was equal to about one third of domestic budget revenues and total debt service ratios rose to 37% in 1986. If not properly handled, these circumstances could have led to a collapse in the domestic economy. It was recognized by GOI officials that the decline in oil revenues was not transitory and drastic measures were in order. Many countries would have attempted to continue borrowing, increase domestic debt financing drastically, and otherwise delay taking strong action to bring about the the structural re-adjustments needed to attempt to continue the process of development.

Although the GOI had already initiated various reforms and adjustments during the early 1980s, it took rapid and strong corrective measures beginning in 1985/86. In short, the GOI "bit the bullet" quickly and hard. The measures taken by the GOI are reported in detail in various World Bank reports.

Of greatest concern to health officials was the GOI action taken to restrain public expenditure through curtailment and rephasing of development project expenditures. A very significant cut in the overall GOI budget was initiated in 1986/87, from 22.8 trillion Rupiah in 1985/86 to to 21.4 trillion Rupiah in nominal terms in 1986/87. However, the development account suffered a more significant absolute and relative reduction, 10.8 as compared to 8.3 trillion Rupiah between the two years, a difference of 2.5 trillion Rupiah.

The World Bank estimates GNP growth on the order of only 2.3% over the interval 1986 to 1988. However, growth rates of 3.4% and 4.0% are forecast for intervals of years between 1989-90 and 1990-1995, respectively. Although these growth rates are not nearly so favorable as those experienced during the 1970s, (roughly 7% per annum), those forecast for the interval beyond 1986-88 are significant. The immediate economic crisis appears to have been overcome and dealt with in an extremely responsible manner. The AID Mission projects total government revenues to increase from 21.9 trillion Rupiah in 1986/87 to Rp.28.7 trillion in 1990/91 in nominal terms. Funds available for the development account, after allowing for debt service and inflation, are projected to decline from Rp.8.3 trillion in 1986/87 to only Rp.7.2 trillion in 1990/91.

It is difficult to predict the growth rates which may occur after that period due to uncertainties regarding future oil prices and production, the large debt service obligations that are likely to persist, and the extent to which the GOI can "upstream" the economy and substitute non-oil related exports for exports of petroleum and related products. Indications are that some growth will occur, but at only modest levels after 1991. Thus, the government will be able to allocate only modest funds to selected domestic programs, including health programs, in the near future.

As will be demonstrated, principal concern focuses on the central government's health allocation to both the development and routine accounts. But attention must first be focused on how much Indonesia spends on health and second on the principal sources of financing. Typically, countries in South East Asia spend comparatively small amounts on health care. However, Indonesia's outlays on health appear to be inordinately low. Current data suggest that Indonesia spends less of its GNP on health care than any country in South East Asia (see Attachment I).

G.1.2 Analysis of Health Expenditures and Budgets

Table 2 presents national expenditures on health in relation to GNP and population growth.

Table 2: National Expenditures on Health in Relation to GNP and Population
(Rp. Billions and percentages where indicated)

	1982/83	1983/84	1984/85	1985/86	1986/87
Nat. H. Exped.	1,603.1	1,778.4	2,020.5	2,266.5	2,457.5
Nat. H. Exped. as % of GNP	2.7	2.5	2.3	2.3	2.2
Pop. Growth %	2.2	2.2	2.2	2.1	2.1
Gov. H. Exped.	489.4	529.6	564.2	673.4	699.9
Gov. H. Exped. as % of Nat. H Exped.	30.7	29.7	28.1	29.6	30.7
Gov. Exped. as of % GNP	.83	.65	.65	.68	.68

Source: Health Expenditure and Financing in Indonesia, Dr. Ridwan Malik, M.P.H., October 5, 1987.

"Nat. H. Exped." represents total expenditures and includes public and private outlays on health services of all kinds. As Table 2 shows, health has received a declining share of GNP over time and in recent years has barely kept pace with the rate of increase population growth. In addition, government outlays on health care have been reduced dramatically since 1982 and during the entire interval has averaged far less than 1% of GNP. Although not shown in Table 2, Malik (ibid.) calculates per capita spending on health from all sources at 14,561.1 Rupiah in 1986/87. At an exchange rate of 1,640 Rupiah to the US dollar, this expenditure is equivalent to about $8.88. Of this, 63.7% of total expenditure was private, or $5.66 per capita, while only $3.22 per capita was spent by government.

Clearly the Indonesian society, and particularly the government, does not spend much on health, yet the incidence of "traditional" developing country diseases and illnesses is very high. This is alarming given the fact that Indonesian society is undergoing a transition toward modernization which will be accompanied by an increasing incidence of chronic, degenerative and expensive-to-treat diseases. It is important not only to "save lives," but also to avoid the debilitating effects of illness survived. Although children survive childhood illnesses, they often do so with actual and/or potential future disability which could be avoided entirely.

Because the workforce of tomorrow consists of the pool of children existing today, future growth and productivity are largely dependent on the investments made in child survival today and in the near future.

Recognizing that the private sector and government are spending so little on health, the types of services financed assume greater importance. It is important that developing societies, including both the government and private sector, spend a great deal on preventable illnesses on behalf of children to enable them to become more productive members of the work force in the future.

Table 3 shows the distribution of funds for health expenditures among administrative levels of government as well as state enterprises and private expenditures.

Table 3: Percentage Distribution of National Health Expenditures

	1982/83	1983/84	1984/85	1985/86	1986/87
Gov. Funds	30.7	29.7	28.1	29.6	30.7
Central	22.0	20.0	18.2	18.1	22.0
Province	4.7	5.2	5.7	6.7	4.7
District	4.0	4.5	4.2	4.8	4.0
State. Ent.	5.7	6.5	6.9	6.6	5.7
Private	63.7	63.8	65.2	63.7	63.7

Source: Health Expenditure and Financing in Indonesia, Dr. Ridwan Malik, M.P.H., October 5, 1987.

Table 3 clearly illustrates the constant contribution that both the public and private sectors have made over time toward financing health care in Indonesia and establishes central-level spending as making up the largest portion of government funding for health care. In addition, a good deal of the funds allocated to provincial and district governments originate from the central government level.

Preliminary indications are that the private sector is an even larger source of funding than the percentages presented in Table 3 indicate. It has been suggested that the private sector share is as high as 75% and that government financing at all levels is on the order of only 25% rather than the 30% suggested by the data currently available.

Table 4 presents the actual expenditures or "realization" by sources of government financing for fiscal year 1985/86 by program or "functional account."

Table 4: Government Health Expenditures by Programs and Sources of Funds (Fiscal Year 1985/86, Rp. Billions)

	Hospitals	Health Centers	Programs	Manpower & Training	Others	Total
CENTRAL						
Dev.	25.4	13.4	35.6	11.0	9.3	94.7
Routine	67.6	2.0	2.0	9.7	41.3	122.6
InPres		84.9	29.7	-	-	114.6
PROVINCIAL						
Dev.	9.0	7.6	12.6	1.0	5.7	35.9
Routine	52.1	.16	.08	.07	64.0	116.5
DISTRICT						
Dev.	1.7	2.8	.04	.64		5.2
Routine	37.1	10.3	1.0	.0	56.2	104.4
TOTAL	212.4	138.4	67.2	29.2	180.0	622.1

Source: Health Care Financing in Indonesia, Broto Wasisto, et al., presented at the Asian Development Bank Health Care Financing Seminar, Manila, August 4, 1987. Under revision.

Principal interest in terms of child survival activities focuses on allocations to hospitals as compared to allocations to health centers and to programs as functional accounts. Most child survival activities are conducted at the health center level and below and also are the bulk of the activities conducted in the category of "programs," which mainly consists of

EPI activities. The "others" category consists mainly of administration at all levels. Manpower and training also "cut across the board."

Clearly, the bulk of funds, even after allocation to lower levels of government, remains under the control of the central government.

Collectively, the bulk of provincial and district level funds are "locked-in" to routine expenditures and are small in comparison to central government funding.

Thus, the analysis here will focus on the central budget/expenditure categories. The major issues concern the levels of central budget allocations over the last three years, during which time central budgets and consequently expenditures were drastically reduced. Table 5 presents MOH central budget expenditures over fiscal years 1982/83 to 1986/87.

Table 5: Central MOH Expenditures, 1982/83 to 1986/87
(Nominal and 1983 Price Adjusted, Rp. Billions)

Fiscal Years	82/83	83/84	84/85	85/86	86/87
DEVELOPMENT (APBN-DIP)					
Nominal	108.4	101.7	101.7	94.8	65.2
Real (1983 Prices)	121.8	101.7	93.2	83.2	46.2
ROUTINE (APBN-DIK)					
Nominal	78.5	83.3	97.3	122.6	138.8
Real (1983 Prices)	88.2	83.3	89.2	107.7	111.9
PRESIDENTIAL SPECIAL FUNDS (INPRES)					
Nominal	98.5	98.5	98.5	114.6	114.6
Real (1983 Prices)	110.6	98.5	90.3	100.6	92.4
SUBSIDY FOR OPERATIONS AND MAINTENANCE (SBBO)					
Nominal	6.5	8.1	8.2	9.5	9.7
Real (1983 Prices)	7.3	8.1	7.5	8.3	7.8
TOTAL (NOMINAL VALUES)	291.9	291.6	305.7	341.5	328.3
TOTAL (1983 PRICES)	327.9	291.6	280.7	268.5	216.5

Source: Bureau of Planning, Ministry of Health, November, 1987.

Note that no effort throughout this analysis has been made to deflate nominal values by converting them into US dollars at exchange rates prevailing at various points in time. Conversion to US dollars is only useful if one wants to make international comparisons (e.g., Japan's GNP versus that of the U.S.), or if a significant portion of expenditures involve importation requiring substantial foreign exchange. Because most MOH expenditures are in local currency, there is little point in converting expenditure data to dollars.

Clearly the MOH central budget (and consequently expenditures) has fallen drastically in recent years. Over the entire interval 1982/83-1986/87, central MOH expenditures declined by over 33% in real terms (1983 prices), and a sizable portion of that occurred in the most recent year when expenditures in real terms declined by 19% from levels in 1985/86.

In nominal terms, total expenditures increased by about 12.5%, with routine expenditures (APBN-DIK) increasing by about 77%, InPres outlays increasing by roughly 16% and SBBO increasing by about 49% over the period. However, development expenditures (APBN-DIP) declined by approximately 40% in nominal terms, or about 62% in real terms over the entire period, and suffered a decline of nearly 50% in real terms between 1985/86 and 1986/87.

In order to fully assess the consequences of these very significant declines in expenditures, it is necessary to analyze the elements financed by each of the major components of central budget/expenditure categories as well as the decision process by which budgets and expenditures are determined.

G.2 Description of MOH Budget Decision Processes and Components

G.2.1 Budget Decision Processes

The basic budget allocation occurs in connection with the development of the Repelita, or national five-year development plan. Theoretically, the planning process is to be a bottom-up process initiated at the district level. However, because the bulk of funding comes from central government sources, the district plans are taken into consideration by central authorities who ultimately make final budget allocation decisions which may be much different from what district planners envisioned.

The national priorities are set by the Cabinet and general guidelines are issued by the central planning agency (Bappenas) to all government agencies including the MOH. Upon receipt of the general quidelines, the Minister of Health, in consultation with the Director Generals of the various directorates, sets the policy priorities for the ministry within the framework of Bappenas, national development guidelines. The various directorates submit their budget requests to the Secretary General of Health and Director General of Planning, who in turn discuss budget requests with each Director General individually.

After first-round consultations, the Planning Director, in consultation with the Secretary General and the Minister, prepares budgets for the entire health sector, attempting to reconcile differences in the perception of priorities among the MOH directorates. This draft is circulated to the Secretary General, Minister, and Director Generals.

Joint meetings are held to discuss differences. Final decisions are made by the Minister, and the Director of Planning begins negotiations with the appropriate officials in Bappenas and the Ministry of Finance (MOF), periodically consulting with the Secretary General and the Minister of Health. Once agreement is reached by all parties, the budget is finalized and included in the Repelita.

However, the plan is a rolling plan and mid-year supplemental budget requests and reallocations among line items are usually permitted. Also, at the beginning of December in each year, resubmissions of the following fiscal year's budget requests are to be submitted to Bappenas and the MOF for final decision, which is reached in much the same fashion prior to April 1st, the beginning of the next fiscal year.

Throughout this process, consultations are held with provincial and district officials and often administrators of individual hospitals and health centers as well as the managers of major programs. Politicians often attempt to influence decisions, particularly development projects such as hospital and health center construction. Often, construction projects that have not been completed due to funding restrictions and work backlogs are included in the plan. Generally speaking, in the past, funds for construction projects not initiated or completed within the scheduled time could be carried over for a period as long as three years. However, in recent years of budget austerity, carry over beyond one year has not been permitted.

G.2.2 Priorities for Repelita V

Of particular interest to the present study are examples of the types of priorities established for the MOH by the Minister of Health. Most relevant are the priorities that have been established for 1989-1993 in Repelita V. These priorities are:

1. Support of Child Survival Programs

2. Support for Maintaining Existing Ongoing Programs

3. Matching Funds Required of Foreign Assistance

4. Support of Continuing Manpower Development

All in all, these priorities make a great deal of sense and fit well with the aims of USAID's strategy for the health sector. In this planning period's negotiations, the MOH is prepared to fight for an increased budgetary allocation or to at least hold out for no additional cuts in either development or routine budgets.

The MOH Planning Bureau is prepared to attempt a reallocation of funds from the support of hospitals to the support of child survival programs given its highest ministerial priority. The MOH is prepared to experiment with raising user fees at hospitals and health centers in selected areas where it appears that people could afford them. The MOH is also anxious to experiment with public and private social financing schemes in an effort to mobilize more community resources to support the provision of health services.

G.2.3 Description of Budget Components

The major budget categories were described briefly in Section 3.2. of the project paper. They are the development account (APBN-DIP), the routine account (APBN-DIK), the presidential or InPres account, a subsidy for operations and maintenance (SBBO).

G.2.4 Investment versus Recurrent Expenditures

The confusing thing about the Indonesian budget categories is that one expects development (DIP) and routine (DIK) budgetary categories to reflect investment and recurrent expenditure categories. This is not the case.

Both the APBN-DIP and the APBN-DIK fund large amounts of recurrent expenditures. Thus, reductions in the DIP account do not reflect a "rephasing" of capital expenditures; rather, they reflect cutbacks in recurrent expenditures as well. Prescott estimates that the recurrent portion of the DIP account has remained fairly constant over the previous five years.*. However, the drastic reduction in the DIP account, which has not been offset by corresponding increases in the DIK account, leads to the conclusion that reductions have occurred with respect to important ongoing programs, including child survival. What is needed is a picture over time of what has happened to expenditures on hospitals, drugs, and child survival as major program elements. Developing this picture requires some ingenuity.

G.3 Expenditures on Child Survival and Proportions Over Time

G.3.1 Expenditures on Child Survival and Other Major Programs

Table 6 presents a breakdown of price adjusted absolute expenditures and percentages by type of health program funded by the Indonesian government from 1982/83 to 1986/87.

*Nick Prescott, Indonesia, Health Planning and Budget, February 1987.

Table 6: Government Health Expenditures and Percentages, 1982/83-86/87
(Rupiah Billions, 1983 Prices Unless Percentage is Indicated)

	82/83	83/84	84/85	85/86	86/87	% Dif.
1. HOSPITALS	175.8	186.8	173.6	187.4	168.6	-4.1
Central	107.7	104.4	92.9	90.0	79.6	-26.1
Prov. & Dist.	36.7	68.8	72.5	87.8	86.1	+134.6
2. PROGRAMS & HEALTH CENTERS	142.3	119.3	123.6	136.5	116.0	-18.5
3. CHILD SURVIVAL	63.0	53.1	54.6	60.3	50.2	-20.3
4. ALL OTHERS	117.4	99.4	93.9	116.0	117.0	-0.3
5. TOTAL GOVT.	467.1	445.8	437.5	490.5	451.8	-3.9
% HOSP.	37.6	41.9	39.7	38.2	37.6	0.0
% CHILD SURV.	13.5	11.9	12.5	12.3	11.1	-17.8

Source: Adapted from Health Expenditure and Financing in Indonesia, Dr. Ridwan Malik, M.P.H., revised November 10, 1987. Note that expenditures over the period were adjusted to 1982/83 prices using the same price indices used to adjust other time series included in this analysis (see World Bank Report No. 6694-IND, Indonesia Strategy for Economic Recovery, May 5, 1987, Statistical Annex, Table 9.1).

Each of the categories above includes total GOI spending from central, provincial and district level development and routine budget categories, plus foreign assistance contributions (allocated under central government expenditures only) in each year. Ministry of Education and Defense outlays on hospital services and manpower are included as well.

The data presented in Table 6 reveal a great deal about the trend in government expenditures over time, in addition to the trend in outlays for child survival. The data indicate that government outlays on health, in constant prices, have been decreasing over time. There has been a modest decline in expenditures on hospitals, accompanied by a shift in spending away from the central level to the provincial and district levels. At the beginning of the period, central government outlays on hospitals were about three times those of lower levels of government, but by 1986/87 it appears that central government hospital expenditures were significantly less than those at lower governmental levels.

Central government outlays on hospitals have declined dramatically over the period in real terms. Thus, there is less to "squeeze" out of central hospital budgets than many observers have suggested. Most of the growth in spending has occurred in favor of provincial hospitals.

Even with this growth in hospital spending, the occupancy rates are still low. Bed occupancy rates of class A, B, C, and D hospitals were 76.9, 67.8, 59.1 and 48.4% respectively, in 1986/87. The fact that these rates are so low suggests either that in the minds of potential clients they offer very little by way of service, or that the user fees charged are beyond the capacity of many or most potential patients.

One reason for the shift from central government to provincial and district level financing has been the GOI's emphasis on "decentralization" and possibly, the increasing reliance on user fees to finance the operations of provincial and district hospitals. However, it is well known that provincial and district governments do not have uniform policies concerning the return of user fees to hospitals or in allowing hospitals to retain them.

Barnum has estimated that routine costs of all hospitals have remained roughly unchanged during recent years (at around 110 billion Rupiah in constant prices) and are just beginning to decline. He correctly observes that this is consistent with a rational policy of reducing capital development outlays while trying to maintain the existing capital stock and consequent level of service (see Howard Barnum, Hospital Expenditures in Indonesia, June, 1987).

Third, spending on programs and health centers has declined in real terms over the period by almost 20%. There is no evidence that this decline has been picked up by health units included in the "others" category. This decline has serious implications for the effective delivery of child survival services, because health centers are an important part of the infrastructure needed to support the provision of child survival program activities.

Fourth, and perhaps most significant for the purposes of this project, spending on child survival has been declining steadily in real terms throughout the period, with the exception of 1985/86, a year in which donors responded with unusual generosity to GOI requests for assistance. Over the period studied, government spending on child survival has decreased in constant prices by over 20%. As a percentage of government spending, child survival has declined from 13.5% to only 11.1%, a relative percentage decrease of nearly 18%.

Independent calculations performed by officials in the Planning Bureau, MOH indicate that central government non-salary spending on child survival amounted to about 10% of total central government development expenditures on health in each of the last three years, for about 32 billion Rupiah in total over the period 1985 to 1987. Thus it would not appear that the central government is being overly generous in terms of its support of child survival.

Note that in spite of the disappointing trends documented in Table 6, it is fair to say that the GOI appears to have attempted to maintain a reasonably strong commitment to child survival programs. Since 1983/84 the amount of spending in nominal terms on these programs has steadily

increased. However, the growth in nominal spending has not kept up with the pace of inflation or the estimated need for services.

Perhaps just as important, the composition of government spending has changed over this period. Given the stringency on government funds, donor agencies have been asked to increase their assistance. However, donors are reluctant to pay recurrent costs such as field worker incentive payments. The government has had to gradually withdraw incentive payments to workers at health centers while donors have responded to requests for increased assistance largely by supplying vaccines and other products. The result is that the "mix" of child survival products and services has changed over time and the consequences are more serious than the decline in total spending in constant Rupiah would suggest.

G.3.2 Target Estimate of Need for Child Survival Funding

Demographic projections indicate that in about 15 years, the bulk of the Indonesian population will be in the productive age group of 18 to 55 years. Thus, 15 years may be adopted as a reasonable period for which emphasis should be given to child survival. This is not to say that strictly non-child survival curative services should not be allowed to grow; rather, it suggests a timeframe in which to give priority to funding child survival programs.

According to USAID's "Health and Population Sector Review and Assessment," child survival indicators (e.g., mother-child health delivery, immunization coverage, diarrhea) suggest an average coverage of about 40%. However, the basis for this estimate was rather sketchy, and more accurate estimates being reported by the MOH suggest that the level of coverage approximated only 30% with a 40% level being achieved only in fiscal year 1985/86. In Table 6, 1985/86 was a year in which spending on child survival approached the highest level of in real terms (1983 prices) over the entire period 1982/83-1986/87. After that year, spending on child survival declined in real terms, and coverage is believed to have declined somewhat as well.

The MOH is currently attempting to extend child survival "outreach" through the further development of the integrated child survival village health posts (PosYandu). When fully organized and understood by members of local communities, this program eventually should facilitate the rapid expansion of service provision to populations for which child survival interventions have significant impact.

It is estimated that the rate of coverage grew from 30% to 40% in the three-year interval 1982/83-1985/86, a simple annual average rate of increase of 3.3%. In order to reach a target objective of 75% coverage over the seven year life of the project, it will be necessary to expand coverage by 5% a year. This implies that the rate of growth in coverage be increased from 3.3% annually to 5% over the next seven years, or an increase in the annual rate of growth of child survival coverage of 1.7% annually. Given that 50% of the population is comprised of women of reproductive age and

children, an increase in child survival coverage of 1.7 percentage points implies that roughly an additional 1.5 million (170)(.5)(.017) children and women of reproductive age who did not receive services in that year due to lack of funds would have received child survival services. In order to elevate the annual rate of growth in coverage to 5%, spending on child survival programs would have to have been increased from 60.3 to 91.36 (5/3.3) (60.3) billions Rupiah in 1983 prices. Converting this volume of spending to 1986/87 prices yields 115 billion Rupiah as the needed level of total annual expenditure.

G.3.3 Project Impact

Because the greatest part of health benefits is private and not public in nature, the government should only have to bear part of their cost. The per unit costs of delivering most child survival services are small (e.g., $2.25 for complete immunization, see Carl Stevens)* and thus are within a range that can be afforded by most households, even in rural areas. While in the long run Indonesians will be able to bear most of the costs privately, in the short run the government is obligated to bear a significant portion of the costs involved through reallocating funds within existing budgets. The private sector will be the dominant source of new funds needed to expand child survival programs in the future.

The project will assist the government to shift funds within the MOH budget and assist the Indonesian society in generating the new funds required to be able to allocate 115 billion Rupiah annually to support child survival programs so as to achieve the target rate of growth in coverage of 5 percent annually. Because a great deal of reliance will be placed on social insurance schemes and other private funding sources, it is estimated that the visible increase in the MOH budget for child survival will be on the order of 35% over the LOP. However, the project does not envision that any of that increase will be the result of an increased allocation from the treasury.

Over a period of 15 years, given that the annual increase in the population served by the project is approximately 1.5 million women and children annually, the project will, in terms of direct receipt of child survival services, ultimately affect at least 22.5 (1.5) (15) million people at an AID cost of $15 million, or an undiscounted $.67 per person. This compares with a current estimated per capita spending on health services in Indonesia from all sources of roughly $9.00. However, because the objective of the project is both to elevate and sustain spending on child survival service delivery, the level of child survival services delivery will be sustained beyond 15 years. The benefits will extend for the entire lifetime of many of those receiving services.

*Carl Stevens, Arie Dodoh, Increasing Efficiency of Health Services in Indonesia: A Key to Child Survival, 1986.

In addition, as a result of the social financing schemes initiated through this project, an estimated 30% of the population will be brought into a organized social insurance schemes (including private health insurance and possibly HMOs) over the same 15-year period. Thus, the project will affect at least 51 million persons, providing them with either completely new or better opportunities to presave and pool the financial risks associated with diseases and illnesses of all kinds during their lifetimes.

G.4 Sources of Funds to Support Child Survival Activities, LOP

G.4.1 Opportunities for Fund Generation and Reallocation

Substantial opportunities exist for a health sector financing structural intervention project to have a major impact on improving the efficiency and the overall performance of Indonesia's health sector as well as on facilitating an increase in spending on child survival programs and other services.

While not one of the project objectives, there appear to be grounds for the GOI to spend more on health services in general. Even a small increase in allocations to the health sector would be very significant, particularly if allocated directly to child survival programs. While not part of the project, it is worth noting that the analysis indicates that government should spend more on health. If the GOI were to bring back spending on health to 2.7 percent of GNP, the level achieved in 1982/83, this would amount to 88.0 billion Rupiah in 1987 prices. However, under current budgetary circumstances, this would involve a major diversion of funds.

Fortunately, consumers are obviously willing to pay for health services; indeed, they are paying for the bulk of them now. The structure of user fees should and will be altered. Community funds of various types are in existence and can be be redirected to serve child survival purposes. Social financing schemes of various types already and are evolving along with new forms that will serve to reinforce this existing institutional phenomenon. The data suggest that while health budgets are moving roughly in the right direction, funding categories can be shifted to bring government spending more in line with stated child survival priorities.

Finally, significant efficiencies could be effected in the hospital sector and in the procurement and dispensing of drugs. Efficiencies range from shifting resources away from underutilized hospitals to enforcing proper prescription patterns among physicians.

G.4.2 Estimates of Sources and Magnitudes of Funds

Shifts in Funds away from Hospitals.

Table 6 showed that although government spending on hospitals (1983 prices) has declined marginally in real terms over the period 1983-1986, the percentage of government spending on hospitals has not changed. However,

real spending on child survival declined in this period by over 25%. In 1986/1987, spending on central hospitals equaled Rp.103.9 billions and spending on provincial and district hospitals equaled Rp.108.5 billion for a total of 212.4 billion Rupiah in 1986/87 prices. Since child survival is the highest priority in the MOH, funds could be shifted from hospitals and diverted to child survival.

Allocations to hospitals are made on the basis of a target rate of 80% of capacity based on bed occupancy. However, Stevens reports that overall in 1985/86, hospitals were operating at only 60% of bed occupancy. Simple division would suggest that hospitals are allocated resources beyond their needs by about 25% (60/80 = 75%). Using this simple calculation would suggest that 53.1 billion Rupiah could be diverted from the hospital account.

There is more to running hospitals than just providing inpatient services, however. Certain fixed or semi-fixed services must be maintained. Nonetheless, the case for diverting some staff and materials is virtually overwhelming. In terms of diversion, more should be diverted from the central budget than from provincial and district budgets so as not to impede the process of decentralization that has been a rational policy of the GOI for several years. Therefore, it seems reasonable that 4.5 to 5% of total resources (Rp.212.4 billions in 1985/86, or Rp.9.5 to 11 billion in round numbers) could be diverted from hospital activities to child survival activities.

This could be apportioned roughly to an 8 to 9 billion Rupiah contribution from central hospital accounts and 1.5 to 2.0 billion Rupiah of manpower and material resources at the provincial and district levels. These are rather conservative estimates and actual resource diversions would have to be made on case-by-case basis. This will obviously involve analysis of time allocation, patient load and cost identification and estimation for individual hospitals.

Changes in the Levels of User Fees: Hospitals. The MOH has already committed itself to raising user fees at both hospitals and health centers next year. The amount by which fees will be raised at hospitals will be determined on a case-by-case basis. The user fees at health centers are scheduled to increase from 500 to 1000 Rupiah per visit. User fees already are high at some facilities, particularly at hospitals. There is some indication that in the case of hospitals, user fees may in part explain low bed occupancy rates. To see why this is so, it is necessary to examine the elasticity of demand for hospital user fees.

The elasticity of demand is a measure of the relative change in quantity demanded in response to a relative change in price, i.e.,

$$e = \frac{\Delta q/q}{\Delta p/p}$$

where e = elasticity of demand
q = quantity demanded
p = price of user fee

In the normal case, the relationship between price (p) and quantity demanded (q) is inverse and the calculated elasticity of demand coefficient is a negative number. If the absolute value of the calculated elasticity coefficient is greater than 1, the relative change in quantity demanded will be greater than the relative change in price and demand is said to be elastic. Thus, if elasticity of demand were greater than 1 and user fees were increased, the negative relative change in quantity demanded would exceed the positive relative change in user fees and total revenues would decline.

Obviously, the determination of whether or not demand is elastic in the range of hospital user fees currently charged requires a significant research effort which must be undertaken during the course of the project. Information already available, however, suggests that the demand for hospital services, and possibly health center services as well, may be elastic. If that is so, increases in user fees will result in a decrease in total revenue and not an increase as most observers expect.

First, it is reported that ASKES beneficiaries who are not required to pay user fees at public facilities use them at a rate of six to seven times more than the average health consumer. Because it is known that ASKES beneficiaries are more sophisticated health consumers who receive better services at public facilities than the average health care consumer, this multiple usage figure must be revised downward.

However, even if the ASKES use rate were roughly halved to three to four times the rate of utilization as compared to that of the average health consumer who must pay user fees, the implication, other things being equal, is that quantity demanded increases by three to four times when price is dropped from its current level to zero. This implies that the relative difference (change) in price is equal to 100% and the relative difference (change) in quantity demanded is 300 to 400% between the two populations.

Assuming that halving the alleged differences in rates of utilization between ASKES consumers and user fees who pay takes into account all differences in population characteristics bearing on the demand for health services at public facilities, the evidence suggests that demand is elastic. One could halve the utilization differences a second time and the result would still suggest a demand elasticity in the range of 1.5 to 2 in absolute value, implying that demand is elastic.

Second, fees, at least at class A and B hospitals, are fairly high relative to income. The higher the elasticity of demand, the higher price becomes relative to income. Stevens presents data on 12 class A and B hospitals for 1985/86 for which user fee revenues per bed day range from 11,330 to 21,000 Rupiah. He also suggests that an average for all hospitals of Rp. 5,000 per bed day would not be unreasonable; when multiplied by 10 days this equals 50,000 Rupiah. This is equal to more than one month's household expenditure (which can be taken as proxy for disposable income) for 40% of rural households and 9% of urban households.

However, there is some demonstrable evidence that for some hospitals, the elasticity of demand is less than one. User fees were raised in Bali last year by about 20% and bed occupancy declined from 70 to 60%, suggesting a crude estimate of demand elasticity of around .7 in absolute terms; hence the demand is inelastic.

For the reasons discussed in the paragraphs above, the MOH has been advised to be very experimental and selective in raising user fees at health facilities. The calculations presented below of the increase in revenues resulting from raising user fees are very conservative.

There are 16 class A and B, 79 class C and 219 class D hospitals, and a reported 5,006 health centers in Indonesia. Stevens reports that fees equal 25% of routine costs at the class A and B hospitals, or 10.5 billion Rupiah in 1985/86. In the same paper, estimates of user fees for a sample of class C and D hospitals suggest much higher rates of user fees as a percentage of routine costs, about 42%.

Barnum estimated total routine costs for the entire hospital system at 108.1 billion Rupiah in 1985. A breakdown of the percentage of recurrent costs by class of hospital (39% for class A and B hospitals and 43% for class C and D hospitals), indicates that the residual applies to speciality hospitals (which are not dealt with in this analysis because data were lacking). Barnum's numbers suggest that class C and D hospitals collected somewhere around Rp. 46.5 billion in revenues in that year from fees from both outpatient and inpatient visits. The actual costs per adjusted bed day for all hospitals average around 7,000 Rupiah in 1985/86 prices.

Bed days were adjusted taking into account outpatient visits at Class A, B, C and D hospitals at a ratio of four outpatient visits equaling the fee revenue of one inpatient visit. Making these adjustments and lumping A and B, and C and D hospitals together yields 4.71 million adjusted bed days for A and B hospitals, and 9.4 million adjusted bed days in the case of class C and D hospitals in 1885/86.

On an adjusted day basis, fees per bed day averaged only 2,229 Rupiah at class A and B hospitals but 4,947 Rupiah at class C and D hospitals in that year. These latter hospitals seem to be more seriously in the cost recovery business than are the vertical hospitals.

Assuming an elasticity of demand of .7, a 50% and a 100% change in user fees at class A and B hospitals would have generated 1.6 and 3.2 billion Rupiah of additional fees, respectively, in 1985/86. An increase in user fees of 25% and 50% at class C and D hospitals, assuming a demand elasticity of -.7, would generate 3.5 and 7.0 billion Rupiah of additional fee income, respectively, in 1985/86.

The formula used to calculate these estimates is a linear approximation, over an interval of a demand curve, or an average of demand elasticities over an aggregate of revenue producing units, of total revenue, $r=p*q$, where r equals total revenue, p equals user fee and q equals quantity

demanded. Therefore, dr=dp*q+dg*p, where dp and dq represent differentials with respect to fees and quantity demanded, respectively. It follows that dr/dp=q(i+e), where e is the elasticity of demand (unsigned). Dividing both sides of the last equation by r and rearranging terms yields dr=(p*q)*(dp/p)(1+e), or total revenue times the relative change in fee times 1 plus the unsigned elasticity of demand.

Note that in all cases, other things being equal, if demand is not elastic, raising fees will reduce hospital utilization, thus making it easier for hospitals to operate with less budget allocation and the case for diverting resources from hospitals to support child survival activities will be even stronger. If demand is elastic, total revenue can only be increased by lowering fees, but this will be accompanied by an increase in utilization. Continuous and sustained statistical research and analysis, plus trial and error demonstration are essential for acccurate policy formulation and implementation. The fact that these are built into the project is just one of many of its novel and strong features.

Changes of User Fees at Health Centers. Current data are not consistent concerning the number of visits at health centers. Several sample studies have been conducted, but there is wide variation in visits reported and some confusion among health center personnel as to how to count the use of health center personnel supervising activities at the PosYandu. Technical assistance and more research are definitely required.

In the absence of definitive data, it was assumed that health centers operate 250 days a year and see on the average 30 patients a day. Given that there are 5,006 health centers in Indonesia, there are 37.5 million visits annually, or less than .25 visits per person per year out of a population of 170 million. It is further assumed that only 50% of the patients visiting health centers pay the official 500 Rupiah user fee, yielding health centers Rp.9.4 billion of revenue each year. Note that careful analysis of Berman's study suggests that the cost per patient visit in the case of 42 health centers in Java is about 2,700 Rupiah.

Assume an elasticity range with endpoints of .8 and .7 in the case of health centers due to the fact that fees are lower relative to income than in the case of hospital fees, but that patients are of the "walk in" type as opposed to "referred" or "admitted" in the case of hospitals. Using the same formula described above, given that the MOH is going to raise health center user fees to 1,000 Rupiah per visit, potential increased revenue from user fees in 1985/86 prices would be Rp.1.9 and 2.8 billion.

Fee Retention by Hospitals. One should be careful in assuming that increased fee retention on the part of hospitals represents an increase in revenues available to the government. Fee retention is one way in which governments at all levels in Indonesia are financing hospital operations. The argument for greater fee retention is to improve efficiency, particularly if coupled with incentives for cost containment and/or greater output or improvements in quality. Since the project involves the diversion of funds from hospitals to support child survival activities, technical

assistance is vitally needed to assist hospitals to handle increased volumes of fee revenues and to be able to use them more flexibly. In short, TA is needed to facilitate hospitals to operate with reduced funding, but to learn to use funds more flexibly and efficiently.

On balance, one cannot expect additional revenues to be generated as a result of greater fee retention unless efficiency gains exceed fund reductions. In the interest of conservatism, no net gain in funds is estimated to originate from greater hospital fee retention.

Fund Generation From Efficiencies Pertaining to Drugs. The pharmaceutical sector presents a set of difficult problems. On the one hand, drugs are being procured and prescribed inappropriately relative to needs. On the other, more drugs, particularly for child survival, are needed. Thus, increases in MOH spending on drugs for child survival will occur as the result of diversions of funds previously used in other facilities, i.e., hospitals.

However, the MOH receives a discount on drugs purchased from state enterprises which depends on the volume of sales to the private sector. To the extent that drug sales can be expanded in the private sector, the MOH discount is greater and more drugs can be purchased with the same amount of money. The increment in the volume of drug purchases resulting from increases in the price discount offered by suppliers by increasing private sector sales will not be reflected as an increase in MOH spending.

The principal way in which the project will contribute to increases in private sector drug sales is through assisting in the expansion of drug revolving funds at village levels through the Dana Sehat. There is no way that one can calculate any of these levels of diversions or savings in the absence of data which can only be collected as a result of the project. MOH personnel have provided the following estimates:

Improvements in Procurement	1.0 to 2.0 billion Rupiah
Improved Prescribing Patterns	.5 to 1.0 billion Rupiah
Total	1.5 to 3.0 billion Rupiah
Increased Private Purchase	.5 to 1.0 billion Rupiah
Grand Total Drugs	2.0 to 4.0 billion Rupiah

Expanded and Efficient Use of Social Insurance Schemes. There are numerous social insurance schemes in Indonesia. For the purposes of this analysis, only those representing the major sources of funds for supporting child survival services will be considered. This includes ASKES, AsTek (PKTK), ASABRI and Dana Sehat.

ASKES is a public health insurance program which covers all non-military civil servants in the country, their dependents and retirees. The population covered is slightly over 12.5 million persons. All civil servants contribute 2% of their salaries and pensioners contribute 5% of their pensions into the fund.

It is reported that in 1985/86, the fund had substantial reserves (roughly 500 billion Rupiah), collected premiums in the amount of roughly 50 billion Rupiah, and earned 6 to 7 billion Rupiah of investment income. Beneficiaries receive services free at public health facilities and are exempted from paying user fees. Special drugs are maintained at health centers and hospitals for beneficiaries of this program. It is estimated that ASKES members use public health facilities six to seven times as often as the average member of the population and account for 30% of all health center visits.

ASKES beneficiaries ought to pay somewhere between the level of user fees and the full unit costs of services at public health facilities. Because of special treatment and services received, observers estimate that the unit costs of services received at public facilities may be 2 to 3 times the average unit cost of delivering services to other consumers. For the purposes of this analysis and in the interests of conservatism, no effort will be made to adjust unit costs for ASKES beneficiaries' consumption of health services.

Given that were 16.7 million general MOH hospital bed days out of a population of 165 million people in 1985, 12.5 million ASKES beneficiaries would have consumed at least 1.2 million of them. However, given that their rate of consumption is said to be 6 to 7 times that of the average member of the public, conservatively, this number may be doubled to 2.4 million bed days. Assuming a mid-point user fee over all hospitals of 3,300 Rupiah per bed day yields 7.9 billion Rupiah as the potential value of user fees collected. Collection of average unit costs per bed day of Rp.7,000 would yield 16.8 billion Rupiah in revenues.

Given that there were an estimated 37.5 million health center visits in 1985/86 and that ASKES members consumed roughly 30% of them yields 11.25 million as the number of health center visits attributable to ASKES members. The collection of a 1,000 Rupiah user fee per visit would yield roughly 11.3 billion Rupiah of new revenues. Collection of the estimated 2,300 Rupiah unit costs per health center visit yields 25.9 billion Rupiah in new revenues.

In total, the range of new revenues estimated to be collected from ASKES is 19.2 (7.9 from hospitals and 11.3 from health centers) to 42.7 (16.8 from hospitals and 25.9 from health centers) billion Rupiah. The upper range of these estimates is less than the annual premium revenues of ASKES in 1985/86 and thus can easily be afforded by the ASKES agency.

ASABRI is the military health insurance plan and covers all military personnel, their dependents and retirees. While in general, beneficiaries use military facilities, they use MOH facilities free of charge when it is inconvenient to consume services from military facilities. Information about this plan is difficult to come by; indeed, no official statistics exist as to how many people are in the armed forces, including police. Thus we can only provide rough estimates of potential fee recovery.

There were an estimated 1.9 million bed days of hospital service provided by military hospitals in 1985/86. Assuming that these represent only 90% of total ASABRI covered bed days and that the remainder were used at public hospitals suggests that ASABRI beneficiaries consumed .21 million bed days in public hospitals. Using a mid-point user fee of Rp.3,300 per bed day, this figure is raised to 1.47 billion Rupiah for public sector use of hospitals by military personnel and dependents.

Given that the ratio of outpatient visits to general MOH hospital inpatient days is 2.24 (37.5 million/16.7 million) and that ASABRI beneficiaries consumed .21 million public sector bed days suggests that they made roughly .471 million health center visits. At a 1,000 Rupiah user fee, about .47 billion Rupiah could be collected. At a unit cost fee per health center visit, the amount of total collections would be about 1.0 billion Rupiah.

In sum, the revenue collection that could be attributed to ASABRI beneficiaries ranged from 1.0 to 2.5 billion Rupiah in 1985/86. This is an extremely conservative estimte because we are attributing a health center use rate equal to the average rate of utilization of the general public and not at rate attributed to ASKES beneficiaries, which is known to be much higher than the average consumer.

The project calls for initiating about ten pilot/demonstration projects following the lines of the PKTK/AsTek demonstration project now being conducted in Jakarta. Using the same assumptions used above, revenue collection possibilities range from .3 billion Rupiah to .6 billion Rupiah per annum in 1985/86 prices, assuming a coverage of only 350,000 persons. However, note that coverage could grow at least to 2 to 6 million persons, depending on pending legislation. By the same token, private health insurance and HMOs could add a similar amount of .3 to .6 billion Rupiah in 1985/86 prices.

Finally, it has been suggested that Pertamina contribute to the government a premium of 2 to 3% of its annual health expenditures if it elects to develop its own HMO to supply services to its members. Because it is estimated that Pertamina spent $40 million on supplying health services directly to the 250,000 persons covered by its system in 1985, this would amount to 1.3 to 1.9 billion Rupiah annually.

G.5 Summary and Conclusions

Table 7 presents estimates of the volume of funds that would be generated as a result of the project and could be used to support an expanded set of child survival activities in Indonesia. Not all of these funds may appear in the MOH budget because this will largely depend on how the social financing schemes are administered (off budget or within normal budget categories) and on what volume of funds are diverted to the private medical sector. The only sources of funds that are sure to be reflected in the government budget are funds shifted from hospitals and drug purchases to support child survival. The estimates summarized below suggest that this would amount to about 18.5 to 28 billion Rupiah representing an increment to an estimated 60 billion Rupiah of spending on child survival. Incremental spending of this magnitude would represent a 30.8%-46.6% increase in government spending on child survival at the end of the project.

Table 7: Sources of Funds to Support Child Survival (Rp. billions)

Sources	Lower bound	Upper Bound
SHIFTS FROM HOS. FUNDS		
Classes A and B	8.0	9.0
Classes C and D	1.5	2.0
USER FEES HOS.		
Classes A and B	1.6	3.2
Classes C and D	3.5	7.0
USER FEES H.C.	1.9	2.8
DRUGS	2.0	4.0
SOCIAL INSUR.		
ASKES	19.2	42.7
ASABRI	1.0	2.5
(PKTK)	.3	.6
Pertamina	1.3	1.9
Priv. H.I. and HMOs	.6	1.2
Total	40.9	76.9

Source: Calculations presented in text.

Table 7 clearly indicates that a great deal of funds can be generated to support additional child survival activities in Indonesia. However, this will not and cannot occur immediately. The change that can be affected most rapidly involves shifting funding priorities within the government. The continued evolution of social financing schemes, the research and demonstration projects which must accompany this evolution, explicit policy formulation, and the passage of formal legislation will take a considerable amount of time.

Funds can be shifted rapidly from one account to another. However, shifting funds necessitate reallocations of human and material resources. The determination of which resources to shift, from where, and how to apply them effectively and efficiently cannot take place over night and will require technical assistance over a considerable period of time.

The project will, to a large degree, determine the success with which these applications of resources will affect overall health sector policy and social financing issues. Policies will be reformulated and new approaches will be adopted over the course of the project as results are critically examined. Therefore, it must be recognized that the project represents a multi-faceted, interrelated program of health sector adjustment, restructuring and reform that is exactly what Indonesia is undertaking in all sectors of its economy due to the recognition of the necessity to do so.

Attachment I

Percentage of Central Government Expenditures Spent on Health in Countries where Central Government Received 90 Percent or More of Tax Revenue, 1977-84

	1977 %	1978 %	1979 %	1980 %	1981 %	1982 %	1983 %	1984 %	1985 %
Developed countries									
Belgium	1.78	1.79	1.86	1.65	1.70	1.65	-	-	
France	14.59	14.83	14.99	15.01	14.72	14.60	-	-	
Greece	8.09	9.89	10.48	10.34	10.54	-	-	-	
Italy	-	7.55	10.47	12.55	10.70	10.64	11.52	11.49	
Luxembourg	2.07	2.27	2.02	2.15	2.37	2.23	2.21	-	
Netherlands	11.79	11.87	11.71	11.68	11.63	11.62	11.29	10.97	
New Zealand	14.98	15.04	15.21	15.17	14.24	13.52	12.65	-	
Developing countries									
African Region									
Kenya	8.16	7.45	7.23	7.83	7.81	7.33	6.96	-	
Lesotho	5.43	-	-	-	-	-	7.18	-	
Liberia	7.89	8.21	6.13	5.20	7.16	7.17	7.27	6.20	
Malawi	5.40	5.27	5.30	5.53	6.16	5.23	6.77	-	
Mauritius	7.98	8.15	8.04	7.48	6.97	7.10	7.84	8.10	
Swaziland	6.48	4.91	6.20	7.15	5.41	7.12	7.37	-	
Zaire	4.01	3.94	3.22	2.47	2.61	3.20	-	-	
Region of the Americas									
Chile	6.86	6.85	6.54	7.37	6.54	6.80	5.95	6.18	
Costa Rica	3.31	25.44	25.00	-	-	32.76	22.48	-	
Dominican Republic	8.98	9.43	9.07	9.30	7.70	10.66	10.55	-	
Mexico	4.38	3.97	3.90	2.37	1.86	1.29	1.20	-	
Panama	14.50	15.08	12.15	12.71	13.24	13.14	-	-	
Paraguay	2.73	2.64	3.67	3.59	4.51	3.67	-	-	
Trinidad & Tobago	7.79	6.86	6.36	5.78	5.91	-	-	-	
South East Asia Region									
Burma	5.88	6.73	6.39	5.28	6.09	6.96	-	-	
Maldives	-	-	5.06	3.46	4.45	5.83	3.80	-	
Sri Lanka	5.95	4.19	5.17	4.88	3.54	3.35	5.12	-	
Thailand	4.69	4.39	4.54	4.09	4.23	4.94	5.11	5.45	
Indonesia	-	-	-	-	-	2.03	1.59	1.58	1.50

	1977 %	1978 %	1979 %	1980 %	1981 %	1982 %	1983 %	1984 %	1985 %
Eastern Mediterranean Region									
Cyprus	5.42	5.92	6.02	6.07	7.73	7.26	6.79	-	
Jordan	3.58	3.71	4.10	-	3.75	3.76	3.63	-	
Kuwait	5.90	5.89	6.25	5.12	4.89	5.38	6.25	6.27	
Oman	2.65	3.17	3.24	2.92	3.04	3.09	3.47	4.13	
Sudan	1.45	1.71	1.46	1.40	-	1.34	-	-	
Tunisia	7.03	7.27	6.43	7.20	7.65	6.66	-	-	
Western Pacific Region									
Philippines	5.08	4.74	5.54	4.54	5.01	5.28	6.80	-	
Singapore	7.37	8.50	7.01	6.88	7.18	6.39	6.41	-	

Source: IMF, Government Financial Statistics Yearbook. Washington, D.C: International Monetary Fund, 1985.

Annex H

ECONOMIC ANALYSIS

H.1 Introduction

The primary objective of the Health Sector Financing Project is to assist in the development of health sector institutions and policies so that a process of committing more government resources to child survival programs will be initiated and sustained over the long run. This is a new genre of health project because it features a number of "structural" interventions rather than the direct "performance" interventions featured by more conventional health projects. This distinction is central to the design of an appropriate cost-benefit analysis for a project such as the HSFP and is addressed further in this section.

Three factors are operative in an economic analysis of markets in general, including markets for health services: performance, structure and conduct. Market performance can be characterized in terms of the prices and rates of output of goods and services, which are determined by the profits and losses generated by the market. Performance is in turn a function of market structure, which refers to such characteristics as whether there is competition or monopoly on the market supply side. Market performance is also a function of market conduct, which refers to such characteristics as whether producers set prices independently of one another or collude to set common prices.

The policy interventions undertaken to improve market performance can be either direct or indirect. Direct interventions (called performance interventions) include regulations to set prices, assign markets, set service standards and the like. Indirect interventions to influence markets include promulgating laws to enhance the degree of competition and diminish the degree of monopoly on the supply side of the market. It can thus be anticipated that improved market performance in the form of more efficient prices and rates of output would result from these structural interventions.

Historically, AID health projects (e.g., in rural health, urban health, ORT and EPI) have been performance intervention projects. These projects have usually sought to improve the performance of the government's service delivery systems and thus have operated essentially in a central planning mode. Planners' preferences are mapped into resource allocation decisions and the government then directly undertakes to produce the planned outputs.

On the other hand, health financing projects such as the HSFP generally feature structural interventions. These projects operate on the health financing system, which is a centrally important market structure feature of the health services sector. Like traditional performance intervention projects, health financing projects seek to improve the health services sector's performance. But unlike the traditional projects, the structural intervention projects do not feature a planned performance target to be directly implemented by planners.

For example, the HSFP will seek to improve the efficiency of government hospitals. A traditional performance intervention project might seek to achieve this objective by the project designers themselves proposing alternate production functions and, operating in the planning mode, conducting a cost-effectiveness analysis to determine the most cost effective production function. The project would then be implemented by having the hospitals put this "optimal" production function into place.

But the approach taken to meeting this objective would be very different under the HSFP, which operates on the way in which the demand for care is financed and on changing hospitals' organizational formats (e.g., budgeting procedures). In these ways, the HSFP seeks to operate on the organization's incentive structure and the opportunities afforded hospital management to manage their hospitals effectively. The expectation is that the incentives and opportunities created will motivate hospital management to increase efficiency and thus facilitate the performance of that task. Under this project, designers are not operating as central planners and thus have no natural reasons, during project design and ex ante project implementation, to employ such tools as cost-effectiveness and cost-benefit analysis, which were developed to assist those operating in the planning mode.

In sum, to achieve efficient resource allocation to health programs, performance intervention projects, which operate in the planning mode, may be forced to rely on such tools as cost-effectiveness and cost-benefit analyses. Structural intervention projects, on the other hand, may rely instead on market structure and conduct (i.e., the incentive structure in which the actors making the resource allocation decisions operate) to achieve a more efficient allocation of resources. This latter approach is in essence the purpose of privatization.

The non-conventional nature of the project, the lack of familiarity with this type of project, and the difficulty in using cost-benefit and cost-effectiveness analyses to inform project design all complicate an analysis of costs and benefits of this project. However, the decision to commit resources to structural interventions can itself be regarded as a kind of planning decision which requires rationalization in terms of some kind of cost-benefit analysis.

The first round economic analysis in the next section follows a somewhat more conventional cost-benefit analysis approach, and provides short-run cost-benefit findings for the HSFP. The second round analysis takes a long-run and broader view of the economic significance of the HSFP for both child survival and other dimensions of health sector performance, but does not take a conventional cost-benefit analysis approach.

H.2 The Logic of the HSFP Response to the Problem

The rationale for the HSFP can be set out in a series of propositions which highlight the functional interdependence among the project's components.

1. It is unlikely, for the foreseeable future, that overall government health budgets in Indonesia will increase significantly in real terms. This proposition is discussed in Section 6.2 of the Project Paper.

2. Thus, and because government health budgets are already fully committed, if there are to be more government resources for child survival programs, they must be diverted from other government health programs. The most promising area for diverting resources is hospital budgets. Because they are the largest government health program budgets, a relatively small percentage reduction in these budgets will still yield substantial resources relative to the much more modest claims of the child survival programs. Table 1 for the year 1985-86 shows that a transfer of 10.0 percent of hospital expenditures to EPI would more than double the GOI's commitment to this program.

Table 1: EPI Budgets as Percentage of CDC/EH Budget, 1984/85-1987/88
(Rp. Billion)

Year	APBN DIP*	CDC & EH	CDC/EH of % APBN DIP	EPI	EPI of CDC/EH %	Hospitals
1984/85	119.0	26.2	22.0	4.1	15.6	143.1
1985/86	94.8	28.2	29.5	7.1	25.2	155.0
1986/87	65.4	13.6	20.8	4.9	36.0	150.1
1987/88	22.8	4.9	21.5	1.4	28.6	162.4

Notes:
EPI: Expanded Program on Immunization. APBN/DIP: Central government development budget. CDC &EH: Communicable Disease Control and Environmental Health.

Source: Indonesia: Expanded Program on Immunization (EPI) (497-0253), Project Paper, Amendment #4, Agency for International Development, July 13, 1987, p. 14.

13V

3. If there is to be a diversion of resources from government hospitals to child survival programs, a necessary condition for this to take place will be increased cost recovery by these hospitals. Cost recovery takes place when government hospitals charge consumers and in this way generate additional revenue from the community. Increased cost recovery will not guarantee such diversion because hospital budgets are already very lean relative to the demands upon them. But without it, the prospect for diversion is virtually nil.

4. Enhanced cost recovery by government hospitals will require that these hospitals deliver high quality services (services that are medically appropriate and that satisfy consumers in other ways, e.g., appropriate amenities (room and diet, appropriate attitudes of hospital staff). An important part of what is meant by increased "efficiency" of hospital performance is increased quality of hospital output.

5. Increased efficiency in government hospitals in the general sense of more output per unit of input will improve the prospect that funds can be diverted to child survival programs. Increased efficiency entails attention to cost containment, avoiding resource wastage, increasing staff productivity by appropriate supervision and incentives, and the like.

6. It would not be realistic to expect the management of government hospitals to seriously engage in the enterprise of increased cost recovery unless appropriate incentives are provided.

7. Even if hospital management is motivated by appropriate incentives, increased efficiency will not follow unless there is also a realistic opportunity to succeed in this endeavor. For example, personnel policy must be such that management can effectively supervise and motivate the staff. Budget policies must make room for some discretionary resources such that management can respond promptly to problems.

8. As a matter of public policy, increased cost recovery in government hospitals must preserve equity with respect to access to these services. In practice, this probably implies some kind of income-related scheme such that the well off pay more than the not so well off and the indigent do not pay at all.

9. The prospects for operating a successful cost recovery scheme in government hospitals will be greatly improved if there can be social financing (e.g., insurance/prepaid schemes) rather than heavy reliance upon out-of-pocket financing.

10. Increasing the proportion of hospital services delivered by the private sector can help relieve pressure on health department budgets. Developing social financing schemes to finance the demand for private hospital services can encourage the growth of the private hospital sector.

11. The extent to which resources diverted to child survival programs result in improved health status will be highly dependent on the efficiency of these programs. Improving the management of drug inputsto these programs can make a major contribution to enhancing the performance of these programs. As with government health programs generally, drug budgets for the child survival programs run very lean. Thus, every effort must be made to ensure that these budgets go as far as possible.

H.3 Economic Analysis: The First Round

The HSFP is comprised of three main components: the social financing component, a component addressed to increasing efficiency in the hospital services sector, and a component addressed to improving the performance of the pharmaceuticals sector, particularly for child survival pharmaceuticals. (There is also a small component for financial and policy analysis, but it can be regarded as playing a supporting role for the three main components.) Because these components are functionally interdependent, they have not been broken down into constituent parts for the first round analysis.

The first round economic benefits of the HSFP will result in an increased flow of resources to the government's child survival programs. Consequently, for the project as a whole, the benefit will be whatever benefits these resources will generate in the child survival programs.

However, the benefits to be counted here will not be contemporaneous, for the most part, with the project outlays responsible for them. This is because the resources committed under the HSFP components can be seen as an investment in structural interventions to change the health services system. For example, the project would change the organizational format of government hospitals, the composition of public and private funding for these hospitals, and the way in which the demand for health care is financed by consumers. The resources committed to this system change are thus more akin to a "one-time" capital outlay than an ongoing, recurrent outlay. This is because once system changes have been effected, they can be expected to be more or less self perpetuating, and for the most part, continued project outlays will not be necessary. It is this characteristic of investments in system changes which gives this type of investment a large amount of leverage and helps to generate a future stream of benefits attributable to the project.

H.3.1 Costs and Performance of the Child Survival Programs: Implications of the HSFP

There are five child survival programs in Indonesia: Maternal and Child Health (MCH), Expanded Program on Immunization, Health Education, Nutrition, and Control of Diarrheal Diseases (CDD), including Oral Rehydration Therapy (ORT). To gain insight into the impact of the HSFP on these programs, it is first necessary to obtain an approximation of their

operating costs for a recent, representative year. In this case, 1985-86 was selected because it represents a budgetary year before fiscal stringency began to reduce the government's capacity to budget for these programs.

Child survival programs in Indonesia are operated by the general health services, mainly the health centers, but also draw from vertical budgets (e.g., those for EPI and CDD), which are budgeted collectively under the heading of PROGRAM. Table 6 in Annex G, shows the yearly expenditures for child survival in real terms using 1983 prices. The 1985-86 resource commitment to child survival programs in Indonesia was roughly Rp. 60.3 billion in real terms.

To determine the implications of transfering resources on the margin from the hospital sector to the child survival programs in the aggregate, a 15 percent transfer was assumed; this figure does not take into account transfers from district-level hospitals. This transfer of approximately Rp. 26 billion would increase the aggregate child survival budget by as much as 43 percent.*

In terms of the child survival loss on the margin in the hospital sector, the consequences of this transfer should be trivial compared to the child survival gain on the margin in child survival programs. There can thus be very little doubt about the cost-worthiness of this resource reallocation in terms of child survival objectives, a position which AID health offices have been urging host county governments to take for several years.

To determine if investing the amount of money represented in the HSFP budget is worthwhile to bring about a reallocation of resources to meet child survival objectives, two approaches can be taken. The first is an investigation of the project's implied IRR and the second is an examination of the project's costs as a "loading" on child survival program costs.

H.3.2 The HSFP's Implied IRR in Terms of Child Survival Benefits

First, assume that the HSFP succeeds so that child survival program budgets are Rp. 26.0 billion larger in real terms than they otherwise would have been -- beginning in the fourth year of the project and continuing for ten years. This can be taken as a measure of the gain in child survival benefits in these programs. This is so because this resource transfer is believed costworthy; thus, whatever the value of the increase in benefits in the child survival programs, it must be at least equal to Rp. 26.0 billion

*Note: In Annex G (Financial Analysis), Section G.5, a possible resource shift of between 30.8% to 46.6% is projected. The project target has been set at a 35% increase which is somewhat more conservative than the 43% shift used to estimate the Project's IIR.

per year. Second, assume that the loss of child survival benefits in the hospital sector can be neglected. Third, assume that the total HSFP budget of Rp. 24.0 billion is expended in equal yearly amounts during the seven-year life of the project. With these assumptions, the implied internal rate of return (IRR) to expenditures for the HSFP is about 97.5 percent. If it is assumed that the HSFP has only a 0.5 chance of resulting in a transfer of Rp. 26.0 billion, then the IRR would be about 58.0 percent.

H.3.3 Cost of the HSFP as a "Loading" on Child-Survival Program Costs

As explained, the expenditures for the HSFP can be regarded as a capital outlay to be charged to expense over the period of time during which the investment in system change continues to yield benefits in the form of a larger resource commitment to child survival programs than would otherwise have been the case. The annualized HSFP expense can thus be regarded as an "add on" or "loading" on the annual costs of operating the child survival programs.

The transfer of Rp. 26.0 billion added to the Rp. 60.3 billion in expenditures for child survival services would bring the total resource commitment to these program to about Rp. 86.3 billion. Assume that once a system change has been effected by the HSFP, it continues to yield benefits in the form of enhanced resources for child survival programs for, say, ten years. Dividing the total HSFP cost of Rp. 24 billion by ten yields a loading of about Rp. 2.5 billion in a representative future year, or about 4.1 percent of the enhanced child survival budgets. For this modest increase in costs, a transfer of resources is effected which increases the resource commitment to the child survival programs by about 43 percent or by 21 percent if it is assumed that the HSFP is only half as effective. Even allowing for some declining yield on the margin to additional resources for child survival, the expenditure for the HSFP would appear, in these terms, to be costworthy.

H.3.4 Cost-Benefit Analysis of HSFP and the Expanded Program on Immunization (EPI)

While it would be desirable to apply a cost-benefit analysis to each of the important child survival programs, only the EPI yielded a description of program performance which is definite enough to permit this type of analysis. The 1985-86 costs of this program were about Rp. 15 billion (nominal terms), while the cost in that year per fully-immunized child was about Rp. 3,750 (about US $2.25). The benefits of EPI are reductions in morbidity and mortality.

In determining whether the benefits of health programs are worth the cost, the most popular way to measure health effects in monetary terms has been the human capital approach. For immunizable diseases such as measles and pertussis, there are very high attack rates (90 and 80 percent, respectively) and very high vaccine efficacy rates (85 and 80 percent, respectively). Thus, it might be expected in principle that some savings to immunization would result from the reduced costs of treating morbidity and reduced time for mothers to care for their sick children.

However, rather than undertaking these kinds of calculations, it is far more instructive to undertake a more general cost-benefit analysis that focuses on the deaths-averted benefits of the EPI. These benefits, along with morbidities averted (in some cases), are the purpose of the immunization program and it is informative if a cost-benefit analysis reflects the main success criteria adopted for such programs.

Benefits of reducing the risk of mortality and morbidity. Program performance data suggest that Indonesia's EPI may have reduced the overall infant and child death rate by about 10.0 percent in 1985-86. Because children who survive childhood diseases eventually die from adult diseases and trauma, it is more preferable to state this benefit with a time dimension, say, a 10.0 percent reduction in the probability of death over a ten-year period.

In determining whether it is worth an average cost of US $2.25 per immunized child to achieve this risk reduction, it is necessary to ask what the benefit yield would have to be in money value terms over the ten-year risk reduction period. Using an appropriate discount rate of 15.0 percent, a benefit value of about US $0.45 per year per immunized child would make the investment in immunization economically worthwhile.

Whether this benefit value can be regarded as a costworthy commitment of resources is an issue requiring judgment. However, it seems likely that for many policy makers, the equivalent of about US $0.45 will appear a very modest value for a year's worth of reduction in the risk of death, and for some of these diseases, a reduction in the risk of disease. Thus, it is likely that such a small assumed investment in the EPI would be sufficient to cover the program costs and yield a normal rate of return, while rendering the program more than costworthy.

The household point of view. Most economic analyses of health programs attempt to include "intangible" benefits such as reductions in pain, grief, suffering and anxiety. Although these benefits are important ones, they cannot be mapped into an economic analysis and their inclusion tends to promote a large underestimate of the economic value of these programs. Generally speaking, these intangible benefits have considerable economic value, as demonstrated by the willingness of consumers to make substantial payments to secure these types of benefits in the general medical market place.

In trying to capture intangible benefits in economic analysis, it is possible to use the calculations of the cost and implied risk reduction of the EPI from the household point of view as a simulated willingness-to-pay test. If each household in Indonesia were to contribute to a fund Rp. 742 (US $0.45) per child for each year of the ten-year risk reduction period, the resulting fund would finance the immunization program. Owing to some savings in treatment costs from reduced morbidity, the net costs of contributions to this fund would be less (perhaps substantially less) than this.

The burden imposed by such payments would depend on the number of children in the household. Using a representative figure of three children, all of whom were in the risk-reduction period at the same time, the gross burden (i.e., not net of savings in treatment costs) would amount to 0.62 percent of annual household income for the poorest 3 percent of households and much less than this for the other 97 percent of households. It is thus likely that informed, rational household members would be willing to pay the cost of immunizations for their children in order to secure the risk-reduction benefits.

If policymakers decide to commit resources to an immunization program, they may feel more secure that their commitment is costworthy if it is highly likely that households (if they were fully informed and making self-serving decisions) would also judge this to be a costworthy use of resources. For it is the households who are the beneficiaries of the program and who will, in the aggregate, pay for the program (with the exception of donors' contributions). Looking at the cost-benefit issue in this way, policy makers would, in effect, be seeking to map consumer preferences rather than planner preferences into their resource allocation decisions. This may be regarded as a kind of "privatization" criterion of program success. This approach is a very compatible way to evaluate structural intervention programs and it is one which will increasingly appeal to policy makers as they explore management approaches other than central planning.

Implications of HSFP loading on EPI costs. To examine the implications of cost loading on the EPI, the following were assumed: 1) the entire Rp. 26 billion transfer from the hospital sector goes to EPI, bringing its budget to about Rp. 41 billion, and 2) the capital outlay represented by the HSFP is spent over a ten-year period, i.e., at a rate of about Rp. 2.4 billion per year. Looked at as a loading on the enhanced EPI budget, the HSFP outlay would represent about a 5.9 percent increase in the EPI's operating costs.

If it is assumed that over this ten-year period, there will not be a decreasing return to scale in the EPI program (i.e., that program performance increases proportionately with resources commitment), the resource diversion would result in the enhanced EPI program delivering about a 25.0 percent reduction in the risk of death over the ten-year period, a considerable gain over the prior 10.0 percent reduction. If, prior to the HSFP, expenditures for EPI appeared well worth it in terms of risk-reduction benefits, and then because the HSFP's impact will be to increase costs less than it increases benefits, expenditures for EPI should be regarded as even more costworthy as a result of the HSFP.

This rather severe sensitivity test for the EPI takes into account neither the benefits to child survival programs in addition to those of EPI nor the second round benefits discussed in the next section. Despite this, relying on EPI benefits alone, it would be fair to expect that most policy makers would judge the HSFP to be costworthy.

H.4 The Social Financing Component: The Second Round

The second round analysis is restricted here to the project's social financing and hospital components. While the first round analysis dealt with the HSFP's contribution to today's child survival events, the second round analysis takes both a longer-run and a broader view of the development of the nation's health services sector. It is in this analysis that the implications of the project as a structural intervention begin to emerge with greater force.

At present, the total health economy in Indonesia claims a rather more modest share of GNP (2.2 percent) than in some other countries with about the same level of GNP per capita. The public share of total health expenditures is about 36 percent, while about 90 percent of private expenditures is financed out of pocket. Thus, social financing accounts for only about 10 percent of private demand, most of which is equally divided between employer health benefit schemes and government compulsory insurance. In terms of expenditures for health services, the private sector is dominant, however, in the largest service sector (hospitals), the public sector is dominant; providing 69 percent of beds.

Although it is relatively certain that as Indonesia develops economically, the health economy's share of GNP will also grow, it is less clear just how this will take place. For example, what will be the pattern of institutional events that embody this development? What will happen to the relative public and private shares of the health economy, on both the demand side of the market for health services and on the supply side? Will there be a specialization of functions between the public and private sectors, with, perhaps, the public sector concentrating on preventive measures and the private sector on curative services? How will the burden for supporting the nation's health services system be shared among the individuals to be served by that system?

To assess the economic implications of the HSFP in this context, it is necessary to note that the configuration of the nation's health sector financing system, particularly the way in which the demand for health care is financed, will be far from neutral in its impact on how these health sector developments take place. Because the HSFP's social financing component will facilitate the development of social financing schemes, it will have an important influence on the future development of the health services sector. As illustrated below, this influence can be expected to be a favorable one and can be counted among the important benefits resulting from the project.

One possible beneficial influence of the social financing component is the division of functions between the public and private sectors in the nation's health system. Assuming that the nation's health economy will continue to grow, that this growth will be accompanied by an enhanced role for the private sector (e.g., private financing of the demand for health services and the provision of acute curative services, particularly hospital services), and that fiscal stringency will continue to dampen prospects for

growth in the government sector, then it would be natural for a division of labor to occur. In this case, the government would concentrate its relatively smaller resources on preventive, promotive public health services, leaving curative care more largely the responsibility of the private sector. This division would have positive implications both for child survival and the efficiency with which the funds committed to these resources are used by operating on the demand side of the market (e.g., by promoting social financing of the demand for health services).

Social financing (health insurance, prepaid schemes, social security-type schemes and others) serves equity objectives in several ways. Under social financing schemes, "well" persons help to support the nation's health care system instead of sick persons (who support the system under out-of-pocket financing). Moreover, it is much more feasible to develop income-related health financing schemes where demand is socially financed rather than financed out of pocket. Further, social financing finances the consumer's desire for risk aversion. Under out-of-pocket schemes, consumers are always at risk of having to pay very large outlays for health services when they are sick. Under social financing, they trade this risk for a situation where they make small, regular payments, thus spreading risk among the insured group over time. Last, social financing could well evoke a supply response, as in the Philippines, where in response to social security-type financing on the demand side there was a significant increase in the capacity of the private hospital sector. Such responses could improve the prospects of the Ministry of Health to move in the direction of becoming a Ministry of Public Health.

Thus, this component's influence will lie in responding to public or private parties, on the supply or demand side of the market, who seek assistance in developing social financing schemes. This component is far removed from the performance intervention modes which have historically characterized most health projects. Rather, because the initiative here is on the part of public or private financing scheme developers, this component does not put project designers and implementers in the role of central planners vis-a-vis the nation's health financing system.

In determining whether the US $5.0 million budgeted for this component is a cost worthy expenditure, it seems clear that the social financing component will help the project to move into the mainstream of developing health sector events in Indonesia. The current serious discussions of the DUKM concept, which calls for a major increase in social financing of the demand for health services, attest to this. Further, this component stands a good chance of making very important contributions to equity and allocative efficiency in the health services sector. Although no simple number value (e.g., net present value) can be put forward to estimate the cost worthiness of this component, in the view of its proponents the expected yield is well worth the investment proposed. And surely, this modest commitment of funds has a far better prospect for large-scale leverage in this type of structural intervention project than in the conventional performance intervention project.

For the hospital component, it is feasible to do a more conventional type of cost-benefit analysis. This component is budgeted for US $2.3 million, or the equivalent of Rp. 3.8 billion. The following assumptions are made:

(1) The amount is paid out in implementing the hospital component in equal parts over five years. (2) At that point, efficiency gains in the hospitals begin to be manifest. These gains are the equivalent in real terms of 10.0 percent of the 1985-86 budget (investment and routine) for the central and provincial level hospitals. This comes to Rp.17.4 billion per year and these savings, owing to the project, continue for 15 years. (That is, in each of these years, the cost of producing services by these hospitals is Rp.17.4 billion less than it otherwise would have been without the project.) Fifteen percent is taken as the appropriate discount rate. These assumptions result in a substantial net present value (NPV) of about Rp.55.0 billion and a large internal rate of return (IRR) of about 88.7 percent. If the assumptions are changed to provide for 5.0 percent savings over ten years, the result is a NPV of about Rp.22.0 billion and an IRR of about 66.0 percent. The project budget is actually very small compared to the assumed savings. These savings could be used on child survival programs.

Annex I

SOCIAL SOUNDESS ANALYSIS

I.1 Beneficiaries

The primary beneficiaries of this project will be the infants and young children of Indonesia and to a secondary degree their mothers. It is this group of people who suffer a disproportionately high risk of disease and death due to difficulties the government experiences in providing high quality curative and preventive health care to everyone. By redirecting government expenditures to support for child survival programs and by providing alternative ways for families to receive dependable, sustainable and managed health services, the quality of life of the young children of Indonesia should be improved and their chances of surviving childhood increased substantially. This will be particularly so for families at the lower end of the economic scale, as these are the people who are in greatest need of the kinds of preventive and promotive health programs on which the government will be able to focus its attention.

It is estimated that total spending for child survival will increase by 35% during the life of the project, or a yearly increase of 5%. Increased funding at this level will increase child survival coverage by 1.7% per year, implying that an additional 1.5 million children and women of reproductive age will receive child survival services as a result of savings generated through this project.

The secondary beneficiaries will be the rural and urban poor who expend a significant portion of their limited resources on purchasing health care services on an unplanned, fee-for-service basis, and on services or products which have minimal long-term beneficial effect on their health. By participating in pre-paid, organized health care financing schemes, they will improve their chances of receiving an appropriate balance of preventive and curative health care and reduce the need to spend large amounts on crisis medical care. By participating in these schemes, they will benefit from sharing the financial risk of illness with others and therefore suffer less economically when illness does occur in the family. Social financing also provides more equitable access to health services, since it precludes the need for single, large, out-of-pocket expenditures which are beyond the means of large segments of the Indonesian population. The project, in the long run, will help improve the therapeutic impact of drug related expenditures by affecting prescribing and drug purchasing patterns and reducing unnecessary expenditures.

And finally, the project will benefit the many health care professionals who will be trained, and whose professional productivity will be affected during the course of implementing this project, both in the government and private sectors. Because of the project's institutional development focus, the capacity to undertake the operations research and continue on the developments initiated under this project will be assured by

building on the human resources of Indonesia. While such people are secondary beneficiaries of the project, the investment in them is critical to assure continuation and institutionalization of the innovations and improvements introduced by the project.

I.2 Social Feasibility

With respect to the social and cultural feasibility of various elements of this project, it is important to point out that the hospital, pharmaceutical, and policy analysis components of the project do not involve any large-scale social change. Interventions in these components address basic structural and organizational problems which do not involve making great assumptions about social or cultural characteristics of the people involved. Changes in hospital management proposed under the diagnostic component will be pilot tested and opportunities will exist to determine whether there are social or cultural factors which make such changes problematic. Likewise, in the pharmaceutical component, existing field experience with trying to change physicians' drug ordering behavior has not raised social issues. Introducing patient education or modern communications techniques to help change patient demand for certain drugs does have a strong socio-cultural element which must be taken into account in the specific design of the mass media messages, for instance. However, the nature of the project will mitigate against making false assumptions because of its research and development stratgegy. For example, patient education materials will be designed by Indonesian advertising and promotion experts and tested thoroughly for impact before application.

The social financing component of the project requires more scrutiny, however, because its success depends upon health care consumers exhibiting a conducive purchasing behavior. The consumer in a health insurance plan must be willing to make periodic pre-payments to avert the financial risk associated with a future event. There are several aspects of this behavior which deserve consideration when assessing potential social feasibility:

- o willingness to prepay on a periodic basis,
- o willingness to pool capital for group benefit, and
- o concern for future financial risk associated with medical treatment.

Several notable examples testify to the the Indonesian society's familiarity with periodic pre-payment. The concept of tabungan, or savings, is commonly practiced by both urban and rural populations on a formal and informal basis. The tabungan are specified for a purpose - such as a wedding, a funeral, a birth, or a religious ceremony - signifying awareness and concern for future financial risk. The concept of installment payments, referred to as cicilan, is commonly used by those income groups unable to make a single out-of-pocket payment to purchase goods or services. Although the cicilan is not strictly a pre-payment, it does indicate the willingness

of Indonesian society to make monthly payments. Finally, pre-payment has been used with little difficulty for the 3 million enrollees in ASKES since 1968. From these examples, periodic payment or pre-payment seems to be a socially acceptable concept in Indonesia.

Pooling capital for group benefit is widely practiced in Indonesia. In the ubiquitous arisan, members of the arisan group make monthly contributions to a capital pool in return for access to the capital at a point in time. The concept of cooperatives has been institutionalized in Indonesia. Groups organized on either a geographic basis or by similar productive enterprise pool their capital or the results of their labor for group benefit. A ministerial-level department has been formed to coordinate their development. Again, the concept of pooling capital for group benefit has been widely accepted in Indonesia.

Concern for future risk accociated with medical care implies that Indonesian society has a concern for the future and associates financial risk with medical care. The Moslem religion, practiced by over 90% of the Indonesian population, imbues its members with a concern for the future. From infancy Indonesians are taught to improve themselves mentally, physically, socially, and spiritually for a better life. Implicit in this philosophy is a concern for future risk to either body or soul which may endanger their well being.

For health insurance to be successful, it is important to determine whether the Indonesian society views the costs related to the treatment of illness as a sufficiently large risk to warrant pre-payment. Data from the 1984 SUSENAS, the 1985 Household Health Survey, and studies on treatment seeking behavior and expenditures for health care conducted by the Faculty of Public Health at the University of Indonesia (FKM-UI) and the Bureau of Planning in the MOH, allow us to draw some conclusions about the population's perception of the financial risk associated with seeking medical care. About 67% of all expenditures on health are made directly by consumers. When consumers use health facilities, about 30% choose public facilities, and the remainder private facilities in the traditional and modern sectors. Severity of illness is the major determinant in their choice of care. The more severe the illness, the greater the likelihood of using modern treatment facilites in the public or private sector for all income groups.

The costs of modern medical care, whether public or private, are several orders of magnitude larger than the cost of traditional medicine. For over 60% of the Indonesian population, the cost of a single health center visit represents 1%-2.5% of their total monthly personal expenditures. If care is sought at a private facility, the costs are substantially higher. These data indicate that the cost of seeking modern medical care represents a substantial financial burden for most of the Indonesian population. As the severity of illness increases, more consumers choose to seek modern medical care, even though the costs are significantly higher. It is probably safe to assume that in view of the financial burden

represented by the modern medical care costs of severe illness, the average Indonesian consumer is concerned about the future financial risk associated with moderate to severe illness. Since consumer decisions are usually motivated by personal benefit and in light of the Indonesian society's familiarity with prepayment, the concept of periodic pre-payment would seem to be a socially sound one in the Indonesian context.

Because of the effects of income on treatment seeking behavior and health services utilization, the health insurance concept will probably be accepted most easily among higher socio-economic groups who receive monthly cash incomes. However, there is sufficient evidence to indicate that it can be adapted successfully in lower income rural groups as well. In his study of rural pre-paid health care schemes, Dr. Ascobat Gani from FKM-UI has found that many different variations of pre-paid pooled risk health insurance schemes have arisen spontaneously among various community groups to defray expenses associated with modern medical care, whether these groups had a monthly cash income or not. He found that pre-paid pooled risk for health care was socially acceptable as long as it had been adapted to existing social and cultural conditions.

Experience in other countries leads to optimism about the importance people place on health care, particularly curative, personal health care for themselves and their families. Illness can have a devastating financial impact on households, and even rural people are generally conscious of the need to insure against the advent of unanticipated illness.

In a concrete sense, there is little solid evidence to rely on at this stage for making sweeping assumptions about the acceptability of pre-paid health care schemes. Each financing scheme proposed will need to be tested for social feasibility. The ultimate test of feasibility will be whether models are able to draw memberships, become successful, and flourish, . Because of the voluntary nature of these schemes, if they are not perceived as being valuable or cost worthy, they will have difficulty in attracting and maintaining membership.

I.3 Spread Effects

Again, the major component requiring attention is the social financing component. The spread effects of the innovations introduced in the hospital and pharmaceutical components will depend largely on the government making the necessary policy and program related decisions based on pilot efforts in the project. For the proliferation of financing schemes, however, much will depend on the demand for such schemes coming from the population and organizations themselves. The spread of the schemes will depend on whether they are successful and whether the demand is such that increasing numbers of people want to join such schemes. It also seems likely that models for successful schemes will not only be promoted by government but also will be spontaneously adopted by other organizations if they are viewed as useful by their memberships.

Because of the emphasis on self-reliance and beneficiary participation, continuity of the schemes beyond the life of the project is much more highly likely than with more traditional health care projects. The project will place emphasis on working with existing urban and rural organizations which are stable and have the institutional capacity to take on the management of a health care scheme. The creation of new institutions for the purpose of organizing health insurance will not be likely.

I.4 Impact

The child survival services which will receive an increasingly larger proportion of the MOH's central development budget throughout the life of this project will have a direct impact on the lower socio-economic segments of the population. This population group is generally at greater risk for mortality due to childhood illnesses and suffers most from lack of access to immunization services and diarrheal disease control programs.

In addition to the increased resources which will be made available for child survival program, larger groups of people will begin receiving higher quality care on a more affordable basis through pre-paid health insurance schemes of various kinds. The project estimates that approximately 30% of the Indonesian population will finance their health care through health insurance within 15 years as a result of the social financing initiatives introduced through this project. While initially population groups who are employed in the formal sector will be most likely to benefit from such schemes, the project will also attempt to develop financing scheme models which are relevant for groups of farmers, fishermen, and other agricultural workers in order to extend the impact of schemes to larger segments of the rural population. Participation in financing schemes across large groups of people allows the sharing of financial risk of illness among those who are rich and poor. The rich can in fact help subsidize care for those who are less well off and who are often at greater risk of illness in general. Financial participation can be geared by percentage of income in order to achieve this type of equity.

This being said, there will always be a segment of the population who are unable to contribute anything at all to financing their own health care. For such people, the government health system will need to continue to provide care. It is anticipated that the quality of care and the ability of the government to target its services to such people will improve as its burden for providing health care across the board decreases.

Annex J

DETAILED JOB DESCRIPTIONS
LONG TERM ADVISORS

I. Project Technical Coordinator and Chief of Party

The Consultant will function as the direct counterpart of the MOH Project Officer in the provision of technical assistance to this project, and will also be the Chief of Party for the U.S. technical assistance contracting agency chosen for this project. The Consultant will work directly with the Project Management Unit as an integral member of its project management structure, and will simultaneously supervise all activities undertaken in the name of the Contractor with regard to this project. The Consultant will assist the MOH Project Officer as follows:

1. Design management systems with standard operating procedures for use by the PMU and PIOs to manage all phases of project implementation.

2. Design and operationalize an annual project planning cycle which formulates comprehensive annual project workplans and budgets in accordance with the GOI annual planning cycle and guarantee timely disbursement of funds.

3. Coordinate the identification of all project technical assistance needs, development of suitable scopes of work, and recruitment of consultants.

4. Provide direct supervision for all long term consultants, both domestic and expatriate, working on the project under the contract.

5. Provide overall supervision for all short term consultants, both domestic and expatriate, working on the project under the contract.

6. Coordinate the determination of training needs and identification of suitable training opportunities to support each component of the project.

7. Oversee the design and implementation of project related studies, assessments, and demonstrations.

8. Oversee financial management and control.

9. Monitor the progress and pace of project implementation.

10. Design the mid-term and final project evaluation.

11. Function as liaison between the MOH, USAID, and the external and domestic contracting agencies on all technical, administrative, and financial matters related to the project.

12. Advise the MOH on technical and policy matters related to the project.

The Consultant will prepare an issues paper on an annual basis which reviews project implementation, identifies operational or administrative problems, assesses the policy environment within which the project is operating and makes recommendations to the Project Director, the Project Advisory Board, and USAID regarding management, implementation, and policy issues which require special attention in the upcoming fiscal year. The issues paper will be submitted in June of each year so that its recommendations can be considered in the planning cycle for the ensuing fiscal year. This first paper is due June 1989.

In order to carry out these responsibilities the Consultant should have a minimum of 10 years experience in the field of Public Health, prior experience working in a developing country an understanding of USAID administrative procedures, and prior experience with project management. The Consultant should be conversant in health financing issues in general and preferably health financing in Indonesia in particular. A doctoral degree or its equivalent in one of the allied health sciences is desirable plus a Masters degree in Public Health. Fluency in written and spoken Indonesian will be required of the Consultant. Funds for language training will be included in the contract.

II. Social Financing Specialist

The Consultant will be the direct counterpart of the Project Implementation Officer for Social Financing, and will function as an integral member of that Office. The Consultant will provide general technical advice and guidance to the PIO for Social Financing but will focus his/her efforts within the Private Health Insurance Unit of the PIO, promoting the proliferation of privately owned and operated health insurance plans. The Consultant will assist the Project Implementation Officer as follows:

1. Develop annual project workplans and budgets for the social financing component.

2. Ascertain short term technical assistance requirements for the ASKES, PKTK, Dana Sehat and Health Insurance Coordinating Mechanism sub-components of the project, prepare scopes of work, and identify suitable consultants.

3. Provide technical oversight and direct supervision of all short term consultants providing assistance to the social financing components of the project.

4. Develop administrative mechanisms and standard operating procedures for a Private Health Insurance unit within the PIO for Social Financing which can respond quickly to private initiatives in social financing.

5. Establish criteria of eligibility to govern the type and magnitude of project assistance available to private groups interested in starting health insurance schemes.

6. Identify private groups interested in starting health insurance schemes who can utilize assistance available through the project for feasibility studies and start up assistance.

7. Conduct feasibility studies and develop business plans for promising health insurance ventures seeking assistance through the project.

8. Design project assistance packages which can be used by promising business ventures to make their health insurance programs operational.

9. Identify banks or large companies with investment capital who are willing to invest in health insurance ventures, and assist groups with promising feasibility studies and business plans developed under the project to access capital.

10. Monitor the pace and progress of project implementation in the social financing component of the project.

In order to carry out these responsibilities, the Consultant should have a minimum of 10 years prior experience working with health insurance programs, with experience in an international setting preferable. The Consultant should be able to conduct feasibility studies and formulate business plans, and be knowledgeable about ways to identify and access venture capital. A Masters of Business Administration degree or its equivalent is desirable. Fluency in written and spoken Bahasa Indonesia is a requirement for the position. Language lessons will be provided.

III. Technical Advisor for Hospital Management

The Consultant will be the direct counterpart of the Project Implementation Officer for Hospitals, and will function as an integral member of that Office. The Consultant will provide general technical advice and guidance to the PIO necessary to design, test, and evaluate structural interventions in the hospital sector aimed at improving efficiency, increasing cost recovery, and reducing government subsidies to government hospitals. The Consultant will assist the Project Implementation Officer as follows:

1. Develop annual project workplans and budgets for the hospital component.

2. Design the format and data collection instruments for a diagnosis or audit of secondary care systems on a province wide basis. Each secondary care system will consist of a government class B hospital at the provincial level, a private hospital at the provincial level and a government class C and class D hospital at

more peripheral administrative levels. The hospital audit will focus on the following features of hospital operation:

a. organizational analysis, looking at structure, mission, responsibilities, and standard procedures;

b. cost accounting analysis which determine actual costs for services;

c. cost recovery potential;

d. staffing patterns and practices;

e. medical and pharmaceutical services;

f. standard of care;

g. hospital support services such as food, linen, transportation laundry, etc.;

h. fiscal and administrative management;

i. regulations and policies which govern hospital operations.

3. Analyze the results of the hospital diagnosis to identify problems which impede efficient operations and cost recovery.

4. Design a program of pragnatic interventions which can be introduced in the "secondary care systems" in three provinces which are aimed at increasing hospital efficiency and improving cost recovery.

5. Conduct a field demonstration of the intervention packages in three provinces.

6. Design a summative evaluation for the three provincial demonstration areas which measures the extent to which government subsidies to the hospitals included in the demonstration secondary care systems have been reduced.

7. Identify short term technical assistance requirements needed to support research and demonstration activities in the hospital component.

8. Provide technical oversight and direct supervision for all short term consultants providing assistance to this element of the project.

9. Determine training needs for the hospital component of the project.

10. Monitor the pace and progress of project implementation in the hospital component of the project.

In order to discharge these responsibilities the Consultant should have a minimum of 10 years experience in hospital administration, with previous experience managing a hospital in a developing country context desirable. The Consultant must possess first hand knowledge of hospital medical services, financial systems, and administrative procedures; and should be cognizant of the regulatory and cultural limitations that exist in developing country settings which impede hospital efficiency. The Consultant should have a Master Degree in Hospital Administration or its equivalent, plus fluency in written and spoken Bahasa Indonesia. Language lessons will be provided in the contract.

IV. Technical Advisor for Pharmaceutical Supply Management

The Consultant will be the direct counterpart of the Project Implementation Officer for Pharmaceutical Supply Management, and function as an integral member of that Office. The Consultant will provide general technical advice and guidance to the PIO necessary to design, a research agenda to study problems in pharmaceutical supply management; design and test appropriate interventions; and demonstrate successful interventions on a large geographic scale. The Consultant will assist the Project Implementation Officer as follows:

1. Develop annual project workplans and budgets for the pharmaceutical component.

2. Conduct a systems analysis of the pharmaceutical sector which can, in a rapid and reasonably accurate fashion, determine major problem areas which impede rational and efficient use of the government pharmaceutical budget. The systems analysis should cover, at a minimum, the following areas:

   a. product selection and procurement planning at the provincial and district administrative levels;

   b. storage and distribution at district administrative levels, district hospitals, and sub-district health centers;

   c. prescribing and dispensing practices in hospitals and health centers, especially their relationship to diagnosis and conformity with standard treatment protocols;

   d. factors influencing the prescribing patterns of providers;

   e. factors influencing community expectations for drug prescribing at Hospitals and Health Centers.

3. Design operations research studies which can further define problem areas and suggest appropriate interventions.

4. Identify research groups within the Ministry of Health, universities, or non-government organizations which can conduct the operations research.

5. Monitor the implementation of the research, working directly with researchers where necessary in the data collection, analysis, and interpretation of research finding.

6. Design, test, and evaluate specific training, management, and communications interventions which could be introduced in the areas of pharmaceutical selection, procurement, distribution, and use.

7. Develop a comprehensive packet of interventions which can be introduced on a district-wide level. These intervention packets should contain elements of the specific interventions tested previously which have been chosen and assembled into the intervention packet because of their collective potential impact on fostering more rational drug use.

8. Design a district level demonstration project which can test the comprehensive intervention package in a large geographic area.

9. Identify short term technical assistance requirements needed to support the pharmaceutical supply management component of the project.

10. Provide technical oversight and direct supervision for all short term consultants providing assistance to this element of the project.

11. Determine training needs for the pharmaceutical supply management component of the project.

12. Monitor the pace and progress of project implementation in the pharmaceutical supply management component of the project.

In order to discharge these responsibilities the Consultant should have a minimum of 10 years experience in public health, prior experience in pharmaceutical supply management, and prior overseas experience. The Consultant should be totally conversant with medical diagnosis and appropriate pharmacologic treatment, and should be familiar with the formulation and use of standard treatment protocols and drug formularies. The Consultant should have an M.D. degree plus a Masters Degree in Public Health. Fluency in written and spoken Bahasa Indonesia is a requirement for the position. Language lessons will be provided in the contract.

Annex K

Projected Annual Expenditures
US FY 1988-1994 (US$ '000)

	1988		1989		1990		1991		1992		1993		1994		1995		Total	
	AID	GOI	AID	GOI	AID	GOI	AID	GOI	AID	GOI	AID	GOI	AID	GOI	AID	GOI	AID	GOI
Technical Assistance	500	-	700	-	1200	-	1100	-	1100	-	500	-	415	-	300	-	5815	-
Commodities	100	20	450	100	100	20	100	16	110	16	-	-	-	-	-	-	860	172
Studies	150	40	150	120	450	200	750	600	1200	850	700	850	500	600	50	200	3950	3460
Training	-	-	125	50	360	160	540	185	350	250	55	300	-	300	125	-	1555	1245
Local Costs	60	38	150	125	240	125	240	125	240	125	240	50	240	50	140	-	1550	638
Contingency	100	-	75	-	150	-	200	-	200	-	120	-	100	-	325	-	1270	-
Total:	910	98	1650	395	2500	505	2930	926	3200	1241	1615	1200	1255	950	940	200	15000	5515

Foreign Exchange and Local Cost Split
Health Sector Financing Project
(U.S.$ '000)

	Social Financing		Hospital		Pharmaceutical		Policy Analysis Unit		Project Administration		Evaluation and Audit		Total:	
	FX	LC	FX	LC	FX	FC	FX	LC	FC	LC	FX	LC	FX	LC
Technical Assistance	1,900	350	850	185	900	120	200	110	1,000		130	70	4980	835
Comodities	-	550	-	105	-	150	-	25	-	30	-	-	-	860
Studies	-	1,150	-	1,000	-	1,300	-	500	-	-	-	-	-	3950
Training	500	200	235	140	150	150	150	30	-	-	-	-	1035	520
Local Costs	-	250	-	250	-	250	-	200	-	600	-	-	-	1550
Contingency	200	200	135	140	150	150	65	65	85	80	-	-	635	635
Total:	2,600	2,700	1,220	1820	1200	2120	415	930	1085	710	130	70	6650	8350

Budget for Health Sector Financing Project (7 Years)
(in US Dollars)

I.	Social Financing				5,300,000
1.	Technical Assistance			2,250,000	
	1 LT Expatriate 5 years	1,000,000 FX			
	2 LT Domestic 5 years	270,000			
	ST Domestic 40 p/m	80,000			
	ST Expatriate 36 p/m	900,000			
2.	Commodities			550,000	
	- Personal Computer Units @ 8,000/unit		296,000		
	AsKes (15 units)	120,000			
	AsTek (10 units)	80,000			
	Health Insurance Board (10 units)	80,000			
	PIO (2 units)	16,000			
	- Office Equipment		120,000		
	Health Insurance Board	100,000			
	PIO	10,000			
	- Office & Data Management equipment for selected financing schemes		134,000		
3.	Training			700,000	
	- Externships at U.S. HMOs				
	15 persons x 20,000	300,000			
	- Short Term overseas training in Health Financing				
	15 persons x 10,000	150,000			
	- Short Term in-country training for AsKes and AsTek				
	10 courses x 20,000/course	200,000			
	- Study tours to neighboring countries				
	10 persons x 5,000	50,000			
4.	Local Costs for PIO			250,000	
5.	Studies			1,150,000	
	AsKes		275,000		
	- Analysis & testing of capitated Prepayment Schedules	25,000			
	- Actuarual Analysis	25,000			
	- Benefit package Analysis	25,000			
	- Development of MIS	25,000			
	- Pilot Tests	175,000			

	AsTek		200,000		
	- Case Studies of existing plans	20,000			
	- Evaluation of Jakarta PKTK	20,000			
	- Market Research	50,000			
	- Pilot Tests	110,000			
	Dana Sehat		175,000		
	- Situation Analysis in 5 Districts	25,000			
	- Pilot Testing of intervention	50,000			
	- Demonstration in 5 District	100,000			
	Startup costs for private social financing schemes		400,000		
	NGO inventory		100,000		
6.	Contingency			400,000	
II.	Hospital Sector Reform				3,040,000
1.	Technical Assistance			1,035,000	
	1 LT Expatriate 3 years	600,000			
	1 LT Domestic 5 years	125,000			
	10 persons mos ST Expatriate	250,000			
	30 persons mos ST Domestic	60,000			
2.	Commodities 10 PC units photocopy office equipment			105,000	
3.	Studies (3 Provincial Sites)			1,000,000	
	- Hospital diagnosis	100,000			
	- Intervention design	50,000			
	- Pilot testing	200,000			
	- Evaluation & Modification	50,000			
	- Demonstration	600,000			
4.	Training			375,000	
	- Long Term Overseas 2 persons x 50,000	100,000			
	- Externships 6 persons x 10,000	60,000			
	- Study Tours 15 persons x 5,000	75,000			
	- In-country Training in Hospital Management 7 courses x 20,000	140,000			
5.	Local Costs for PIO			250,000	
6.	Contingency			275,000	

III.	**Pharmaceutical Sector Reform**			3,320,000
1.	Technical Assistance		1,020,000	
	1 LT Expatriate 3 years	600,000		
	2 LT Domestic 2 years	100,000		
	12 persons mos ST Expatriate	300,000		
	10 persons mos ST Domestic	20,000		
2.	Commodities		175,000	
	15 PC units @ 8000	120,000		
	Office equipment	55,000		
3.	Training		300,000	
	- Program Training			
	5 courses x 20,000	100,000		
	- Study Tours			
	10 persons x 5,000	50,000		
	- Short Term Overseas training			
	15 persons x 10,000	150,000		
4.	Studies		1,300,000	
	- Focussed Assessment			
	5 x 75,000	275,000		
	- Intervention design	100,000		
	- Pilot testing	300,000		
	- Evaluation & Modification	50,000		
	- Demonstration	575,000		
5.	Local Costs for PIO		250,000	
6.	Contingency		275,000	

IV.	Financial and Policy Analysis			1,345,000
1.	Technical Assistance		310,000	
	55 persons mos ST Domestic	110,000		
	8 persons mos ST Expatriate	200,000		
2.	Commodities		24,000	
	3 PC units x @ 8,000	24,000		
4.	Studies		501,000	
	- Economic impact studies of child survival programs	100,000		
	- Development of data base on health financing	160,000		
	- Studies on private sector expenditures & development	50,000		
	- Research dissemination/ regional health economics workshops	125,000		
	- Project monitoring, documenting lessons from financing schemes	66,000		
4.	Training		180,000	
	- Long term Domestic 3 persons x 10,000	30,000		
	- Long term Overseas 2 persons x 50,000	100,000		
	- Short Term Overseas 5 persons x 10,000	50,000		
5.	Local Costs for Health Finance and Policy Analysis Unit		200,000	
6.	Contingency		130,000	

V.	Project Administration				1,795,000
	1. Technical Assistance			1,000,000	
	1 LT Expatriate 5 years		1,000,000		
	2. Commodities			25,000	
	3 PC units x @8,000	24,000			
	Office equipment	6,000			
	3. Local Costs for PMU		600,000		
	- Operating expenses 7 years x 71,400	500,000			
	- Planning Workshops	100,000			
	4. Contingency		165,000		
VI.	Evaluation and Audit				200,000
	Mid Term Evaluation	40,000			
	Final Evaluation	60,000			
	Audits	100,000			
	Total:				15,000,000

Budget GOI Counterpart Expenditures
(in U.S. Dollars)

I.	Technical Assistance			485,000
	1. Tax on Expatriate Advisors			
	- Long Term Expatriate			
	16 person years x 200,000 x 10%	320,000		
	- Short Term Expatriate			
	66 person months x 25,000 x 10%	165,000		
II.	Commodities			172,000
	Tax, Materials, Supplies & Training 20% of Commodities Expenditures			
	860,000 x 20%			
III.	Training			1,245,000
	1. Salaries for persons while in all Long and Short Term Training programs		245,000	
	1.1. Social Financing	98,000		
	- Externships in U.S.			
	15 persons x 1,200	18,000		
	- Short Term Overseas			
	15 persons x 1,000	15,000		
	- Study Tours			
	10 persons x 500	5,000		
	- Short Term In-Country			
	10 courses x 6,000	60,000		
	1.2. Hospitals	67,000		
	- Long Term Overseas			
	2 persons x 5,000	10,000		
	- Externships			
	6 persons x 1,200	7,200		
	- Study Tours			
	15 persons x 500	7,500		
	- In-Country Training			
	7 courses x 6,000	42,000		
	1.3. Pharmaceuticals	50,000		
	- Short Term Overseas			
	15 persons x 1,000	15,000		
	- Study Tours			
	10 persons x 500	5,000		
	- In-Country Training			
	5 courses x 6,000	30,000		
	1.4. Policy Analysis	30,000		
	- Long Term Overseas & Domestic			
	5 persons x 5,000	25,000		
	- Short Term Overseas			
	5 persons x 1,000	5,000		

2.0	GOI Sponsored Short-Term In-Country Training.	1,000,000		
	Conducted as continuation of project funded in-country training for AsKes AsTek, Hospitals and Pharmaceuticals			
	2.1. AsKes 15 courses x 20,000 300,000			
	2.2. AsTek 10 courses x 20,000 200,000			
	2.3. Hospitals 15 courses x 20,000 300,000			
	2.4. Pharmaceuticals 10 courses x 20,000 200,000			
IV.	Local Costs (rounded)			638,000
	Value of space provided for PIO/PMU/ Health Policy Analysis Unit at $\$12/m^2/months$			
	1. PMU 100 m^2 x $\$12/m^2/mo$ x 12 mos x 7 years		100,800	
	2. PIO/Health Policy Unit 60 m^2 x $\$12/m^2/mo$ x 12 mos x 7 years x 4 sites		241,920	
	3. Capital generated through Indonesia Financial Institutions as start-up capital for Social Financing		295,000	
V.	Studies and Assessments		3,160,000	3,460,000
	1.0. Value of staff salaries, facilities, transportation utilities, and routine expenditures at all gov't health facilities in which pilot tests and demonstrations will take place.			
	1.1. Hospitals 9 hospitals x 350,000 x 20% x 4 years	2,520,000		
	1.2. Health Centers 20 facilities x 40,000 x 20% x 4 years	640,000		
	2.0. Studies undertaken at GOI expense 15 studies x 20,000		300,000	
Total:				6,000,000

Budget GOI Counterpart Expenditures
(in U.S. Dollars)

I.	Commodities			172,000
	Materials, Supplies & Training 20% of Commodities Expenditures 860,000 x 20%			
II.	Training			1,245,000
	1. Salaries for persons while in all Long and Short Term Training programs		245,000	
	1.1. Social Financing	98,000		
	- Externships in U.S. 15 persons x 1,200	18,000		
	- Short Term Overseas 15 persons x 1,000	15,000		
	- Study Tours 10 persons x 500	5,000		
	- Short Term In-Country 10 courses x 6,000	60,000		
	1.2. Hospitals	67,000		
	- Long Term Overseas 2 persons x 5,000	10,000		
	- Externships 6 persons x 1,200	7,200		
	- Study Tours 15 persons x 500	7,500		
	- In-Country Training 7 courses x 6,000	42,000		
	1.3. Pharmaceuticals	50,000		
	- Short Term Overseas 15 persons x 1,000	15,000		
	- Study Tours 10 persons x 500	5,000		
	- In-Country Training 5 courses x 6,000	30,000		
	1.4. Policy Analysis	30,000		
	- Long Term Overseas & Domestic 5 persons x 5,000	25,000		
	- Short Term Overseas 5 persons x 1,000	5,000		

2.0	GOI Sponsored Short-Term In-Country Training. Conducted as continuation of project funded in-country training for AsKes AsTek, Hospitals and Pharmaceuticals	1,000,000		
	2.1. AsKes 15 courses x 20,000	300,000		
	2.2. AsTek 10 courses x 20,000	200,000		
	2.3. Hospitals 15 courses x 20,000	300,000		
	2.4. Pharmaceuticals 10 courses x 20,000	200,000		
III.	Local Costs (rounded)			638,000
	Value of space provided for PIO/PMU/ Health Policy Analysis Unit at $12/m^2/months			
	1. PMU 100 m^2 x $12/m^2/mo x 12 mos x 7 years		100,800	
	2. PIO/Health Policy Unit 60 m^2 x $12/m^2/mo x 12 mos x 7 years x 4 sites		241,920	
	3. Capital generated through Indonesia Financial Institutions as start-up capital for Social Financing		295,000	
IV.	Studies and Assessments		3,160,000	3,460,000
	1.0. Value of staff salaries, facilities, transportation utilities, and routine expenditures at all gov't health facilities in which pilot tests and demonstrations will take place.			
	1.1. Hospitals 9 hospitals x 350,000 x 20% x 4 years	2,520,000		
	1.2. Health Centers 20 facilities x 40,000 x 20% x 4 years	640,000		
	2.0. Studies undertaken at GOI expense 15 studies x 20,000		300,000	
Total:				5,515,000

Projected Commitments by Fiscal Year
Health Sector Financing Project
(U.S.$'000)

Line Item	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95
1. Technical Assistance	3,600	-	500	100	1,515	-	-	100
2. Commodities	310	-	550	-	-	-	-	-
3. Studies	550	-	500	-	1,200	1,200	500	-
4. Training	662	-	250	-	300	343	-	-
5. Local Cost	410	200	50	50	250	200	200	190
6. Contingency	250	-	18	-	400	400	202	-
Total:	5,782	200	1,868	150	3,665	2,143	902	290

ANNEX L

UNITED STATES GOVERNMENT

memorandum

DATE: February 3, 1988

REPLY TO ATTN OF: Dr. E. Vou'garopoulos, Chief, OPH

SUBJECT: Request for Blanket Waiver for International Travel Costs of Long and Short-Term Participants Under the Health Sector Financing Project No. 497-0354

TO: Mr. David N. Merrill, Director

Thru: Mr. James M. Anderson, Deputy Director

Waiver Control No. IND/88/ 06

ACTION MEMORANDUM TO THE DIRECTOR

Problem: A blanket waiver is required to authorize AID funding of the international travel cost for long and short term participants under the Health Sector Financing Project.

Discussion: A.I.D. Handbook No. 10, Chapter 15, Paragraph 15.B.1, requires that the host government pay the cost of international travel of participants, except in instances where the Mission Director has justified and authorized a waiver.

Because of sharp recent declines in the Ministry of Health budget, it is virtually impossible to get agreement to send participants to various short courses or conferences abroad if the GOI must cover the cost of international airfare and per diem. It is also difficult to get agreement and adequate funding for covering such costs for participants going overseas for long-term academic training. Based on this experience in recent years, the Health Sector Financing Project has been planned to include travel and per diem costs for international training in the project budget. The Project has planned for a number of different kinds of participant training. They range from short courses in the U.S. on health care financing or pharmaceutical supply management to the academic masters degree training required for four MOH officials who will help strengthen the institutions being developed in the project. Managers will also be sent to the United States for "externships" to work as apprentices in Health Maintenance Organizations or other institutions to gain practical experience in management and administration of pre-paid health schemes. Taking advantage of these training opportunities on a timely basis is critical to the success of the project. Development of the necessary skills within each component of the project (i.e., in social financing, hospital management, pharmaceutical supply management,

OPTIONAL FORM NO. 10
(REV. 1-80)
GSA FPMR (41 CFR) 101-11.6
5010-114
★ U.S.G.P.O.: 1986-491-248/20641

and health economic and policy research) will constitute one of the most important contributions the project will make to institutionalizing the reforms envisioned in each area.

Over the life of the Health Sector Financing Project, budgetary stringencies for these kinds activities are likely to remain in place. Therefore, instead of preparing individual waivers for each set of participants, the purpose of this waiver is to seek authority to cover international travel costs up to $800,000 over the life of the project.

Recommendation: That you approve a blanket waiver to permit utilization of up to $800,000 of project funds to cover international travel costs for long and short-term training activities which are of direct relevance and benefit to the project.

Approved: David N. Merrill
Director

Disapproved: _____
David N. Merrill
Director

Date: 2/8/88