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HEALTH SECTOR FINANCING PROJECT
MONOGRAPH SERIES

**ANALYSIS OF HEALTH FINANCING
IN INDONESIA
1982/83 - 1988/89
(DATA UPDATING)**

Monograph No. 10

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IN INDONESIA
1982/83 - 1988/89
(DATA UPDATING)**

**MINISTRY OF HEALTH, REPUBLIC OF INDONESIA
SECRETARIATE GENERAL
BUREAU OF PLANNING
HEALTH ECONOMICS AND POLICY ANALYSIS UNIT**

CONTENTS

	Page
FOREWORD	i
PREFACE	ii
I. INTRODUCTION	1
II. DATA COLLECTION	3
A. FUNDING SOURCE	3
A.1. Central	3
A.2. Province	6
A.3. Regency	7
A.4. Other Ministries	9
B. DATA COLLECTION INSTRUMENT	9
C. DIFFICULTIES ENCOUNTERED	10
III. DATA PROCESSING	11
IV. ANALYSIS RESULTS	13
A. BUDGETARY AND HEALTH FINANCING TRENDS FROM GOVERNMENT SOURCES	13
B. REALIZATION OF GOVERNMENT HEALTH FINANCING ACCORDING TO FUNDING SOURCES	15
C. HEALTH BUDGET UTILIZATION	22
C.1. Health Budget Utilization According To Investment, Operations and Maintenance Costs	22
C.2. Health Budget Utilization Accordign To Development and Routine Expenditures	24
C.3. Health Budget Utilization According To Health Efforts	26
C.3.1. Puskesmas Health Efforts	27
C.3.2. Medical Referral/Hospital Services	29
C.3.3. Health Personnel Education And Training	30
C.3.4. Research And Development	32
C.3.5. Administration/Improvement of Management	32
C.3.6. Other Health Units	33
C.4. Health Expenditure Distribution According To Location (Province)	34
ANNEX	36

P R E F A C E

As a continuation of the Health Financing Analysis activities for the years 1982/83 - 1986/87, the Health Economics and Policy Analysis Unit has undertaken the updating of data and an Analysis Of Health Financing by the Government for the year 1986/87 - 1988/89.

It is hoped that all parties both within and without the Ministry Of Health would be able to utilize the Health Financing data from the year 1982/83 up to 1988/89 contained in this report, as an input in the formulation of future health sector policy and planning.

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Ridwan Malik, MD., MPH.



Chief, Health Economics and
Policy Analysis Unit

CHAPTER I

INTRODUCTION.

Health financing data is important in the evaluation, planning and development of public health policy. Analysis of financing data, provides information on health financing trends over time, cost utilization or allocation according to service type and province, the contribution of each funding source, and much more. Based on this information, evaluation can be made of implemented policies, for example, whether cost allocation among provinces is really equitable. In addition, future trend projections can be made, taking into account population increase, and change in disease patterns.

Health financing data collection is not easy. Health financing sources can usually be divided into two groups, **community funding, including the private sector, and government funding.** To collect community and private funding single comprehensive data, several studies are required, because of the absence of a complete source of data. To gather government funding data also needs special efforts, because of the multiplicity of government funding sources and the origination of data in numerous locations.

In 1987, the Bureau Of Planning collected and analyzed data on health financing costs, both for the private and government sector, covering the period 1982/83 to 1986/87. The results were quite satisfying. The analysis result were used in the formulation of funding policies in the Repelita V and also in planning health financing. Besides that, several papers were prepared and presented in national and international seminars, and many were published in scientific journals.

Realizing the great benefit gained, it was felt necessary to update the funding data every year, to obtain a more accurate picture of health financing. Data on government expenditures were first collected and analyzed, while those from the community and private sector are still in the process of collection. Data collected on health expenditures cover **allocation and realization data** for the period of **1986/87 until 1988/89**, while **1989/90** data cover **allocation data** only.

In collecting government expenditure data, the approach used is as follows:

- * examination of the financial flow of allocations from the central level to the provincial and regency levels.
- * examination of provincial and regency ability to collect revenues (true local revenues) for health funding.
- * collection of quite thorough data at each level (central, provincial and regency), to obtain a profile of allocations according to level, program and function.

To fulfil those criteria, two methods of data collection were employed, primary and secondary data collection. Primary data collection was undertaken in 11 provinces, i.e. 5 big provinces, 3 provinces in the CHIPPS project and 2 provinces in the World Bank Health Project III. Provincial data were obtained from the Governor's Office while regency level data were collected from the Regency Health Service by visiting each regency in those eleven provinces. In that way comprehensive data were obtained on allocation according to program and function. The information collected from the eleven provinces already covered 71 % of the entire government expenditure (central, provincial and regency), and 77.5 % of the entire Indonesian population. Detailed information of the eleven provinces can be examined in annex 1. Secondary data from the other 16 provinces were obtained from provincial data contained in books available at the Ministry of Internal Affairs, and regency data were obtained from books available at the provincial level.

The collection of data by the two methods above, is an improvement on the data collection procedures used in 1987. More comprehensive data can be obtained in this way, considering that general data can usually be acquired from secondary data rather satisfactorily.

The updating of government data has gone through a long process. Starting in the beginning of 1989 with the arrival of Glen A. Melnick, a foreign consultant, to help design the Health Financing Data Updating methodology, both for the government sector and the community and private sector sources. Based on that design, operational plans, data collection forms, provincial and regency level data collector training, data collection and other preparations for data processing were made. A domestic consultant, Amak Rochmad, assisted in the implementation. Most of the data collection was completed in August 1989 and data in the form of DBase files were brought to UCLA for analysis. The analysis was unfortunately not completed according to schedule, so the whole data set was brought back to Indonesia in December 1990. All data processing subsequently was done at the AKEK unit (Health Economics and Policy Analysis Unit), assisted by Ken White, a Health Economic advisor from USAID Jakarta. Finally, financing data analysis was undertaken by the full time professionals of the AKEK unit themselves with the assistance of consultants. The whole process took approximately 20 months.

In presenting data, several tables were constructed, providing a general picture of health financing and financing trends from 1982/83 up to 1989/90. Trends were established according to services and programs, budget items and provinces. Various specific analyses were also made, e.g., child survival expenditures.

It is hoped that the results of this updating of the financing data can be utilized to assess various policies and can be used in planning future financing of health services.

CHAPTER II.

DATA COLLECTION

A. FUNDING SOURCES

In this report, funding source means expenditures of the **government only**, covering the central, provincial and regency levels. It can be detailed as follows:

1. **Central**
 - * Central Development Budget (APBN-DIP)
 - * Central Routine (Operational) Budget (APBN-DIK)
 - * Presidential Instruction (Inpres) on Health Facilities Development Assistance
 - * Operational Expenditure Subsidy Assistance (SBBO)
 - * Foreign Aid
2. **Provincial Budget (APBD I)**
 - * Provincial Development Budget (DIPDA I)
 - * Provincial Routine Budget (DIKDA I)
3. **Regency Budget (APBD II)**
 - * Regency Development Budget (DIPDA II)
 - * Regency Routine Budget (DIKDA II)

All the information of the above expenditures are available at various locations, requiring special efforts in their collection. Funding data consists of two kinds data, **allocation data** and **realization data**. In the collection of these funding data, **double counting** must be avoided. Funding calculated as central level funding, can not be recounted as regency or provincial funding.

The way of obtaining data is as follows:

A.1. Central Level

These data are available at the central level (Jakarta), and were collected from the various units of the Ministry of Health.

- * **APBN-DIP allocation** data were obtained from various documents:
 - i. Operational Guidance (PO) Documents of MOH Sectoral Projects available at the Development Planning Division of the MOH Bureau of Planning.
 2. MOH Budget Book (grey book), a review of the various aspects of the results of annual health planning. This book is published by the Development Planning Division of the MOH Bureau of Planning, in July, about three

months after the start of each current financial year. This book contains health budget data, also sectoral, Health Inpres and the MOH routine budget.

This book is based on:

- a. DIP and PO of Sectoral Health Development Projects;
 - b. Health Facilities Development Program/Inpres Assistance Budget Approval Letter (SPABP);
 - c. MOH DIK
3. Budget recap by the Bureau of Finance, based on the DIP and DIK documents, including its amendments. This document is available at the beginning of each fiscal year and is similar to the grey book published by the Bureau of Planning. In accordance with its function, the Bureau of Finance always updates all budgetary data, so that their data is more accurate than those available from other sources.
 4. MOH Development Budget (DIP) Realization List, a book published by the MOH Inspectorate General. Besides realization expenditures, it also contains final allocation information. The difference with other books is that this book contains all DIP revisions, An Additional Budget (ABT) or DIP Supplements awarded in that year. Unfortunately this book is published about 5 months after the end of the fiscal year (around August). DIP revision means the switching of utilization of budgetary items without changing the overall value. ABT captures additions to the original DIP budget managed by the same personnel. Supplementary DIP are additional DIP funds managed by different personnel. For example, Supplementary hospital DIP is managed by the Ministry for Public Works.

In this instance, DIP allocation data were collected from documents 1 and 2 for the years 1986/87 up to 1989/90.

* Data on the APBN-DIP realization were collected from: The MOH Development Budget (DIP) Realization List book for 1988/89. The book was published by the MOH Inspectorate General in 4 volumes, and contains detailed expenditures according to province, program, organizational unit, and expenditure classification. The most appropriate data were found in the expenditure classification series. Realization data were based on the available payment documents (SPM or SPJ), collected by the Inspectorate General during visits to each province. This book is usually published each August of the following fiscal year (for the 1988/89 fiscal year, the book was published in August 1989). Besides realization expenditures, this book also contains allocation data.

* Data on the APBN-DIK realization were collected from:

1. Bureau of Finance DIK data for vertical implementing units (central technical implementing units/UPT).

2. **MOH Budget Book (grey book).** This book contains total figures, but no details for each implementing unit.
3. **MOH Routine Budget (DIK) Realization List,** a book published by the MOH Inspectorate General. Besides realization, it also contains information on allocation. The difference with other books is that it contains the Additional Budget (ABT) for the respective year. This book is published 5 months after the end of the respective fiscal year (around August).

For this study, data were collected from document 1 for the years 1986/87 up to 1989/90.

- * **Data on the DIK realization** were collected from:

The MOH Routine Budget (DIK) Realization List book for 1988/89. This book is published by the MOH Inspectorate General in 2 volumes, detailed according to province and organizational units. Realization is based on the available payment documents (SPM or SPJ), collected by the Inspectorate General during visits to each province. This book is usually published each August of the following fiscal year (for the 1988/89 fiscal year, from which data were collected purposes of this study was published in August 1989). Addition to realization data, this book also contains allocation datam.

- * **Data on the Inpres Health Facilities Development Assistance** were collected from:
 1. **Health Facilities Development Program/Inpres Assistance Budget Approval Letter (SPABP),** a document containing the INPRES activities and budget with its disbursement guidelines process, which provide implementation guidance for project officers. Specific documents for the Puskesmas, covering drugs, Puskesmas facilities and equipment, personnel and operational expenditures are located at the Directorate General for Community Health. Documents on Clean Water Supervision are located at the Directorate General for Communicable Disease Control and Environmental Health Development, while information concerning clean water physical development are at the Ministry for Public Works. All of the documents can be found at the Development Planning Division.
 2. **The MOH Budget Book (grey book),** which is a review of the various aspects of results of the annual health planning.

For this study, data were collected from document 2 for the years 1986/87 up to 1989/90.

- * Data on the **Operational Expenditure Subsidy Assistance (SBBO)** given to hospitals in a province/regency were collected from the Finance Division of the Directorate General For Medical care Secretariat. This division has a list of all hospitals in Indonesia receiving the SBBO.

- * Data on **Foreign Aid** could be collected from 2 sources:

For Foreign Aid that is listed in the DIP, then the usual DIP procedures are used;

For Foreign Aid in the form of grants, data must be collected from the General Planning Division, Bureau of Planning.

A.2. Province (APBD I)

In collecting provincial funding data, 2 techniques were used: primary data collection from the provinces and secondary data collection from documents available at the Ministry of Internal Affairs.

Primary data collection was undertaken in 11 provinces. This had the advantage of permitting the collection of very accurate information for the bank of the population of Indonesia. The eleven provinces were provinces with big populations (East Java, Central Java, West Java, Jakarta, North Sumatra and South Sulawesi), Provinces previously within the CHIPPS project were conducted (Aceh, West Sumatra and East Nusa Tenggara) and provinces with the Third Health Project (East Kalimantan and West Nusa Tenggara). Based on previously collected health financing data, it was found that those 11 provinces represented 71 % of the total government financing (Central, Provincial and Regency) and the population represented 77.5 % of the Indonesian population. Thus, these eleven provinces provide a good general picture of Indonesia.

Primary data were collected as follows:

- * DIPDA I data were collected from the Provincial Health Service Planning Division. More accurate descriptions were found in the PO and Implementation Paper (LK) of each project funded by the DIPDA I.

- * DIKDA I data were collected from the Provincial Health Service Finance Division and other units (local technical implementing units) having their own DIK, for instance Provincial hospitals.

- * In addition , the provincial APBD, both development and routine was examined. It was possible to obtain a picture of the proportion of health financing received from the APBD I compared to all Provincial expenditures, both development and routine. This document is located in the Finance Bureau of the Governor's Office.

Secondary data collection was performed for all the provinces. Data were obtained from the Directorate for Local Finance Development, Directorate General for General Governance and Local Autonomy, Ministry of Internal Affairs. Comparisons of collected primary and secondary data were made for the eleven provinces. In this way, the differences between both data could be assessed and then used in various computations under various assumptions. The methods of data collection were as follows:

- * Each province sent their **APBD I Allocation** book, which had previously been agreed upon by the DPRD I (**Provincial Legislative Body**), to receive final approval by the Minister for Internal Affairs. This book is usually received between April and June in the same fiscal year. Modifications can occur during the implementation because of funding limitations, requiring the preparation of a second APBD I document called **APBD I Modification**. This book is usually received between August and December in the same fiscal year.
- * The health sector development and routine budget was extracted from both books. The allocation book data was extracted first, then corrected with the changes in the modification book.
- * After the conclusion of the activities of the fiscal year, a **Final Realization Determination** book is prepared, based on the accomplishment reports of each activity. This book is usually received in June - July of the next year and was used for purposes of this study.
- * The **APBD I Allocation** and **APBD I Modification** books were obtained from the **Sub-Directorate for Budget Processing**, while the **Final Realization Determination** book was obtained from the **Sub-Directorate for Budget Determination**; which also provided useful data.

A.3. Regency (APBD II)

In collecting APBD II financing data, two methods can be used: collection of data direct from each regency within a province, or from the Governor's Office. Of course, each method has its advantages and drawbacks. Several provinces do not have APBD II e.g. Jakarta, Bali and East Timor.

For the above ten provinces, with the exception of Jakarta, data were collected directly from the regency by trained provincial personnel visiting each regency. It was hoped that with this method more accurate information could be collected, although at higher cost. In this way, a more definite picture of regency level health funding could be obtained. The regencies in the 11 provinces represented 63.4 % of all the regencies in Indonesia.

For the other 14 provinces, data were collected from the Governor's Office in each Provincial Capital. A description of the methods used to obtain the data required is described immediately below.

Direct Collection Of Data From The Regency

- * DIPDA II data were obtained from the Regency Health Service Planning Sub-Division. More detailed descriptions were obtained in the Project Officer (PO) of each project funded from the DIPDA II.
- * DIKDA II were obtained from the Regency Health Service Finance Sub-Division and other units (Local Technical Implementing Units) that have their own DIK, for example, the Regency general hospitals.
- * In addition the development and routine APBD II Document was examined in order to obtain a more general and global picture. This document was obtained at the Regent's Office. To determine the proportion of health expenditures originating from the APBD II to the overall Regency expenditures, the whole APBD II expenditures for development and routine were used in these calculations.
- * The advantages of these approach are:
 1. More accurate information was obtained, because additional expenditures (ABT) were identified.
 2. Both allocation and realization expenditures can be identified.
 3. Expenditure distribution can be itemized according to program or activity, budget item etc.
- * The drawbacks are:
 1. A longer time needed, because each regency must be visited.
 2. Greater expenditures for transportation and lumpsum.

Data Collection From The Governor's Office

- * All APBD II documents of the regencies located within the province can be found at the Division for Lower Region Reckoning, Bureau of Finance of the Governor's Office. The documents contain DIPDA II and DIKDA II, it

presents the distribution of funds to all the sectors and revenues received from the various sectors. In this way, health sector DIPDA and DIKDA information were gathered from these documents.

- * The advantages of this method includes
 1. Only very short time was needed for data collection, because all data were found in one location.
 2. This resulted in modest expenditures.
- * The drawbacks are:
 1. Only general data can be gathered, which are difficult to itemize according to budget item.
 2. Expenditure realizations are not entirely valid.
 3. Additional expenditures (ABT) are inadequately or not documented.

A.4. Other Ministries (NON MOH)

Figures for 1987/88 up to 1988/89 were obtained through an estimation based on:

1. National Budget
2. Non-Health Budget (National Budget - Health Budget)
3. Non MOH Budget trends 1982/83 - 1986/87

An extrapolation was made using the formula:

$$\text{Health Budget Non MOH} = 10.13 + (0.001639 \times \text{Sectoral Budget Non MOH})$$

$R^2 = 97\%$
 $P = 0.002$ (see Annex 2)

B. DATA COLLECTION INSTRUMENT

In accordance with the division corresponding to the financing data sources, several forms were designed:

Form I	for DIP
Form II	for DIK
Form III	for INPRES
Form IV	for SBBO
Form V	for DIPDA I
Form VI	for DIKDA I
Form VII	for DIPDA II
Form VIII	for DIKDA II
Form IX	for Foreign Aid

Each form was divided again into **Form A** for budget allocation and **Form B** for realizations. The forms and their filling techniques can be examined in Annex 2.

There are several special things to be considered:

- * The realization and allocation of SBBO and INPRES are considered similar, so there was only one form for each of these sources.
- * In obtaining the DIPDA I and II allocations, it should be noted that what is meant by allocation is **the expenditure/budget after modifications**. The APBD I and II experience several steps of modifications:
 1. Allocation (around April or May)
 2. Modification (around September or October)
 3. Final Realization Determination, at the end of the fiscal year.
- * As far as possible, the SPJ and SPM are traced as closely as possible in filling out the realization forms.

C. DIFFICULTIES ENCOUNTERED

The data collection process involved many people from various units within the Ministry of Health and also personnel from every province. Many problems were encountered in the implementation.

Central level data collection was done by personnel from the Bureau of Planning, Bureau of Finance, Directorate General for Community Health Care, Directorate General for Medical Care and the Inspectorate General. These personnel were trained before starting data collection. Their task were to transfer data from the various documents to the prepared forms. Central level data collection did not face much difficulty, because all documents were located within the Ministry of Health. Foreign aid funding data collection posed a problem. There is no single unit responsible for foreign aid funding information. Data on the planning and initial allocation at the signing of a grant or loan is available at the General Planning Division of the Bureau of Planning, but data on realization every year is only available from each project officer, who are dispersed among various units. Corrections in monitoring foreign aid funding should be undertaken immediately, in view of the increasing role of foreign aid.

Provincial and Regency level data collection in the eleven selected provinces was accomplished in cooperation with the staff of the MOH Provincial Office and the Provincial Health Service in each Province. Each province sent 3 to 5 personnel to receive training in Jakarta. The number of personnel trained was in proportion with the number of regencies in each respective province. Provincial level data collection did not face many difficulties. As at the central level, the task of the data collectors were to transfer data from the various documents to the prepared forms. Difficulties encountered were mostly in recording expenditure realization data, in trying to trace the SPJ and SPM data (as far as possible). To collect regency level data, difficulties were encountered, because not all regencies had complete data for every year. Moreover, the different expenditure documentation system of each regency had to be made consistent. In the provinces which had computers, data entry was done at province offices.

CHAPTER III.

DATA PROCESSING

The next step after data collection is **data processing**. Data processing was done using computers and went through several stages.

The first step was to inspect the data written on the forms. These data were then assigned codes for each province and program. Data entry of all central level funding data, provincial and regency data were performed at the Bureau of Planning, using the personnel of the Bureau, under the supervision of Amak Rochmad. Except for these provinces, who performed their own data entry. The data were entered into DBase files.

Many errors occurred due to the unavailability of a program for error checking. Errors in transferring data from the document to the forms should have been detected during data entry. For example, a record from one hospital, includes cost components such as salaries, land, material, equipment, travel, construction etc. and a total of these data forms were copied from the documents. However, two total values were produced during data entry, the total calculated by summoning individual items using the computer, and the total reported in the document. These two values should be identical. Often they are not identical, suggesting copying errors, or errors in the components or errors in the reported total. As a result of no error checking, error correction took quite a long time since large discrepancies were xxxxxx to their original sources.

Data in the form of DBase files that were not yet "cleaned" were brought to UCLA, USA. The original purpose was to analyze it with more sophisticated methods. Because the "cleaning" process took such a long time and the documents were in Indonesia, this strategy was not feasible and the data were then brought back to Indonesia. Data correction and completion of insufficient data was continued at the AKEK Unit and took almost 6 months. Various documents had to be opened and retraced.

Subsequently, with the help of Ken White, a Health Economics Advisor from USAID, the data was processed with the SAS program. The SAS program was used because it allowed processing and manipulation of big data sets. Consequently, consistency checks could be done more easily, for example, by assessing the changes of totals of each source or each program from year to year, both percentage- or nominal- wise. The raw data of any striking changes could then be checked for errors. Additionally, SAS also has the capability of transferring portions of a data

set to a smaller data set in another program, including DBase. This is important because, at this moment, the analysis expertise of the AKEK Staff is limited to the DBase program. In the future, more training should be done to enable staff to undertake more sophisticated analysis.

Using the DBase program, the AKEK Unit Staff then produced various tables according to needs for analysis. In comparison to previously collected expenditure data, there appears to be consistency between both results. This obviously strengthens previous findings as well as those produced as a result of the present study.

CHAPTER IV.

ANALYSIS RESULTS

A. Budgetary And Health Financing Trends From Government Sources.

Table 1 provides a general picture of Government Health Funding from 1982/83 up to 1989/90. Every source of Government funding, central, provincial and regency level, foreign aid and also non-MOH Ministries are combined here, although as explained earlier, non-MOH data consist of very preliminary estimates. The 1988/89 fiscal year budget for all health expenditures were Rp 815 billion or Rp 4.641,50 per capita, and in 1989/90 the allocation was Rp 949,4 billion or Rp 5.299,90 per capita. Compared with the 1982/83 health allocation budget using nominal values, there was an increase of 92 %. But using 1983 constant values, there was actually a decrease of 10 % over the last eight years, with the greatest decline in 1987/88. Actually, if the health care level of the 1983/84 was to be maintained with the population of 1990, then the government should have allocated Rp 6.168,37¹ per capita or Rp 1.126 billion. The proportion of Government Health Financing as compared to the whole National Budget for 1988/89, was 2.8 %. This proportion tended continually to decrease since 1982/83. This might have been caused by national development policies which gave priority to supporting economical development or sectors which would produce results in a short time, while the health sector only produces long term results.

The proportion of the central level funding in 1988/89 was 1.2 % of the total National Budget. Obviously its growth was not encouraging, and besides being small, there was a tendency of continually decreasing every year. Examining the proportion of health financing to the Gross Domestic Product (GDP), reveals that it was only 0.6 % of GDP, and the value has stayed relatively constant over the last 8 years.

The Indonesian population health expenditure per capita for 1988/89 was only Rp 4.641,50 or about US \$ 2.80. In present value, there was actually a 45 % increase compared to 1982/83, but using US \$ to compare with the condition of other countries, there was a 61 % decrease, from US \$ 4.60 in 1982/83 to US \$ 2.80 in 1988/89 (table 1). These figures are very small compared to other countries.

The percentage of government health budget as a proportion of the GDP has tended to always decrease. Thus it can be inferred that there are no correlation between the increase of GDP or National Budget and the health budget allocation.

Apparently health development is not yet a priority, although there were transitions and the need for human resources development to accelerate development in the coming take off stage of national development.

1

Rp 3.414,20 (constant value 1983)

x Rp.5 299,10 = Rp 6 168,37

Rp 3.414,50 (constant value 1990)

**TABLE 1 : REALIZATION OF INDONESIAN GOVERNMENT HEALTH BUDGET 1982/83 - 1989/90
(Billion Rupiahs).**

	Sector	1982/83	1983/84	1984/85	1985/86	1986/87	1987/88	1988/89	1989/90*
1	Health Budget (Present Value)	494.8	539.8	574.9	691.8	655.6	627.7	815.0	949.4
2	National Budget	14,358.3	18,315.1	19,385.5	22,824.6	21,422.0	22,783.0	28,964.0	36,575.0
3	% of Health Budget to National Budget	3.4	2.9	3.0	3.0	3.1	2.8	2.8	2.6
4	Health Budget (1983 constant value)	548.3	539.8	470.7	542.8	471.2	412.2	507.7	525.5
5	Population (mill)	154.7	158.1	161.6	164.6	168.3	172.0	175.6	179.1
6	Health Budget per capita								
a	Present value	3,198.4	3,414.2	3,557.9	4,202.2	3,894.3	3,649.2	4,641.5	5,299.9
b	Constant value	3,544.3	3,414.2	2,913.1	3,297.1	2,799.0	2,396.4	2,891.4	2,933.5
7	Health Budget per capita in US \$	4.6	3.4	3.4	3.5	3.5	2.2	2.8	3.0
8	Gross Domestic Bruto	62,646.5	73,697.6	87,535.5	94,491.5	96,491.5	114,137.1	141,137.1	165,643.4
9	% of Health Budget to GDP	0.8	0.7	0.7	0.7	0.7	0.5	0.6	0.6

Source: AKEK Unit/HE & PAU, Bureau of Planning, MOH
 Indonesian Statistics 1989, Central Statistic Bureau
 Notes: *) Allocation Data

Several data from other countries can be examined as a basis for comparison of the respective government health budget against their total national government budget².

Table 2. Percentage of Government Health Budget against Total Government Budgets in Several Countries, 1983.

Country category	Average percentage to Total Gov't Budget
Low income economies	2,7
Middle income economies	4,5
* Lower middle income	4,2
* Upper Middle income	4,7
Industrial Market economies	11,2

In that report, Indonesia was categorized as being in the group of "lower middle income" countries, where the proportion of government health expenditures as compared to total government budget was 4.2 %. It is clear that the allocation figure of 2.6 % of 1989/90 for Indonesia is far below the average figure for countries in the same category.

The above discussion reveals a contradiction. On the one hand, the government health budget declines continually, but on the other hand, health status is continuing to improve. This can be seen from the declining Death Rates and lengthening Life Expectancy. A more detailed analysis is needed to answer the above contradiction.

B. Realization Of Government Health Financing According To Funding Sources.

Government health funding sources can be divided into 3 major sources, i.e.:

1. Central Level: Development Budget (DIP), Routine Budget (DIK), Presidential Instruction (INPRES) and Operational Expenditure Subsidy Assistance (SBBO).
2. Provincial Level: Provincial Development Budget (DIPDA I) and Routine Budget (DIKDA I).

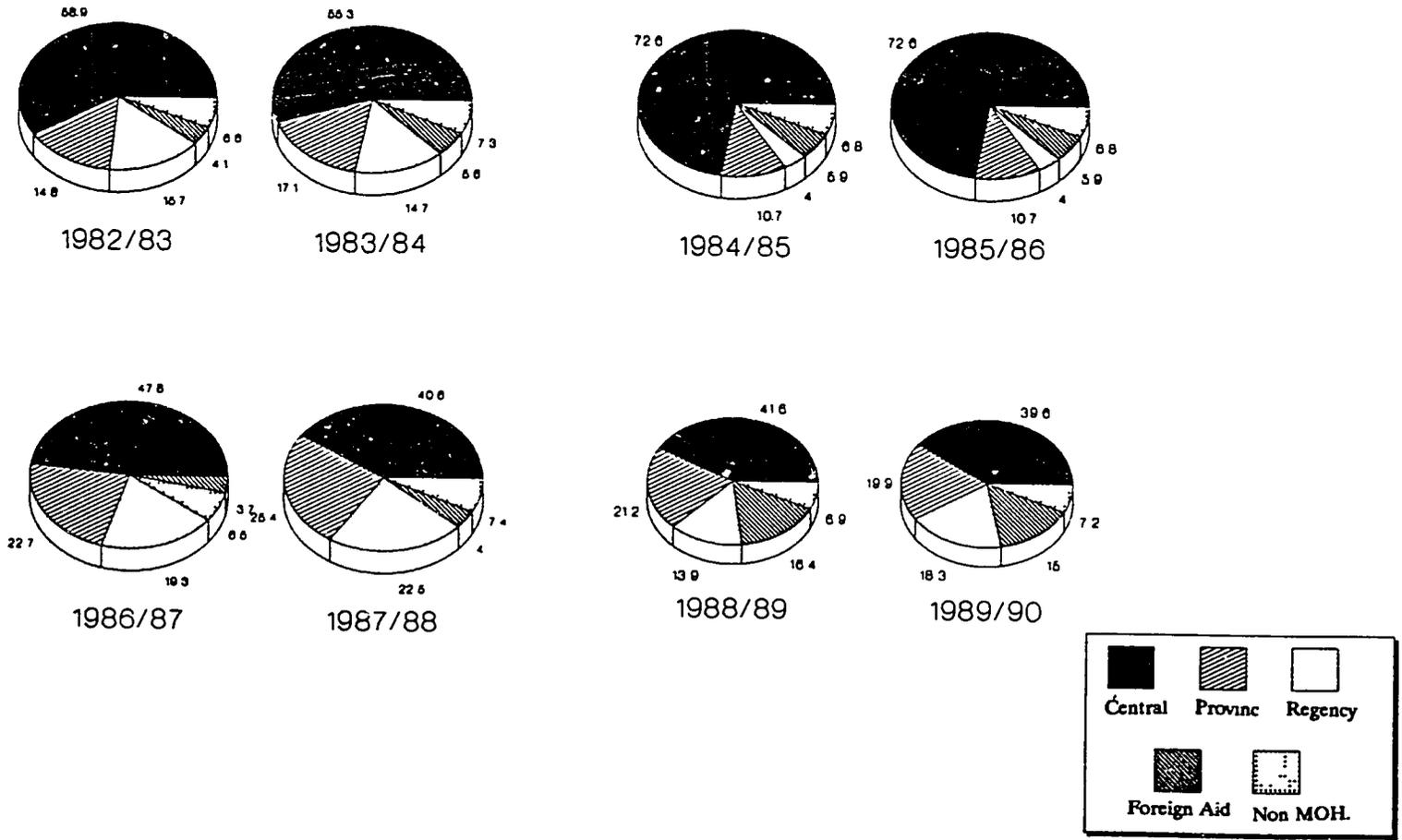
² A World Bank policy study, Financing health services in developing countries, 1987

3. Regency Level: Regency Development Budget (DIPDA II) and Routine Budget (DIKDA II).
4. Foreign Aid.
5. Other Ministries (Non-MOH).

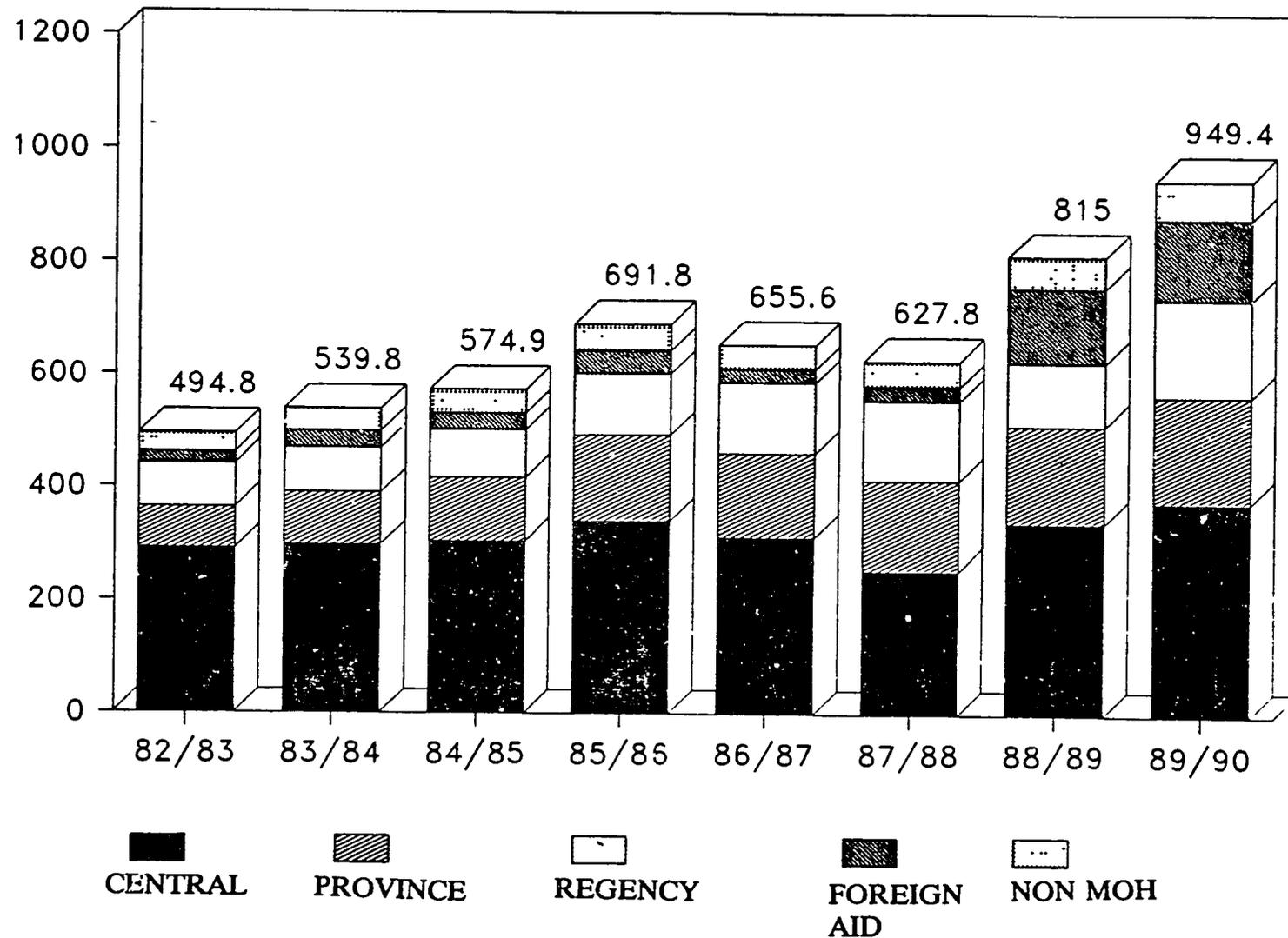
Furthermore, there are also budgets from the central level as provincial and regency salary subsidies in the form of regional health personnel salary through the Autonomic Region Subsidy (SDO). This salary budget is allocated in the DIKDA I and DIKDA II.

Exhibits 1 and 2 show the proportion of government budget according to funding source for the financial years 1982/83 up to 1989/90. In the financial year 1988/89, central level funding was Rp 339,3 billion (41.6 %), provincial level funding was Rp 172,7 billion (21.2 %), regency level funding was Rp 113 billion (13.9 %), and other Ministries Rp 56,3 billion (6.9 %). After careful examination, changes can be detected in the proportions of the 4 funding sources. In 1982/83, the major source of funding was the central level, covering 58.9 %, the provincial level 14.8 %, regency level 15.7 %, other ministries 6.6 %, and foreign aid only 4.1 %. It is clear that the role of foreign aid has increased in the 1988/89 budget and in 1989/90 is almost twice the central level development budget (DIP). It seems that foreign aid budget has become a replacement for dwindling government budget funding (see annex 2).

**PICTURE I
REALIZATION OF HEALTH BUDGET
ACCORDING TO FUNDING SOURCE
1982/83 - 1989/90
(%)**



PICTURE 2
REALIZATION OF HEALTH BUDGET
ACCORDING TO FUNDING SOURCE 1982 - 1989
(Rph.Bill)



Central Level Funding

The central level government funding has shown a steep decline over the last seven years, particularly for financial years 1986/87 and 1987/88. This decline was a reflection of the overall reduction of the government development budget. This was caused by the country's declining financial situation. But increases occurred in 1988/89, and the development budget can be maintained through the increasing foreign aid. Foreign aid has become prominent. Since 1988/89, where its amount in 1987/88 was almost the same as the central DIP, in 1988/89 and 1989/90 it reached a level almost twice the central DIP.

Central level routine budgets increased every year, and is xxxxxx to support the maintenance of everything constructed and to pay the salaries of the health personnel which usually increase every year.

The 1987/88 INPRES budget experienced a sizeable decrease, but in 1988/89 increased a modestly and in 1989/90 increased again. In the last three years, the SBBO budget has remained stable, but declined slightly in 1986/87, increasing again in 1987/88.

If the central level funding, including foreign aid, is compared with the national budget as an indicator of the government's commitment toward health, a clear picture emerges :

Table 3. Percentage of Central Level Government Health Budget Against Total Government Budget 1982/83 - 1989/90.

82/83	83/84	84/85	85/86	86/87	87/88	88/89	89/90	Average
2,2	1,8	1,7	1,7	1,6	1,2	1,6	1,4	1,65

It can be seen from this table that the proportion of government spending on health as proportion of total government spending tended to consistently declined, with an average of 1.65 % of the total budget. Compared to the World Bank report mentioned before, where the "lower middle income" countries have 4.2 % of the total budget for health, the Indonesian figure is very low. Noted that the 4.2 % World Bank figure is really only the central level funding source health budget, so Indonesia's relative position is even less favourable than is so revealed by comparison just discussed.

Provincial Level Funding

As mentioned above, provincial funding consists of development and routine budgets. The development budget is usually an addition to the development budget received from the central level and is typically for hospitals and community health efforts. The routine budget is used to finance the salaries of health personnel who are local government (provincial) personnel, often seconded from central level personnel. Actually, the funds for these salaries are central level subsidies earmarked to pay for salaries through the SDO. Provincial level funding tended to increase over the interval of years 1982/83 to 1989/90.

Provincial funding in 1988/89 was Rp 172,8 billion or 23 % of the total government health budget (annex 2). On inspection, provincial funding has increased annually since 1982/83, except for the year 1986/87. This was caused by the reduced DIPDA I, although the biggest component of the provincial budget is the DIKDA I. If the salary budget as a central level subsidy is taken out, however, the provincial budget is only 10 % of the total budget (annex 3). And salaries from the SDO can be considered local government budget, which also shows the region's capability.

Regency Level Funding

There was an increase of regency level budget during the last eight years, both in quantity and proportion up to 1987/88, and but this budget decreased in 1988/89. Regency level funding in 1988/89 was only 15 % of the total budget, including salaries as a subsidy from the central level (annex 2). If salaries are excluded, the pure regency budget is only 5 %. An evaluation shows that since 1982/83 the pure regency budget has not played a very significant role, although all revenues from health services are passed on to the local exchequer as local revenues. The revenues should then be returned intact as the regency routine budget (DIKDA II) (annex 3), because those revenues are generally used for hospital and puskesmas operations and maintenance.

Foreign Aid Funding

Between 1982/83 and 1988/89, the government received assistance for the health sector from 13 sources of foreign aid. The assistance was in the form of loans or grants. IBRD and ADB provided most of the of loans, while USAID, WHO and Unicef were the major source of grants.

Annex 2 shows that foreign aid increased both in volume and proportion to the total government budget up until 1985/86. There were a sharp increase in 1988/89, from Rp 25,3 billion in 1987/88 to Rp 133,6 billion in 1988/89, or a fivefold increase. This was mostly caused by the high absorption of the IBRD (World Bank) assistance for the South Sulawesi, Central Sulawesi and Southeast Sulawesi Provinces Integrated Health Development Project, and Health Personnel Development Project besides the new USAID projects.

Foreign aid was utilized between 1984/85 and 1986/87 mostly for hospital services, nutritional development programs, immunization improvement, health education, health personnel education and training, communicable disease eradication and supply of clean water. Table 4 shows an illustration of the grouped activities for 1988/89.

Table 4: Foreign Aid Utilization 1988/89 (in millions of Rupiahs)

Program or Service	Amount	Percentage
Hospital services	76.274.0	57.1
Primary Health Care	4.258.9	3.2
Manpower	47.070.8	35.2
Research & Development	1.391.5	1.1
Administration etc.	4.594.0	3.4
Total	133.589.2	100.0

Foreign aid was generally utilized for the physical construction of buildings, medical equipment and other facilities. Hospital services received the biggest portion or 57.1 % of the whole foreign aid, in the form of hospital construction and the furnishing of hospital medical and other equipment.

Likewise, health manpower development was primarily for the physical construction of BLKM and Health Education School buildings besides for various in- and out of country training. Assistance for manpower absorbed 35.2 % of the entire foreign aid allocation.

Primary Health Care activities appears to have been primarily government funded, whereas foreign aid was only as a supplement in the form of training or consultant personnel in this area.

Numerous research and health development projects were assisted both in funding and consultant personnel through foreign aid. There is now a tendency to utilize foreign aid to also finance operations and maintenance, in addition to investment needs.

C. Health Budget Utilization

Health Budget utilization analysis can be done in many ways. For example, we can undertake analysis according to:

1. Investment, operations and maintenance costs
2. Development and routine costs
3. Health efforts (programs and services)
4. Geographical distribution (province), and
5. Other groupings.

C.1. Health Budget Utilization According To Investment, Operations and Maintenance Costs.

Based on types of expenditures, budget utilization can be divided according to **investment and operations and maintenance**. Investment expenditures are expenditures for goods with a useful life of over one year. Investment expenditures can be grouped for land acquisitions, equipment procurement and construction. Operations and Maintenance Budget can be defined as those budgets that are consumed in one year and are recurrent in nature. Operational budgets are costs of operating and maintaining the various investments. The operations and maintenance costs are generally used for salaries, drug purchases, material purchases, equipment maintenance, travel and other operations and maintenance needs.

**TABLE 5: HEALTH BUDGET REALIZATION BASED ON TYPES OF EXPENDITURE
1982/83 - 1988/89 (billions of Rupiah)**

Type of Expenditure	1982/83		1983/84		1984/85		1985/86		1986/87		1987/1988		1988/89	
	REAL	%	REAL	%	REAL	%								
A INVESTMENT	107.3	23.2	106.5	21.3	109.4	20.5	109.11	16.9	95.9	15.6	37.3	6.4	131.2	17.3
1 Land	5.3		3.2		1.8		6.5		2.3		0.4		1.1	
2 Equipment	25.7		20.3		26.4		23.0		14.8		7.8		57.4	
3 Construction	76.4		83.0		81.3		79.6		78.8		29.1		72.7	
B OPERATIONS	334.4	72.4	360.4	72.1	393.1	73.8	465.2	72.1	501.7	81.9	533.1	91.7	562.5	74.1
1 Salaries	149.4		171.0		171.4		230.9		266.6		279.0		279.9	
2 Drugs	56.3		57.6		64.7		71.3		75.5		93.0		106.7	
3 Other Maternal	36.7		37.5		50.9		59.5		95.2		92.2		106.4	
4 Travel	3.5		12.5		15.2		16.3		15.8		12.5		14.0	
5 Maintenance	55.0		58.5		60.2		71.2		17.9		29.1		21.0	
6 Others	23.6		23.3		30.8		16.1		30.8		27.3		34.5	
C UN-CLASSIFIED	20.4	4.4	33.3	6.7	30.4	5.7	70.6	10.9	15.2	2.5	10.8	1.9	64.9	8.6
T O T A L	462.2	100.0	500.2	100.0	532.9	100.0	644.9	100.0	612.8	100.0	581.2	100.0	758.6	100.0

Source. AKEK Unit/HE & PAU, Bureau of Planning, MOH
Indonesian Statistics 1989, Central Statistic Bureau

* Note : The above figures do not include Non MOH budget

Table 5 shows that in the 1988/89 financial year, investment totaled Rp 131,2 billion or 17.29 % of the total budget, consisting of: land acquisition, Rp 1,1 billion, equipment procurement, Rp 57,4 billion, and construction, Rp 72,7 billion. In the last eight years the budget for this investment increased up to 1985/86, then decreased to the lowest point in 1987/88. Operations budget for 1988/89 totaled Rp 586,5 billion or 74.1 % of the total, consisting of salaries Rp 279,9 billion, drugs Rp 106,7 billion, material Rp 106,4 billion, travel Rp 14 billion, maintenance Rp 21 billion, and others Rp 34,5 billion. Unfortunately Rp 65,9 billion or 8.56 % of total spending expenditures could not be itemized because of lack of specificity in the data.

The ratio between investment and operations for 1988/89 was 0.23. This picture has not changed much in the last eight years except for 1987/88 when this ratio became 0.07. It can be assumed that operations and maintenance budgets were adequately allocated. Salaries by far constituted the biggest expenditure. Salaries absorbed in 1988/89 36 % of the total expenditures. This picture seems to have stayed the same over the last eight years.

C.2. Health Budget Utilization According to Development and Routine Expenditures.

According to convention, Development Budget sources are:

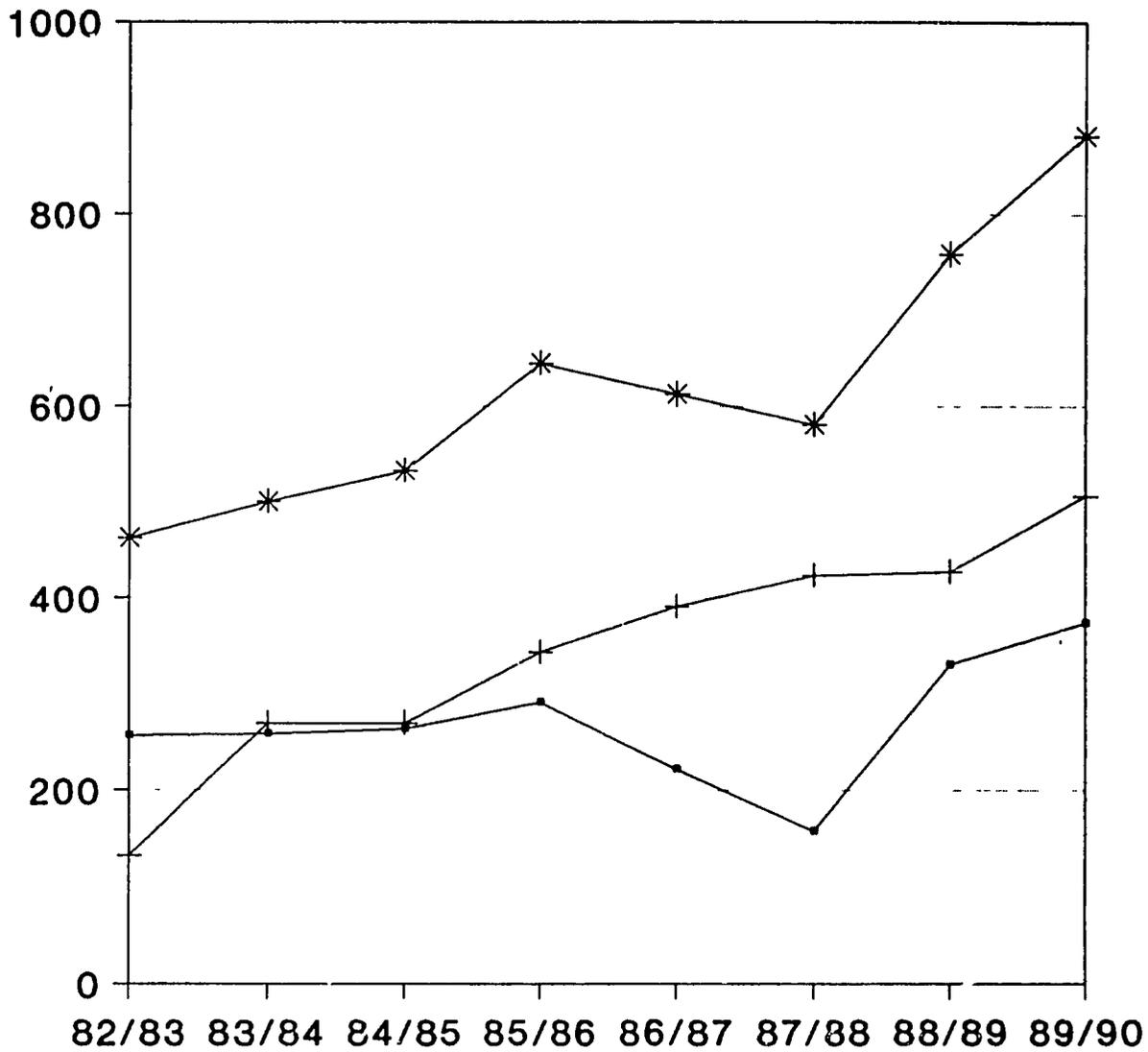
- a. Central : Development Budget (DIP)
INPRES
- b. Province : Provincial Development Budget (DIPDA I)
- c. Regency : Regency Development Budget (DIPDA II)
- d. Foreign Aid : Budget (usually for development)

Routine Budget sources are:

- a. Central : Routine Budget (DIK)
SBBO, for hospital maintenance
- b. Province : Province Routine Budget (DIKDA I)
- c. Regency : Regency Routine Budget (DIKDA II)

Caution should be exercised in interpreting the data, because there are really many routine activities in the development budget, and also routine budget often is used to finance development expenditures.

PICTURE 3
Health Budget Utilization
According to Development and Routine Expenditures
1982 - 1989



Develop.

 Routine

 Total

The development budget shows fluctuations between 1982/83 to 1988/89. A drastic reduction occurred in 1987/88 which improved in 1988/89. The development budget absorbed 374,3 billion or 42.5 % of the total budget in 1989/90.

The routine budget increased every year with the biggest increase occurring in 1985/86. The annual increase of the budget can be explained by routine budget, which includes salaries for the health personnel which increased annually, and the growth of drug procurement and the maintenance of purchased equipment.

The ratio between the development and routine budgets has changed from 1.2 in 1982/83 to 0.7 in 1988/89.

C.3. Health Budget Utilization According To Health Efforts (health programs and services)

Health efforts are addressed and developed according to a form or a pattern of health efforts of Puskesmas, Community Participation and Health Referral.

The utilization of the health budget according to services and programs can be grouped in several ways. In this analysis they are grouped as follows:

1. Puskesmas Health Efforts.
2. Medical Referral/ Hospital Services.
3. Health Personnel Education And Training.
4. Research And Development.
5. Administration/ improvement and securing management.
6. Other Health Units.

**TABLE 6 : HEALTH BUDGET UTILIZATION ACCORDING TO HEALTH EFFORTS
1982/83 - 1988/89 (Billions of Rupiah).**

PROGRAM	1982/83		1983/84		1984/85		1985/86		1986/87		1987/88		1988/89*	
	REA	%	ALL	%										
1. Puskesmas	178 0	38 4	177 0	35 5	187 0	35 1	226 0	35 0	198 0	32 3	151	26 0	183	24 1
2. Hospital	154 2	33 4	182 1	36 4	185 4	34 8	216 3	33 5	213 3	34 8	220 0	37 9	323 1	42 6
3. Education/ Training	15 8	3 4	19 2	3 8	23 5	4 4	23 5	3 6	36 2	5 9	45 6	7 8	74 6	9 8
4. Research & & Development	2 0	0 4	3 2	0 6	2 8	0 5	2 1	0 3	3 0	0 5	1 9	0 3	2 3	0 3
5. Administration	66 4	14 4	64 7	12 9	74 9	14 1	98 6	15 3	149 7	24 4	149 9	25 8	161 7	21 3
6 Other Health Units	46 1	10 0	53 6	10 7	59 1	11 1	78 8	12 2	12 6	2 1	12 5	2 2	14 0	1 8
TOTAL	462 2	100 0	500 2	100 0	532 9	100 0	644 9	100 0	612 8	100 0	581 2	100 0	758 6	100 0

Source: AKEK Unit/IIE & PAU, Bureau of Planning, MOH
Indonesian Statistics 1989, Central Statistic Bureau

Note

*) 1989/90 Budget are allocation data

**) The above figures do not include Non MOH budget

Table 6 shows health expenditure distribution according to the above grouping for 1982/83 to 1988/89. Annex 5, 6, and 7 gives a more detailed picture of funding sources for each group presented above for 1986/87, 1987/88 and 1988/89.

C.3.1. Puskesmas Health Efforts.

The Puskesmas is a center for health services that functions to foster and supervise community health and also provides front line health services nearest to the community in supplying comprehensive services and plays an integral roles in its territory.

Puskesmas health efforts are identical with the definition of Primary Health Care whose minimal endeavor components cover 8 activities: nutrition, clean water, basic sanitation, mother and child care + family planning, disease control, health education and simple treatment.

TABLE 7: HEALTH BUDGET UTILIZATION FOR PUSKESMAS HEALTH EFFORTS ACCORDING TO DEVELOPMENT AND ROUTINE BUDGETS 1986/87 - 1988/89 (millions of Rupiah)

Funding Source	1986/87	%	1987/88	%	1988/89	%
Development	152,460.65	77.01	102,547.88	67.76	135,285.98	73.91
Routine	45,511.61	22.99	48,801.04	32.24	47,762.27	26.09
T O T A L	197,972.26	100.0	151,348.92	100.0	183,048.25	100.0

Source: AKEK Unit, Bureau of Planning, MOH

The above table shows that the development budget funded a major portion of the above health efforts. Funding for these efforts from 1986/87 to 1988/89 showed a slight decrease in 1987/88 which improved in 1988/89, which was caused by the fluctuations of the Inpres budget.

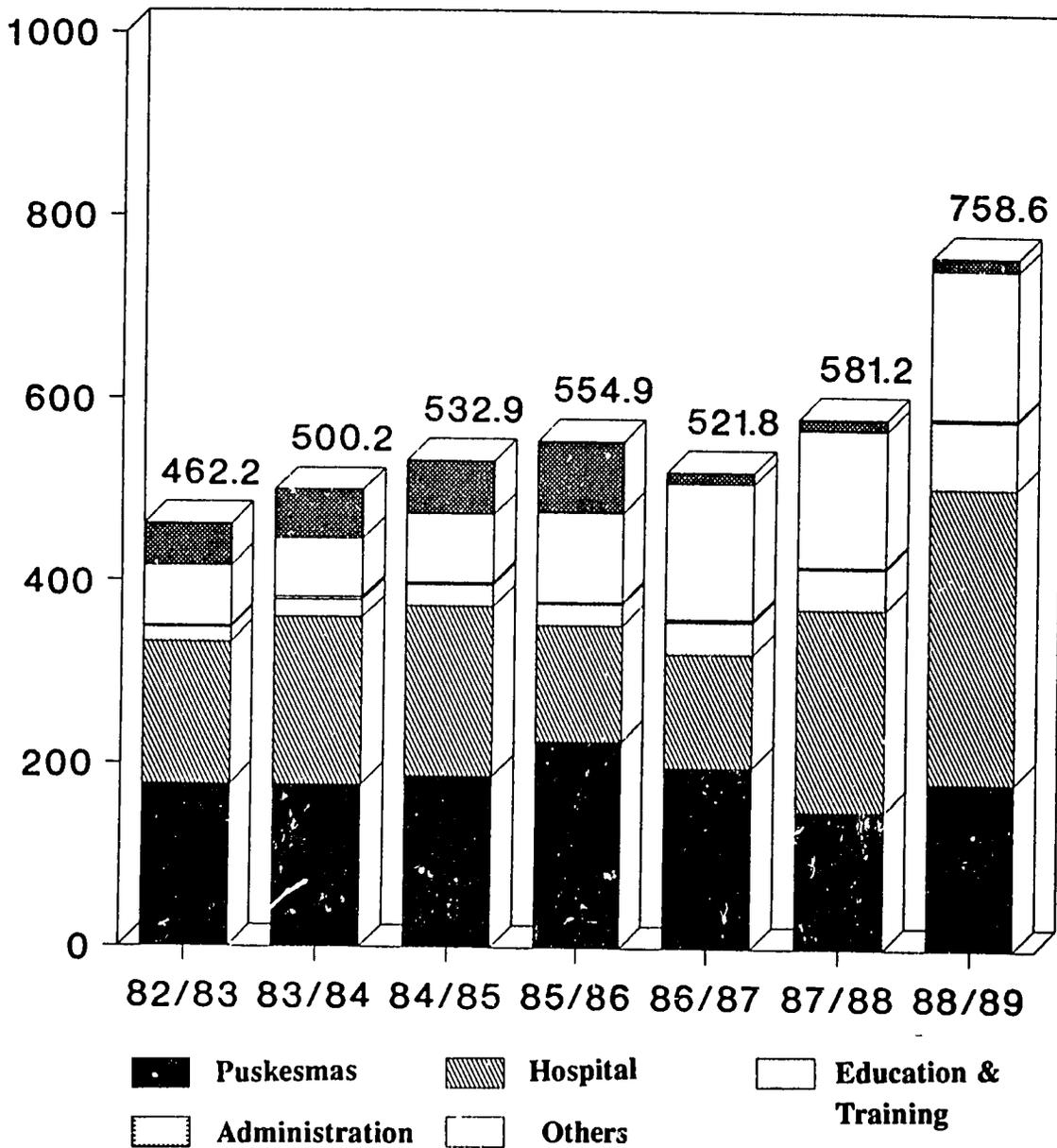
Table 8: HEALTH BUDGET UTILIZATION FOR PUSKESMAS HEALTH EFFORTS ACCORDING TO FUNDING SOURCES 1986/87 - 1988/89 (millions of Rupiah)

Funding Source	1986/87	%	1987/88	%	1988/89	%
Central	141,309.10	71.38	89,565.20	59.18	123,865.20	67.67
Provincial	82,700.69	4.39	10,755.95	7.11	13,964.36	7.63
Regency	42,773.58	21.61	45,166.28	29.84	40,959.78	22.38
Foreign Aid	5,188.94	2.62	5,861.34	3.87	4,259.00	2.33
T O T A L	197,972.31	100.00	151,348.77	100.00	183,048.34	100.00

Source: AKEK Unit, Bureau of Planning, MOH

As mentioned above, the decrease of funding in 1987/88 was caused by the fluctuation of the Inpres budget, which influenced the decrease of central level funding. Other funding sources, however, showed annual growth. Puskesmas health efforts were mostly financed from the central level budget, between 59.18 % to 71.38 %, followed by regency level funding of between 21.61 % to 29.84 %, the provincial level funding varying between 4.39 % to 7.63 %, and a relatively small portion from foreign aid, varying between 2.33 % to 3.87 %. Primary Health Care is 24.1 % of the total government budget including foreign aid.

**PICTURE 4 :
HEALTH BUDGET REALIZATION
ACCORDING TO PROGRAM 1982 - 1989**



C.3.2. Medical Referral/ Hospital Services.

The utilization of the health budget for hospitals efforts consist of healthcare services in vertical (central level owned) hospitals, general hospitals, mental hospitals, special hospitals and private hospitals.

There was a 1.5 times increase between year 1985/86 to 1988/89 induced mainly by foreign aid. Growth occurred both quantitatively and proportionately against the total funding. Hospitals received funding from almost every source except from Inpres. For investment, in this case building construction equipment procurement, financing came mostly from central DIP, foreign aid and DIPDA I. Routine funding came from DIK, DIKDA I and DIKDA II.

Table 9 : HEALTH BUDGET UTILIZATION FOR HOSPITAL SERVICES ACCORDING TO DEVELOPMENT AND ROUTINE BUDGETS 1986/87 - 1988/89 (millions of Rupiah)

Funding Source	1986/87	%	1987/88	%	1988/89	%
Development	21,515 88	10 09	18,959 43	8 62	119,490 65	36.99
Routine	191,768 93	89 91	201,008 71	91 38	203,547.73	63.01
T O T A L	213,284 81	100 0	219,968.14	100 0	323,038 38	100.0

Source. AKEK Unit, Bureau of Planning, MOH

Table 9 shows changes that occurred in the hospital budgets, both in development and routine budgets. The development budget in 1986/87 which was 10 %, changed to 37 % in 1988/89. There was only a slight increase in the routine budget every year. The ratio of the development budget to the routine budget changed from 0.1 in 1986/87 to 0.59 in 1988/89.

Table 10 : HEALTH BUDGET UTILIZATION FOR HOSPITAL SERVICES ACCORDING TO FUNDING SOURCES 1986/87 - 1988/89 (millions of Rupiah)

Funding Source	1986/87	%	1987/88	%	1988/89	%
Central level	87,810 91	41 17	83,904.50	38 14	121,452.50	37.60
Provincial level	83,626 46	39.21	88,306.03	40.14	82,608.20	25.57
Regency level	41,847 42	19 62	47,602.97	21.64	42,703.69	13 22
Foreign Aid	0 00	0 00	154 63	0 07	76,273 97	23.61
TOTAL	213,284 79	100 00	219,968 13	100 00	323,038.36	100.00

Source AKEK Unit, Bureau of Planning, MOH

The above table shows funding sources for hospital services. Changes occurred in nominal and percentage terms from each funding source. Central level funding increased nominally by 1.4 times, while province and regency funding remained relatively constant, but foreign aid increased significantly. This was probably caused by the rapid acceleration of foreign aid disbursement in 1988/89. Proportional changes occurred in 1988/89, where local budgets only covered 38.7 % of the total hospital services budget.

C.3.3. Health Personnel Education And Training.

These activities are primarily for the education and technical training for health personnel and prospective health personnel. Management training is arranged under the administration classification or grouping as an health supporting activities.

These also include expenditures for physical facilities construction, and other supporting activities. Funding for these activities have increased in the last eight years.

Table 11 : HEALTH BUDGET UTILIZATION FOR PERSONNEL ACCORDING TO DEVELOPMENT AND ROUTINE BUDGETS 1986/87 - 1988/89 (millions of Rupiah)

Funding Source	1986/87	%	1987/88	%	1988/89	%
Development	24,550.65	67.80	27,275.99	59.82	59,595.23	79.91
Routine	11,658.03	32.20	18,322.59	40.18	14,986.57	20.09
T O T A L	36,208.68	100.0	45,598.58	100.0	74,581.80	100.0

Source: AKEK Unit, Bureau of Planning, MOH

The above table shows an increase of almost two fold between 1986/87 and 1988/89. Changes occurred with a high increase in the overall development budget, although the routine budget decreased. The ratio between the development and routine budgets which was 2.1 in 1986/87 rose to 4.0 in 1988/89.

Table 12 : HEALTH BUDGET UTILIZATION FOR PERSONNEL SERVICES ACCORDING TO FUNDING SOURCES 1986/87 - 1988/89 (millions of Rupiah)

Funding Source	1986/87	%	1987/88	%	1988/89	%
Central level	27,791.63	76.75	29,706.37	65.15	26,597.46	35.66
Provincial	362.90	1.00	535.84	1.18	605.74	0.81
Regency level	63.66	1.00	274.31	0.60	307.76	0.41
Foreign Aid	7,690.49	21.24	15,082.06	33.08	47,070.84	63.11
T O T A L	36,208.68	100.0	45,598.58	100.0	74,581.80	100.0

Source: AKEK Unit, Bureau of Planning, MOH

The above table shows that the volume of funding for personnel increased four times, compared to 1982/83. Proportionally, there were also an increase from 5.94 % in 1986/87 to 9.8 % in 1988/89. There were also a shift of funding sources from the central level to foreign aid. The main sources of these programs are the central budget and foreign aid. Table 17 shows that the main source was the central level, amounting to Rp 27.791,6 million or 76.75 % in 1986/87. This central level budget stayed relatively constant, but foreign aid for these programs increased more than twice. The role of the provincial and regency level budgets is insignificant in this instance.

C.3.4. Research And Development.

These activities have not received attention and priority, as shown in the budget allocation. They primarily were financed through the development budget, primarily from the central level and foreign aid. These activities tended to stay constant since 1982/83, averaging between Rp 1,9 - 3,2 billion or 0.3 - 0.6 % of the total government budget.

C.3.5. Administration / Improvement of Management.

This program is primarily directed to supporting health development, covering facilities, software, improving the government management apparatus, information system, and education in the personnel career pathway.

Table 13 : HEALTH BUDGET UTILIZATION FOR ADMINISTRATION ACCORDING TO DEVELOPMENT AND ROUTINE BUDGETS 1986/87 - 1988/89 (millions of Rupiah)

Funding Source	1986/87	%	1987/88	%	1988/89	%
Development	16,884.11	11.28	4,874.68	3.25	8,547.66	5.29
Routine	132,815.38	88.72	144,989.31	96.75	153,103.40	94.71
TOTAL	149,699.49	100.0	149,863.99	100.0	161,651.06	100.0

Source: AKEK Unit, Bureau of Planning, MOII

The above table shows that almost 90 % of this activity was for routine activities, and the ratio between the development and routine budget was 0.006 in 1988/89.

Table 14 : HEALTH BUDGET UTILIZATION FOR ADMINISTRATION ACCORDING TO FUNDING SOURCE 1986/87 - 1988/89 (millions of Rupiah)

Funding Source	1986/87	%	1987/88	%	1988/89	%
Central	46,496.50	31.06	41,886.50	27.95	56,897.40	35.20
Provincial level	52,314.60	34.95	56,263.52	37.54	73,567.70	45.51
Regency level	40,840.54	27.28	47,715.77	31.84	28,311.73	17.51
Foreign Aid	10,047.90	6.71	3,998.19	2.67	2,874.27	1.78
TOTAL	149,699.54	100.00	149,863.98	100.00	161,651.10	100.00

Source: AKEK Unit, Bureau of Planning, MOII

The supporting activities increased rapidly every year. It increased from Rp 66,4 billion in 1982/83 to Rp 161,7 billion in 1988/89, or an increase of almost 2.5 times.

The major sources of funding for these activities were the routine budgets from the central, provincial and regency levels. Almost 100 % of these supporting activities were financed by the government, with almost no foreign aid.

C.3.6. Other Health Units.

Included here are all the financing (physical construction, maintenance, salaries, etc) for activities and programs not yet included in the above mentioned programs or activities. Included here are laboratory improvement, food and drug control, and dental clinics.

The budget for the other health units decreased from 1986/87. It was Rp 46,1 billion in 1982/83 or 10 % of the total budget, and decreased to 14 billion or only 1.8 % from the total government source health budget.

Table 15 : HEALTH BUDGET UTILIZATION FOR OTHER SERVICES ACCORDING TO DEVELOPMENT AND ROUTINE BUDGETS 1986/87 - 1988/89 (millions of Rupiah)

Funding Source	1986/87	%	1987/88	%	1988/89	%
Development	4,215.18	33.43	3,783.18	30.27	6,429.45	46.05
Routine	8,392.69	66.57	8,716.03	69.73	7,531.09	53.95
TOTAL	12,607.87	100.0	12,499.21	100.0	13,960.54	100.0

Source: AKEK Unit, Bureau of Planning, MOH

The budget for these activities stayed relatively the same because of off-setting changes in funding components between the development and routine budgets. The ratio between the development and routine budgets which in 1986/87 was 0.5, changed to 0.85 in 1988/89.

Table 16 : HEALTH BUDGET UTILIZATION FOR OTHER SERVICES ACCORDING TO FUNDING SOURCES 1986/87 - 1988/89 (millions of Rupiah)

Funding Source	1986/87	%	1987/88	%	1988/89	%
Central	8,163.50	64.75	8,060.30	64.49	9,511.80	68.13
Provincial	3,689.83	29.27	3,714.89	29.72	2,000.25	14.33
Regency level	518.85	4.12	537.37	4.30	728.80	5.22
Foreign Aid	235.65	1.87	186.65	1.49	1,719.69	12.32
TOTAL	12,607.83	100.00	12,499.21	100.00	13,960.54	100.00

Source : AKEK Unit, Bureau of Planning, MOH

The above table shows that the biggest funding component source was the central level. A slight decrease occurred in 1987/88, which upon further study reveals that a reduction in the central level and foreign aid funding component occurred in 1987/88 while the other funding components increased.

C.4. Health Expenditure Distribution According To Location (Province)

Given the picture of provincial funding distribution, an indirect evaluation can be undertaken of the distribution of health funding throughout Indonesia. Table 9 shows the distribution for 1983/84 to 1988/89, both in quantity and funding per capita. Furthermore, the amount of funding managed and utilized at the central and regional levels can be observed. Note that annex 4 shows that the budget managed and utilized at the central level averaged between 10.6 - 16.1 % in the last eight years.

It would be preferable to use per capita funding variables for each province to obtain significant analysis results, because of population differences in each province.

Funding per capita for each province varies widely, depending on their respective funding source. Central level funding allocation varies for each province every year, likewise for the provincial and regency level funding. The amount of funding allocated for health in each province and regency heavily depends on respective local policy.

Per capita expenditure depends on the existing program or program priorities of the province. Geographical differences, population, disease patterns and the socio-economic situation should also be considered in funding allocations.

The Table in annex 4 shows health funding distribution per capita for every province in Indonesia. Generally there were almost no changes in the last eight years. The highest per capita funding in 1983/84 were for Irian Jaya, East Timor and Central Kalimantan provinces shifted to Jakarta, East Timor and Irian Jaya in 1988/89. The lowest per capita funding in 1983/84 were for Lampung, West Jawa and East Jawa provinces, which shifted to Lampung, West Jawa and Riau in 1988/89.

The per capita increase in East Jawa was caused by the increased local government funding. West Sumatra decreased because of the conclusion of foreign aid.

Comparing all provinces against the national per capita reveals that 17 provinces were above average per capita funding in 1983/84, and 10 provinces were below. By 1988/89 where only 10 provinces were above the average of per capita funding, while all remaining provinces were below the average.