The Indonesian National Health Accounts
Year 2002-2004

2009
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Ministry of Health, Government of Indonesia
World Health Organization

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Executive Summary

Background

The MoH has done a systematic data collection on health expenditures started in 1984 with support from USAID. This activity continued until 1995. However, there were some limitations which information was obtained from the budget allocation perspective instead of spending. Based on this study, MOH reported that most of the health funds were from the public source (85-95%). The activity discontinued, and no NHA reported during the 1995-2000 period.

The implementation of decentralization that started in 2001 had significant impact in tracking of health expenditure due to absence of policy in standardized reporting procedures. In this era, financial authority has been delegated to the local governments to allocate public funds to various sectors including health. To develop accountable planning and evaluation on health financing, transparent information on detailed health expenditures and its use is important and consequently a standardized classification is required.

In mid 2007, a new NHA team was set up to revisit the NHA of 2002-2004. Based on SK Menkes RI No. HK. 00.SJ.SK.X.0546 dated June 12, 2007, the NHA team agreed to revisit previous estimation on national health expenditures for the period of 2002 to 2004. Considering resources and time limitation, priorities were made by the NHA team to utilize existing data without conducting any additional surveys.

Results

Overview

Most of the available data did not have details as required by ICHA classification while data from provinces/districts were still major challenges. Private expenditure data from surveys also had some limitations. To obtain figures according to the classification of the four standard tables, - source and agent (FsxHF), agent and provider (HFxHP), agent and function (HFxHC), and provider and function (HPxHC) -, assumptions were used.

Total Health Expenditure (THE)

The results of NHA in Indonesia shows increasing expenditure on health over the last 3 years, from Rp 38.84 trillion in 2002 to Rp 52.06 trillion in 2004 at current price (Figure 1). The level of health spending as a share of GDP was relatively low at 2.6% in 2004. In constant price, it was even lower. Overall, health spending in Indonesia is lower than the other Asian countries. Corresponding figures in current prices are much higher in Thailand (3.5% in 2004), Malaysia (3.8%), Cambodia (6.3%), Vietnam (5.5%), Philippine (4.3%) and Chinese Taipei (6.02% in 1998).
Table 1 Total Health Expenditure on Selected Indicators on Health Spending Indonesia, 2002-2004, at current year prices

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population *</td>
<td>211,063,000</td>
<td>213,722,300</td>
<td>216,415,100</td>
</tr>
<tr>
<td>GDP (in billion Rp) **</td>
<td>1,619,062,4</td>
<td>1,794,663,4</td>
<td>2,032,824,9</td>
</tr>
<tr>
<td>THE (in billion Rp)</td>
<td>38,838,9</td>
<td>48,829,2</td>
<td>52,059,6</td>
</tr>
<tr>
<td>THE Public</td>
<td>13,194,5</td>
<td>17,665,8</td>
<td>18,456,7</td>
</tr>
<tr>
<td>THE Non Public</td>
<td>25,251,7</td>
<td>30,497,5</td>
<td>32,837,1</td>
</tr>
<tr>
<td>THE as % GDP</td>
<td>2,40%</td>
<td>2,72%</td>
<td>2,56%</td>
</tr>
<tr>
<td>% THE from Public</td>
<td>34,0%</td>
<td>36,2%</td>
<td>35,5%</td>
</tr>
<tr>
<td>% THE from Non Public</td>
<td>65,0%</td>
<td>62,5%</td>
<td>63,1%</td>
</tr>
<tr>
<td>GDP per Capita (in Rp)</td>
<td>7,670,991,1</td>
<td>8,397,174,2</td>
<td>9,393,174,9</td>
</tr>
<tr>
<td>THE per Capita (in Rp)</td>
<td>184,015,6</td>
<td>228,470,3</td>
<td>240,554,3</td>
</tr>
<tr>
<td>Exchange Rate ***</td>
<td>10,320</td>
<td>8,876</td>
<td>8,441</td>
</tr>
<tr>
<td>GDP per capita (in USD)</td>
<td>$743,31</td>
<td>$946,05</td>
<td>$1,112,8</td>
</tr>
<tr>
<td>THE per capita (in USD)</td>
<td>$17,83</td>
<td>$25,74</td>
<td>$28,50</td>
</tr>
</tbody>
</table>

* Central Bureau Statistic: Projection of Population, Indonesia 2000-2010  
** Central Bureau Statistic, 2006 - Jakarta: Main Economic Indicators, BPS 2006  
*** Source: Central Bank Indonesia

The growth rate per capita for THE is relatively high, averaging 16% per year in current price over the last 3 years. The study revealed that THE per capita accounted for Rp 184,015.9 (USD 17.8) in current price in 2002, increasing to Rp 240,554.3 (USD 28.5) in 2004. An international comparison states that a country requires a minimum of US$ 40 per capita annually to improve health status of its population. Having a continuing low health spending/capita will hamper Indonesia in achieving health status stated in the Millennium Development Goals (MDGs). However, one should be cautious when making absolute comparisons as purchasing power varies between countries. A more solid approach may be to use relative measures that relate spending to purchasing power. GDP has been increasing sharply for the last 3 years from Rp 1,6 trillion in 2002 to Rp 2,03 trillion in 2004 (at current year price). As presented in the figure below increase in total GDP was not followed by commensurate increase in THE.

The proportion of health expenditures by source or by agent during three years was not significantly changed. The result shows that the proportion of public : non public : rest of the world was 34% : 65% : 1% in 2002; become 36.2% : 62.5% : 1.4% in 2003; and finally 35.5% : 63.1% : 1.5% in 2004.

Territorial Government Health Expenditure (THE)

The major bulk of territorial government funds was under control of districts/municipals government (48% of total territorial government share in 2004), in line with the decentralization policy. This sub-National funds consists of the sum of total balance funds, those are general allocation funds (DAU), local revenue (PAD) and special allocation funds (DAK). Meanwhile, provincial level (includes deconcentration funds – DEKON) contributed about 19% of total sub-National expenditure.

Central government (MoH and other health expenditure by non-health government) has relatively spent approximately one third of total public expenditure in directing health funds to various providers and public health programs. (Figure 2).
Trend analysis shows that there is no significant change on health expenditure by provider in these three consecutive years. Even though there is a significant increase in nominal term i.e. spending for provision and administration of public health programs increased from Rp. 6.8 trillion in 2002 to Rp. 9.3 trillion in 2004 (almost 50% increased in two years), in term in proportion, it remain in the same level at 17-18% of total expenditure in health.

Trend of THE by function during these three consecutive years indicated that 32.9% to 37% of total health expenditure was spent for curative services. A relatively high proportion (one third) was used for medical supplies for outpatients. Education, training and research spend relatively small proportion (1%) of THE. While capital spending was 9.4% of THE, relatively higher than education, training and research.

Conclusion

- With all of the limitations and challenges in producing this first round Indonesia NHA 2002-2004, some assumptions were used to obtain the four international standard tables (ICHA).
- Health spending during this phase was relatively low compared to the GDP (2.4-2.6%) as well as compared to other neighborhood countries. The growth of GDP was not commensurate with growth of THE.
- Total health expenditure per capita form 2002-2004 had average growth rate 16%, but the proportion by source and agents was stable.
- The majority of health expenditure by provider was for hospitals and ambulatory cares (about half), while only 17% spent for public health programs.
- While in term of functions, one third was spent for curative services, followed by medical supplies (another one third), and only 5% for preventive and public health programs.
Recommendations

- Health financing is one component in the National Health System (SKN) and NHA is one credible source of information for health financing, not only for international comparison but especially for developing national health policy. MOH need to pay more attention on the development of NHA methodology, the provision of accurate data, as well as improving skill of human resources for NHA development.

- NHA needs to be reported routinely to update information about health financing in Indonesia at national and international level. Therefore, development of national information system on health spending/budget realization based on NHA standard is needed. It has to be suitable with government’s financial reporting system as well.

- Studies and supplies to support data accuracy are needed, the process should be institutionalized to ensure continuity and sustainability of the NHA, legitimacy and acknowledgment both nationally and internationally. A road map of NHA next round has been discussed and need to be followed up.

- NHA results is a ‘mirror’ of how the fund flows and had been used. Therefore, its findings should be optimally used for decision-making process and developing health financing policy to improve efficiency and equity. It could also shows transparency and accountability of the funding mechanism for health.

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