



Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending

Health Public Expenditure Review 2008



HPEA



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Foreword

Indonesia's health sector is entering a period of transition. By 2015, Indonesia is expected to have a population of around 250 million. In addition to this major demographic change, epidemiological and nutritional transitions are also occurring. Taken together, all these changes will require a very different Indonesian health system from the one that exists today. But although Indonesians are living longer, too many children continue to die of preventable diseases and too many mothers die in childbirth. While Indonesia still has this heavy, albeit declining, burden of fighting communicable diseases, the number of non-communicable diseases (diabetes, heart diseases, etc) is increasing rapidly. This double burden of high communicable and increasing non-communicable diseases is placing additional pressures on the health system.

In the past few years, Indonesia has introduced some major changes into its health system: decentralization has empowered districts and provinces to manage and finance midwives, nurses and doctors; and the introduction of a health insurance system for the poor (Askeskin) has created the opportunity to protect vulnerable Indonesians against slipping into poverty when they fall ill. However, Indonesia is encountering difficulties in implementing these bold reforms. For example, it still remains unclear to whom health workers are accountable, and one consequence of this lack of accountability is high levels of absenteeism from work. Askeskin has led to a substantial expansion in health spending and raises important questions concerning the financial sustainability of universal health insurance coverage. These difficulties are a reflection of the broader challenges that will face Indonesia's health sector in the decade ahead.

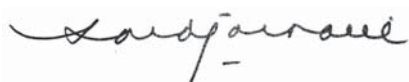
This Health Public Expenditure Review (Health PER) is a very timely and welcome analysis that supports Indonesia in the development and implementation of its health sector strategy and a first important input for the Government's next Medium-Term National Development Plan (2009-14). This Health PER highlights a number of different facets of public expenditure on health in Indonesia and prompts a series of fundamental questions about the future. These questions include the overall adequacy of funding, the role of public versus private expenditures in the health sector, the roles of central and regional budgets, appropriate mechanisms for mobilizing resources and purchasing services, and the proportion of public expenditure that should be devoted to public health, as opposed to individual medical care. This report provides nine ideas for making the health system more efficient.

The Health PER is a follow-up to the 2007 Indonesia Public Expenditure Review and follows its successful model of collaboration between the Government of Indonesia and the World Bank. The Health PER is also a product of the Initiative for Public Expenditure Analysis (IPEA), which is a consortium of key government ministries, including the Ministry of Finance, State Ministry of Development Planning (Bappenas), the Coordinating Ministry for the Economy, Indonesian universities and the World Bank. The Dutch Government provided substantial financial support. This report was written in close collaboration with the staff from the Ministry of Health and Bappenas.

As a first step, with this Health PER we hope to provide the Government and its partners with opportunities to maximize the efficiency of health spending. Following this report, we also look forward to subsequent analyses that will address the various components of the Indonesian health system.

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Executive Summary

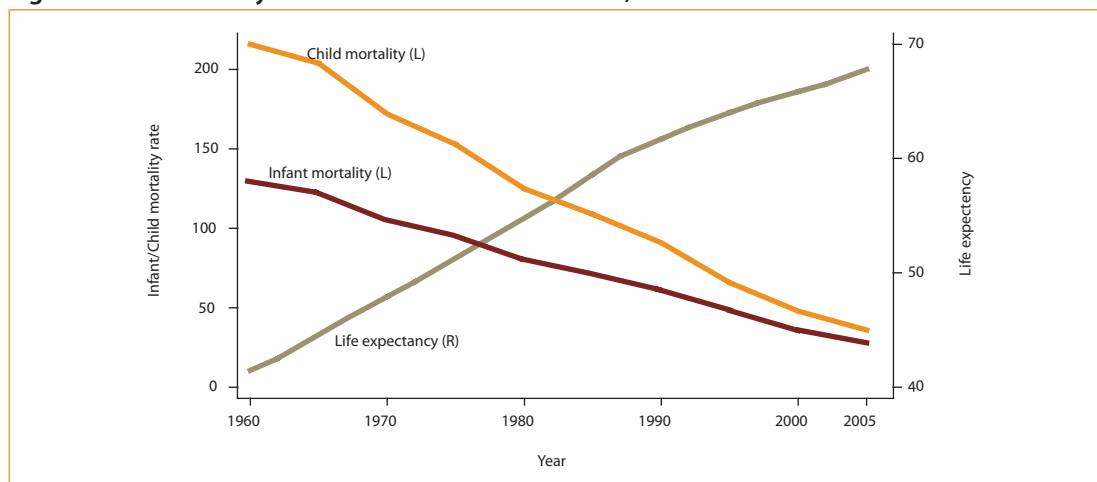


Indonesia has made major improvements over the past three decades in its health system, but is struggling to achieve important health outcomes, especially among the poor. This can be explained by not only continuing, but also new, challenges that the country is facing due to demographic, epidemiological and nutritional transitions that are increasing the demand for healthcare. Indonesia's growing economy, its political stability and the trend towards decentralization allow it to think expansively about healthcare, as is needed. However, improvements are also needed in spending efficiency and quality of services. Although improvements have been made in increasing access to health services, the performance of the current health system is inadequate for achieving today's and future health outcomes, or providing financial protection for poor Indonesians. Already, important steps have been taken with the introduction of the Askeskin program for the poor. Nonetheless, utilization of health services in Indonesia is low and self-treatment high by international comparisons, and health insurance coverage has remained almost stagnant over the past three decades at less than 20 percent. Despite substantial increases in public health spending in recent years, overall health spending in Indonesia remains low and continues to be inequitably distributed between and within provinces, while analysis also reveals major inefficiencies.

Indonesians live far longer today than they did four decades ago, but important health challenges remain

Indonesians are living longer and child mortality has fallen dramatically. Since 1960, life expectancy at birth in Indonesia has increased from 40 to 69 years, only slightly lower than China, Thailand or Turkey. In the same period, Indonesia has reduced child mortality by more than a third and infant mortality by 25 percent (Figure 1).

Figure 1 Trends in key health indicators for Indonesia, 1960-2005



Source: WDI, 2007.

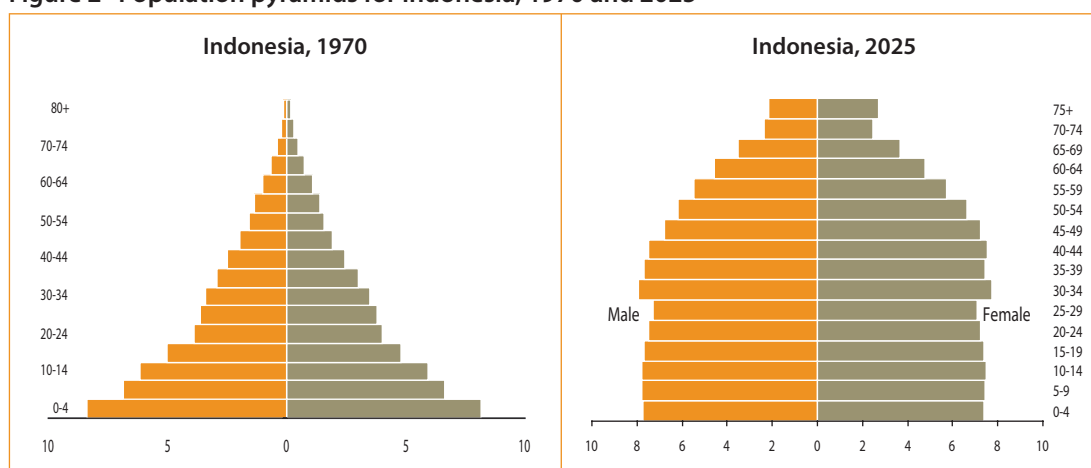
However, Indonesia continues to underperform in a number of important areas and, as a result, is unlikely to achieve several of its health-related MDGs. In particular, the country has made very little headway in reducing maternal mortality, improving child nutrition and other health determinants or addressing geographic health disparities:

- **Maternal mortality.** In Indonesia, more than four mothers die out of every 1,000 live births. This is one of the highest maternal mortality rates in East Asia: about double the Philippines, three times that of Vietnam and four times that of Thailand.
- **Child malnutrition.** Although Indonesia has substantially reduced child malnutrition from 38 percent in 1990 to 25 percent in 2000, malnutrition rates have stagnated since 2000 and are even increasing in some provinces, such as Papua and Maluku.
- **Female literacy and access to clean water and sanitation.** Important health determinants such as female literacy and access to clean water and sanitation remain low among the poorest population groups.

- **Geographical disparities.** Similar to other sectors, health indicators are on average better in Java and Bali, while eastern Indonesia lags behind. For instance, in Bali and Yogyakarta fewer than 25 out of 1,000 children die before reaching their fifth birthday, while in Gorontalo close to 100 children in every 1,000 fail to reach the age of five.

While Indonesia is still addressing these more traditional healthcare challenges, the country is also undergoing a major demographic transformation that will demand a different — and more expensive — health system. Indonesians are living longer and fewer children are dying from communicable diseases. Today, the composition of Indonesia's population looks very similar to most European countries in the 1950s and, by 2025, the number of 30-60 year olds will be equivalent to the 0-30 year olds (Figure 2).

Figure 2 Population pyramids for Indonesia, 1970 and 2025



Source: World Bank staff calculations based on Bappenas/ BPS growth projections and UN, 2007.

Indonesia is in a period of epidemiological transition: Communicable diseases, such as tuberculosis and measles, albeit in decline, remain high, while NCDs, such as diabetes, heart disease and cancers are increasing. The increase in NCD is primarily attributable to changes in dietary behavior and more sedentary lifestyles. The implications of these changes in the demand for healthcare are important for decisions regarding health financing and allocation of resources.

In the mid-1970s, during the first oil windfall, Indonesia made the most of its additional revenue by embarking on a massive expansion of basic social services, including health. This program (Inpres) led to a rapid increase in the numbers of health centers, doctors, nurses and midwives. However, despite this expansion, today the provision of health services remains uneven and Indonesia continues to face a challenge in the geographical distribution and quality of its health workforce:

- **Doctors: Indonesia does not have enough doctors in remote areas, and absenteeism at public health centers is high.** Indonesia only has 13 doctors per 100,000 people, one of the lowest ratios in Asia. In Lampung province (Sumatra), the ratio is as low as 6 doctors per 100,000. In addition, this low coverage is exacerbated by high levels of absenteeism. Up to 40 percent of doctors have been found to be absent from their posts without valid reason during official public working hours.
- **Nurses: In contrast, Indonesia has relatively more nurses than its regional peers, but many are poorly qualified and not permitted to provide the required care.** Although poorly qualified, nurses in Indonesia are numerous and well distributed. In remote areas, they are

Indonesia's health system increased access to healthcare but poor quality and inefficiencies remain major concerns, especially as demand is set to increase going forward

often the only health workers available. Consequently, nurses are regularly required to provide curative and diagnostic services that they are currently not legally permitted to perform.

- **Midwives: In aggregate terms, Indonesia has a large number of midwives thanks to its previous *bidan-di-desa* policy of placing midwives in every village.** But today, as with other health workers, their distribution is uneven. These distributional problems are particularly pressing in remote rural areas: a recent study, based on survey data from two districts in Java, found that 10 percent of villages have no midwife, but only a nurse as a midwifery provider. In addition, midwives who are assigned to remote areas tend to be less experienced and manage fewer births, making it hard for them to maintain/develop their professional midwifery skills.

Although Indonesia's health workforce is growing, the legitimacy of "dual practice" without proper oversight hinders the effectiveness of the system. The government has allowed its staff to engage in "dual practice" since the 1970s in recognition of the low level of public salaries. However, allowing public health workers to simultaneously take jobs in the private sector has, despite positive effects, also negative effects. Proper oversight mechanisms to ensure accountability for public working hours and maintain quality standards are still weak in Indonesia. In addition, since urban areas are generally more attractive to private health service providers, dual practice may also contribute to the shortage of health workers in rural areas. As an example of unequal distribution of health personnel, 18 out of Indonesia's 33 provinces have less than one doctor per Puskesmas.

So far, decentralization has failed to deliver its full potential to improve health service delivery. Within the current civil service and decentralization regulations, local governments have limited authority in managing their staff. The current fiscal transfer formula contains a fiscal incentive to expand staff levels. This has led to substantial increases in the number of teachers and is likely to be having a similar effect on health sector staffing. However, local governments have limited flexibility in deploying health workers or in sanctioning staff, for example, for absenteeism. This lack of local authority and accountability hinders the development of a more efficient and well-distributed health workforce at the district level, resulting in some health centers being overstaffed while others face staff shortages.

Health infrastructure is also deficient in quality and many health centers are poorly equipped. The average local health center (Puskesmas) serves around 23,000 people within a service area of 242 km², and is supported on average by three sub-health centers (Posyandu). Puskesmas also often lack adequate infrastructure such as clean water, sanitation or regular access to electricity. Furthermore, ensuring sufficient stocks of basic medicines, medical supplies and equipment remains problematic, especially in remote areas.

These inefficiencies and poor quality in the health sector have resulted in low utilization rates of both public and private facilities. Overall outpatient utilization of health services decreased in the wake of the financial crisis in 1997/98 and has failed to recover since then, while self-treatment has continued to grow. Indonesia is one of the few countries in the region where health utilization rates have yet to return to their pre-crisis levels. Utilization rates are especially low among the poor for outpatient services, although since 2005 with the Askeskin program this has been improving, particularly for public sector facilities.

Inpatient utilization is also very low in Indonesia, particularly among the poor, who use inpatient services 60 percent less than the better-off. When the poor do seek inpatient care at a health facility they invariably look towards Puskesmas, followed by public hospitals. Although inpatient utilization figures appear to be on the rise following the introduction of the Askeskin program, they remain low for the poorest segment of the population. Further detailed research is needed to assess the impact of Askeskin on healthcare-seeking behavior in order to better understand the reasons behind continued low utilization by the lowest income groups.

Despite substantial increases in recent years, Indonesia still spends comparatively little on health. In total, Indonesia spends less than 3 percent of GDP on the health sector (which is split between private and public spending in a ratio of 2 to 1). In contrast, Vietnam, the Philippines, Malaysia and most of Indonesia's other neighbors spend more and score better on most conventional measures of health outcomes, such as DPT and measles vaccinations, as well as on child and maternal mortality rates.

Indonesia's public expenditures on health have increased substantially. In real terms, total public spending on health has more than quadrupled from about US\$1 billion (Rp 9.3 trillion) in 2001 to over US\$4 billion (Rp 39 trillion) in 2007, surpassing for the first time 1 percent of GDP.

In the years directly after decentralization, more than half of public health spending was carried out by provinces and districts. Until 2005, districts accounted for around 50 percent of total health spending, the central government for a third and provinces just below 20 percent. However, since 2005, with the introduction of the national health insurance program for the poor (Askeskin), the share of total spending by the center has increased substantially, resulting in renewed prominence of central government spending.

Local governments have limited opportunities to make decisions regarding spending on local needs. In 2007, it is estimated that the central government and the districts both managed about 40-45 percent, while provinces managed about 15 percent of public health expenditures. The multiple funding channels and specific mandates that accompany them restrict the scope for district governments to make spending choices. The high share of salaries in routine expenditure illustrates this issue, as salaries are centrally directed expenses. There is very little room for reallocation and, as a result, very little scope for funding choices or discretion in the supervision of public health activities.

Often significant resources at the local level remain unspent, while the need for health spending remains high. In 2006, only 73 percent of the total public health budget was spent. Particularly low disbursements were seen in the categories of goods, consultants and civil works. Systemic weaknesses in public financial management largely explain these low disbursement rates. However, this is not just an issue in the health sector but a more general problem that affects the entire public sector (World Bank, 2007c).

Despite substantial increases in public spending, private health spending still comprises the bulk of total health expenditures. About 65 percent of all spending on health is private and, of that, 75 percent is direct out-of-pocket spending. The remaining private spending from companies and insurance funds is limited in Indonesia. This makes OOP spending half of all health spending in Indonesia and compensates for low public spending and limited health insurance coverage. As long as high OOP levels exist in Indonesia, equity in health financing will be difficult to achieve.

Although it affects only a relatively small and apparently declining segment of the population, catastrophic health expenditures still drive people into poverty. Almost half of all Indonesians live at an income level that is vulnerable to poverty. As a consequence, unanticipated health expenditures are a major cause of these near-poor falling into poverty, in addition to causing extreme suffering among the poor. Almost 2.3 million of Indonesian households (1 percent) currently fall into poverty annually due to catastrophic spending, which is defined as occurring when households spend more than 40 percent of their income on health-related costs. While on average Indonesians spend less than 3 percent of their income on health expenditures (compared with 11 percent on tobacco!) the group that is affected by catastrophic costs still comprises more than 6 million households in absolute numbers.

While spending on public health has increased substantially from a low base, it remains low with large out-of-pocket spending resulting in inequities and poor health outcomes

The government's Askeskin health program for the poor aims to protect both poor and near-poor households from catastrophic expenditures and, despite inefficiencies and mistargeting, appears to be achieving results. Between 2005 and 2006, the share of people sliding into poverty due to healthcare spending declined from 1.2 percent to 0.9 percent. However, more analysis is needed to fully understand the link between the Askeskin program and these results, as well as the financial and implementation sustainability of the program.

Increasing health spending, decentralization and the Askeskin program have yet to translate into clearly improved health outcomes. In part this is due to a lack of demand resulting from shortcomings in health literacy and relatively high non-medical costs (opportunity and transportation costs, as well as user fees). It is also due to inefficiencies in the health system itself, such as high levels of absenteeism and shortcomings in health workforce education, together with low quality infrastructure and geographic disparities. However, poor health outcomes are also a consequence of weakness in Indonesia's public financial management, including difficulties in making investments early in the fiscal year and stronger incentives to hire staff than invest in operations and maintenance (World Bank, 2007c). Last but not least, low levels of spending on other determinants of health outcomes — such as improved water and sanitation, female literacy and early child nutrition — is also a crucial factor in Indonesia and adversely affects health outcomes.

Inequity and inefficiencies are drivers of sub-optimal health outcomes among the poor

High rates of self-treatment are a major driver of inequity. Susenas data suggest that Indonesians' first source of healthcare in the event of illness is private vendors of pharmaceuticals. Pharmaceuticals constitute a large share of OOP. Prices of frequently prescribed drugs are often higher than international prices. This, together with high self-treatment rates, drives high levels of OOP spending. With higher numbers of the poor driven to seek self-treatment in the absence of wide health insurance coverage, this is an important driver of inequality in health spending.

Current public health spending for secondary healthcare tends to be regressive. The use of state subsidies and user charges to finance the public provision of healthcare has had an adverse impact on equity in the health sector. To date, public health spending has generally benefited richer income groups more than the poor through regressive subsidies for secondary healthcare. This can be partially explained by the very low utilization rates of hospital care by the poor who, prior to the Askeskin program, were deterred by high user charges. However, the hope is that the regressive nature of secondary healthcare spending can be partially corrected through the Askeskin program, assuming that the program can be well targeted. At the same time, spending on secondary care should not necessarily be diminished, particularly when bearing in mind Indonesia's growing dual disease burden and the increasing need for hospital treatment that this will entail.

Askeskin is providing the poor with better healthcare access, but richer quintiles are also benefiting. The Askeskin program has provided a large number of previously unprotected poor with the opportunity to benefit from free healthcare, reducing the financial barrier to health service access. As a result, utilization has been rising, while catastrophic spending has declined. However, richer income groups have also benefited from Askeskin, indicating a need to improve the targeting of the program.

Low hospital occupancy rates indicate economic inefficiencies that may increase average costs of services, even though these are already considered excessive by many Indonesians. Nonetheless, at 56 percent, Indonesia's low average bed occupancy rate is on a par with rates in most other East Asian countries. Although this low rate is partly due to geographic and epidemiological trends, potential efficiency gains that could be made through improvements should not be underestimated. Low occupancy rates are often linked to the perceived poor quality of hospital services which, in turn, is a reflection on the limited availability of skilled personnel. As such, improvements could be made by adopting new staffing policies and increasing the number of specialized staff in hospitals.

POLICY OPTIONS: Nine ideas for a better health outcomes in Indonesia

- 1. Make better use of the existing resources available for health, while also making more resources available in the medium term.** Current financing arrangements provide few incentives for efficiency by local governments or individual healthcare providers. Modern provider-payment schemes, improved oversight and contracting of private providers, results-based financing pilots, improved accountability over public working hours to reduce absenteeism and other creative solutions to dual practice, and revisiting the skills mix in remote areas, could all contribute towards improving system inefficiencies.
- 2. In particular, make more resources available for reproductive health and allocate resources for referral and institutional deliveries.** Public awareness of financial coverage for better pre-natal/delivery care through Askeskin should be raised and appropriate incentives for midwives should also be provided to ensure the appropriate availability of institutional deliveries. Create a reimbursement mechanism for institutional deliveries that reflects the real costs.
- 3. Improve the allocation of resources for preventive care and allow for sufficient resources for operations and maintenance to ensure quality of basic care.** Strengthen the focus on preventive interventions both in transition and early transition areas. Not only areas with persistently high communicable disease burdens require preventive health services. To a great extent NCDs can also be prevented, or their onset delayed, through appropriate preventive health behaviors, such as reduced smoking, increased exercise and healthy eating. In focusing on prevention, health literacy and demand-side factors need to be given a higher priority.
- 4. Devote additional resources and attention to all major public goods that determine health outcomes.** In general, more attention and resources are needed in order to address major public goods that determine health outcomes, namely water and sanitation, female literacy, etc. Such interventions could have an enormous impact, especially for the poor, in addressing those MDGs in which Indonesia is lagging, such as infant mortality.
- 5. Adjust the general allocation fund (DAU) to provide incentives for local civil service reform and amend PP No.55 to allow operational use of deconcentrated funding.** More than half of the recent DAU increase goes towards financing sub-national civil service wage bills. Full coverage of the sub-national wage bill provides a disincentive for sub-national governments to streamline their civil services. Removing full coverage would strengthen the equalizing impact of DAU transfers. Such a measure would empower sub-national governments to find a more optimal combination of inputs (size of workforce, capital, intermediate inputs and outsourcing) for public health service delivery and encourage a more efficient distribution of the health workforce. Amending PP No.55 to allow deconcentrated use for operational costs would contribute to better efficiencies in staff and facility use.
- 6. Improved health outcomes and financial protection for the poor may be possible by increasing the coverage of Askeskin.** Askeskin has the potential to substantially increase access of poor Indonesians but it is not yet well targeted. In addition to Askeskin, other types of demand-side interventions are needed to promote better access and encourage those currently using self-treatment to switch to more appropriate healthcare. Current initiatives such as conditional cash transfers (CCT) linked to child and maternal care are examples, but good public information campaigns also fall under this category. Regarding CCT, supply-side issues need to be reviewed carefully to ensure that demand will be met by a quality supply of services.
- 7. Ensure better financial sustainability of Askeskin by introducing cost-containment options.** The costs of the Askeskin program will continue to rise and increase pressure on the supply side. The financial sustainability of Askeskin will depend on careful cost-containment. The various cost-containment options will require decisions on the benefit packages, population coverage and

targeting mechanisms, together with the introduction of co-payment mechanisms. Related to this are the important questions of how the demand side will respond and the nature of future utilization patterns.

- 8. Increase efficiency of service provision for publicly insured enrollees by allowing program beneficiaries to also use private providers.** As long as the private sector remains practically excluded from the scheme (due to its unwillingness to accept the uniform tariffs set by the MoH), supply-side problems are likely to become increasingly common and could contribute to additional inefficiencies in service delivery. It is important to create a level playing field through effective provider-payment mechanisms. However, effective regulatory capacity and provider-payment reforms are key pre-requisites in achieving this and ensuring equity. Once these reforms are in place, the government can adopt the principle of *money following patients* and the equal payment for efficient provider services irrespective of ownership.
- 9. Improve reporting systems and data availability.** Since decentralization, the challenges to reporting systems have spiraled. The government is currently establishing the District Health Accounts system in order to improve budget transparency. Such data are crucial for feedback into the budget cycle and will allow for intra and/or inter sectoral reallocations based on need and performance. In particular data availability on functional spending needs to be improved to allow for more detailed, better targeted and locally-specific solutions. Currently, data are problematic, with significant deconcentrated funds being spent in the regions under ambiguous classifications from the MoH.

