Australian Government
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INDONESIA
NATIONAL HEALTH ACCOUNTS 2014
Final Report

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FINAL REPORT

Submitted to AIPHSS

Preface

Health financing is one of health sub systems in national health system, which can be figured out by using National Health Accounts (NHA). The NHA can be one of the instruments in monitoring health expenditure and use of resources and gives information on the flow of funds, distribution, and uses of health spending in a health system. It also further reflects the health financing issues, such as adequacy, equity, effectiveness, and sustainability.

NHA provides information on the size of Indonesia health expenditures, for what, who pays, who manages the fund, and who provides the goods/services in the whole health system. NHA can also provide comprehensive and consistent information on detailed description of health expenditure by using evidence. Therefore, the NHA can be used as an input for policy makers in formulating health policy, particularly in health planning and budgeting.

Indonesia has produced NHA based on System of Health Accounts (SHA) methodology, an international guideline in producing national health accounts for countries over the world. Currently, Indonesia NHA is being developed based on SHA version 1.0 and SHA 2011.

In this final report, NHA team will deliver the following output:

1. Report on full figure of national health expenditure estimation for 2014
2. Update estimation of MOH health expenditure for 2014
3. Update estimation of other ministries health expenditure for 2014
4. Update estimation of subnational health expenditure for 2014
5. Update estimation of social security health expenditure for 2014
6. Update estimation of private insurance health expenditure for 2014
7. Update estimation of households' out of pocket health expenditure for 2014
8. Update estimation of corporation (parastatal and private companies) for 2014
9. Update estimation of NPISH and rest of the world (ROW) health expenditure for 2014

Acknowledgments

Indonesia National Health Accounts (NHA) production is an activity of Center for Health Financing and Insurance (*Pusat Pembiayaan dan Jaminan Kesehatan*-PPJK) Ministry of Health Government of Indonesia. The development of 'Indonesia National Health Accounts 2014' final report has been made possible through a collaborative effort between public & private sector and academic institution. NHA production team – CHEPS of School of Public Health Universitas Indonesia and PPJK of MOH with AIPHSS support has resulted in the NHA production presented in this report. This NHA production has made various progress compared to previous years.

This report would not have been finished without the continuous commitment and generous support from the Ministry of Health, especially Bureau of Finance as well as the Bureau of Planning and Budgeting for providing data on MOH spending; the Directorate General of Treasury (DJPB), the Ministry of Finance (MOF) for providing data spending of other ministries, as well as to the Directorate General of Fiscal Balance (DJPK) MOF for providing regional financial data (*data keuangan daerah*). We thank all stakeholders, who actively involved in both discussion and consultation meetings for production Indonesia NHA 2014, including units under the Secretariat General, Inspectorate General, Directorate General of Nutrition and Maternal and Child Health, Directorate General of Health Services (DG BUK), Directorate General of Disease Control and Environmental Health (DG P2PL), Directorate General of Pharmaceutical Services and Medical Devices (DG Binfar), National Institute of Health Research Development (NIHRD), and the Center for Development of Human Resources for Health (PPSDM for Health), BPJS Kesehatan, Central Bureau of Statistics (CBS), National Population and Family Planning Board (BKKBN), Ministry of Defense, Private Insurance Enterprises, and other related stakeholders that cannot be mentioned one by one.

Our greatest appreciation and gratitude to ISP AIPHSS team – Coffey International Development for the support and funding of this NHA initiative, which has produced the NHA results that can contribute to health policy in Indonesia.

Highlights

- Indonesia's total health expenditure (THE) in 2014 was estimated at Rp377.8 trillion, equivalent to US$31.8 billion. Of this, 96.2 percent (Rp363.5 trillion) was current health expenditure (CHE) and the remaining 3.8 percent (Rp14.3 trillion) was expenditure for capital spending.
- Indonesian THE and CHE as share of GDP in 2014 was 3.6 percent and 3.4 percent.
- THE and CHE per capita in 2014 was amounted for Rp1,498,091 and Rp1,441,525.
- From the year 2010 to 2014, the average annual growth rate of CHE was 6.8 percent, with the highest growth in 2014 at 11.6 percent.
- The majority (89.7 percent) of CHE in 2014 was spent for personal healthcare and the rest for collective healthcare (10.3 percent). Approximately, 64.6 percent of personal healthcare spending was financed from private agents; reversely 72.5 percent of collective healthcare spending was from public agents.
- Hospitals accounted for the largest share of CHE in 2014 at 54.8 percent, followed by providers of ambulatory health care (14.9 percent), retailers and other providers of medical goods (13.7 percent), providers of preventive care (9.7 percent), provider of health care system administration and financing (5.3 percent). The rest of CHE (1.5 percent) was spent at providers of ancillary services, rest of economy and rest of the world.
- Household out-of-pocket payment in 2014 was Rp171.2 trillion or 47.1 percent of CHE. The OOP payment declined as much as 3.1 percent from 2013. It indicates a shifting in Indonesia health expenditure figure, the share of social security funds increased while the share of OOP decrease along with the implementation of National Health Insurance (*Jaminan Kesehatan Nasional*).
- Spending by social security agency in 2014 reached Rp48.7 trillion, which accounted for 13.4 percent of CHE. Health spending under social security has increased almost doubled (Rp24.0 trillion in nominal terms or 7.8 percent of CHE) from 2013. The role of social security is expected to continue in upcoming years, which is aligned with the government's plans to reach universal health coverage by 2019.

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Abbreviations

AIDS	:	*Acquired Immune Deficiency Syndrome*
APBD	:	*Anggaran Pendapatan dan Belanja Daerah* – the Regional Government Budget
APBN	:	*Anggaran Pendapatan dan Belanja Negara* - the State Government Budget
Askes	:	*Asuransi Kesehatan* – Health Insurance
AusAIDs	:	*Australian Agency for International Development*
Balitbangkes	:	*Badan Penelitian dan Pengembangan Kesehatan* - National Institute of Health Research Development
BKKBN	:	*Badan Kependudukan dan Keluarga Berencana Nasional* - National Population and Family Planning Board
BLU	:	*Badan Layanan Umum* – Public Service Agency
BOK	:	*Bantuan Operasional Kesehatan* –Health Operational Assistance Program
BPJS Kesehatan	:	*Badan Penyelenggara Jaminan Sosial Kesehatan*
BPOM	:	*Badan Pengawas Obat dan Makanan* - National Agency of Drug and Food Control
BPS	:	*Badan Pusat Statistik* – Central Bureau Statistics
BUMN	:	*Badan Usaha Milik Negara* – Parastatal Companies
CBG	:	Case Based Group
CCM	:	Country-Coordinating Mechanism
CHE	:	Current Health Expenditure
COFOG	:	Classification of the Functions of Government
DAK	:	Dana Alokasi Khusus – Special Allocatication Funds
DHA	:	District Health Accounts
DJPBN	:	*Direktorat Jenderal Perbendaharaan Negara* - the Directorate General of Treasury
DJPK	:	*Direktorat Jenderal Perimbangan Keuangan* - the Directorate General of Fiscal Balance
FA	:	Financing Agents
FP	:	Factors of health care provision
FS	:	Revenues of health care financing schemes
GAVI	:	Global Alliance for Vaccines and Immunisation
GDP	:	Gross Domestic Product
GF-ATM	:	Global Fund-AIDS, TB, Malaria
GGHE	:	General Government Health Expenditure
HC	:	Health care functions
HF	:	Health care financing schemes
HK	:	Capital Account
HP	:	Health care providers
HIV	:	Human Immunodeficiency Virus
HSS-CU	:	Health System Strengthening Coordinating Unit
IBNR	:	Incurred But Not Reported
Jamkesda	:	*Jaminan Kesehatan Daerah*
Jamkesmas	:	*Jaminan Kesehatan Masyarakat*
Jampersal	:	*Jaminan Persalinan*
Jamsostek	:	*Jaminan Sosial Tenaga Kerja*
JKN	:	*Jaminan Kesehatan Nasional*

JPK	:	*Jaminan Pemeliharaan Kesehatan*
KIA	:	*Kesehatan Ibu dan Anak* - Maternal and Child Health
LGF	:	Local Government Finance
LRA	:	*Laporan Realisasi Anggaran* - Budget Realization Report
MOF	:	Ministry of Finance
MOH	:	Ministry of Health
NCC	:	National Casemix Center
NHA	:	National Health Accounts
NPISH	:	Non-Profit Institutions Serving Households
OECD	:	Organization for Economic Co-operation and Development
OJK	:	*Otoritas Jasa Keuangan*
OOP	:	Out of Pocket
P2PL	:	*Pengendalian Penyakit dan Penyehatan Lingkungan* - Disease Control and Environmental Health
PBI	:	*Penerima Bantuan Iuran*
Permenkes	:	*Peraturan Menteri Kesehatan* – Ministrial Decree
PKLN	:	*Pusat Kerjasama Luar Negeri* - Center of Foreign Cooperation
PMK	:	*Peraturan Menteri Keuangan*
PNS	:	*Pegawai Negeri Sipil* – Civil Servant
POLRI	:	*Kepolisian Republik Indonesia*
PPJK	:	*Pusat Pembiayaan dan Jaminan Kesehatan* - Center for Health Financing and Insurance
PPP	:	*Purchasing Power Parity*
RKAKL	:	*Rencana Kerja Anggaran Kementerian/Lembaga*
ROW	:	*Rest of the World*
Sakernas	:	*Survei Angkatan Kerja Nasional*
SHA	:	System of Health Accounts
SJSN	:	*Sistem Jaminan Sosial Nasional*
SNA	:	The System of National Accounts
Susenas	:	*Survei Sosial-Ekonomi Nasional*
Tabel IO	:	Tabel *Input-Output*
TB	:	Tuberculosis
THE	:	Total Health Expenditure
TP	:	*Tugas Pembantuan*
UHC	:	Universal Health Coverage
USAID	:	United States Agency for International Development
WHO	:	World Health Organization

Full Figure of National Health Accounts 2014

Health Expenditure Indonesia 2014

1. Introduction

The year of 2014 is a historical moment for health sector, when a comprehensive health sector reform had been initiated to restructure health financing and health services delivery system. Integration of all existing contributory and non-contributory social health insurance schemes began merging in 2014 to provide streamlined uniform benefit under a single national scheme. PT Askes, which previously managed the scheme for civil workers, was transformed to become a new agency so called BPJS Kesehatan. The adoption of Social Security Law in 2011 appointed BPJS Kesehatan as a single purchaser of health services that responsible to manage Social Health Insurance (SHI) for the country. Under this new national scheme, all members were entitled to the same benefit packages.

Prior to 2014, several public schemes were in operation to serve different parts of the population including the schemes covering active and retired civil servants (Askes PNS), social insurance for formal worker (Jamsostek), Social protection for members of the Army and Police scheme, Social assistance for the poor (Jamkesmas scheme) and local government scheme to cover the additional poor population. Under these fragmented schemes, the system left significant gaps in coverage, mostly informal workers and retirement of private sectors. There was also a large variety among schemes of benefit packages offered.

Indonesia NHA results have helped track and clarify how resources are allocated, indicating a need for greater financial risk protection for the country. After several round of NHA production, Indonesia has started to use some of the health resource tracking results to convince the high policy makers on the need to ensure equity in resource allocation across regions and health program. There is also an urgent need to improve transparency and accountability in Indonesia's health sector. NHA results showed the country's performance relative to its regional neighbors in terms of health spending levels and trends. From the policy and planning perspective, the government also use the data to monitor the implementation of the government commitments which suggests that the country allocate 5 percent of their budgetary resources to finance health. The data highlights that there is still a lack of financial risk protection with high proportion of out-of-pocket (OOP) spending for households. Health resource tracking data have revealed that households are the largest contributor to health spending, accounted for around 50 percent of Total Health Expenditures (THE). Highlighting these data, NHA results of 2012 and 2013 have encouraged key policy questions at the national level to response and take action to do financing reform to reduce households' OOP payments for health services at the point of services. Previously, many policy makers are not aware that the health expenditure

numbers in published reports come from NHA and explicit awareness raising would give them added value.

As suggested by the WHO, Indonesia has firmed to expand coverage toward Universal Health Coverage (UHC) through SHI in early 2014, as a way to improve financial access to care and reduce the health financing burden of OOP borne by the household.

Currently, NHA remain under the PPJK, MOH. As stated in the yearly planning, the MOH requires the annual production of NHA and mandating all entities in health to provide the data inputs for production. Local production is led by a technical team at the Faculty of Public Health, University of Indonesia who develop standardized production tools, apply standardized methodologies, and ensure uniform reporting of data output. Technical and methodological issues are discussed by an expert group as well as informally with economists and other experts from time to time. In 2016, the country has committed to produce NHA figures using System of Health Account (SHA) 2011 framework, while previous NHA production was submitted using SHA framework 1.0. This report provides health expenditure in 2014 using the System of Health Accounts (SHA) 2011 framework.

SHA 2011 framework applies a complete and comprehensive dimension. Based on data avaliability, the NHA figures using SHA 2011 has resulted the health expenditure by the following dimensions:

1) *Health Care Financing Schemes* (HF) – informs how a health financing is managed
2) *Financing Agents* (FA) – encompasses institutions or entities that manage a health financing
3) *Health Care Providers* (HP) – comprises of organizations and actors that deliver health care goods and services
4) *Health Care Functions* (HC) – represents the type of health care goods and services consumed
5) *Capital Expenditure* (HK) – records of the investment on construction and procurement

In the production of NHA using SHA 2011 framework, there are some efforts to improve and progress in the estimation process. A detailed description of figures by providers and functions presented in this report is only figures for year 2014 , as consequence of using this framework the result shown has different perspective as compared to NHA reports of previous years.

2. Structure of the Health Financing and Flow of Funds, 2014

Health financing in Indonesia is managed by public sector, private sector, and external donors (rest of the world – ROW). Up to 2014, public sectors have been dominated by local government scheme, while private sector financing mainly was out-of-pocket spending (OOP).

The government sector comprises central government (Ministry of Health and other ministries/ institutions), local government (provincial and district government), and social

security scheme. Government health financing at the central level is funded by the State Government Budget (*Anggaran Pendapatan dan Belanja Negara* – APBN) disbursed by Ministry of Finance as national treasury, to all ministries/ institutions, including Ministry of Health.

Ministry of Health implement various health programs through hospitals or primary health care providers. Beside Ministry of Health, Central government programs related to health are also performed by other ministries/ institutions. Some of these central government programs are also managed by local government, such as for programs channeled through deconcentration and co-administration (tugas pembantuan) mechanism.

Local government through Local Health Offices and other local offices (at provincial and distrcit levels) also deliver health program supported by Regional Government Budget (*Anggaran Pendapatan dan Belanja Daerah* – APBD). Sources of the local government budget (APBD) are local Revenue (Pendapatan Asli Daerah – PAD), as well as fiscal balance transfer (a transfer from central budget/APBN to local government) disbursed by Ministry of Finance.

Structure of the government health financing in 2014 has shown a major change after the Social Security Agency or *Badan Penyelenggara Jaminan Sosial Kesehatan* (BPJS Kesehatan) has been assigned as a single payer for social health insurance scheme. The BPJS Kesehatan is responsible to collect contribution from central and local government, private enterprises and other memberships.

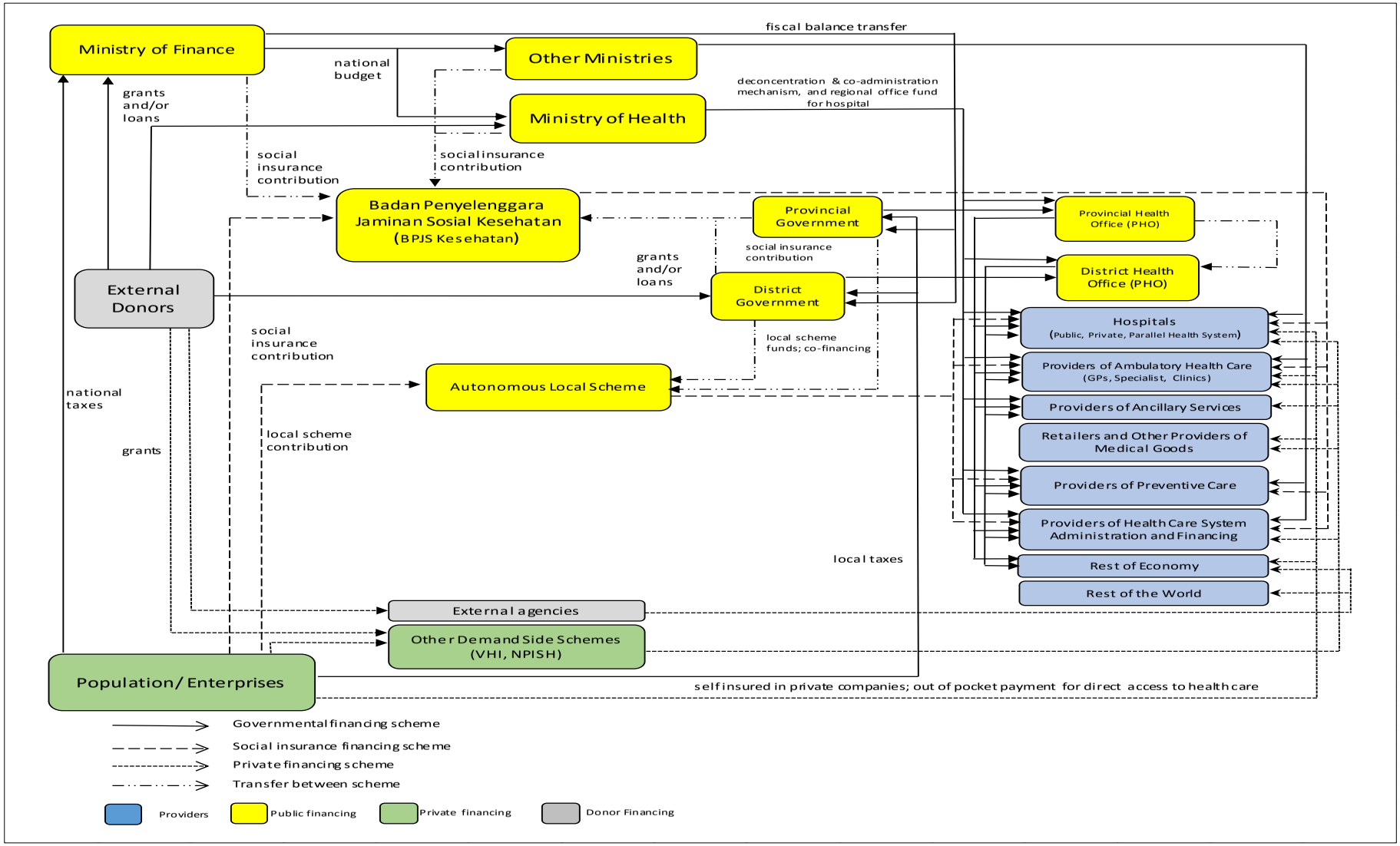

Figure 1. Flow of Funds in the Indonesian Health Care System, 2014

3. Total Health Expenditure

NHA figures using SHA 1.0 Framework presents the aggregate figure of health expenditure or Total Health Expenditure (THE) covering *Current Health Expenditure and Capital Expenditure*. The estimation using SHA 2011 has resulted the aggregate figure and presented as CHE, while Capital Expenditure is classified as different dimension.

Indonesia THE in 2014 was accounted for Rp377.8 trillion, or equal to US$31.8 billion (figure 2). About 96.2 percent of THE (Rp363.5 trillion) was CHE and the remaining 3.8 percent (Rp14.3 trillion) was capital expenditure. The proportion of THE to GDP in 2014 was estimated at 3.6 percent, slightly increased from previous years. While THE per capita reached Rp1, 498,091 (US$126).

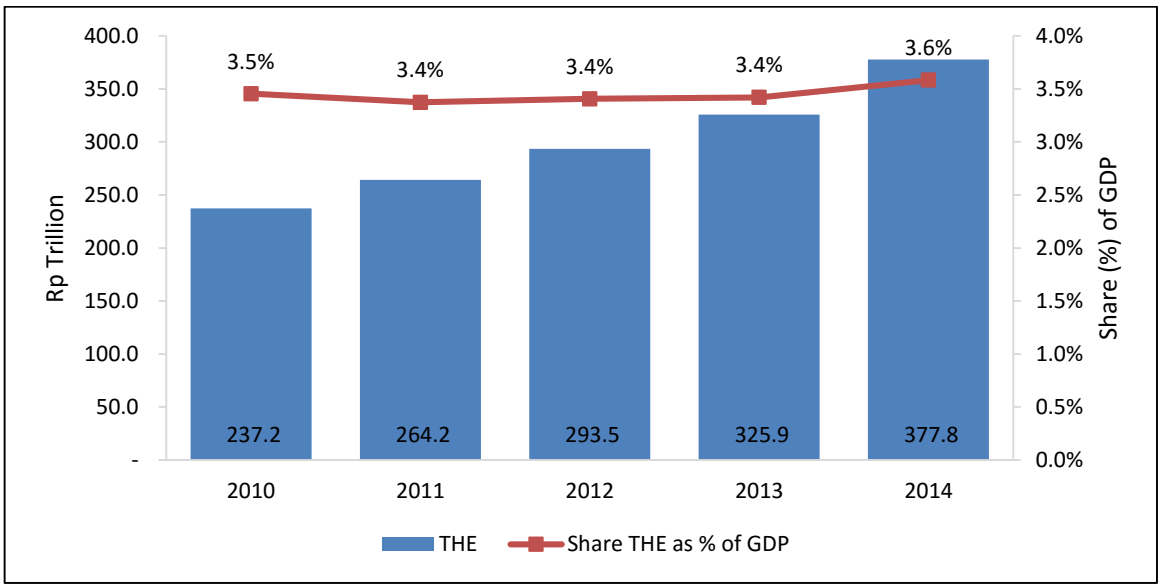

Figure 2. THE and the Proportion of THE to GDP, 2010 - 2014

4. Current Health Expenditure (CHE)

Total Health Expenditure terminology in SHA 2011 illustrates final consumption on health goods and services by population (individual or group) in one country for 1-year period, excluding capital expenditure. Capital expenditure or investment in health is spent to improve resource capacity or production factor in health system for long period (more than one year) of accounting time.

4.1 Trend of CHE

Total CHE in Indonesia in 2014 was estimated around Rp363.5 trillion or US$30.6 billion (figure 3). The health expenditure comprises all spending for curative care, rehabilitative care, ancillary services, health equipment, public health, and health administration.

Within five years (2010-2014), CHE tended to increase. According to current price index, CHE raised at 59.6 percent and 29.7 percent as in constant price in that particular year.

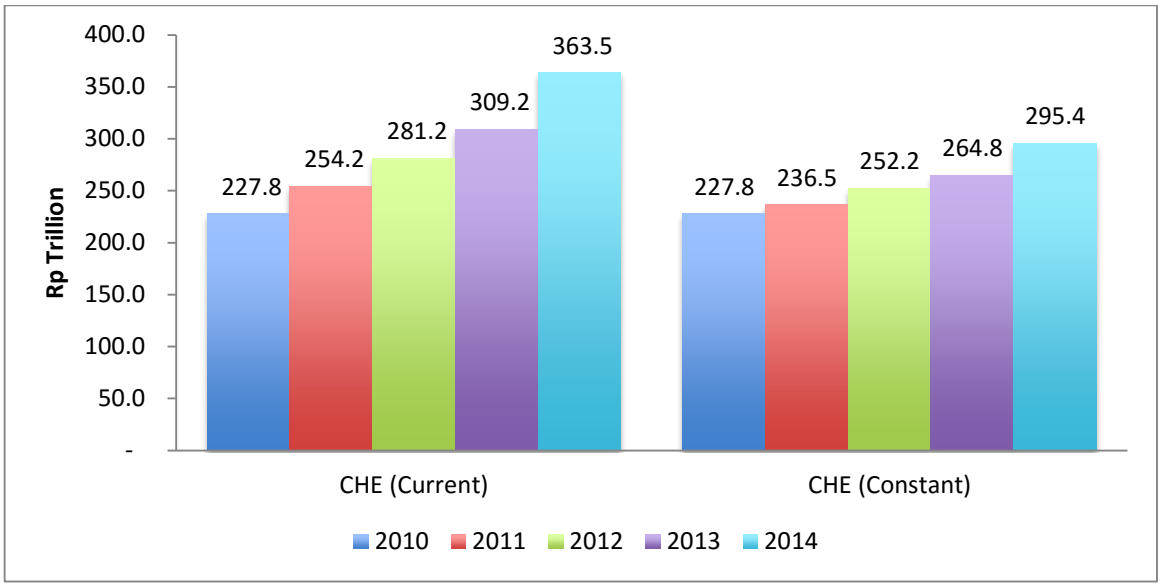

Figure 3. Current Health Expenditure (Current and Constant Prices)

CHE growth in 2014 remain higher (12 percent) as compared to the average growth during 2010-2014 (table 1) wherein the real growth rate had been below 10 percent.

Table 1. Current Health Expenditure, Current and Constant Prices (2010), and Annual Growth Rate, 2010 - 2014

Year	Amount (Rp trillion)		Growth rate over previous year (%)	
	Current	Constant*	Current	Constant*
2010	227.8	227.8	-	-
2011	254.2	236.5	11.6	3.8
2012	281.2	252.2	10.6	6.6
2013	309.2	264.8	10.0	5.0
2014	363.5	295.4	17.6	11.6
Average annual growth rate 2010-2014			**12.4**	**6.8**

*Constant price are expressed in terms of 2010 prices (GDP deflator of Indonesia)

4.2 CHE and GDP

The proportion of CHE to GDP illustrates health sector contribution for the overall economic activities in Indonesia. Within 5 years (2010-2014), annual average share of CHE to GDP in Indonesia was 3.3 percent. To increase proportion of CHE to GDP, the growth of CHE has to be higher than the growth rate of GDP.

Table 2. CHE, GDP, Growth Rate and Share of GDP (Current Prices)

Year	CHE		GDP		CHE as % of GDP
	Amount (Rp trillion)	Growth Rate (%)	Amount (Rp trillion)	Growth Rate (%)	
2010	227.8	-	6,864.1	-	3.3
2011	254.2	11.6	7,831.7	14.1	3.2
2012	281.2	10.6	8,615.7	10.0	3.3
2013	309.2	10.0	9,524.7	10.6	3.2
2014	363.5	17.6	10,542.7	10.7	3.4

4.3 CHE per Capita

Demand for goods and services will likely increase along with increased number of population in one country and so health-spending pattern. CHE per capita analysis describes the average of individual health spending in one country in 1 year.

In 2014, CHE nominal per capita is around Rp1.4 million (US$121.5), increased up to Rp200 thousand compared to last year. In real terms, the average of health spending per capita was accounted to Rp1.2 million, increased around Rp108 thousand compared to year 2013.

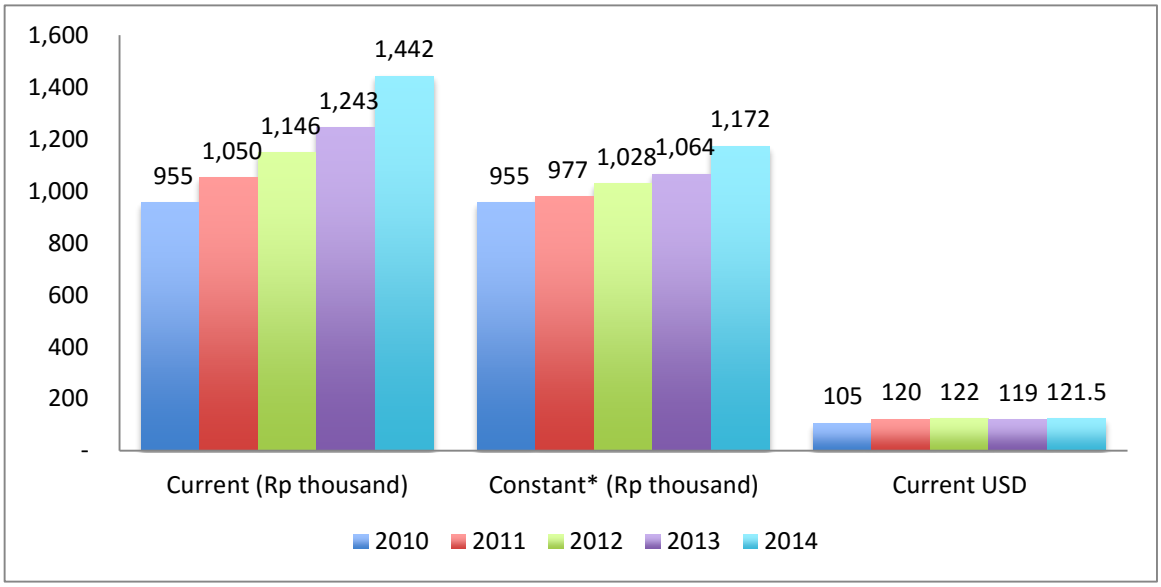

Figure 4. CHE per Capita, 2010-2014

4.4 Financing Schemes

Health care financing schemes are the type of arrangement through which people get access to health care. This scheme includes direct payment by households for goods and

services and third party financing arrangements. Third party financing scheme allows planning and managing membership, coverage, and revenue collection, (SHA 2011).

Figure 5 shows distribution of CHE by financing schemes in 2014. Household out-of-of pocket payment was still the major scheme in Indonesia in 2014 (47.1 percent), followed by government schemes (the addition of subnational and central government schemes). The remaining were contributed by social health insurance schemes, other private schemes (addition of voluntary health insurance, NPISH, and enterprise financing), and rest of the world.

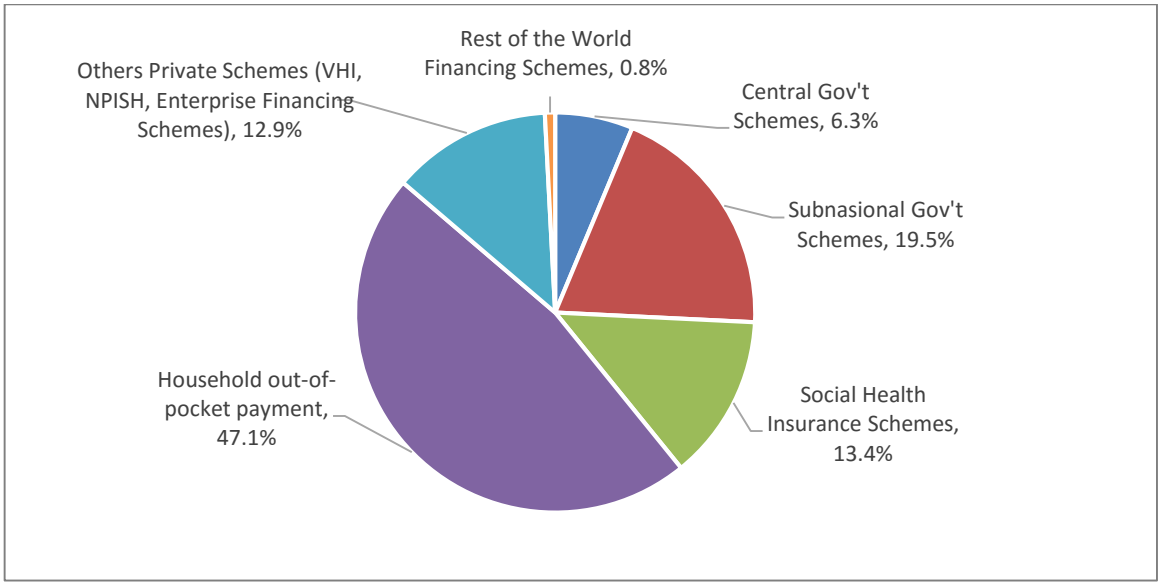

Figure 5. Current Health Expenditure by Financing Schemes, 2014

4.5 Financing Agents

Transaction in particular health scheme is executed by institution or the financing agent, according to the rules of designated financing schemes. The financing agent can be government unit, a social security agency, private insurance corporation and so on that in practice operate the financing schemes. In reality, the scheme may be operated by some different institutional units. For example, a social insurance scheme defines who is obliged to participate in the scheme, benefit package provided, how to use the benefit package and premium collection. The scheme may be operated by a single government agency or by appointed social health insurance carrier or joint collaboration between a government agency and insurance company (SHA 2011).

In general, each financing schemes in Indonesia managed by one financing agent. However, central government scheme is not only managed by central government but also sub-national government. Figure 6 revealed that household is the major agent (47.1 percent), followed by subnational, central government, and social security agency.

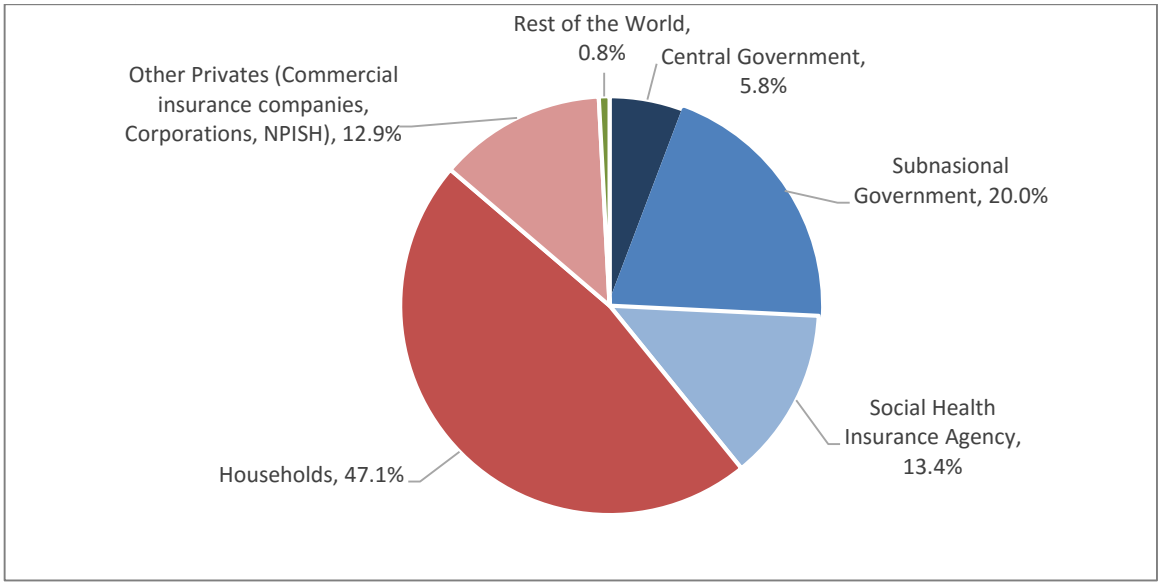

Figure 6. Current Health Expenditure by Financing Agents, 2014

4.6 Functions

Health expenditure by function illustrates for what goods and health services the money has been spent. Analysis by function can also be used for policy input by presenting health expenditure and its uses, compared with priority program(s) that have been targeted. For example, inpatient and outpatient care services, share for preventive care and administrative expenditure executed by government. Health expenditure by function can also be used as the basis to change the input-based to output-based policy development process.

CHE by function using SHA 2011 differs from SHA 1.0 in terms of definition and boundary of each classification. Table 3 reflects differences in CHE by function using SHA 2011 and SHA 1.0, for outpatient curative care, ancillary care, medical goods and preventive care.

Spending on curative care using SHA 2011 revealed higher than figures using SHA 1.0, while ancillary care and medical goods were smaller. This is because function on ancillary care and medical goods for out-patient care using SHA 1.0 is classified differently, while SHA 2011 classifies ancillary care and medical goods into one classification code, which is outpatient curative care.

Preventive care function also shown differences in classification. SHA 2011 shows higher spending proportion on preventive care compared to analysis result using SHA 1.0. According to SHA 2011, all preventive care is classified as preventive care function, whereas in SHA 1.0 individual voluntary care provided by outpatient care provider will be categorized as curative outpatient care function. For example, influenza vaccine is not classified as national immunization program.

Table 3. CHE by Functions Based on SHA 2011 and SHA 1.0, 2014

Functions	SHA 2011	SHA 1.0
In-patient curative care	37.9%	37.9%
Out-patient curative care	34.4%	28.6%
Services of rehabilitative care	0.2%	0.2%
Ancillary services to health care	3.5%	3.9%
Medical goods dispensed to out-patients	13.5%	19.1%
Prevention and public health services	6.6%	6.4%
Health administration and health insurance	3.9%	3.9%
Total	**100.0%**	**100.0%**

Spending by function in CHE and financing agent can also be analyzed using this SHA framework (figure 7). Approximately, 64.6 percent of personal healthcare spending was financed from private agents; reversely 72.5 percent of collective healthcare spending was from public agents. Personal health care covers inpatient, outpatient, rehabilitative and ancillary cares, drugs and medical goods, while collective healthcare covers preventive care and administrative management, system and health financing.

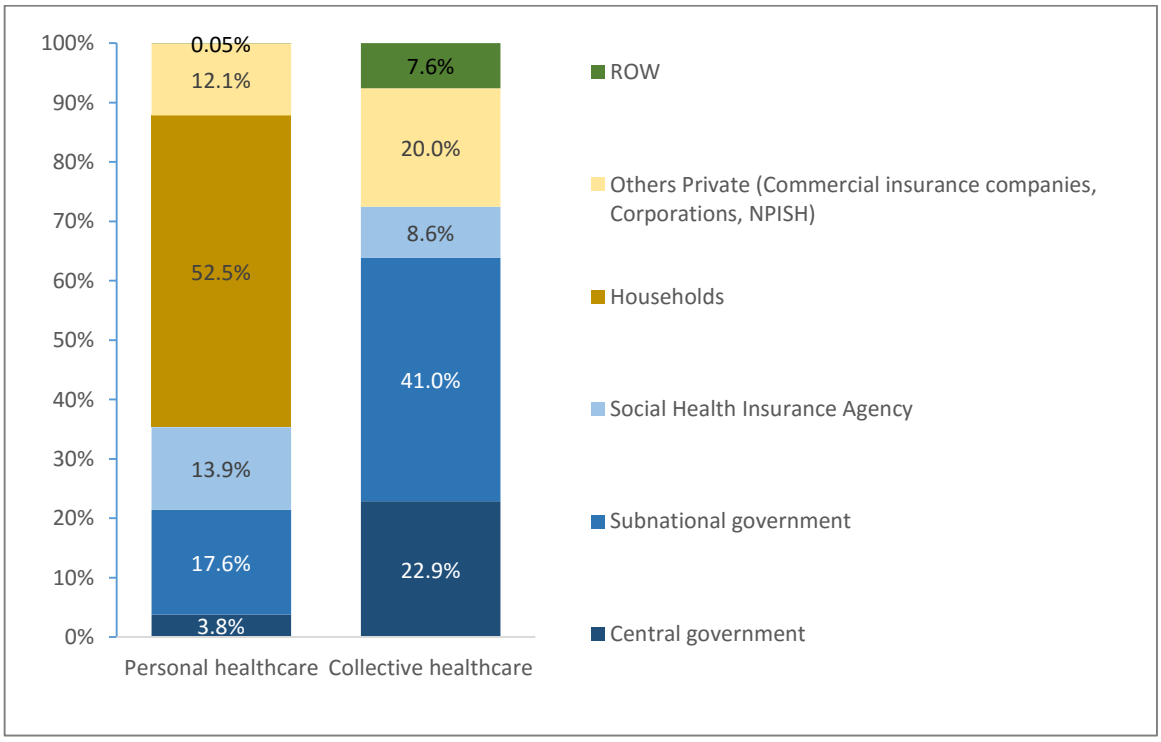

Figure 7. CHE and Function according to Healthcare Financing Agent, 2014

During 2010-2014, CHE by function using SHA 1.0 showed a different pattern as compared to figures using SHA 2011 classification, particularly function for administration, system, and health financing (table 4). Better process on data collection by involving stakeholders

and consultation with related unit within MOH and other ministries has resulted credible data for NHA production.

Table 4. CHE by Function (Rp Trillion), 2010 - 2014

Functions	2010	2011	2012	2013	2014
In-patient curative care	70.7	80.8	89.3	101.4	137.6
Out-patient curative care	55.1	60.6	65.2	70.6	104.0
Services of rehabilitative care	0.3	0.4	0.5	0.4	0.6
Ancillary services to health care	13.1	13.0	14.2	18.1	14.1
Medical goods dispensed to out-patients	56.1	64.6	69.1	70.1	69.6
Prevention and public health services	14.7	13.6	17.0	14.7	23.3
Health administration and health insurance	17.7	21.1	25.9	33.9	14.2
Total	**227.8**	**254.2**	**281.2**	**309.2**	**363.5**

Expenditure for outpatient and inpatient care has increased over the years during 2010-2014 (figure 8). The trend showed higher expenditure on inpatient curative care compared to outpatient care. Increased proportion of curative care to total in 2014 was higher than in previous years. This was influenced by JKN implementation, whereas access has increased substantially and consequently health expenditure was increased.

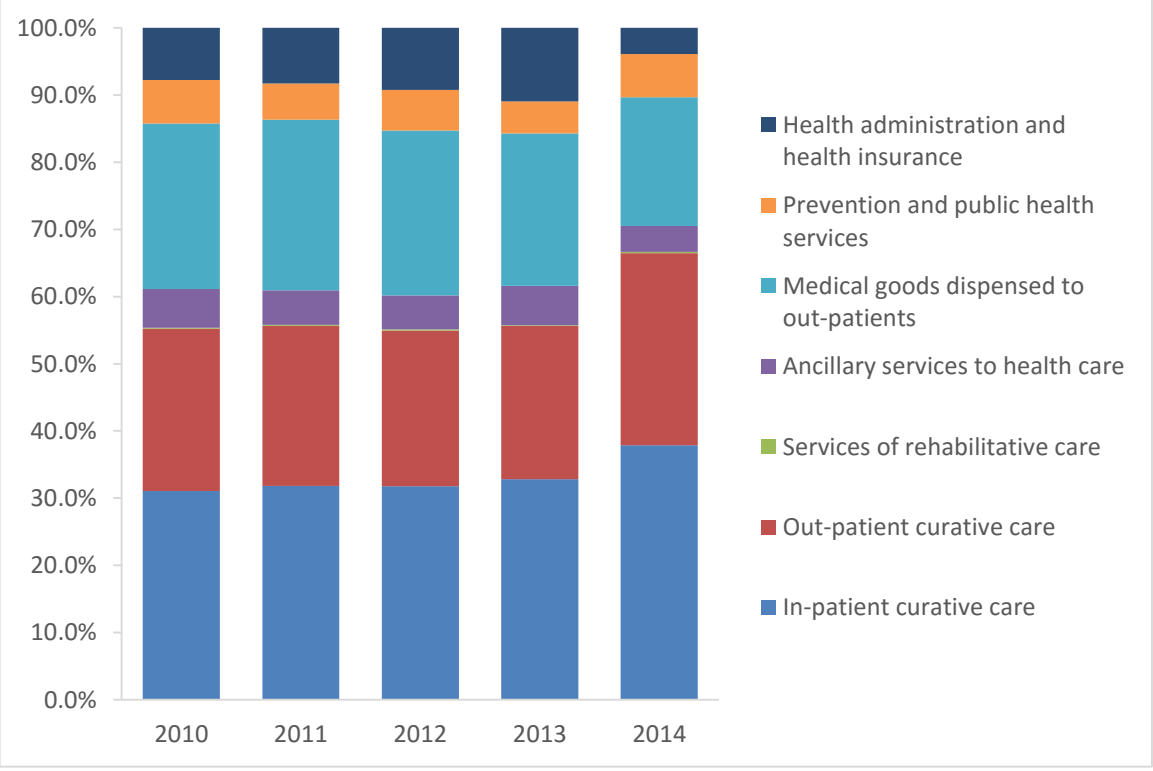

Figure 8. CHE Composition According to Function in SHA 1.0, 2010-2014

During 2010-2014, the biggest proportion of CHE was used for personal health care. In 2014, the proportion of CHE that is used for personal healthcare amounted to 89.7 percent,

and the rest is used for the collective healthcare. Detailed composition can be seen in the following figure.

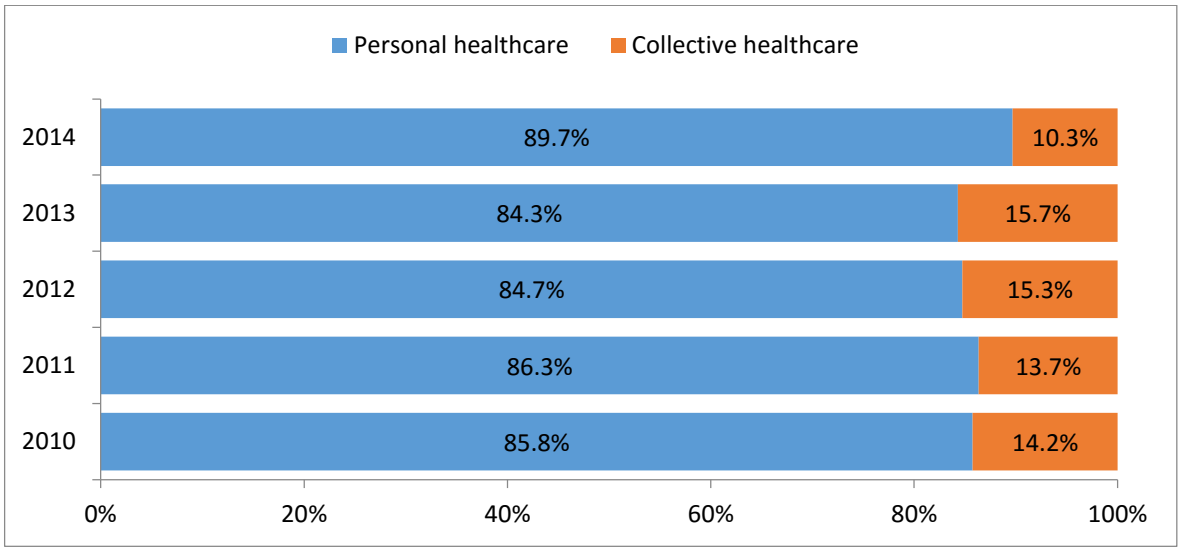

Figure 9. Composition of Personal Healthcare and Collective Healthcare in CHE (SHA 1.0), 2010-2014

4.7 Providers

Figures by provider explains the organization and the player who provide health care goods and services. This report is not able to present trend on CHE by provider, based on either SHA 1.0 or SHA 2011 framework due to differences in assumption used in classification process between year 2014 data and previous years. For example, in the 2014 NHA report, health center (*puskesmas*) is classified as provider for preventive care, whereas in the previous year as a provider for outpatient care. Unlike district health office, in 2014 this office was categorized as providers of health care system administration and financing, while previously it was considered as providers for preventive care, and other cases for different providers. Converting data classification using latest SHA has brought the different perspective in figures, and trend analysis cannot be done.

Composition of CHE by provider in 2014 is illustrated in Figure 10, depicts that hospitals, providers of ambulatory health care, and retailers and other providers of medical goods acted as the top three providers in Indonesia.

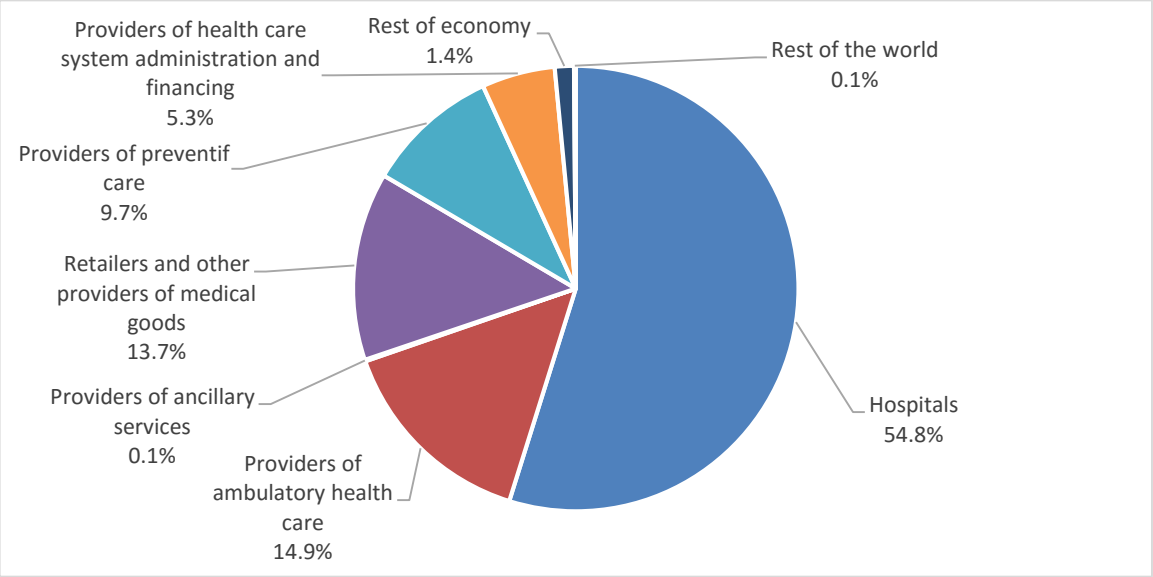

Figure 10. Current Health Expenditure by Providers, 2014

The composition of CHE can be shown by provider and type of health financing agents, as shown by figure 11. Hospitals, providers of ambulatory health care, and retailers and other providers of medical goods were mostly financed by households. While providers of preventive care was majority financed by subnational government (district and provincial government) and ministry of health.

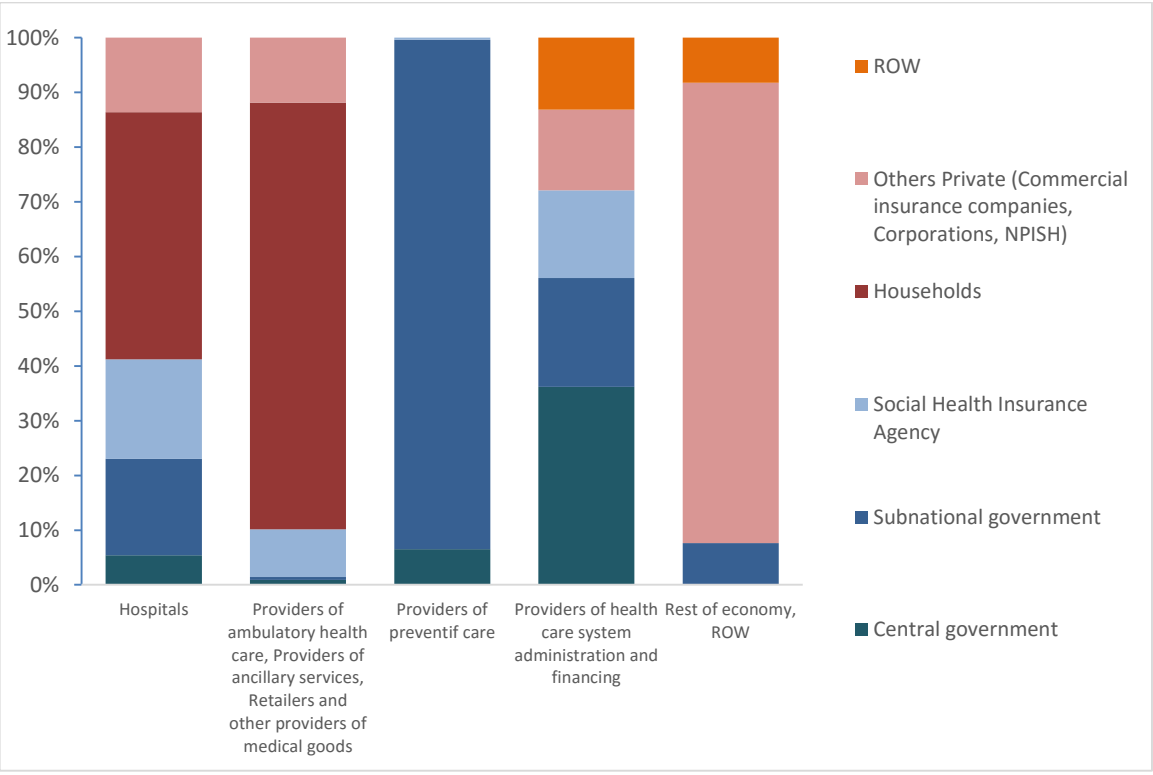

Figure 11. Composition of Provider in CHE According to Financing Agents, 2014

Ministry of Health

a. Data Collection

The Ministry of Health (MOH) has the task to assist the Presidency in performing government affairs for the development of the Indonesian health system, as stated in Health Law No. 36 / 2009 that the government's responsibility in health sector includes planning, actuating, controlling, supervising and monitoring health provision to achieve equitable and affordable health care services. In performing their duties, the MOH organizational structure in 2014 includes the following main units (Echelons): the Secretariat General, Inspectorate General, Directorate General of Nutrition and Maternal and Child Health (*DG Gizi KIA*), Directorate General of Health Services (*DG BUK*), Directorate General of Disease Control and Environmental Health (*DG P2PL*), Directorate General of Pharmaceutical Services and Medical Devices (*DG Binfar*), National Institute of Health Research Development (NIHRD), and the Center for Development of Human Resources for Health (*PPSDM* for Health).

Each echelon has duties and responsibilities in the organizational structure governed by Ministerial Decree of MOH (*Permenkes*) No.1144/Menkes/PER/VIII/2010 on the Organization and Administration of the MOH. Each respective echelon has the authority to manage funds for activities through direct implementation in its echelon or through transfers to the Local Health Office (provinces and districts/municipalities). The funds will be further distributed for functional support in delivering health care in the respected areas including institution of public providers such as District Health Office (DHO) at the provinces and districts, public hospitals (provinces and districts) and other institutions.

In attempts to obtain the overall picture of MOH health spending, the NHA team collected Budget Realization Report (LRA) of MOH generated from the Bureau of Finance, with coordination from the Center of Health Financing and Insurance – MOH. The collection process for realization of MOH data has improved substantially as compared to previous years. Since 2010, MOH LRA data has been shared in a softcopy file that eases and accelerates the process of data storage, data gathering, data cleaning, and minimizes human error.

The quality of data provided has also improved, as it contains more variables with more complete cells of health spending. After several training and meetings on NHA methodology involving stakeholders, most importantly from the MOH, there has been much progress in the sharing of data accompanied with significant improvements in the quality of data.

In this estimation process, allocation data of '*Rencana Kegiatan Anggaran Kementerian/Lembaga*' (RKAKL) was also used since it offered more comprehensive data as compared to LRA. RKAKL provides detailed description on activity plans budgeted to the related Ministries. RKAKL provides additional variables including sub-output, component, sub-component, sub-account, and value of allocation (ceiling budget) in RKAKL. This is very useful to be used as a base to disaggregate data realization of LRA that is often not broken down into detail. With using detailed data supplied by RKAKL, detailed estimation could be provided to fulfill NHA production according to the predetermined standards. The NHA team received document of LRA from the Bureau of Finance – MOH in May 2015 and the document of RKAKL from Bureau of Planning and Budgeting in June 2015.

The MOH LRA document was received through a formal inquiry that was coordinated by the Center of Health Financing and Insurance – MOH. A designated format that was custom made to the standards of NHA table was provided to the Bureau of Finance – MOH. During the process, continuous discussions took place to complete NHA data, consuming almost 3 months to modify LRA data of 2013 and 2014 into standard format. Through further meetings and discussions with the Bureau of Finance – MOH, the NHA team was able to translate the LRA data according to SHA 2011.

The RKAKL documents received from the Bureau of Planning – MOH experienced a similar process. The softcopy of RKAKL data was received in line with the standard format so that the NHA team could further translate it into SHA 2011.

b. Data Management and Analysis

The data management stage focuses on the process of coding and translating LRA data into SHA 1.0 and SHA 11 classifications. There were 3 dimensions of SHA 1.0 that needed to be produced i.e. health care financing (HF), health care providers (HP), and health care functions (HC). In addition, there were five dimensions of SHA 2011 that had to be produced i.e., health care financing schemes (HF), revenues health care financing schemes (FS), financing agents (FA), health care provider (HP), and health care functions (HC).

The LRA Data, which comprises of 42.410 rows, were translated into SHA 1.0 using combined variables in the LRA and RKAKL documents. Below were the guidelines used in the SHA classification process:

Table 5. Identification of Given Variables of LRA and RKAKL and Translated into SHA 1.0 and SHA 2011

Given Variables	Dimension of SHA 1.0	Dimension of SHA 2011
Type of authority, echelon, working unit, function, activities	*Health care financing*	*Financing agents*
Source of funds		*Revenue of financing schemes*
Program, Activities, Source of funds, type of authority, type of spending		*Health care financing schemes*
Echelon, working unit, function, program	*Health care providers*	*Health care providers*
Echelon, working unit, function, program, activities, output, sub-output, category of goods bought, budget account, component	*Health care functions*	*Health care functions*
Category of goods bought, budget account, component, detail		*Gross fixed capital formation*

In addition to LRA and RKAKL data, other data were used to support the detailed breakdown needed to fulfill the NHA dimensions. One of the biggest challenges was to produce expenditures by function. An example of this challenge is the realization data of Echelon DG BUK, whose funds were intended for vertical hospitals that have become a public service agency (*Badan Layanan Umum* – BLU). This data does not include information on the functions of outpatient or in-patient curative care, drugs, supporting services, etc., when such information is much needed in the translation process to meet the standard classification in accordance with SHA dimensions of function.

With these limitations, involvement from units of MOH proved to be valuable and vital in determining and grouping the data into the most suitable classifications. A series of consultations with the echelon units in MOH were held to present the initial results of data translation and seek consent for the appropriate classifications.

The process of verifying the accuracy of previous years' data (for example 2014 data verification was done in 2016) encountered various obstacles. One of the most commonly experienced issue was the change in personnel in charge of the program and information (PI) typically due to rotations, while the officials in charge of the finance of the echelons concerned did not understand in detail the activities of the units that reported to them. The verification was then taken through a process of expert opinions panels to validate the figures.

c. Results

From the LRA report documents, the total realization of health spending by the MOH calculated for 2014 was Rp47.6 trillion. The majority (88.8 percent) of actual health spending could be categorized as Current Health Expenditure (CHE) in accordance with SHA 2011, amounting to Rp42.2 trillion. Meanwhile, the remaining Rp3.2 trillion (6.7 percent) was categorized as capital spending; then Rp0.9trillion (1.8 percent) was categorized as memorandum and Rp1.3 trillion (2.7 percent) was not classified as health expenditure.

Analysis on the dimension of Financing Agents (FA) exhibited four different agents of financing for MOH CHE realization: MOH itself (40.3 percent), Social Security Agencies (55.1 percent), Provincial Government (1.8 percent) and Districts/ Municipalities Government (2.7 percent). The 40.3 percent of CHE sourced from the Ministry of Health is equivalent to Rp17.0 trillion (Figure 12), an increase of Rp1.5 trillion (9.7 percent) over the previous year.

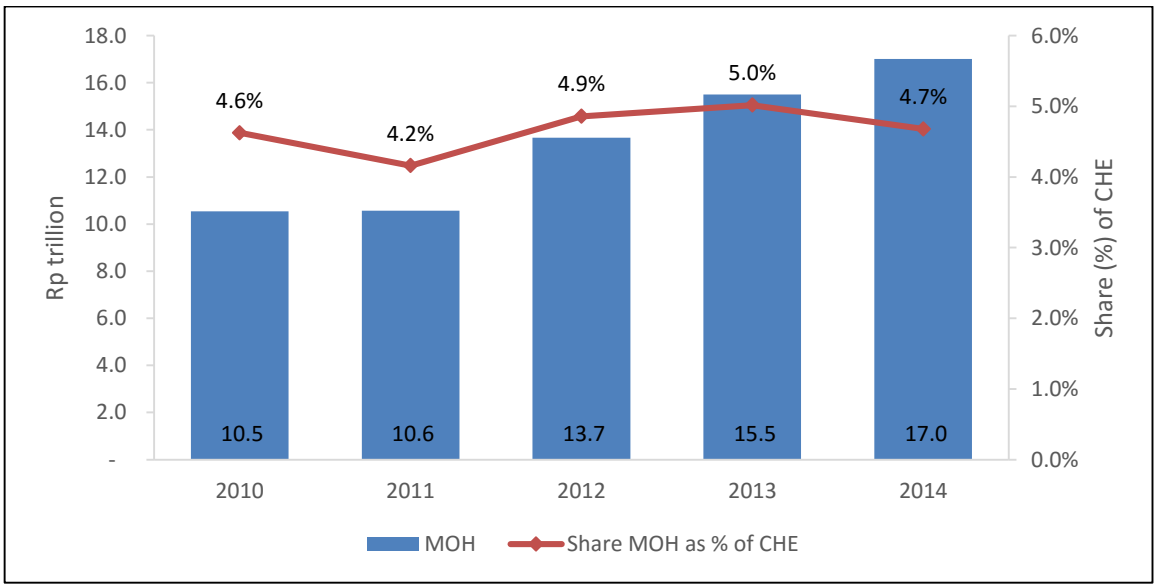

Figure 12. General Trends in Ministry of Health Expenditure, 2010 - 2014

Figure 13 below shows the breakdown of MOH health expenditures in the dimension of Health Function, demonstrating that the majority of MOH spending were disbursed to serve individual health care (65.0 percent). Personal health care includes in-patient curative care, outpatient curative care, rehabilitative services, ancillary services, and medical supplies. One of the reasons of the high share of health spending disbursed to individual health care is due to MOH's efforts in managing vertical hospitals across the country. It should be noted that this figure does not include funding to subsidize contribution for the poor, since that funding is transferred directly from the MOH to BPJS Kesehatan.

The figure also shows that 19.2 percent of MOH's current health expenditures were spent on preventive care. A note of caution that although this figure may be interpreted as low, this does not include the Social Health Operational Assistance or '*Bantuan Operasional Kesehatan*'(BOK) which was mainly disbursed to support additional promotion and prevention care across Indonesia. The total budget spent for BOK in 2014 was Rp1.2 trillion

and was recorded as funding channeled to sub-national (provinces and districts) in the form of de-concentration funds and *Tugas Pembantuan* (TP). The remainder shares include the 15.8 percent disbursed for management, health system and financing.

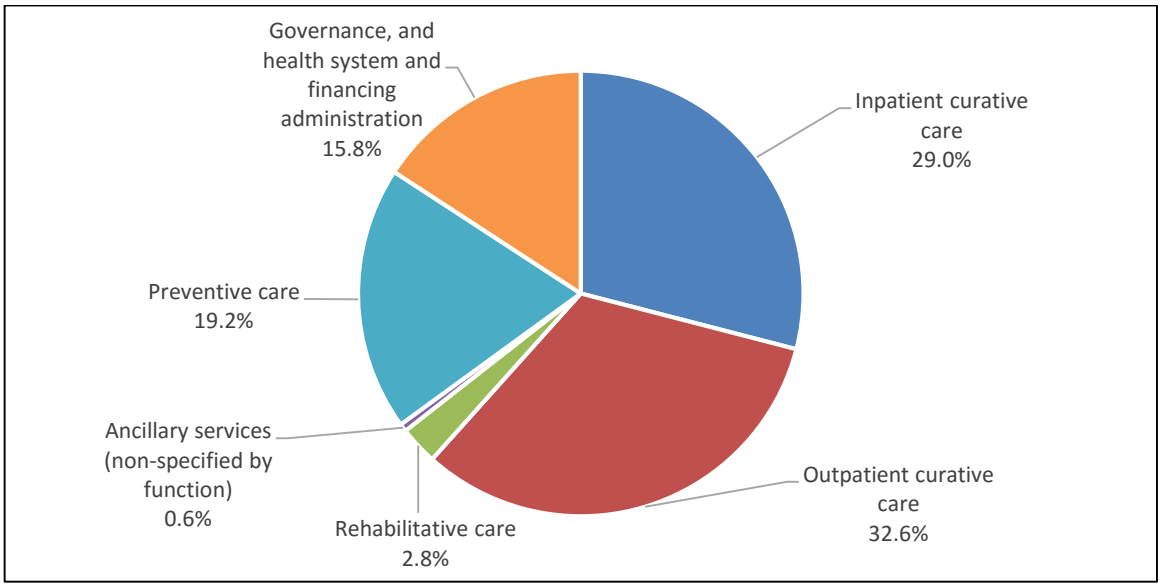

Figure 13. Ministry of Health Expenditure by Functions, 2014

Looking at the dimension of Providers in Figure 14, it is evident that the majority of MOH health expenditures was disbursed through hospitals (57.8 percent), with the following detailed composition: General Hospitals (43.3 percent), Specialty Hospitals (11.9 percent) and Psychiatry Hospitals (2.5 percent). The second largest share of MOH health is disbursed through providers of health care system administration and financing (26.1 percent), that consists of Secretariat and Directorates under the MOH organizational structure. Other providers are disbursed for support of preventive care (representing 13.4 percent), while the remainder funds were spent in clinics, laboratories, and other clinical supports (2.8 percent).

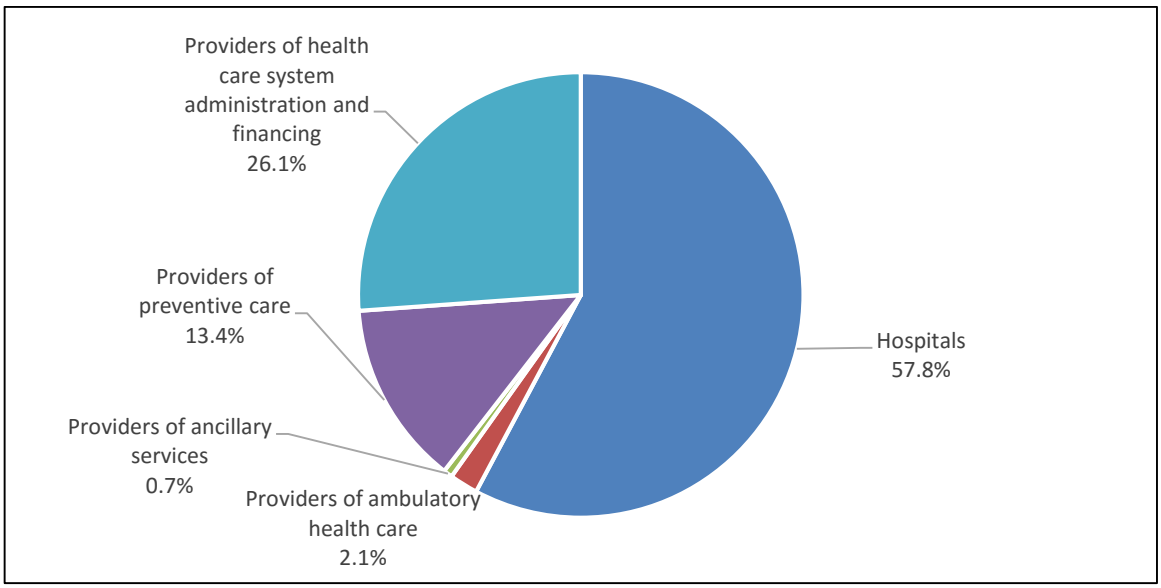

Figure 14. Ministry of Health Expenditure by Providers, 2014

Other Ministries

a. Data Collection Process

Health expenditure of other ministries is part of the central government health spending, covering health expenditures from various ministries and government institutions. Similarly to the previous estimation in 2013, the data source used to estimate the health expenditure of other ministries in 2014 was obtained through the Directorate General of Treasury (DJPBN), the Ministry of Finance. Data gathered was from Budget Realization Report (LRA) of various ministries/institutions involving 13 variables such as names (ministeries), echelon units, authority, working unit, function, sub-function, program, activity, budget account, and output, source of funds, amount of budget, and amount of realization. The number of rows of other ministries' LRA data collected in 2014 were 512,599 rows.

b. Data Management and Analysis

Based on LRA data collected from the variable function with the code 07 (health), it was found that other ministries/institutions having health expenditures are only National Population and Family Planning Board (*BKKBN*) and National Agency of Drug and Food Control (*BPOM*). Other than those two ministries/institutions, the NHA team also undertook identification of health expenditure from other ministries/institutions through following steps:

1. Identify variables of echelon units, which may relate to health, for instance Directorate General of Human Settlement within the Ministry of Public Works.
2. Identify variables of working units, which may relate to health, for instance hospitals, *Bidokke*s, *Pusdokke*s, *Puske*s, *Balai Kesehatan*, etc.
3. Identify variables of budget accounts (MAK) which may relate to health, for instance budget accounts of medical benefits, endurance enhancers
4. Identify keywords which may relate to health, such as health, medicine, medical equipment and supplies, medical care, HIV/AIDS, disease/illness, therapy/therapeutic, etc.

Every single rows containing one of above qualifications were gathered into other ministries' database. This database consisted of 12.273 rows of 56 ministries/ institutions.

The next step was to translate/transfom the data in accordance to SHA classifications based on the available variables' information and additionally with information searched from the internet. Following were the references of translation process:

Table 6. References of Data Translation Process into SHA 1.0 and SHA 2011' Classifications

Variables	Dimensions of SHA 1.0 Classifications	Dimension of SHA 2011 Classifications
Authority, echelon, working unit, function, activity	Health care financing	Financing agent
Program, activity, source of fund, authority, budget account		Health care financing schemes
Echelon, working unit, function, program, activity, output	Health care providers	Health care providers
Echelon, working unit, function, program, activity, output, budget account	Health care functions	Health care functions

Better translation process will be more possible if there were RK/AKL of related ministries/institutions, but unfortunately, these data cannot be gathered yet since no buy in meeting with the ministries beforehand. In overcoming the issues and in order to maintain the quality of translation process, the NHA team conducted meeting with some ministries/ institutions to validate and crosscheck data provided in terms of classifying spending according SHA 2011 During the meeting, the NHA team received inputs for further development.

c. Results

Aside from the Ministry of Health, organizers of health programs and health-related programs at the central level is also supported by other ministries and institutions, despite its specific duties and responsibilities (*Tupoksi*) are not directly related to health. Based on other ministries data translation process in accordance to SHA 2011, it was discovered that health spending by other ministries/ institutions (except Ministry of Health) was around Rp4.0 trillion or 1.1 percent of CHE. During 2010-2013, CHE of other ministries/ institutions in nominal terms showed an increase trend, although there was a decrease of Rp0.1 trillion in 2014. Conversely, the proportion of health spending from other ministries/ institutions to CHE showed a decrease trend during 2010-2012, although experienced an increase in 2013, but then continue to decrease in 2014. The overall trend of health spending proportion from other ministries/ institutions to CHE during 2010-2014 tends to decline (Figure 15).

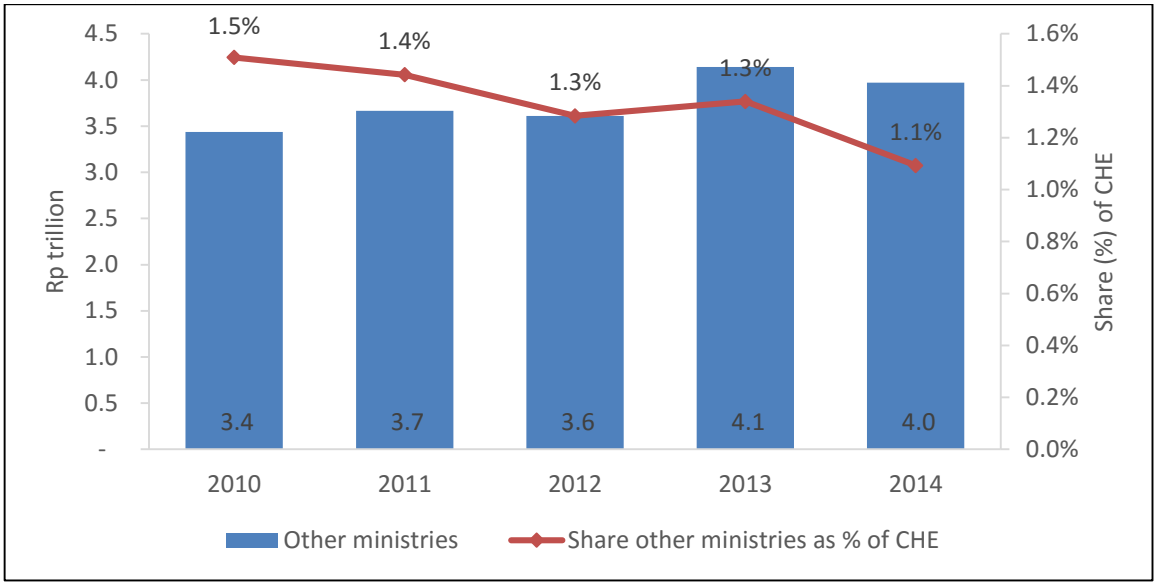

Figure 15. General Trends in Other Ministries Health Expenditure, 2010 - 2014

The observation by function showed that health spending of other ministries/ institutions consisted of various functions including personal curative care and public health services. The biggest proportion of spending was for preventive care accounted 53.2 percent, while the lowest proportion was for rehabilitative care at 0.6 percent. Besides, represented 12.8 percent was recorded for governance, and health system and health financing administration function, such as framing of regulations or policies related to health (Figure 16).

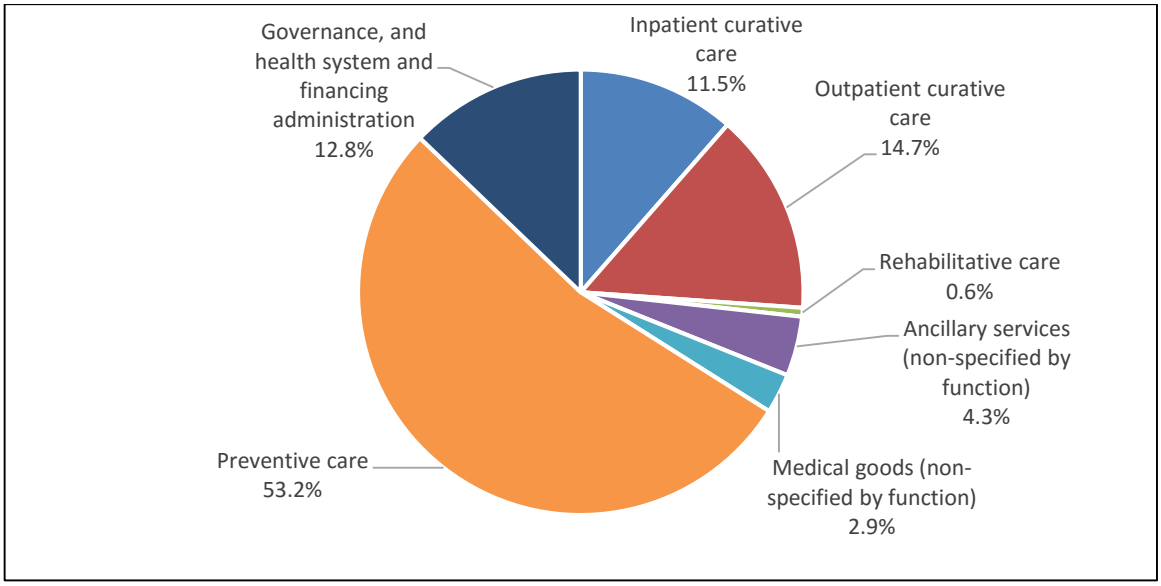

Figure 16. Other Ministries Health Expenditure by Functions, 2014

The analysis by provider showed that health spending of other ministries/ institutions was mostly provided by its own ministries/ institutions accounted 64.3 percent, which in accordance to SHA 2011 was categorized as providers of health care system administration and financing. Furthermore, the share of hospitals was represented at 22.9 percent.

Besides hospital, health spending was also carried out through providers of ambulatory health care at 12.3 percent and the lowest share amounted 0.5 percent was spent through providers of preventive care (Figure 17).

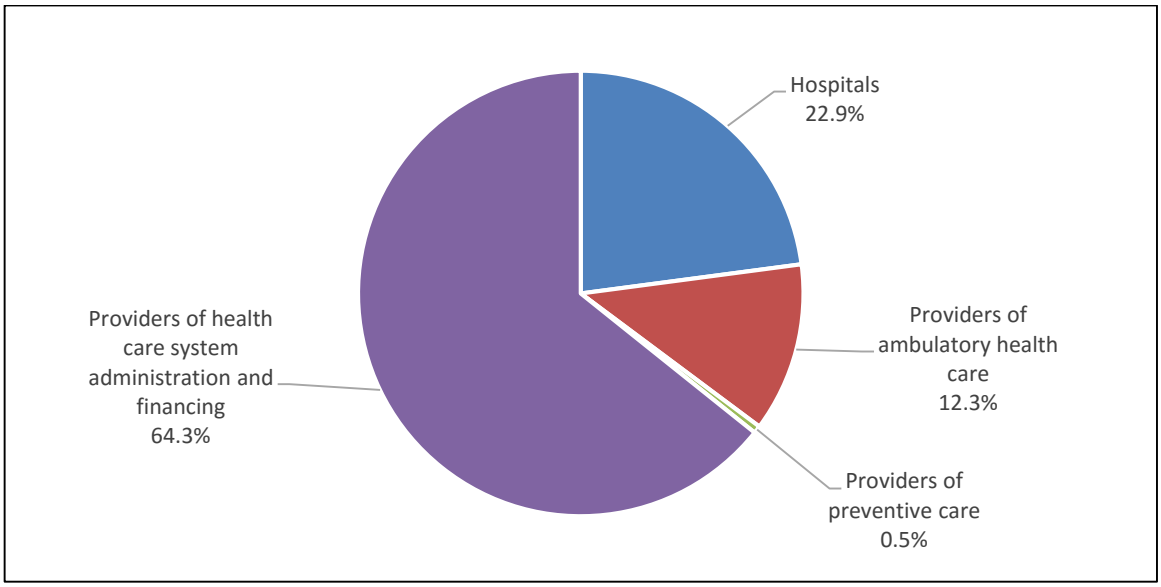

Figure 17. Other Ministries Health Expenditure by Providers, 2014

Sub-National

a. Data Collection Process

The main data utilized in estimating sub-national health expenditure for 2014 is obtained from two sources. The first source is budget allocation derived from Local Government Finance (LGF) that provides budget allocation by function (LGF allocation by function) and the second source is the realization of local finance both from provincial and district/ municipality levels (LGF realization by function). These two sources were published at the website of Directorate General of Fiscal Balance, Ministry of Finance (MOF) (http://www.djpk.depkeu.go.id). The NHA team together with Center of Health Financing and Insurance, MOH made an official inquiry to get direct access to the budget allocation and budget realization through the Directorate for Evaluation and Reporting of Local Finance and the Directorate General of Fiscal Balance, Ministry of Finance. With the official letter from the secretariat general of MOH, aggregate data of budget allocation and realization by function of APBD (by provinces and by districts/ municipalities) were received in an electronic document.

In addition to the provincial and districts/municipalities APBD realization data, De-concentration Funds and *Tugas Pembantuan* Funds on MOH realization data also accounted as aggregate of Sub-National health expenditure. District Health Account (DHA) data from several districts/municipalities were also used as a base for disaggregation.

b. Data Management and Analysis

Methods in Estimating Aggregate Data

Sub-national health spending has a relatively substantial share of the total health expenditures by the public sector. Thus, the estimation process has to be approached with prudence and consideration since the result will highly affect the total health spending of the public sector, as well as the overall total health expenditures.

In strengthening the methodology and improving accuracy, the NHA team together with the staff of Center of Health Financing and Insurance, MOH has conducted intense discussions with MOF related to the availability and validity of local finance data. The discussions provided the team with further information and clarification on local finance reports and its' production, as well as suggestions on the NHA's institutionalization plans. The following are the main suggestions from the discussion:

1. The local government submit reports to DJPK-MOF following guidelines from the Finance Minister Regulation No.04/PMK.07/2011 on Procedures to Submit Regional Financial Information. The regulation requires reports to follow the standard format and sets the deadline for submission. Accountability report of APBD in the second semester

has to be submitted by Local Governments to DJPK-MOF no later than August 31st of the current year. A delay in submission results in an imposed sanction of postponement of disbursement of funds (only delayed disbursement, not a reduction) of the General Allocation Fund (GAF) up to 25 percent. Despite the sanction applied, there are still plenty of districts that have not submitted its reports on time. Overall, only 70 percent of total districts have submitted reports in late August.

2. In PMK No.04 / PMK.07 / 2011, it is stated that the standard format of reports submitted to DJPK-MOF have to be in two forms, softcopy and hardcopy. Sub-national governments are requested to upload the softcopy file using an application called '*Komandan*', which allows detailed variables in the format of the report. One of the drawbacks of this application is the file can only be read, without the ability to download or convert to another format. It was also informed that the IT team of Ministry of Finance is developing an application to overcome this issue through Regional Financial Information System (*Sistem Informasi Keuangan Daerah*). Application '*Komandan*' is no longer used and was deleted in January 2016.

3. Differences of APBD values listed in the softcopy and hardcopy report were often found. To validate the data, DJPK verifies the softcopy and hardcopy of data. It is important to note that many local governments receive assistance from consultants in preparing for the APBD report. Based on discussions with DJPK, differences may be due to the limited capacity of local government in preparing the reports or many other possible problems. Thus, in the data verification stage, it was often found that the local government could not provide proper response to the questions raised by the Ministry of Finance.

4. DJPK-MOF can provide data in the form of allocation and realization of spending by health function in the respected provinces and districts. This means that health spending is not merely disbursed through health offices, but can also spent through non-health offices. It should be restated that only a limited number provinces and districts submitted their financial reports on time, therefore the challenge is how to get the overall estimation of sub-national spending despite the limitations and how to differentiate spending managed by the Local Health Office and by non-Local Health Office. From DJPK-MOF's point of view, it is suggested that technical ministries, in this case MOH, should mandate completion of standard forms on total health spending by local offices. Similar sanctions can be applied if provinces/districts fail to comply with the procedures. Sanctions can be varied, including reduction on transfer to local government, similar to what has been applied to Special Allocation Funds of DAK. With these reforms set in place, the MOH should be able to get the information needed.

5. In the context of institutionalization, the directorate under DJPK-MOH is willing to be officially part of the NHA Team to support the future production of NHA.

Considering the limited condition on data availability, estimation of aggregate numbers of sub-national data is gathered through several stages:

1. The summation of the LGF Budget Allocation by function published by the MOF representing the total allocation for health by provinces and districts/municipalities (COFOG 07).
2. Realization data for health function by provinces and districts/municipalities, as defined in government regulations, is to multiply realization percentages reported in the Realization Report of APBD with the total funds allocated for health.
3. Further identification of health spending in accordance to SHA dimension is adjusted using CBS data, this allows estimation of the share of health spending in respected provinces and districts/municipalities. This proportion is then further multiplied with the realization data by health function in respected provinces and districts/municipalities. With these steps, the total health spending sourced by APBD in respected provinces and districts/municipalities can be calculated.
4. Disaggregation process are then performed using DHA data.

Methods to Estimate Disaggregated Data (Detailed)

In the production of 2014 Sub-National figures, data from District Health Account (DHA) is used as the base data in disaggregating the total value of sub-national data. DHA data represents results of tracking health expenditures at the district/municipality levels and contains detailed descriptions on programs/activities, sub-activities/detail activities, line item expenditures, sources of financing, financing agents, service providers, program, type of activities, budget lines, activity levels and beneficiaries. It should be noted that DHA data is also supported by other data sources in order to disaggregate Sub-National data. Additionally, the DHA data is not used in its entirety, the data taken from DHA is the health expenditures at districts /municipalities solely sourced by APBD at provinces and districts.

Production of DHA in year 2014 has been limited due to the fact that not all districts/municipalities produce DHA data routinely. In 2014, there were 14 districts and 2 municipalities that produced DHA and reported to the MOH. Of the 16 districts/municipalities, the NHA team further selected districts by comparing the aggregate value of district health spending based on DHA report with the one published by DJPK-MOF. Only seven districts/municipalities were selected since the differences of in total spending is less than 15 percent. The seven districts that were selected and fulfilled the criteria include the Cilegon Municipality, Blitar District, Banyuwangi District, Jember District, Sumenep District, Bondowoso District, and Ngada District. Seven districts/municipalities who produce DHA were used as a reference to disaggregate total health spending by functions and providers in respected districts.

After districts were selected as a sample, the following step is to utilize this sample as a base for disaggregating Sub-National figures by classifying the DHA data of these 7 district/ municipalities (around 11,529 lines) into the SHA1.0 and SHA 2011 methodology. The main classification for SHA 1.0 includes classification in three dimensions: health care financing

(IF), health care providers (IP), and health care functions (IC). Whereas SHA 2011 classifies its data into health care financing schemes (HF), revenues of health care financing schemes (FS), financing agents (FA), health care functions (HC), health care providers (HP), factors of health care provision (FP), and gross fixed capital formation in health systems by type of asset (HK). Given the limited time for the 2014 DHA data classification process, the classifications that can be presented here is in the dimensions of FA, HC, and HP. In the disaggregation process, some components that were loaded into the district/municipality DHA spreadsheet were readjusted with the 2011 SHA classifications. For example, the production team separated a row of salary in the DHA data that served for management and curative functions.

Table 7. Identification of Variable List of DHA into Classification Dimension of SHA 1.0 and SHA 2011

Variable Information of DHA	Classification Dimensions of SHA 1.0	Classification Dimensions of SHA 2011
Source of Funds, Financing Agents, Health Providers	*Health care financing (IF)*	*Financing agents (FA)*
Financing Agents, Health Providers, program, Type of activities, level of activities	*Health care providers (IP)*	*Health care providers (HP)*
Program/activities, sub-activities / detail of activities, line item of spending, health care providers, program, account, type of activities	*Health care functions (IC)*	*Health care functions (HC)*

c. Results

The total health spending of Sub-National for 2014 amounted to Rp72.7 trillion or 20 percent of CHE. Of the total sub-national health spending were sourced not only from APBD Health function data but also from De-concentration funds and *Tugas Pembantuan* funds that were allocated through the MOH. Around Rp26.6 trillion or 31.5 percent was calculated as provincial level health spending, while the remaining Rp57.9 trillion (68.5 percent) was health spending at the districts and municipalities level. Based on figure 18, current health spending of Sub-National for 2014 in nominal terms showed an increase trend over the years from 2010 – 2014.

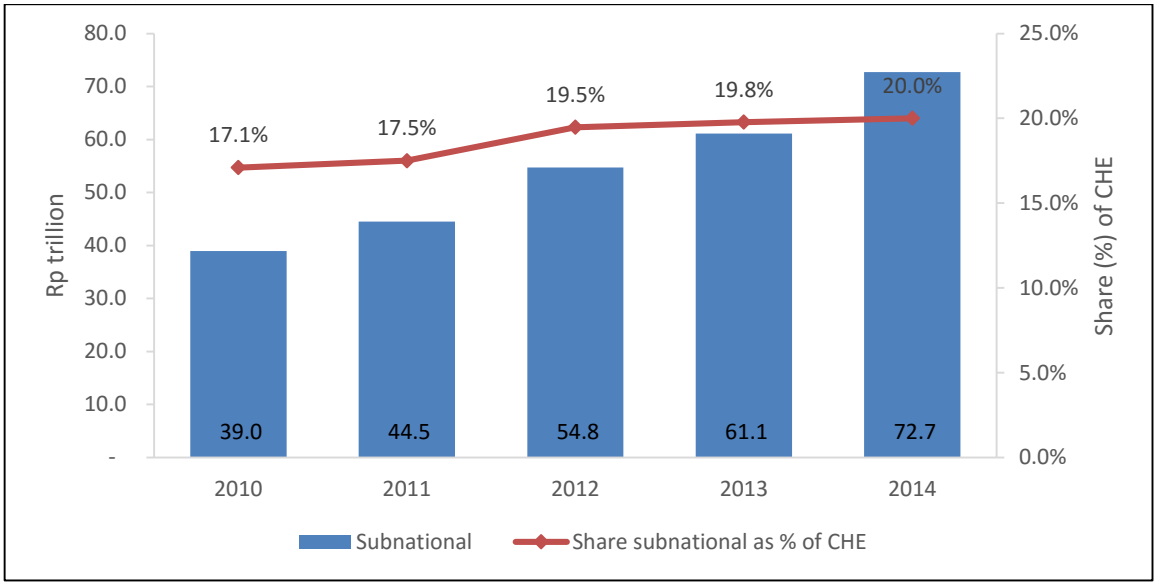

Figure 18. General Trends in Subnational Health Expenditure, 2010 - 2014

The analysis of 2014 sub-national health spending by function shows that health funds were mainly disbursed for curative services for in-patient care, representing 39.7 percent of the total. Outpatient curative care also had a similar share of 38.2 percent, while spending for preventive care represented around 19.5 percent. The lowest health spending of sub-national is for rehabilitative care with only around 0.01 percent share of total sub-national spending (Figure 19).

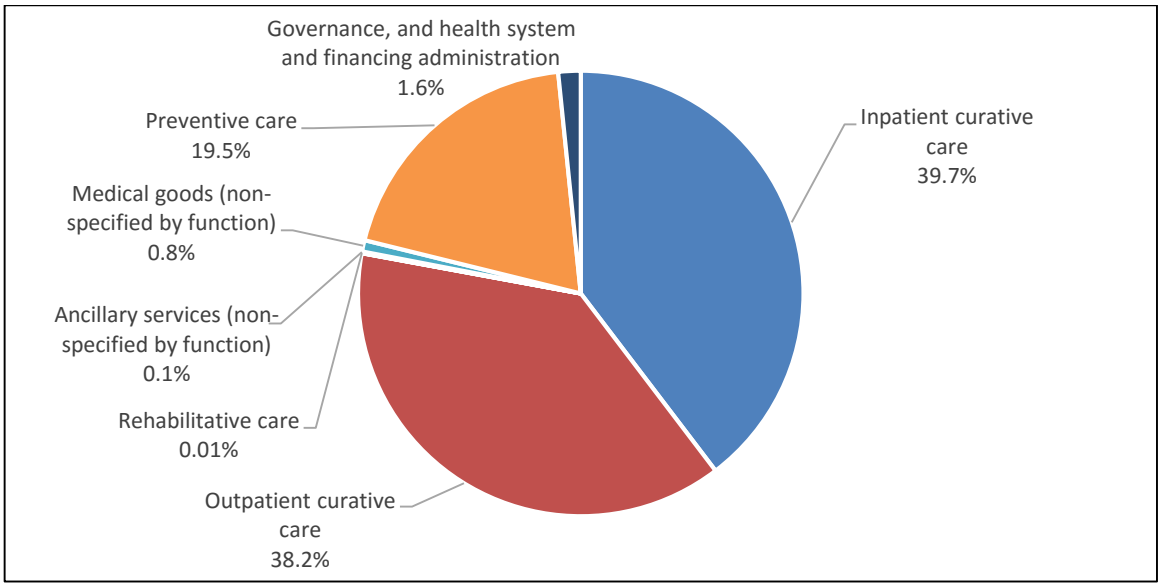

Figure 19. Subnational Health Expenditure by Functions, 2014

Studying the classification by health providers, it can be seen that the major realization of total sub-national health spending in 2014 is for hospitals, at 48.3 percent. Whereas the share of sub-national health funds spent at providers of preventive care was around 45.1 percent of total sub-national health spending. The lowest health spending, unfortunately, is for health supports including diagnostic tools and laboratories, representing only 0.3 percent of total sub-national realization data (Figure 20).

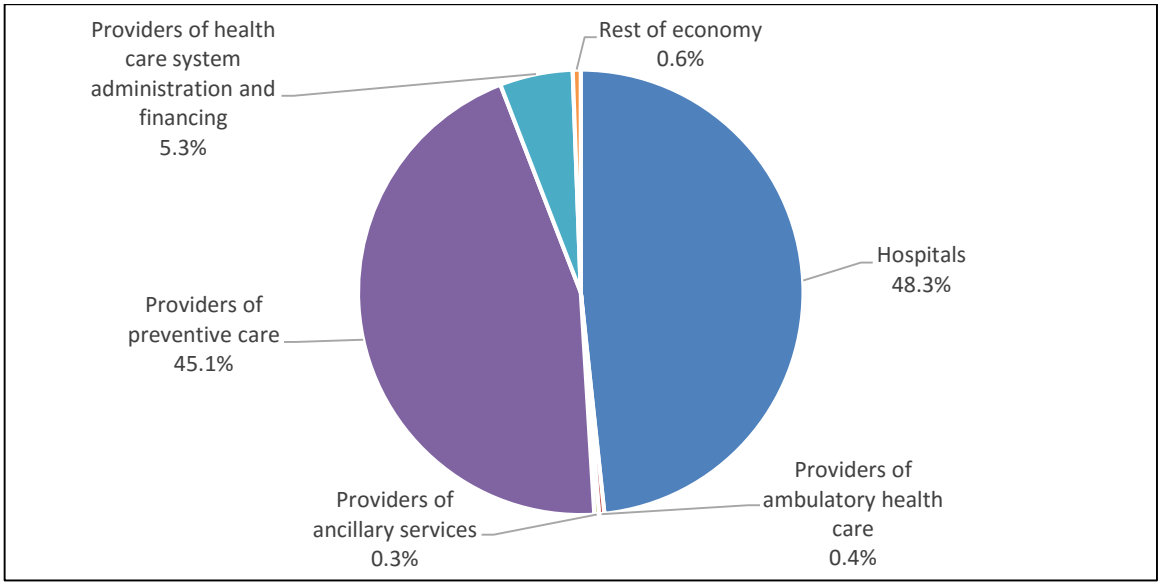

Figure 20. Subnational Health Expenditure by Providers, 2014

Social Security Funds

Social Security Funds are defined as schemes of National Health Insurance (NHI) or Social Health Insurance (SHI) that cover the entire or part of the population of a country and is managed by government units (SNA 93, 4.130). There were many social schemes implemented in Indonesia prior to 2014, but as of January 1, 2014, the Government committed to implement the law of National Social Security System as stated under the Law No. 40, 2004 and Law No.24, 2011 on the Social Security Agency recognizing the responsibility of the government in the development of a social security policy. For Social Security of Health, Indonesia has chosen to expand health coverage through SHI to reach Universal Health Coverage (UHC) with funding mainly sourced from contributions. The Government institutionalized BPJS Kesehatan as the single-payer administrator for managing revenue collection and purchasing for appointed members.

As stated in the roadmap of SJSN, the Government is committed to reach UHC in stages. Beginning on January 1, 2014, there has been a massive integration from all existing contributory and non-contributory social health insurance schemes to be merged and streamlined into the new unified national health scheme. Integration was performed in many dimensions including integration of membership, contribution collection, benefit package adjustment, information technology, purchasing scheme and provider payment mechanism. There were at least five social schemes that were integrated at once in January 1, 2014, including social insurance for civil servants and pensions (*Askes* PNS), social insurance for formal workers from private enterprises (*Jamsostek*), social assistance for the poor (Jamkesmas), scheme for army and police (*Asabri*), and selected local government schemes (*Jamkesda*).

a. Data Collection Process

Data collection of social security funds in 2014 is derived from a single scheme of National Health Insurance (NHI) that is managed by BPJS Kesehatan. Data source of real spending on health through NHI is taken from the audited 2014 BPJS financial report "*Laporan Pengelolaan Program dan Laporan Keuangan BPJS Kesehatan*". This year, the data collection has been simplified compared to previous years where data were collected from 3 (three) different schemes: Civil Servant Scheme for families and pensions (*Askes PNS*), Formal workers Scheme (*Jamsostek*) and social assistance for the poor and near-poor (*Jamkesmas* and *Jampersal*).

b. Data Management and Analysis

Methodology to Estimate Aggregate Figures

In the health accounts, total health spending managed through social security on health not only covers the amount of resources paid to health facilities on services provided for its members for various aspects of healthcare, but also covers the operational cost and non-operational cost incurred by BPJS Kesehatan as the administrator.

The following is the basic estimation on aggregate spending of social security on health in the year of 2014:

1. Identification of various line items of health expenditures listed in the audited Management Report of BPJS Kesehatan, including amount spent for services for promotive and preventive care, capitated spending, non-capitated spending, Case-Based Group (CBG) spending (outpatient and inpatient care), and non-CBG spending.
2. In addition to health spending paid to various health providers, spending to support the management for operational and non-operational expenditure incurred by BPJS Kesehatan are also counted. It includes spending for personnel, supplies for administrative matters, capital expenditures such as investment on land and buildings, office equipment, information technology, and other expenses that are recorded in the accounting term.
3. Referring to the System Health Account (SHA) version 11, health spending is based on the accrual principle. As such, total spending managed by BPJS Kesehatan also includes all estimated health spending recorded as Incurred but not Reported (IBNR).
4. Total aggregate of current health spending from BPJS Kesehatan is thus the sum of total health spending paid to health providers, operational and non-operational spending for the management of BPJS Kesehatan, and IBNR.

Methods Utilized to Disaggregate NHI Data

As suggested, estimation to disaggregate health spending on social security managed by BPJS Kesehatan are classified using guidelines of SHA 1.0 and SHA 11. In the version of SHA 1.0, classification reflects of 3 (three) main classifications i.e., Health care financing (IF), health care providers (IP), and health care functions (IC) for SHA 1.0. Meanwhile, main classifications of SHA 11 posed more challenges, since it requires classification on more detailed dimensions of spending that includes Health Care Financing (HF), Revenues Health Care Financing Schemes (FS), Financing Agents (FA), Health Care Function (HC), Health Care Provider (HP), Factors of Health Care Provision (FP) and Gross Fixed Capital formation in health systems by type of asset (HK). Due to data limitations, classification using SHA 2011 for social health security in Indonesia in year of 2014 produced the following three classifications: FA, HP, and HC. With the support of more detailed data from other sources,

further detailed classification as guided in the SHA 11 should be further explored in the efforts in the following years.

c. Results

As guided in the classification of Health Account using SHA 2011, BPJS Kesehatan is the Social Security Agency that is appointed by law to manage social security funds for health. As the administrator of the single-payer insurance, the flowchart of funds managed by this institution reflects funds derived from various sources according to types of memberships. BPJS Kesehatan collects contribution from government workers and pensions, collective financing by employers and employees, formal workers, central budget (for the poor and near poor population), sub-national budget to cover supplementary contribution for the poor, and informal workers or others who directly contribute to become a member of BPJS Kesehatan. Total health spending managed by BPJS Kesehatan should provide an overview of coverage of health services for its members at various levels of health providers. Following is an illustration of flow of funds managed by BPJS Kesehatan as the appointed single-payer social security agent for health (Figure 21).

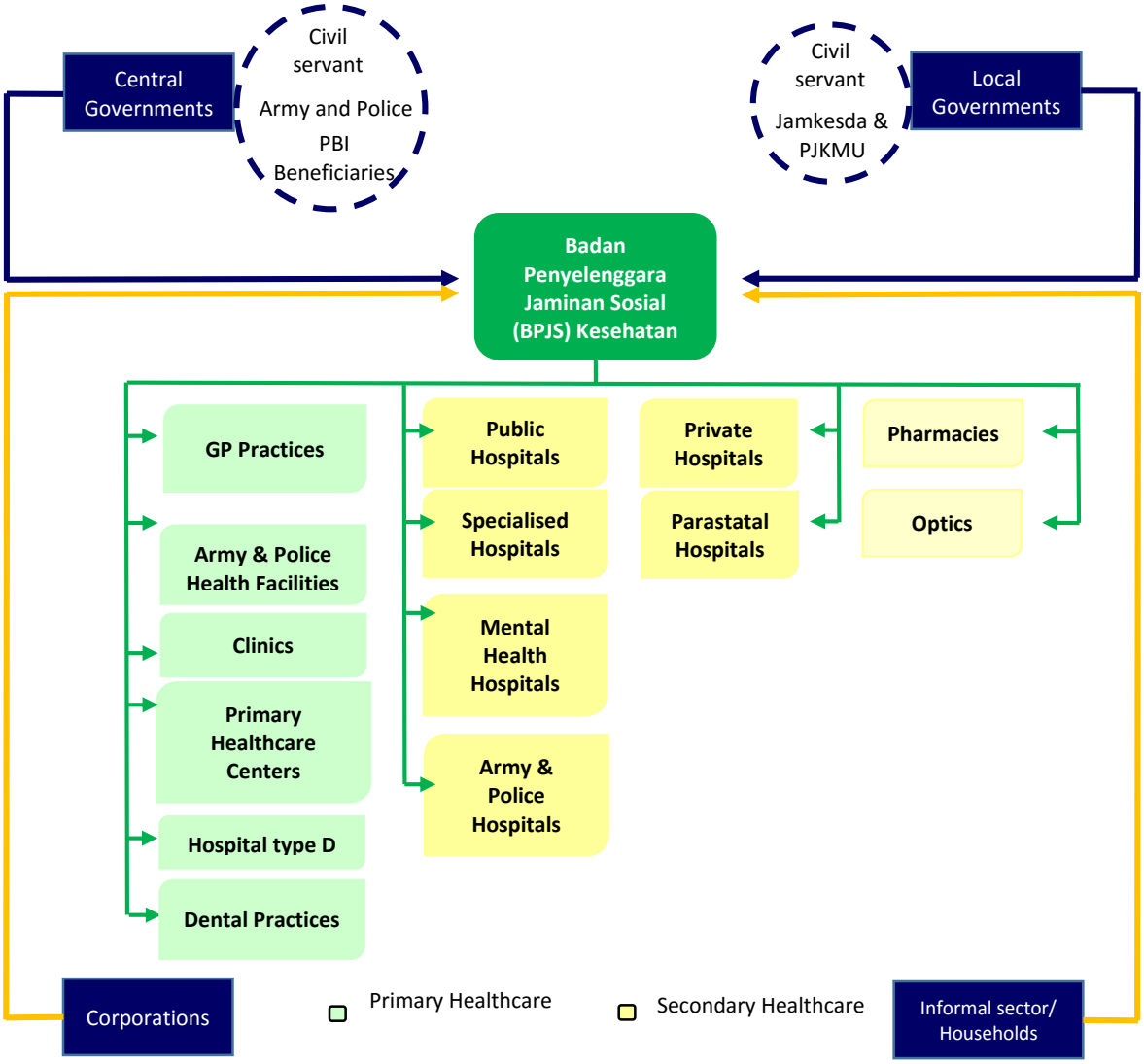

Figure 21. Flow of Social Security Funds Managed by BPJS Kesehatan

As reported in the "*Laporan Pengelolaan Program BPJS Kesehatan*" of 2014, the total membership coverage by National Health Insurance amounted to 133 million memberships. This membership figure comprises of poor/near-poor membership, formal workers (civil servants and private companies), informal workers, unemployed, and members from local schemes integrated to BPJS Kesehatan. Figure 22 demonstrate the contribution by types of memberships.

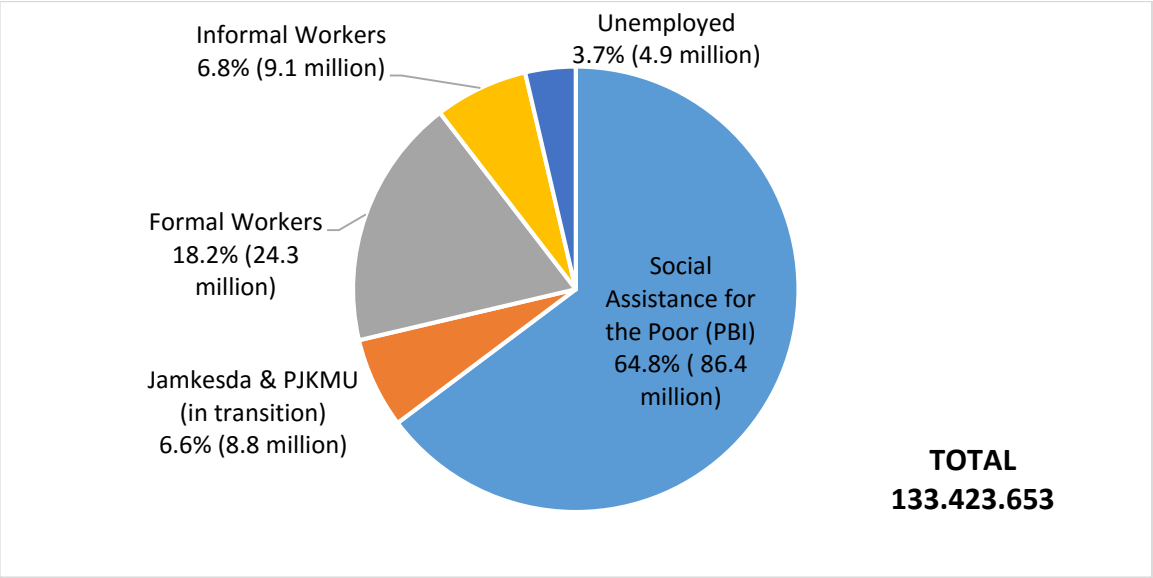

Figure 22. Total Membership of BPJS Kesehatan by December 31, 2014

The above figures present the health coverage of Indonesia a year after NHI implementation, where the country has achieved health coverage for more than half of the entire population of Indonesia. This is aligned with the government's plans to incrementally extend coverage to the entire population by 2019. Almost 65 percent of social security funds managed by BPJS Kesehatan are sourced from contribution for the poor/near-poor. There has been an incremental expansion on health coverage among the formal workers that requires government intervention to speed up the fulfillment of mandatory participation in this national scheme. It is important to note the high demand of immediate participation among informal workers, particularly to those who are suffering from catastrophic illness and in high financial risk, but lower contributions from informal workers who do not intend to immediately use the insurance.

The total aggregate health spending by social security funds for the 2014 year totaled to Rp48.7 trillion, representing 13.4 percent of current health expenditures. When compared to previous years, health spending under social security has experienced a substantial increase of more than 50 percent (nominal terms). As a percentage to current health expenditures, there has been a significant increase of 5.6 percent so that the 2014 social security spending represents around 13.4 percent of the CHE (Figure 23).

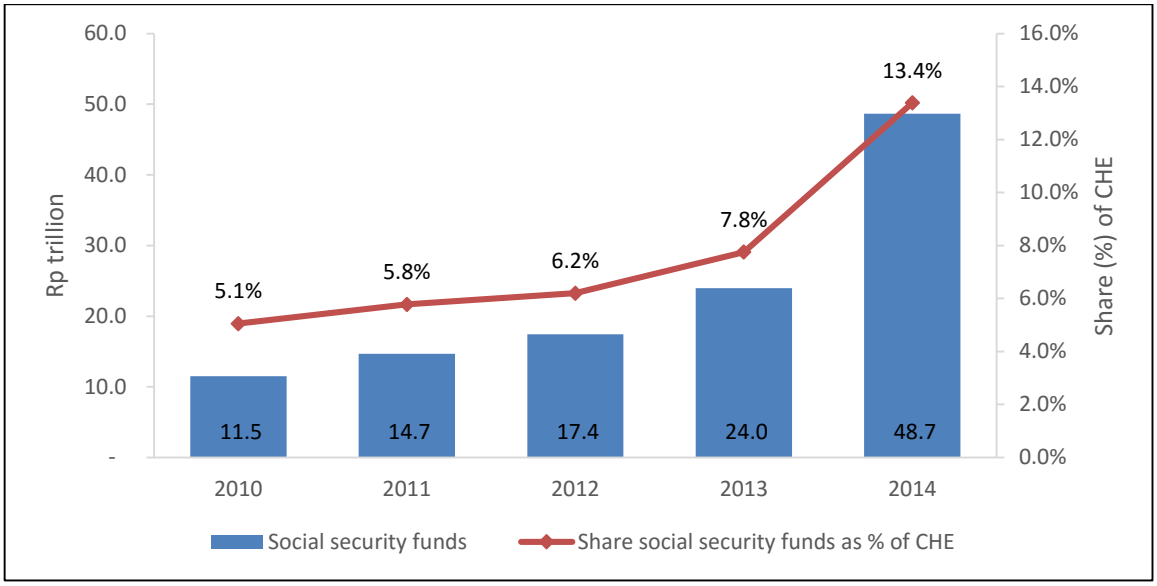

Figure 23. General Trends in Social Security Funds, 2010 - 2014

Analyzing by health functions, current health expenditures of social security are mostly allocated for inpatient care, representing around 58.8 percent in 2014. Furthermore, outpatient care represented around 34.5 percent of health spending of social security, and only a small portion of 6.4 percent was allocated for management. Unfortunately, a very low share of health spending was allocated to prevention and promotion care, representing only 0.3 percent of total health spending of social security (Figure 24).

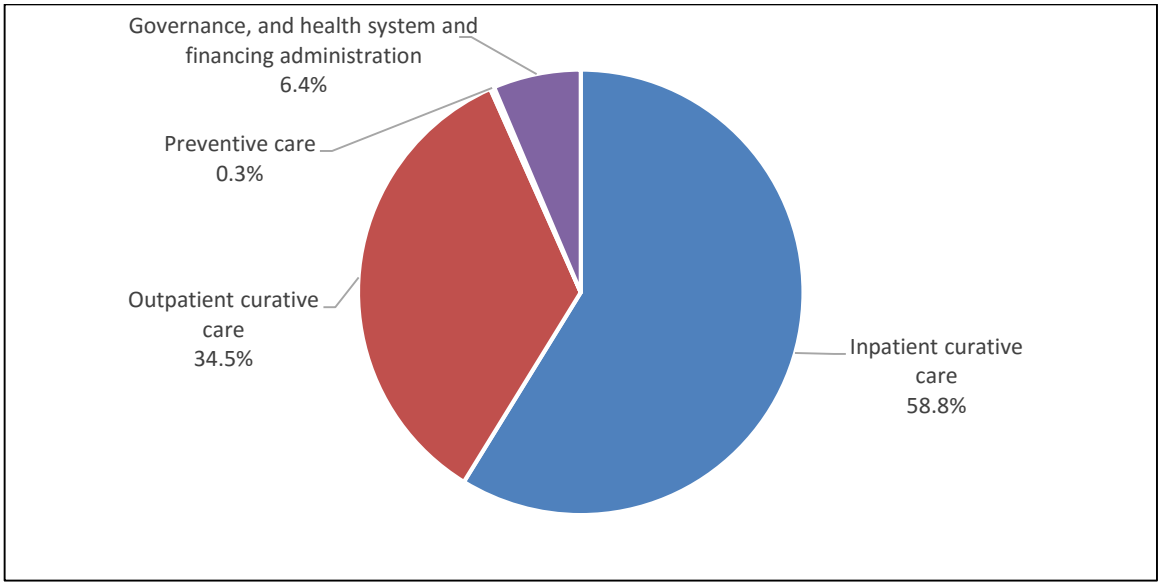

Figure 24. Social Security Funds by Functions, 2014

From the total social security health expenditures shown above, as much as 74.7 percent was used for services in the hospital, and 18.7 percent was outpatient care providers. Total health expenditures incurred by preventive care health providers was only 0.3 percent from total health expenditure of social security, and the remaining 6.4 percent from social health insurance providers (Figure 25).

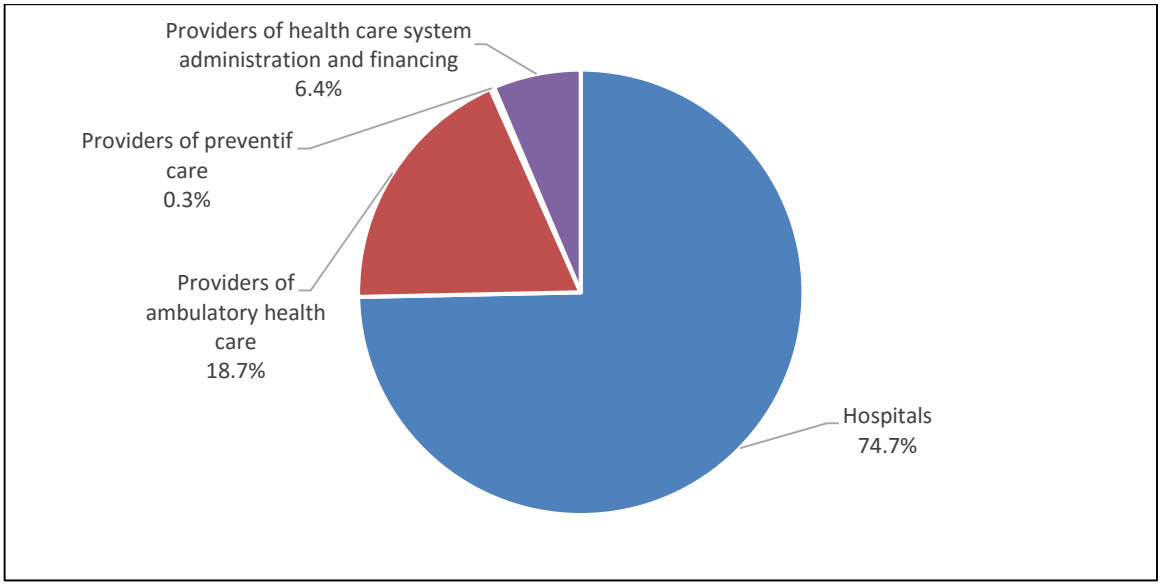

Figure 25. Social Security Funds by Providers, 2014

Private Insurance Enterprises

a. Data Collection Process

Similar to NHA production in previous years, aggregate health spending of private insurance in year 2014 is also estimated using Insurance Statistics from *Otoritas Jasa Keuangan* (OJK) Annual Reports. Detailed information of health spending for private insurance are gathered from claim reports of private health insurance companies.

b. Data Management and Analysis

Methods in Estimating Aggregate Figures

The process to estimate the aggregate figure of health spending of private health insurance began by developing a database derived from Insurance Statistics. Unfortunately, the NHA team does not receive soft copies of the file, requiring the team to perform data entry just for the private health insurance. The NHA team entries data from damage insurance and re-insurance, both conventional and sharia, including information on contribution, report of net contribution, report on cost assumption for branches in health insurance and accidental insurance. Whereas from the life insurance, also both conventional and sharia, the data entered included information of the portfolio of the amount of insured individuals, premium reports, as well as assumed costs for the branch of health insurance and personal accident insurance.

Following this process, the total health expenditure of private health insurance is calculated by summing the private insurance health claims, health cost assumption from damage insurance companies, life insurance, sharia insurance companies, and sharia life insurance companies. The amount is then added with assumed costs of administration, management, and operation of insurance companies to get the aggregated health expenditure of private insurance companies.

Methodology to Estimate Disaggregated Data

The process to disaggregate health spending of private insurance for 2014 is different from previous years, since this is the first year of SHA 2011 implementation. The disaggregation process is done to be able to describe in detail the breakdown of the total health spending of private insurance in the dimensions of health care financing schemes (HF), financing agents (FA), health care functions (HC), and health care providers (HP). Information that is used as a base to disaggregate is the proportion of health spending derived from claim data of private insurance companies. The team also consulted with experts to discuss the estimation for management and operational costs of private health insurance.

Data Validity

Triangulated meetings were held with several private health insurance companies to gain their insight and perspectives on the estimations completed. This meeting served as a forum to validate data obtained from OJK, and assure data published by OJK is synchronous with data from internal private health insurance. During the meeting, the NHA team also received inputs for further improvement.

c. Results

According to SHA 2011, private health insurance spending is classified into HF.2.1 voluntary health insurance scheme, due to the voluntary nature of the membership for individuals/ corporations. The benefits obtained varies depending on the agreed upon policy. Pooling funds are also paid out in accordance with the premium of each participant, which is typically calculated based on the level of risk. The role and contribution of private health insurance as an agent of health financing in Indonesia is considerably small compared to other private funding sources. This suggests that the scope of private health insurance coverage in Indonesia is small and only for a certain group of people.

The current health expenditure of voluntary health insurance scheme managed by private insurance companies in Indonesia for 2014 is Rp6.3 trillion, as shown in Figure 26 below. This is a 4 percent decrease from the 2013 total of Rp6.5 trillion. In comparison to Indonesia's current health expenditure (CHE), the share of private health insurance expenditure is around 1.7 percent of CHE. Looking at the trend from 2010 to 2014, it can be seen that the average share of private insurance from CHE is less than 2 percent. It is also important to note that there was an increase, both nominally and in share of CHE, in the three years prior to BPJS implementation, from 1.7 percent (2011) to 2.1 percent (2013). Despite the implementation of JKN in 2014 where the government plans to incrementally extend coverage to the entire population by 2019, private health insurance will still have role in providing additional and supplementary insurance benefit packages.

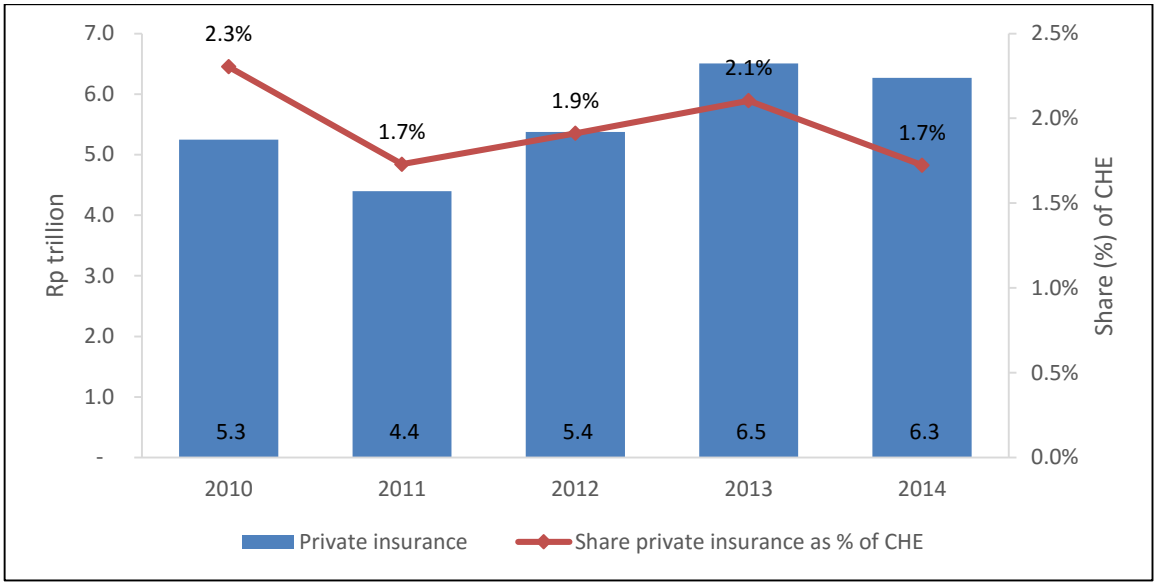

Figure 26. General Trends in Private Insurance Health Expenditure, 2010 - 2014

Private health insurance expenditures were also disaggregated by health function, where it was found that around 80 percent of private health insurance was spent on curative care, consisting of 39.4 percent for in-patient curative care and 40.4 percent for outpatient curative care (Figure 27). Expenditures spent on curative care includes the cost of medical services, cost of supporting services, costs of medicine, as well as other costs incurred by curative services, for both in-patient curative care as well as out-patient curative care. As much as 18 percent of the total private health insurance expenditure is used for administrative purposes, system, and insurance companies' operational purposes. The remainder 2.1 percent is spent on medical expenditures, such as the purchase of glasses, hearing aids, etc.

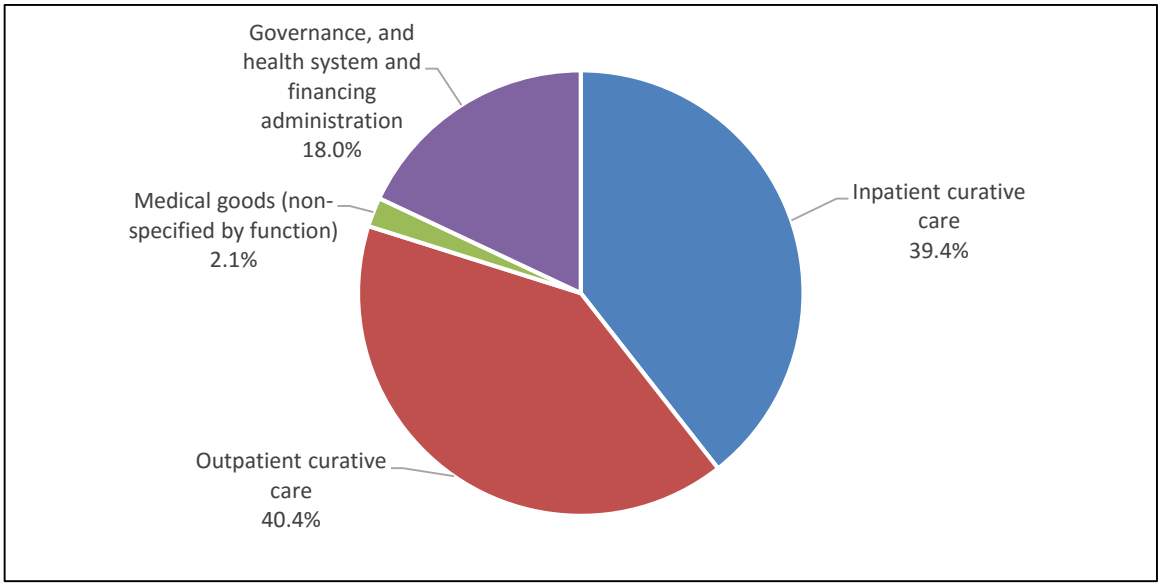

Figure 27. Private Insurance Health Expenditure by Functions, 2014

Figure 28 shows the disaggregation of private health insurance by provider (providers of health services), where the majority is spent in hospitals (56.5 percent) and out-patient care providers (23.4 percent). Around 18 percent of expenditures is used for provider management, system, and health financing expenses (18.0 percent) and retailers of medical goods (2.1 percent).

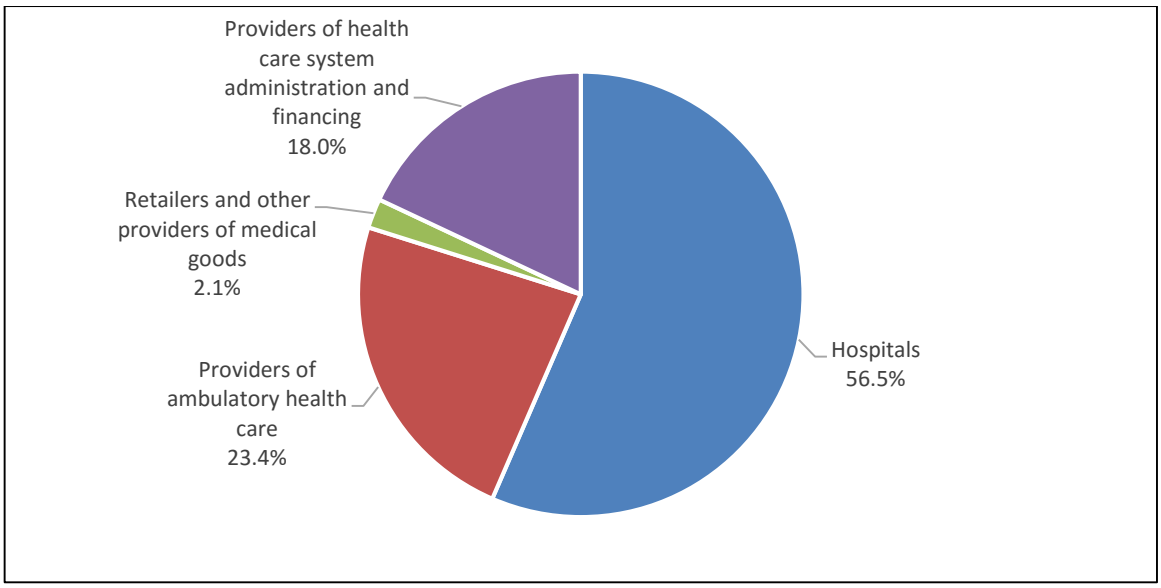

Figure 28. Private Insurance Health Expenditure by Providers, 2014

Households (Out-of-Pockets)

a. Data Collection Process

The methodology used to estimate health expenditures of OOP is always crucial in estimating overall health spending since OOP is often used as one of the indicators of health financing performance in countries. Many countries, especially in developing countries, still heavily rely on OOP payment as the bulk of its health financing system and thus the OOP reflects a high proportion of its' THE. In the process of estimating OOP, WHO published a guideline book to be used by countries to improve OOP estimation as part of NHA production (Rannan-Eliya, 2008).

From the very beginning, OOP estimation for NHA Indonesia utilized survey data from National Socio Economic Survey (SUSENAS) regularly produced by CBS. There are two types of Susenas data: core data of Susenas and consumption module. It was realized from the onset that this survey data was not meant to estimate health expenditures, since it was mainly intended for estimating socio economic consumption. However, since this is the only data available that has representative samples across the nation; Susenas is still used with several modifications using input-output data produced by CBS to estimate Gross Domestic Product (GDP). The definition of health consumption in Susenas is slightly different from the definition of health consumption in the context of NHA, thus adjustments and corrections had to be made to gain a more fitting estimation of OOP.

In our definition, household health spending used in the context of NHA and GDP is expenditures paid only by its household, whereas the definition of household health spending used in SUSENAS includes direct payment of its household and reimbursement by third parties i.e. private insurance, NPISH, and self-insured of private companies.

Data quality for essential goods produced by Survey on Household Consumption (including Susenas) is mostly reliable and representative, but other commodities (such as non-essential goods & services) has a tendency to be underestimated. This may possibly be due to errors in the data collection process, including sampling errors such as selecting household samples of high socio-economic quintiles or due to non-sampling errors such as measuring non-routine consumption goods and services. In that respect, adjustment and correction had to be made to the Susenas data for estimating OOP spending and the NHA team had conducted comparison with other survey results (Rannan-Eliya, 2008).

Ideally, correction is primarily made for data source by providers that contain information on consumers of health services. Due to the unavailability of data, the I.O. table and GDP data are used as a data source to make corrections and adjustments of Susenas data. I.O. Table data provides information on the Supply-Demand of all economic activities in

Indonesia, while GDP – especially Gross Added Value of health services in sub-sector social welfare – reflects development of health services activities from time to time.

Additional corrections were needed to adjust household health expenditures using different tools to balance the estimation from demand and supply side. For this purpose, the survey on living cost was also utilized in this process.

With all the considerations mentioned above, the estimation of household OOP health expenditures is estimated using a variety of data sources, mainly Susenas, GDP, and table Input-Output. Further challenges are in disaggregating the OOP spending. In this report, data from National Case-mix Center (NCC) is used to disaggregate OOP spending within hospitals.

b. Data Management and Analysis

Methods in Estimating Aggregate Data

As mentioned earlier, estimating OOP is very crucial since OOP spending represents a high proportion of THE in Indonesia and this figure has become one of the indicators of performance of health financing of a country. Therefore, it is important to reiterate that in NHA production for years up to 2012, household health spending (OOP) was estimated with adjustments using Table I.O. and GDP, as elaborated above.

CBS released Indonesia's national GDP figure in February 2015. One of the anticipated features of this release is the improvement of output measurement due to changes in the GDP base year. The new figures utilized 2010 as the new base year, as compared to the old data with the base year of 2000. Simultaneously, as recommended by the United Nation, CBS also improved the methodology to System National Account (SNA) 2008, updating the SNA 1993 methodology previously used.

The change in this base year is due to lots of developments that occurred in both the local and global structures in the past 10 (ten) years, and has impacted the national economy as a whole. This includes the global financial crisis in 2009, implementation of free trade across China-Asean countries (CAFTA), modifications in recording system on international trade, and expansions of the capital market. CBS has chosen 2010 as the new base year due to relatively stable economic conditions in Indonesia that year, availability of new data from the 2010 Demographic Census, availability of tables to set the GDP, and others. This is in accordance with the United Nation's recommendation to change the GDP base year every 5 to 10 years as stated in SNA 1993. The change of base year of 2010 has proven very useful to obtain estimations that better represents the existing economic condition, with improved data quality to estimate GDP, and allowing for more representable inter-country comparisons.

As the process in producing GDP continues to progress and improve, estimation on OOP health spending for previous years needs to be corrected in accordance with the new

adjustment of Table I.O. and GDP. For this purpose, triangulation meetings were held to obtain confirmation on final estimation of OOP and proper justifications for OOP adjustment. Furthermore, the NHA team in coordination with CBS, PPJK-MOH, and experts in health financing has set a series of workshop to agree on assumptions and final estimation of OOP. The result has produced a new estimation of OOP household spending from 2010 to 2014. It should be noted that with the new estimation, OOP health spending increased quite substantially as compared to the figures derived from previous methodology. The major change is not merely due to updates in methodology, but it is also due to improvement in the quality of data inputted because the data recording system is more accurate and detailed.

Unfortunately, there is a downside in the CBS data monitoring in producing GDP, where CBS concentrates on sectors that has continuous activities and represents the majority portion (> 80 percent – 90 percent). Meanwhile sectors that represent small portion of activities are not as closely monitored and utilize estimations instead.

Methods for Disaggregate Data Estimations

Estimation on household health spending has two stages beginning with multiplying aggregate data of OOP with the structure of household health consumption generated from consumption module of Susenas. Therefore, the value of OOP is estimated based on the structure of health services and health commodity. The second stage involves translating the OOP structure into the SHA 2011 classifications.

c. Results

The SHA 2011 classification defines all direct payments by the community and payments that was performed at the same time as health care services rendered, is considered and classified as OOP payment scheme (HF.3). In 2014, total health spending of OOP reached Rp171.2 trillion with an increase of 8.6 percent as compared to previous years (Figure 29). As in previous years, OOP as a health financing agent has a major contribution to Indonesia's current health expenditure (CHE), amounting to 47.1 percent of 2014 CHE. Although in nominal terms, OOP figures have increased since previous years, its' share of CHE has declined as much as 3.9 percent. This can be attributed to the implementation of JKN in 2014, showing a turning point in the pattern of health spending in Indonesia, where the share of government contribution through social security funds has increased, resulting in a lower share of OOP.

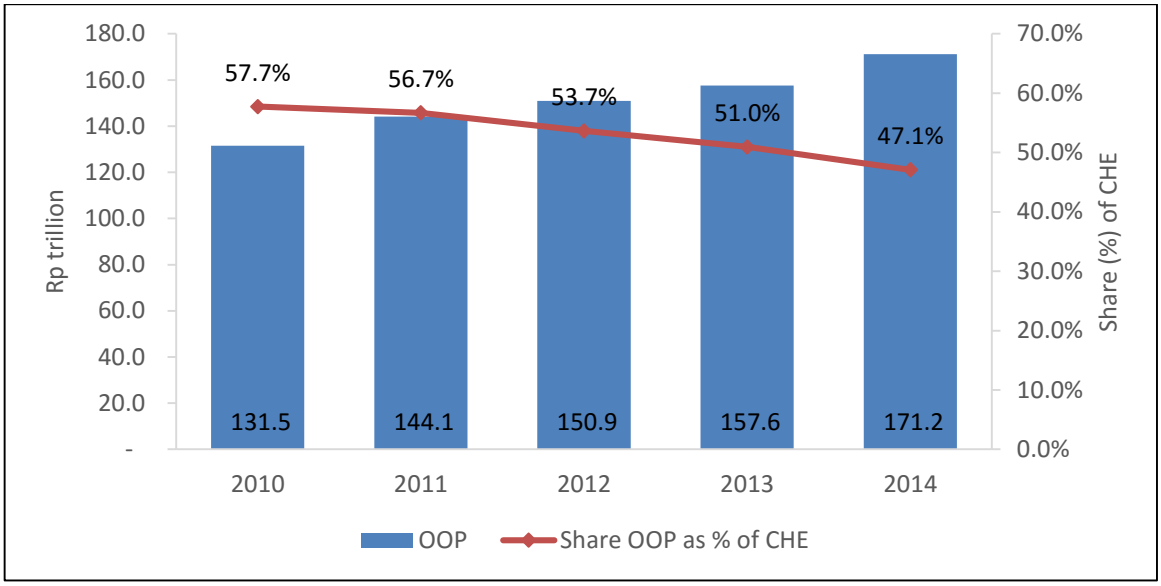

Figure 29. General Trends in Household Out-of-Pocket (OOP) Health Expenditure, 2010 - 2014

Out-of-pocket health expenditures is used as one of the measures of success of Universal Health Coverage (UHC). A country is said to have managed catastrophic health financing conditions if the portion of OOP towards THE can be kept around 15 – 20 percent (OECD, 2014)[1] . In several countries that have implemented UHC earlier than Indonesia, this target is yet to be achieved. For instance, Philippines has implemented UHC from 1995, but the OOP still has a higher than 50 percent[2] share of THE . Meanwhile, one of the neighboring countries that have achieved UHC (in terms of a low share of OOP towards THE) is Thailand, where the share of OOP of THE started around 33 percent at the beginning of UHC[3] implementation and has declined to under 20 percent 6 years after UHC implementation. The differences are a result of the OOP schemes applied by the respective countries.

Through the process of disaggregation, it was found that nearly 65 percent from the total OOP health expenditures were spent on curative services, consisting of 31.5 percent for inpatient curative care, and 32.6 percent for outpatient curative care (Figure 30). The share of health expenditures, 28.1 percent, was used on medical goods (no specifics on the function/ purpose of goods). This category consists of drugs (prescribed or OTC), other medical non-durable goods as well as therapy tools (glasses, hearing aids, dentures, etc.), all of which cannot be determined as in-patient curative care, outpatient curative care, or other functions. As for the remaining, 7.3 percent of total OOP spending was used for supporting services (also no specifics on the function) and 0.4 was spent on preventive care.

[1] OECD (2014). Measuring Financial Protection and Access to to Services in the UHC Agenda
[2] http://www.who.int/gho/en/ [diakses November 2015]
[3] http://www.who.int/gho/en/ [diakses November 2015].

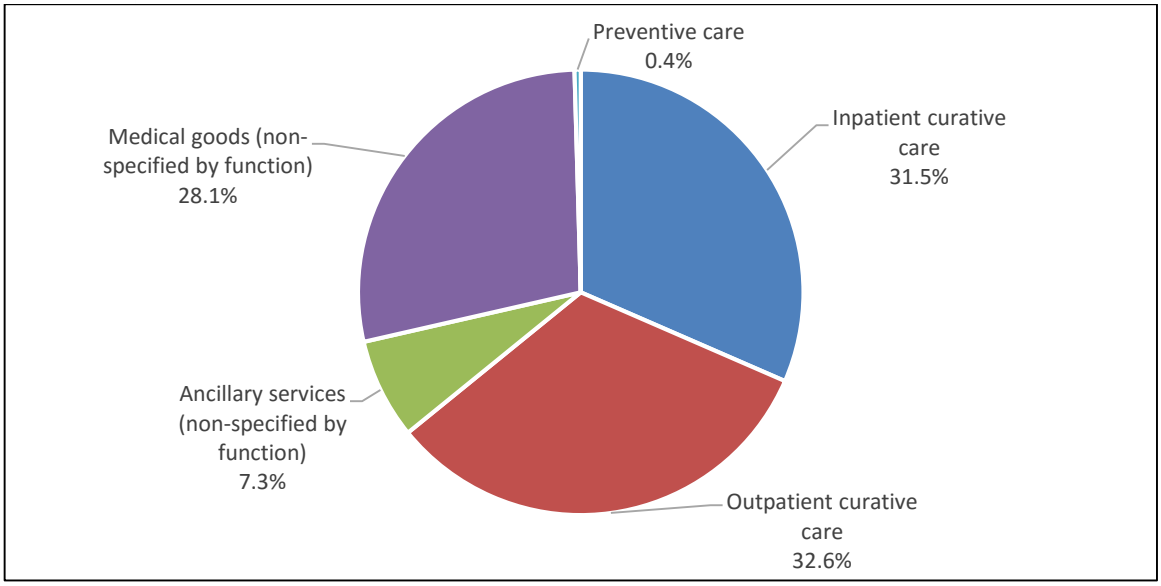

Figure 30. Out-of-Pocket Health Expenditure by Functions, 2014

When analyzed by provider (Figure 31), the majority of OOP expenditures were spent in hospitals (52.5 percent), followed by retailers of medical goods (28.9 percent) and outpatient care providers (18.5 percent). The classification of retailers of medical goods include pharmacies, opticians, etc. Whereas outpatient care providers include doctor's private practices, dentistry, specialists, midwives, clinics and others.

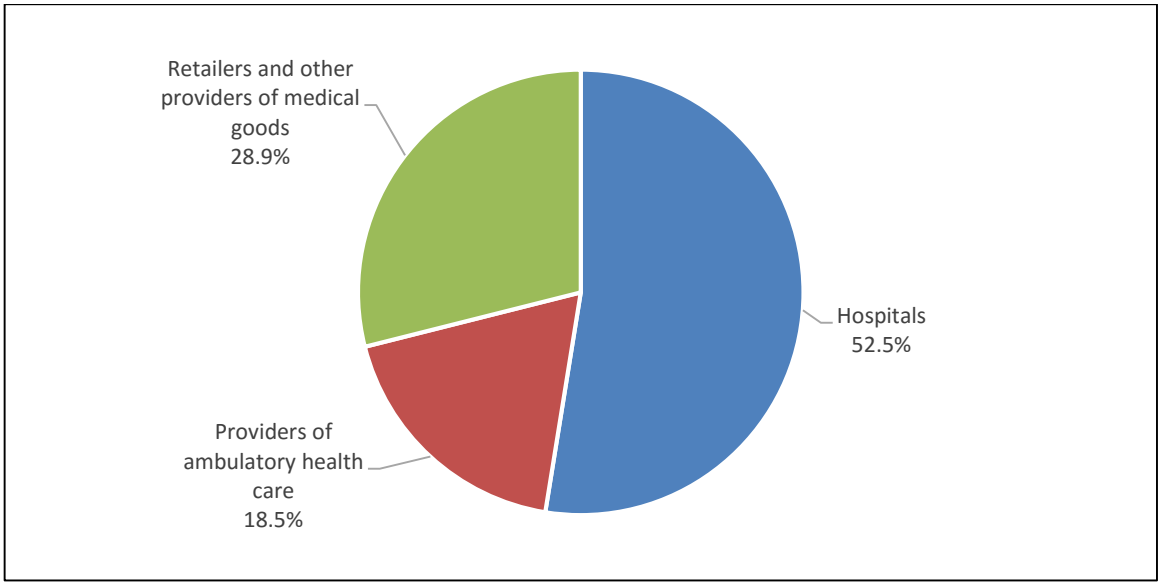

Figure 31. Out-of-Pocket Health Expenditure by Providers, 2014

Corporations (Parastatal and Private Companies)

a. Data Collection Process

Company's estimation (Private and State Owned Company/Parastatal) remain challenging in NHA production. This is due to the unavailability of data routinely as in the public sector. The main data source to estimate parastatal and private companies health spending obtained through direct surveys on a number of selected companies.

Aggregate data to estimate parastatal health expenditure in 2014 refers to the "Health Spending Survey on Parastatal Companies (*Survei Belanja Kesehatan Perusahaan Badan Usaha Milik Negara*)" which is conducted by PT Daya Makara Universitas Indonesia in 2009 through Ministry of Health (MOH) funding, and also refer to a similar survey conducted by *Balitbangkes* MOH in 2002. While aggregate data to estimate private companies obtained from the results of "Health Spending Survey on Private Companies year 2010 and 2011 (*Survei Pengeluaran Kesehatan Perusahaan Swasta tahun 2010 dan 2011*) which was conducted by Faculty of Public Health Universitas Indonesia (FoPH UI) through funding from AusAID in 2012, and also health spending survey on private companies which performed by Center for Health Economics and Policy Studies (CHEPS) Faculty of Public Health Universitas Indonesia in 2002.

Health spending survey on parastatal and private companies should be undertaken regularly, for instance in every 3 years. The aim is to accommodate the policy changes that has sectoral impact, such as the implementation of Social Security Fund in 2014 which drive companies to modify their employees' health insurance coverage.

b. Data Management and Analysis

Aggregate estimation on corporations in 2014 is derived from the result of the previous survey. Then, it is corrected by using growth data on the number of workers as well as inflation data from the Economic and Social Data Report (*Laporan Data Sosial Ekonomi*) and Strategic Data Report (*Laporan Data Stategis*) CBS. Based on that reports, the number of workers in Indonesia in 2014 accounted for 42.4 million or an increase of 3.3 percent compared to the previous year. While the inflation rate data in general recorded by 8.36 percent in 2014.

The analysis on parastatal and private companies health expenditure shows a linear increase in the last 5 (five) years. NHA team conduct the consultation and meeting with related stakeholders to triangulate as well as obtain relevant data for further analysis in estimating health spending on Corporation in 2014.

Related stakeholders, which actively involved are Center for Health Financing and Health Insurance (PPJK) MOH; Social Security Agency including Research and Development; Marketing and Membership; as well as Sub-Directorate of Labor Statistics CBS. Here are the several results discussed on that occasion, as follows:

A. Sub-Directorate of Labor Statistics CBS
   1. National Labor Force Survey (*Survei Nasional Angkatan Kerja*), surveys aimed to calculate the number of the labor force in Indonesia. Sakernas data is not currently able to provide information about health spending on workers.
   2. In 2013, CBS had conducted a Survey on Monitoring Crisis Impact (*Survei Monitoring Dampak Krisis*). This survey provides data on the ownership of health insurance in workers. Recorded about 15 percent informal workers already have health insurance. In 2016, this similar survey will be re-conducted to refine the data collection to formal and informal workers. The result will provide an information of the estimated population of workers who have social security (including health insurance).
   3. Based on statistical data of employment recently, the number of workers in Indonesia is accounted for 115 to 120 million in which the number of informal workers is higher than formal workers.

B. BPJS Kesehatan
   1. Until December 2014, the participation of private employees in Social Security Agency BPJS Kesehatan reached 10 million workers or 12.91 percent of the total target of population. Consist of 8.5 million former employees of JPK Jamsostek, 63.3 thousand employees of parastatal companies, and 1.5 million from another private employee (Table 8).

Table 8. Membership Data of Private Employees

No	Description	Population 2014 (*Captive Market*)	Number of Participants in Desember 2014	%
1	Eks JPK Jamsostek	7,351,275	8,469,527	115.21%
2	Parastatal Companies	2,238,060	63,327	2.83%
3	Other Private Employees	68,498,782	1,544,544	2.25%
	Total	**78,088,118**	**10,077,408**	**12.91%**

   2. To confirm the health spending data on employees, it is necessary to learn about the Jamsostek data in the previous year as well as informal workers data. Based on the annual report of PT Jamsostek, the number of participants on JPK Jamsostek in 2013 was 7.6 million; while based on data from Group of R&D Social Security Agency BPJS Kesehatan, the number of former employees of JPK Jamsostek in 2014 reached 8.5 million. It means that there is an increase in the number of participants at 0.9 million in 2014. One of the chances is there has been a transition gradually in managing health insurance employees of the companies to the Social Security

Agency BPJS Kesehatan. By this assumption, the growth of health spending on companies becomes not linear as in the previous years.

In summary, the participation of private workers in the Social Security scheme is still low for 2014. This information is valuable as input to re-estimate and re-analysis the aggregate of health spending on parastatal and private companies for 2014.

In addition, this activity also delivered plans and follow-up actions to analyze and estimate the aggregate of health expenditure on parastatal and private companies in the future, as follows:

1. Both Sakernas data and another labor survey data which conducted by CBS will be a good data source for NHA production, especially data about social security ownership of the group of workers. Then, data of health insurance schemes for workers, whether social health insurance or reimbursement is also needed. If using social health insurance, then contribution fee of 4 percent will be borne by the employer and 1 percent from the employee. After all, to estimate the overall contribution rate is required the following information, such as the scale of the company (number of employees, turnover, etc.) where they work and other information related to the companies.
2. Presented by PPJK that NHA production in the future will be conducted regularly and continuously. The triangulation and validation meeting on parastatal and private companies health expenditure are one of the activities as a part of institutionalization of NHA. This is intended to make the process of data collection in the various institutions can be accessed more easily and automatically.

After triangulation and validation, the next step is data classification according to the methodology of System of Health Accounts (SHA) version 1.0 and SHA 2011. Based on SHA 2011 classification, parastatal and private companies is classified as HF.2.3 Enterprise financing schemes. While according to the agent, it is classified as FA.3 Corporation (other than providers of health services). The last step is data disaggregated by health care functions and health care providers. Up-to 2014, disaggregation by functions and providers on companies health expenditure is still using disaggregate data of JPK Jamsostek.

c. Results

The analysis presents total health expenditure on parastatal companies in 2014 amounted Rp9.6 trillion, while total health expenditure on private companies accounted for Rp29.0 trillion.

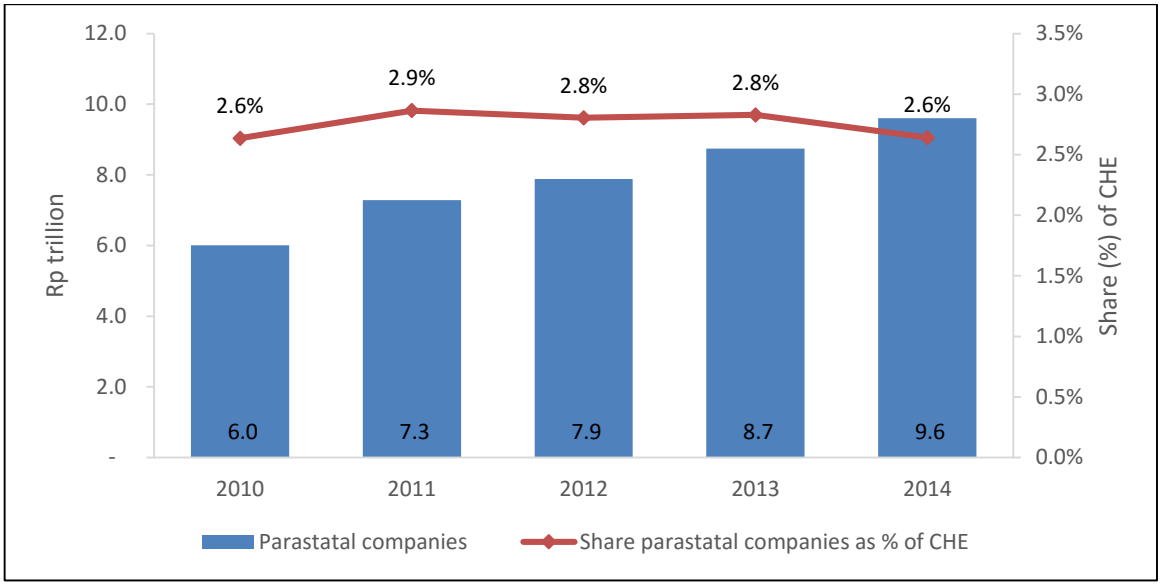

Figure 32. General Trends in Parastatal Companies Health Expenditure, 2010 - 2014

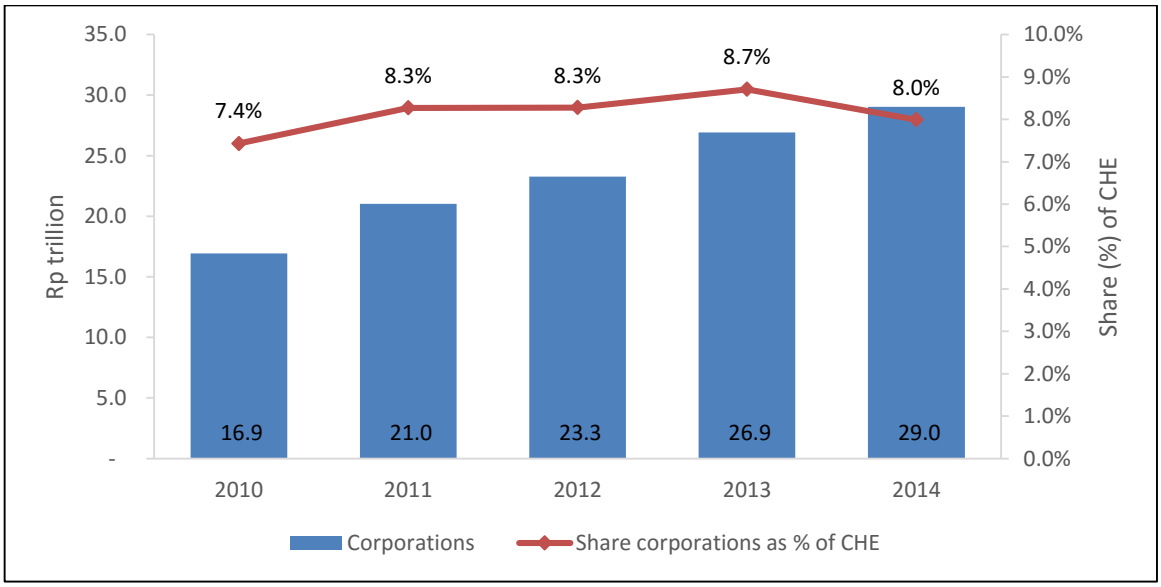

Figure 33. General Trends in Private Companies Health Expenditure, 2010 - 2014

Figure 32 and 33 above shows the trend of health spending on parastatal and private companies from 2010 to 2014. From 2010 to 2013, the trend of share parastatal and private companies as a percentage of Current Health Expenditure (CHE) are likely to increase by an average of respectively at 2.8 percent and 8.1 percent to CHE. In 2014, share parastatal and private companies as a percentage of CHE decrease, respectively at 2.6 percent and 8.0 percent.

Of the corporations' health spending, almost 88.0 percent were spent on curative services, consisting of inpatient curative care (47.5 percent), outpatient curative care (40.3 percent), and rehabilitative care (0.2 percent). The component of health spending in curative care is not only for curative inpatient and outpatient services but also for medicines in either primary health care or secondary health care, as well as delivery services. Then, accounted for 12 percent were spent on managing health administration in the corporation. The

smallest proportion of 0.02 percent were spent on preventive services, including spending on immunization activities (Figure 34).

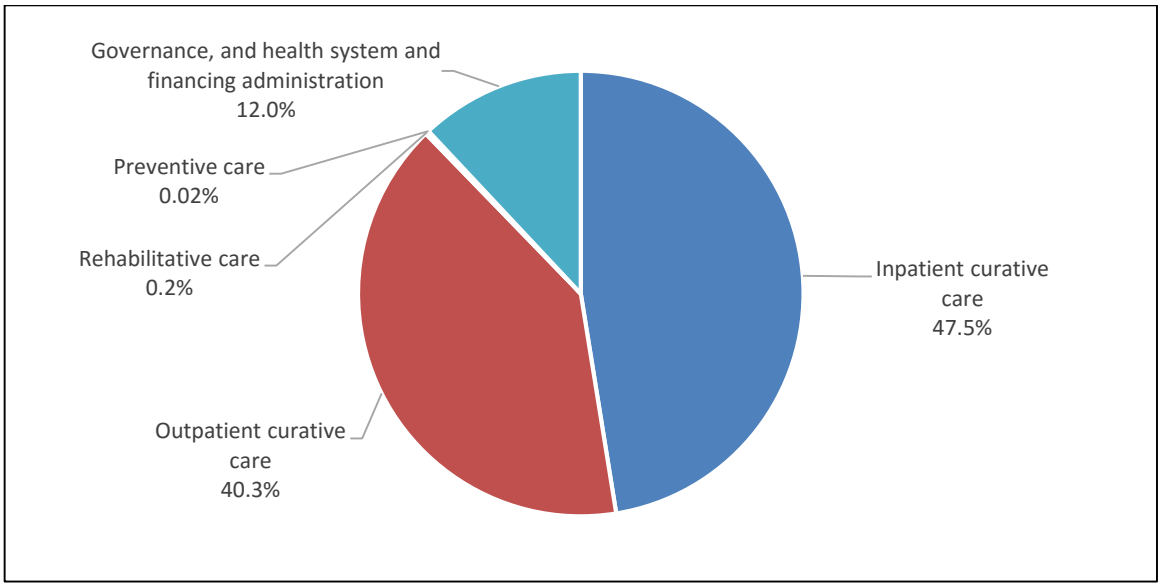

Figure 34. Corporations Health Expenditure by Functions, 2014

By health care provider point of view, more than 60 percent of health expenditure on corporation were spent in hospital, then 27.1 percent in provider of ambulatory health care, e.g. clinic. While the remainder 12 percent is by corporation for administration activities (Figure 35).

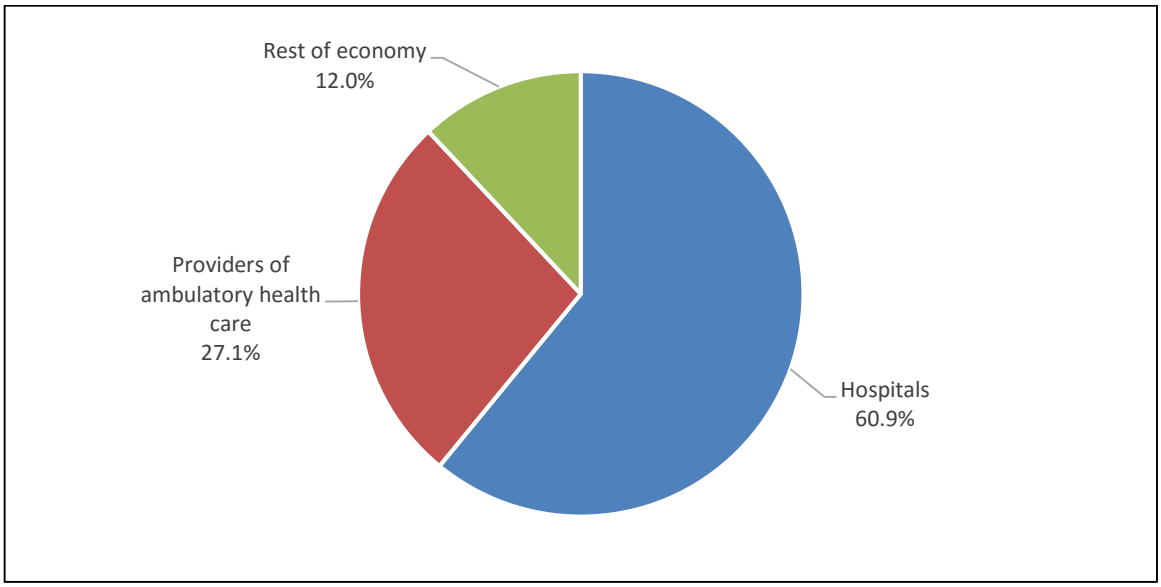

Figure 35. Corporations Health Expenditure by Providers, 2014

Non Profit Institutions Serving Households (NPISH) and Rest of the World (ROW)

One of the financing agents of the private sector is known as “Non Profit Institution Serving Household” (NPISH) or in Indonesia, it is often referred to as *Lembaga Non Profit yang Melayani Rumah Tangga* (LNPRT). This standard term is also been used by Central Bureau Statistic as one of the financing agents in the health sector. In addition, there is other financing agent called “Rest of the World” (ROW) or donor agencies.

a. Data Collection Process

One of the main challenges in estimating health spending of NPISH and Donors is the very limited data source; this has become a common issue among NHA experts and is among the main problems faced when producing NHA. Up to 2014, data source to estimate NIPSH and Donors are mostly derived from survey data done several years prior, using some adjustments in assumptions to incorporate changes. The total figures of NPISH is derived from results on “Consumption Survey of NPISH” (*Survei Konsumsi Lembaga Non-Profit Rumah Tangga*) conducted by CBS. Another small study from PT. Kalta Bina Insani funded by PPJK, MOH done in 2011 is used to disaggregate health spending of NPISH by providers and functions. The study was performed in 10 provinces across the country and included 136 NPISH. Although the situation of health spending and pattern of financing may have changed since then, unfortunately there has not been a recent study available to update the financing patterns of NPISH, therefore the estimations from the 2011 study is still used a pattern.

Similar to NPISH, estimation of the total health spending of ROW for 2014 also refers to the surveys done in 2005 on “Donor Activities in the Indonesian Health Sector” funded by the WHO Indonesia. Disaggregation by providers and functions utilizes data from OECD on donor contribution of various countries (including Indonesia).

Health spending funded by donors can be allocated through various schemes: (1) self-managed funding by donors; (2) funding managed by the MOH through grants and recorded as on budget; (3) funding managed by NPISH; and (4) other schemes. ROW in this report represents the self-managed funding by the Donors. It should be noted that ROW in the context of NHA is not translated, as donors as a financing source, but it is donors as a financing agent. This can be interpreted that the funding is self-managed by donors. This is important to emphasize in avoiding miss understanding of interpreting NHA data.

b. Data Management and Analysis

Health expenditure of NIPSH and Donor as financing agent demonstrated a linear increase, using assumptions and adjustments from previous years’ data. In the process, a cross-

sector triangulation is performed to ensure relevancy of data to the current situation. Several stakeholders are involved in the data validation, including Center of Foreign Cooperation, MOH (*Pusat Kerjasama Luar Negeri Kemenkes*), Sub Directorate of Non-Profit Institutions Serving Households Accounts, Central Bureau of Statistic (*Subdit Neraca Rumah Tangga dan Institusi Nirlaba BPS*), Representative of Country-Coordinating Mechanism (CCM) GF-ATM Indonesia, Bureau of Finance of the MOH, Bureau of Planning and Budgeting of the MOH, Subdit TB Ditjen P2PL, Program and information Unit of Ditjen Community Health MOH (*PI Ditjen Kesmas Kemenkes*), Health System Strengthening Coordinating Unit (HSS-CU), as well as Center of Health Financing and Insurance, MOH. Meetings organized to triangulate and validate data are not merely to obtain data and information for further analysis in estimating aggregate health spending of NPISH and Donors in Indonesia for 2014. However, these meetings also serve as an opportunity to build connections, network and trust for future collaborations to obtain valid data supply for the following years. Ideally, the information covered starts from methodology, tracking source of data, up to focal point of data.

The following are several information collected from the meetings that can be used as references for data analysis of NPISH and Donor:

1) Information provided by Center of Foreign Cooperation-*Pusat Kerjasama Luar Negeri* (PKLN), MOH

   a. PKLN is one of the entry point that is responsible to prepare all collaborations with foreign aids in the health sector. The above funds will be integrated in the system in respective programs executed by the MOH. Planning will be included in the Bureau of Planning and related ecehlons, while the accounting is under the Bureau of Finance, the MOH.

   b. Health system Strengthening Coordinating Unit (HSS-CU), is a special team that is established with the support of AIPHSS. HSS-CU, under the Bureau of Planning, has to monitor foreign aids assistance that is channeled through the MOH. As such, all data Donors that provided grants to respected echelon in the MOH is recorded as HSS-CU. In addition, there are foreign assistance for technical collaborations such as procurement for training that are not recorded in the financial system.

   c. There are at least 3 (three) types of collaboration: bilateral, regional, and multilateral coordination. Example of multilateral collaboration includes special assistances from Global Fund, GAVI, the World Bank, WHO. Bilateral collaboration are partnerships such as with the United States of America (USAID) and Australian Government (DFAT).

   d. According to PKLN, the largest Donor support for health sector in Indonesia is from USAID. The data is derived from the Memorandum of Understanding (MOU), where PKLN was involved in the process of data inventory. Detailed activities of

collaboration can be traced through existing document of MOU from the respected main unit within the MOH. There are various types of modalities of fund channeling from foreign aids through the MOH. Sources can be disbursed through third parties and the MOH, or third parties without the MOH but still under agreement with the MOH.

e. PKLN at MOH is supportive and willing to collaborate in providing related data needed for future NHA production. However currently PKLN-MOH has not been able to provide an estimation on the total incoming donor assistance received to support health sector in Indonesia, although data and information can be tracked if needed. One of the issues during discussion is in knowing the level of donor independency. If agent is the MOH, then health expenditure tracking requires special effort. For instance, funding to support AIDS, TB and Malaria program is highly dependent on Global Fund. In fact, almost all units under the MOH has executed tracking process to record the funds from donors (tracking expenditures). However, as the financing system is still fragmented, prudence and effort to coordinate all systematic recording is necessary to support MOH.

2) There are a variety of source of funds available for NPISH. Sources can be collected from grants or donors both national and international, but also include assistance in terms of government transfer, transfer to companies, or transfer from households.

3) Country-coordinating Mechanism (CCM) GF-ATM Indonesia has provided data related to total funding from Global Fund allocated to Indonesia, with both disbursement data and total expenditures. There are many modalities of flow of funds from GF. Part of the funds are allocated through the MOH but there are also funds allocated directly to the principal recipient non-government, i.e., Family Planning Association (PKBI), NU and Aisyiyah.

4) Government regulation on grants for Indonesia is explained in PP No. 10 2011 which states that all grants have to be registered and channeled through the Central Budget mechanism. The grants have to be registered at the Ministry of Finance (MOF) by designated ministries who are to receive the above grants. The MOF has prepared a report of reconciliation for all grants received by related Ministries to be registered in Directorate Evaluation, Accounting and Settlement & Risk (PRR) under the MOF. In addition, the unit below Directorate General of PRR, i.e. Directorate Loan and Grants has used e-grants application that can summarize all grants in both money and non-money terms received by various ministries. Only personnel at Bureau of Finance in respected ministries can access application of e-grants.

5) If the policy obliges donors to go through the central budget (APBN), then the financing agent is Government of Indonesia. As such, can ROW or funds that is totally managed by donors be traced? Can the data derived from WHO or OECD be cited as ROW data? In fact, not all grants from donor is allocated through central budget since some still

use direct disbursement to local NGOs. For direct disbursement to local NGOs, the financing agent is then the local NGOs who received the funds.

6) An example of donors who are willing to manage their own funds, without government involvement is KNCV, therefore in this case KNCV will be seen as the financing agent.

7) Currently, all grants and foreign assistances are encouraged to go through the government channel through DIPA, in the hopes that there will be better planning for grant funds. Foreign assistance for health received by Indonesia are not only through the MOH, but also through other related ministries such as National Planning and Development Board (*Bappenas*), for example for a big project on sanitation under health sector.

8) It was stated by Subdit TB, MOH that all of grants for Directorate General of Disease Control and Environmental Health (DG P2PL) are already using central budget mechanism. There are two principal recipients (PR) for grants from Global Funds: first through Aisyiyah (activities more toward community) and second to the MOH, specifically the Subdit TB as the unit responsible. Funds received will be further distributed to Sub-Recipient (SR), to be directly disbursed to provincial health office (PHO) and SR allocated to Ministry of Justice and Human Rights (*Kemenkumham*) to support activities at the prison. All SR has to report of all activities to *Subdit* TB–P2PL, MOH.

9) It is important to note that foreign aids to Indonesia is not only in monetary and non-monetary term, but also in term of Technical Assistance (TA).

10) CBS has raised the double counting issue and the possibilities of underestimating or overestimating when calculating ROW data. One of the methods to confirm the final estimation is to validate by comparing figures presented by OECD and figures from the MOF (all grants through APBN mechanism). If it is relatively similar figures, then all funds allocated directly to NGOs are not yet incorporated in the figures. To avoid double counting, if donors are treated as financing agents, then it needs to be insured that they are not yet included in the central budget mechanism (APBN).

11) One of the challenges is to trace based on period or time frame of all data donors derived, especially with the integrated data of total grants received from the MOF. In general, there are a high variation of time frame, some has a term period of 3 years, while others may be more or less.

There are at least two main issues addressed from the meeting:

1. Considering there are still limited information and data for triangulation of health spending of NPISH and ROW, one initial step that need to be taken is to identify and to trace mechanism and activities of all donors in health sector in Indonesia. It is

important to note that the NHA team still rely on surveys to do analysis in estimating aggregate figures of health spending of NPISH and Donors for 2014.

2. As a country, it is important to have a better estimate on total grants for health designated for Indonesia. There should be improvement in tracing back the expenditures in more systematic manners.

Some follow up steps needs to be taken for better estimation of total aggregate of NPISH and ROW, such as:

1. Information needed to do further analysis in estimating health spending of NPISH is to list the total numbers of NGOs health in Indonesia. Once this can be performed through surveys with successfully identifying the total population of NGOs, then an appropriate sample can be determined.

2. PJK-MOH is expected to have ability in describing flow of fund or fund channeling mechanism from respected donors. For instance, how many are allocated using fund channeling of central budget mechanism (APBN) through related ministries, and how many are allocated through third parties. PPJK-MOH should also identified whether the third parties are legal institution, or semi-legal, or others.

3. A designated workshop should be held to discuss foreign aids for health involving related unit under the MOH, PKLN-MOH, HSS-CU MOH, and related donor agencies located in Indonesia i.e. USAID, GF, and others. This workshop would attempt to:

    a. Gather overall perspective on mechanism and fund channeling of donors/foreign aids for health sector in Indonesia.

    b. Obtain valid estimation on total contribution of donors for health sector in Indonesia

4. For institutionalization of NHA, it is required to have supporting data and information across sectors.

In the next stage, after triangulation of data is performed, it is necessary to classify data according to methodology of SHA version 1.0 and SHA 2011. Using guidelines of SHA 2011, NPISH is classified as financing scheme NPISH (HF.2.2.) while by classification by agents as FA.4. NPISH (FA.4 Non Profit Institution Serving Households (NPISH)). From the total aggregate data, further disaggregation by health care functions and providers are performed.

c. Results

Non-Profit Institutions Serving Households (NPISH)

NPISH has a relatively small portion of overall health spending. Based on national survey of NPISH performed in 2011, most of NPISH acts as providers to implement various public health program that is funded by foreign aids and local aids. Some of funding support are

in the form of grants to the government, and some are a combination of local and foreign aids support. Total health spending that is managed by NPISH in 2014 amounted to Rp2.1 trillion.

Figure 36 demonstrated an increase trend of NPISH health spending (in nominal term) from 2010 to 2014. As proportion of overall current health spending, there is a light reduction from 0.7 percent in year of 2010 to 0.6 percent in year of 2014.

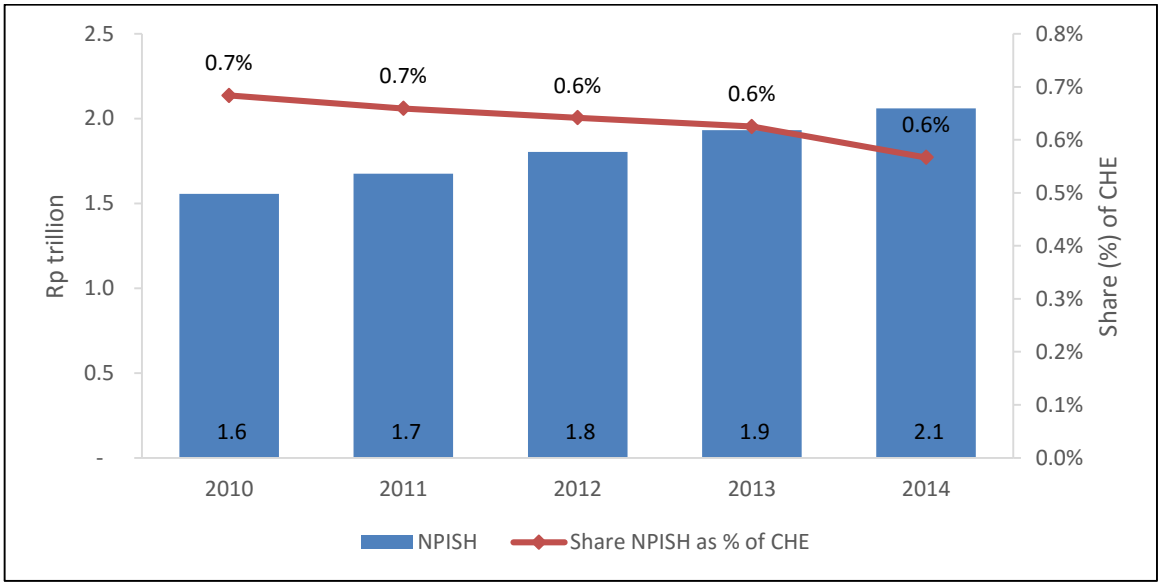

Figure 36. General Trends in Non-Profit Institution Serving Household (NPISH) Health Expenditure, 2010 - 2014

Based on tracking of health spending managed by NIPSH, it is reported that 58.6 percent of the total Rp2.1 trillion spent in 2014 was used for preventive care including to support Maternal and Child Health program, Family Planning, school health, program for preventing of NCDs, and other promotion/preventive program. Less than 15 percent of total NPISH is disbursed for curative care to cover inpatient and outpatient care. These include supporting services and medicines. The other 25.2 percent is for administrative matters. (Figure 37).

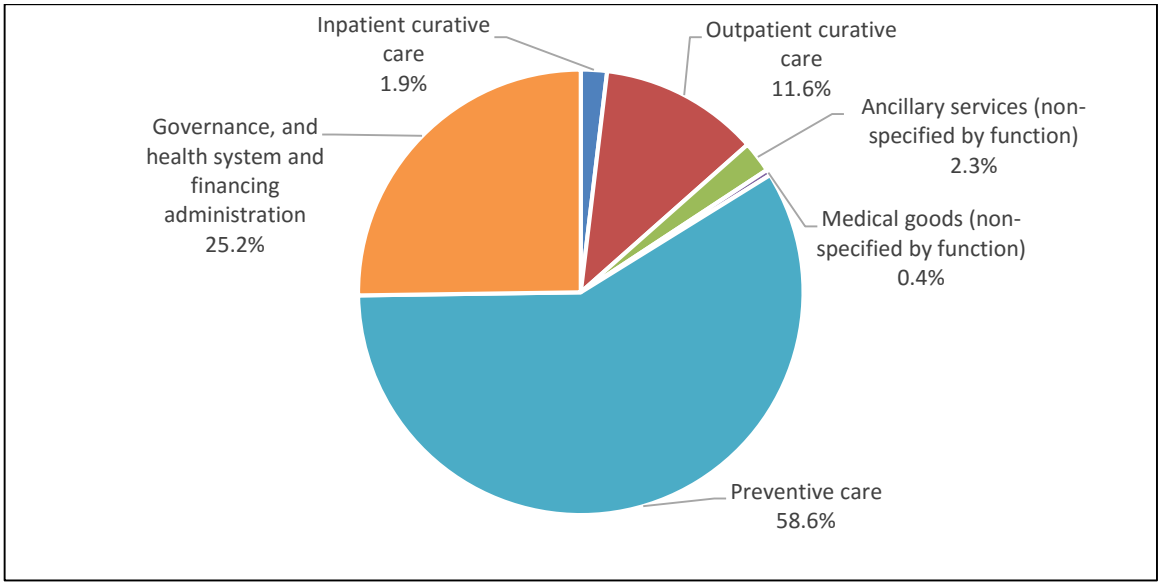

Figure 37. NPISH Health Expenditure by Functions, 2014

Figure 38 presents NIPSH funding by providers, demonstrating that the majority of health spending (83.8 percent) is self-managed by NIPSH. Around 11.2 percent is managed by provider of outpatient (clinics), hospitals 3.1 percent and supporting services such as laboratories amounting to 1.9 percent.

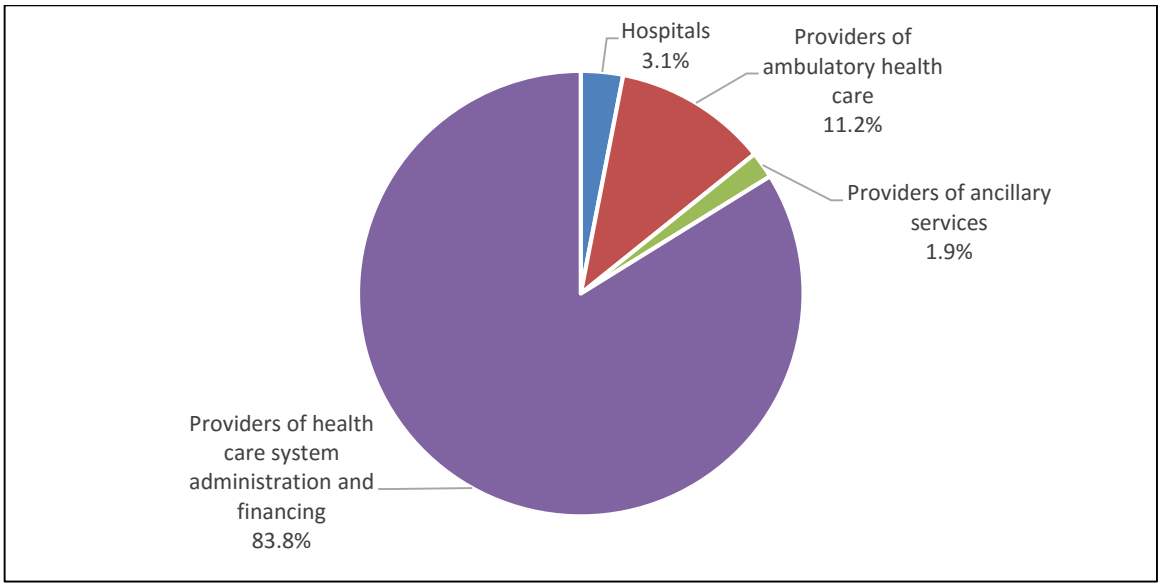

Figure 38. NPISH Health Expenditure by Providers, 2014

Rest of the World (Donor)

The total health expenditure that is managed directly by donors in 2014 reached Rp3.0 trillion or less than 1 percent of CHE. Based on the trend from 2010 – 2014, donor health expenditures had an increasing trend nominally. However, in comparison to CHE, the share of health spending decreased by 0.1 percent in 2014 (Figure 39).

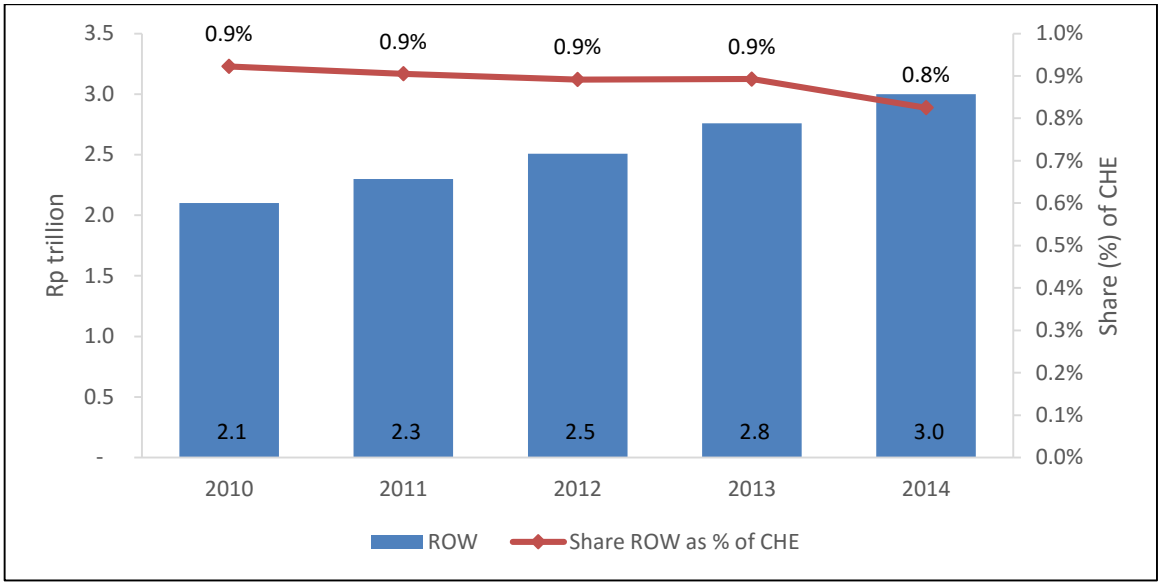

Figure 39. General Trends in Rest of the World (ROW) Health Expenditure, 2010 - 2014

Furthermore, information on OECD data on the contribution of donors in Indonesia showed that most of the funds directly managed by the donor is intended for preventive health care amounting to 79.7 percent, this includes programs such as basic nutrition, basic sanitation, family planning, health education, malaria and TB control, and other infectious disease control. Then the second largest expenditure is for health policy and administration management, population policy and administration management as much as 15.2 percent. (Figure 40).

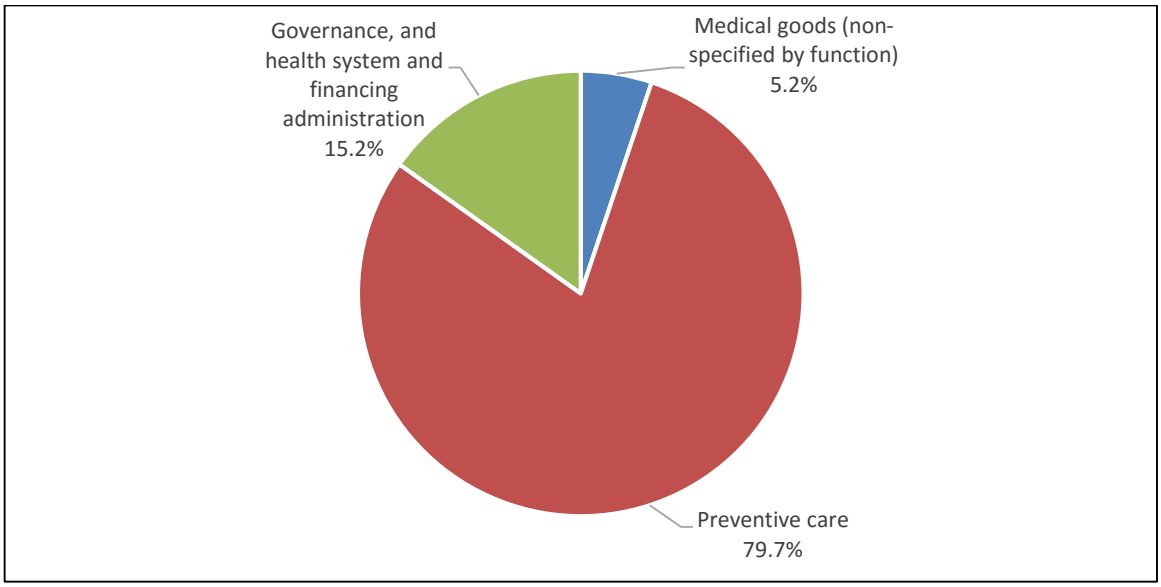

Figure 40. ROW Health Expenditure by Functions, 2014

Looking at health spending by provider, it can be seen that as much as 84.8 percent of total spending is classified as provider management, systems and health financing, while the remainder 15.2 percent is by Rest of the World (Figure 41).

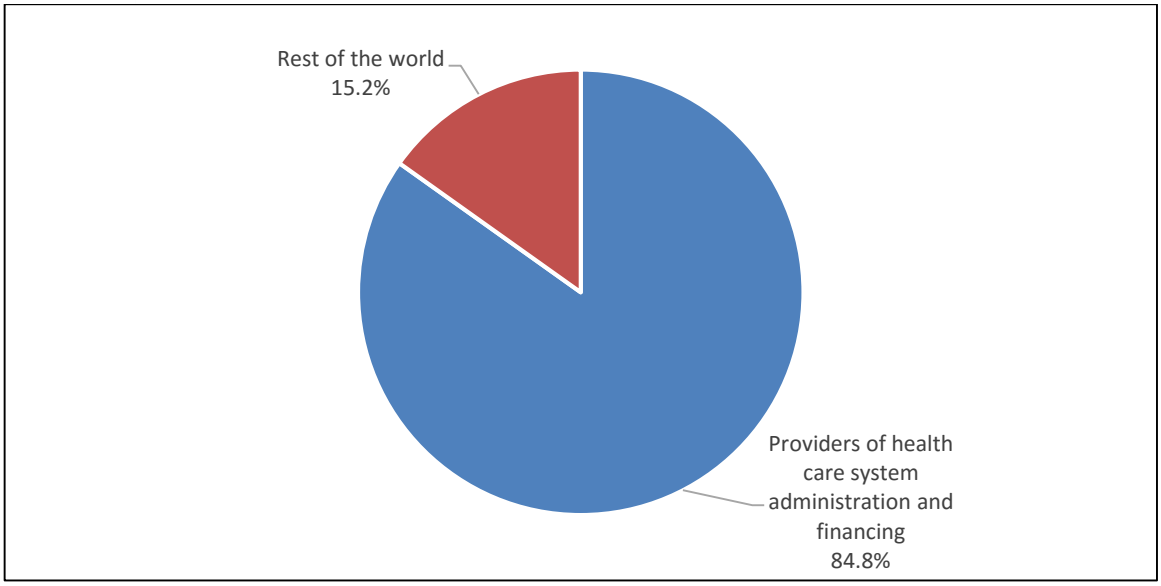

Figure 41. ROW Health Expenditure by Providers, 2014

International Comparison

International Comparison

1. Total Health Expenditures of Selected Countries

Total health expenditure (THE) and ratio of THE to GDP in 2014 was relatively low as compared to other countries in the Asia-Pacific region (Table 9). The ratio of Indonesia's THE to GDP was at 3.6 percent, lower than many other developing countries, such as Viet Nam (7.1 percent) and Philippines (4.7 percent), even though Indonesia's GDP per capita is higher than both of those countries. It was even much lower compared to the developed countries such as Australia (9.4 percent) and Japan (10.2) percent. It is expected that GDP per capita of a country reflects it's the per capita health expenditure, the higher income of the country, the higher its health expenditure.

Table 9. GDP per Capita, THE Per-capita, and Share of THE to GDP in Selected Countries in the Asia-Pacific, 2014

Country	GDP per Capita (US$)	THE (US$ million)	THE per Capita (US$)	THE as % of GDP
Myanmar	891.5	1,084.1	20.3	2.3
India	1,600.7	97,139.9	75.0	4.7
Laos	1,745.9	217.9	32.6	1.9
Viet Nam	2,014.7	13,158.7	142.4	7.1
Philippines	2,870.5	13,403.8	135.2	4.7
Sri Lanka	3,634.6	2,625.5	127.3	3.5
Indonesia	**3,523.6**	**31,838.1**	**126.3**	**3.6**
Thailand	5,519.4	24,407.3	360.4	6.5
China	7,565.2	574,799.0	419.7	5.5
Malaysia	10,933.5	13,630.1	455.8	4.2
Republic of Korea	27,942.7	103,989.1	2,060.2	7.4
Japan	36,201.4	470,671.7	3,703.0	10.2
Singapore	55,909.7	15,155.9	2,752.3	4.9
Australia	64,008.9	140,035.3	6,031.1	9.4

Per capita health expenditure of a given country can be compared with other countries using the Purchasing Power Parity (PPP). Per capita health expenditure in Indonesia in 2014 was around US$380.3 (Figure 42), which was higher than Sri Lanka (US $369.2) and Filipina (US$328.9), but still much lower than the neighboring countries of Viet Nam (US$390.5) Thailand (US$950.1), Malaysia (US$1,040.2), and Singapore (US$4,047.0). This may be influenced by differences in health care prices combined with the purchasing power of the Indonesian population.

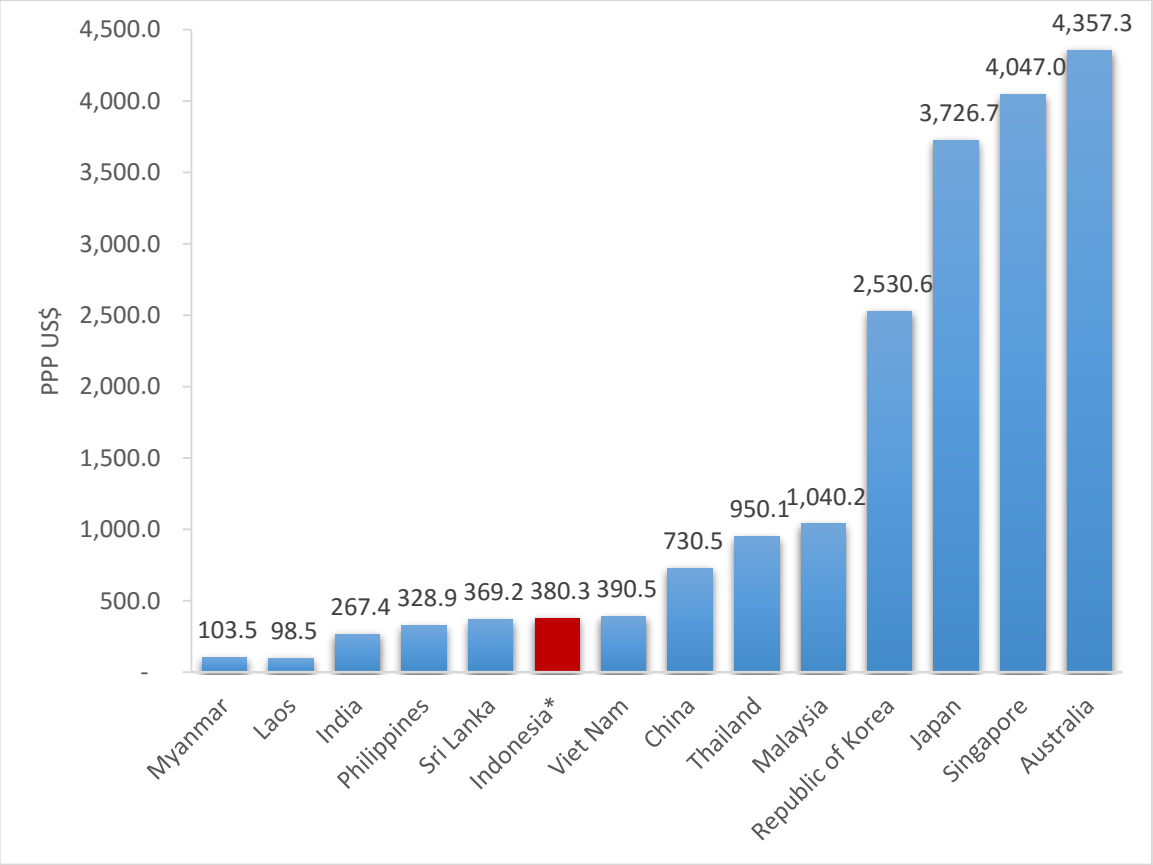

Figure 42. Total Health Expenditure Per-capita by Purchasing Power Parity (US$) in Selected Countries within the Asia-Pacific, 2014

Source: WHO Global Health Expenditure Database - Table of key indicators, May 2016
*Indonesia National Health Accounts, updated May 2016

2. General Government Health Expenditures

The role of the government to support universal health coverage and financing health care is reflected by the share of government health expenditure (GGHE) as compared to total health expenditure of the country (Figure 43). The share of government spending in Indonesia tend to increase, reaching 41.4 percent from the total health expenditures in 2014. However, when compared internationally, GGHE Indonesia is still far behind Malaysia (55.2 percent), Japan (83.6 percent), and Thailand (86.0 percent), that have implemented universal health coverage.

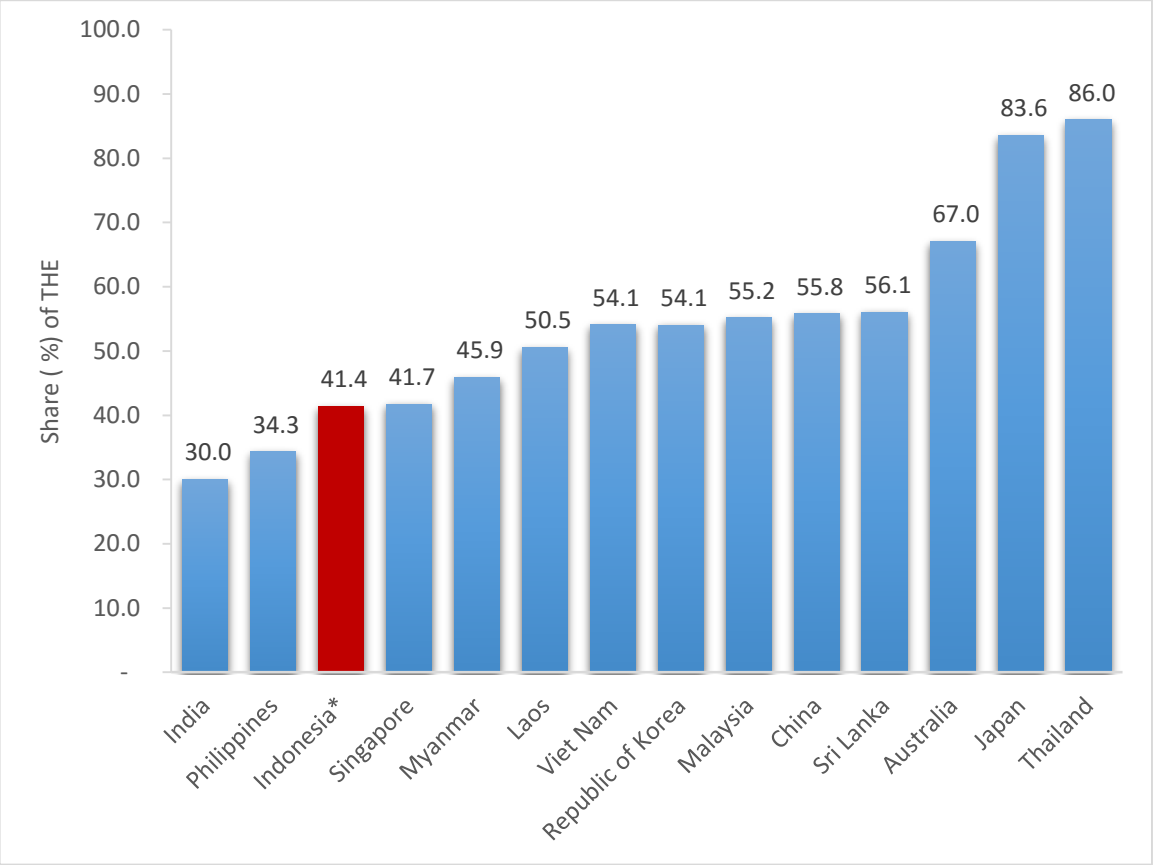

Figure 43. Share of General Government Health Expenditure (GGHE) of Total Health Expenditure (THE) of Selected Countries in the Asia-Pacific, 2014

Source: WHO Global Health Expenditure Database - Table of key indicators, May 2016
*Indonesia National Health Accounts, updated May 2016

3. OOP Health Expenditures

In 2014, OOP health expenditures per-capita in Indonesia was estimated to be at Rp678.8 thousand, with a share of 45.3 percent from total health expenditures (Figure 44), showing a decline of 3 percent from the previous year. Although the share of OOP in relation to THE has shown a decreasing trend over the years, Indonesia's OOP figures are still considerably high when compared to Thailand (7.9 percent), Japan (13.9 percent), Australia (18.8 percent), and Malaysia (35.3 percent). The share of OOP spending to THE of Indonesia is only slightly better when compared Myanmar (50.7 percent) and Philippines (53.7 percent).

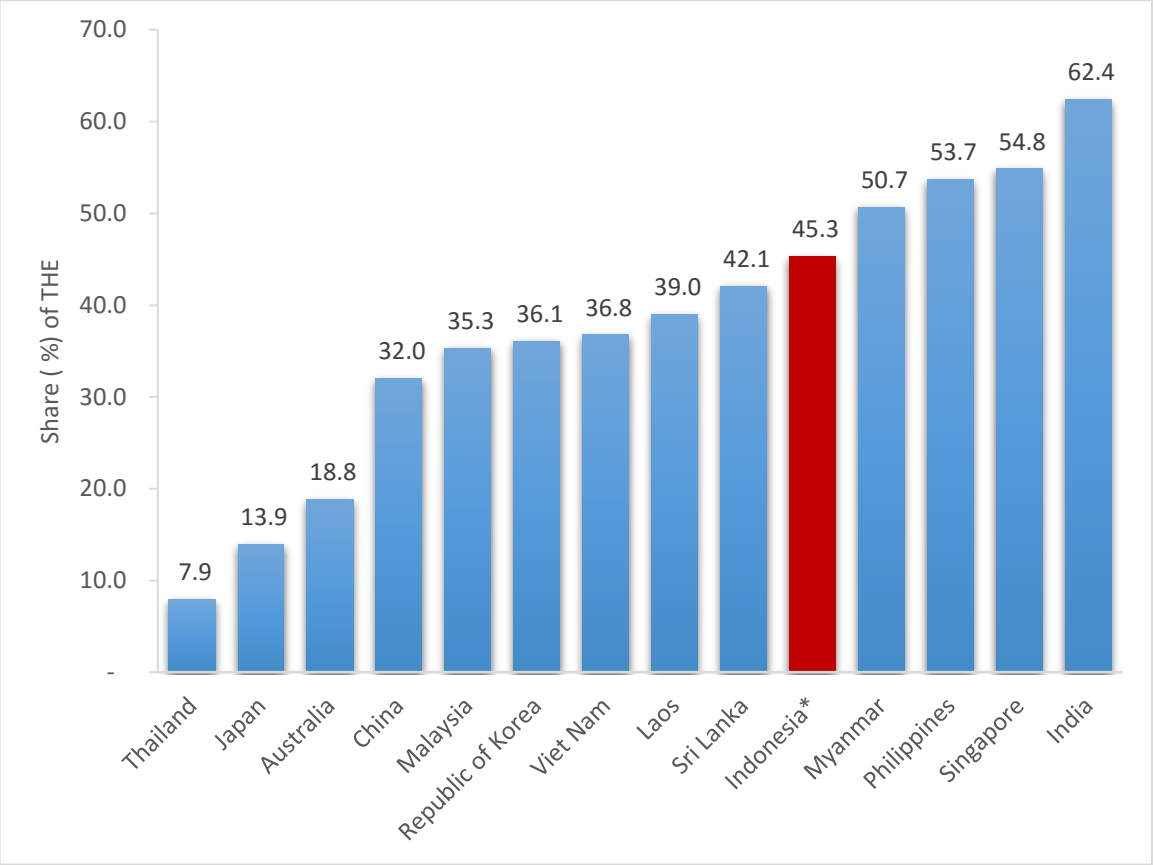

Figure 44. Share of Out-of-Pocket (OOP) Health Expenditures from Total Health Expenditure (THE) of Selected Countries in the Asia-Pacific, 2014

Source: WHO Global Health Expenditure Database - Table of key indicators, May 2016
*Indonesia National Health Accounts, updated May 2016

4. Financing of Health Expenditures

Agent manage health expenditures of a country from various sources. In Indonesia, the private sector has had a larger role than the government (Figure 45). Indonesia's THE predominantly relies on household OOP with the largest share at 45.3 percent of THE, followed by government financing that includes social security funds (41.4 percent), private insurance (1.7 percent), and other financing agents (11.7 percent, including NPISH, companies, and ROW). As a whole, Indonesia's health financing pattern resembles that of India, where the role of the public sector is relatively lower than OOP. On the contrary, this pattern is significantly different from many Asia Pacific countries such as South Korea, China, and Japan that have provided social health protection for all its citizens, hence government and social security funds hold a significant role in the country's health financing.

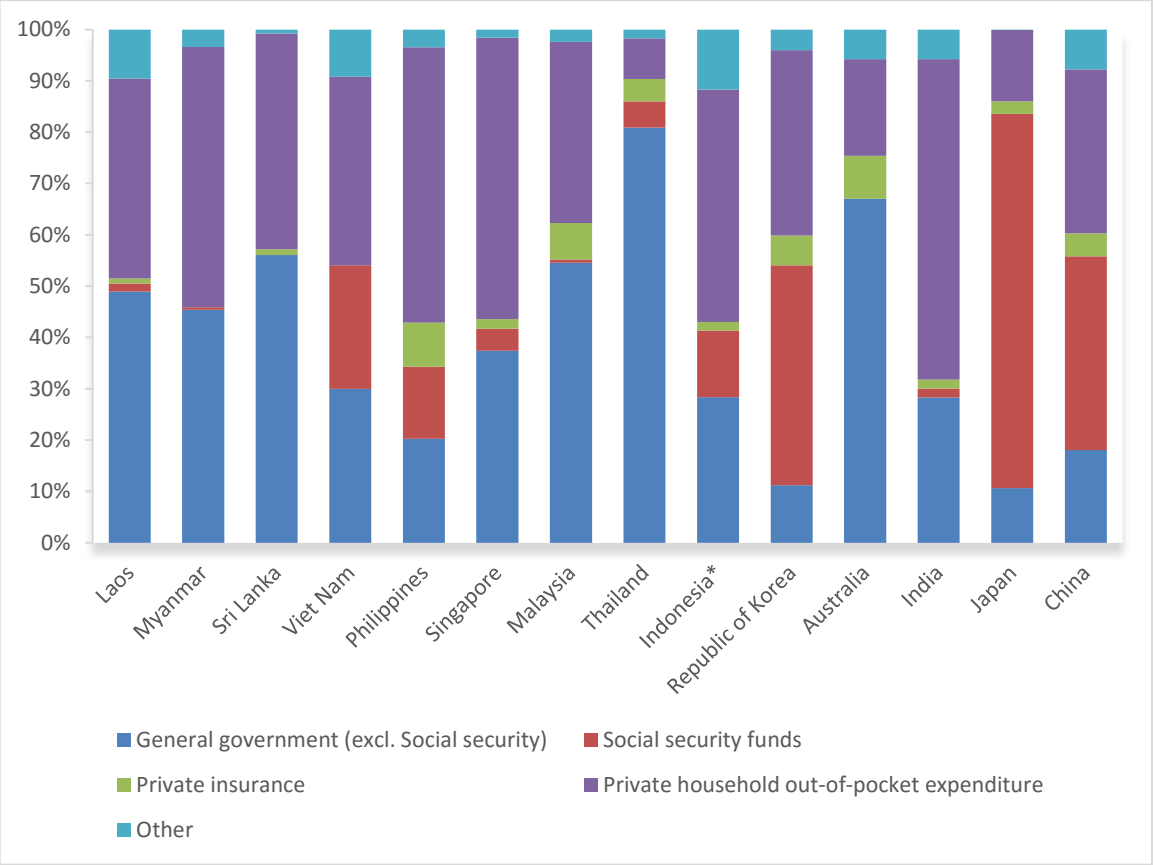

Figure 45. Total Health Expenditure by Financing Agents for Selected Countries in the Asia-Pacific, 2014

Source: WHO Global Health Expenditure Database - Table of key indicators, May 2016
*Indonesia National Health Accounts, updated May 2016

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APPENDIX:

SHA standard tables showing Current Health Expenditure (CHE) in Indonesia, by Healthcare Financing Schemes, Healthcare Financing Agents, Healthcare Providers, and Healthcare Functions 2014

SHA Table A 1. CHE by Providers and Functions (Rp million), 2014

Functions		Providers Billion of national currency	HP.1 Hospitals	HP.2 Residential long-term care facilities	HP.3 Providers of ambulatory health care	HP.4 Providers of ancillary services	HP.5 Retailers and other providers of medical goods	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.8 Rest of economy	HP.9 Rest of the world	All HP All providers
HC.1		Curative care	174,109.0		53,631.7	225.9	12,420.1	21,025.5	1,153.9			262,566.0
	HC.1.1	Inpatient curative care	135,560.3		928.4			1,128.5	29.7			137,646.8
	HC.1.2	Day curative care										
	HC.1.3	Outpatient curative care	38,548.6		52,703.3	225.9	12,420.1	19,897.0	1,124.2			124,919.1
	HC.1.4	Home-based curative care										
HC.2		Rehabilitative care	594.1		0.9			9.9	0.9			605.7
HC.1+HC.2		Curative care and rehabilitative care	174,703.1		53,632.5	225.9	12,420.1	21,035.3	1,154.8			263,171.7
HC.3		Long-term care (health)										
HC.4		Ancillary services (non-specified by function)	12,663.8			168.7		37.0				12,869.5
HC.5		Medical goods (non-specified by function)	11,165.5		0.5		37,230.1	598.5	154.7			49,149.3
HC.6		Preventive care	770.4		437.0	0.9		13,556.3	8,914.6	421.3		24,100.5
HC.7		Governance, and health system and financing administration							9,123.6	4,632.7	454.6	14,210.9
HC.8		Other health care services not elsewhere classified (n.e.c.)										
All HC		All functions	**199,302.9**		**54,070.0**	**395.4**	**49,650.2**	**35,227.2**	**19,347.7**	**5,054.0**	**454.6**	**363,501.9**

SHA Table A 2. CHE by Providers and Functions (% of expenditure by Provider), 2014

Functions		Providers %	HP.1 Hospitals	HP.2 Residential long-term care facilities	HP.3 Providers of ambulatory health care	HP.4 Providers of ancillary services	HP.5 Retailers and other providers of medical goods	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.8 Rest of economy	HP.9 Rest of the world	All HP All providers
HC.1	Curative care		87.4%		99.2%	57.1%	25.0%	59.7%	6.0%			72.2%
HC.1.1	Inpatient curative care		68.0%		1.7%			3.2%	0.2%			37.9%
HC.1.2	Day curative care											
HC.1.3	Outpatient curative care		19.3%		97.5%	57.1%	25.0%	56.5%	5.8%			34.4%
HC.1.4	Home-based curative care											
HC.2	Rehabilitative care		0.3%		0.0%			0.0%	0.0%			0.2%
HC.1+HC.2	Curative care and rehabilitative care		87.7%		99.2%	57.1%	25.0%	59.7%	6.0%			72.4%
HC.3	Long-term care (health)											
HC.4	Ancillary services (non-specified by function)		6.4%			42.7%		0.1%				3.5%
HC.5	Medical goods (non-specified by function)		5.6%		0.0%		75.0%	1.7%	0.8%			13.5%
HC.6	Preventive care		0.4%		0.8%	0.2%		38.5%	46.1%	8.3%		6.6%
HC.7	Governance, and health system and financing administration								47.2%	91.7%	100.0%	3.9%
HC.8	Other health care services not elsewhere classified (n.e.c.)											
All HC	All functions		100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SHA Table A 3. CHE by Providers and Functions (% of expenditure by Functions), 2014

Functions		Providers %	HP.1 Hospitals	HP.2 Residential long-term care facilities	HP.3 Providers of ambulatory health care	HP.4 Providers of ancillary services	HP.5 Retailers and other providers of medical goods	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.8 Rest of economy	HP.9 Rest of the world	All HP All providers
HC.1	Curative care		66.3%		20.4%	0.1%	4.7%	8.0%	0.4%			100.0%
HC.1.1	Inpatient curative care		98.5%		0.7%			0.8%	0.0%			100.0%
HC.1.2	Day curative care											
HC.1.3	Outpatient curative care		30.9%		42.2%	0.2%	9.9%	15.9%	0.9%			100.0%
HC.1.4	Home-based curative care											
HC.2	Rehabilitative care		98.1%		0.1%			1.6%	0.1%			100.0%
HC.1+HC.2	Curative care and rehabilitative care		66.4%		20.4%	0.1%	4.7%	8.0%	0.4%			100.0%
HC.3	Long-term care (health)											
HC.4	Ancillary services (non-specified by function)		98.4%			1.3%		0.3%				100.0%
HC.5	Medical goods (non-specified by function)		22.7%		0.0%		75.7%	1.2%	0.3%			100.0%
HC.6	Preventive care		3.2%		1.8%	0.0%		56.2%	37.0%	1.7%		100.0%
HC.7	Governance, and health system and financing administration								64.2%	32.6%	3.2%	100.0%
HC.8	Other health care services not elsewhere classified (n.e.c.)											
All HC	**All functions**		**54.8%**		**14.9%**	**0.1%**	**13.7%**	**9.7%**	**5.3%**	**1.4%**	**0.1%**	**100.0%**

SHA Table A 4 CHE by Financing Schemes and Functions (Rp million), 2014

Functions	Financing schemes	HF.1	HF.1.1	HF.1.1.1	HF.1.1.1.1	HF.1.1.1.2	HF.1.1.2	HF.1.1.2.1	HF.1.1.2.2	HF.1.2	HF.2	HF.2.1	HF.2.2	HF.2.3	HF.3	HF.4	All HF
	Billion of national currency	Government schemes and compulsory contributory health care financing schemes	Government schemes	Central government schemes	Ministry of Health schemes	Other ministries schemes	State/ regional/ local government schemes	Provincial government schemes	District government schemes	Compulsory contributory health insurance schemes	Voluntary health care payment schemes	Voluntary health insurance schemes	NPISH financing schemes	Enterprise financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	All financing schemes
HC.1	Curative care	113,572.7	68,160.6	11,525.9	10,488.7	1,037.2	56,634.8	18,068.7	38,566.0	45,412.1	39,193.0	5,005.3	277.5	33,910.3	109,800.3		262,566.0
HC.1.1	Inpatient curative care	62,830.7	34,224.5	5,393.8	4,938.9	454.9	28,830.7	9,198.1	19,632.5	28,606.2	20,849.4	2,471.0	39.1	18,339.3	53,966.8		137,646.8
HC.1.2	Day curative care																
HC.1.3	Outpatient curative care	50,742.0	33,936.2	6,132.1	5,549.8	582.2	27,804.1	8,870.6	18,933.5	16,805.9	18,343.7	2,534.3	238.4	15,570.9	55,833.5		124,919.1
HC.1.4	Home-based curative care																
HC.2	Rehabilitative care	510.2	510.2	500.4	474.8	25.6	9.8	3.1	6.7		95.5			95.5			605.7
HC.1+HC.2	Curative care and rehabilitative care	114,082.9	68,670.8	12,026.3	10,963.5	1,062.8	56,644.5	18,071.9	38,572.7	45,412.1	39,288.6	5,005.3	277.5	34,005.8	109,800.3		263,171.7
HC.3	Long-term care (health)																
HC.4	Ancillary services (non-specified by function)	351.6	351.6	267.5	95.8	171.7	84.1	26.8	57.3		47.0		47.0		12,470.9		12,869.5
HC.5	Medical goods (non-specified by function)	713.1	713.1	114.6		114.6	598.5	190.9	407.6		142.8	134.0	8.8		48,138.7	154.7	49,149.3
HC.6	Preventive care	19,725.2	19,578.3	7,031.4	4,918.2	2,113.3	12,546.8	4,002.9	8,543.9	146.9	1,215.8		1,207.7	8.0	769.3	2,390.2	24,100.5
HC.7	Governance, and health system and financing administration	7,475.7	4,380.3	3,443.8	2,934.0	509.8	936.6	298.8	637.8	3,095.4	6,280.6	1,128.1	519.7	4,632.7		454.6	14,210.9
HC.8	Other health care services not elsewhere classified (n.e.c.)																
All HC	**All functions**	**142,348.6**	**93,694.2**	**22,883.7**	**18,911.5**	**3,972.2**	**70,810.5**	**22,591.4**	**48,219.2**	**48,654.4**	**46,974.6**	**6,267.4**	**2,060.7**	**38,646.5**	**171,179.1**	**2,999.6**	**363,501.9**

SHA Table A 5. CHE by Financing Schemes and Functions (% of expenditure by Financing Schemes), 2014

Functions	Financing schemes	HF.1	HF.1.1	HF.1.1.1	HF.1.1.1.1	HF.1.1.1.2	HF.1.1.2	HF.1.1.2.1	HF.1.1.2.2	HF.1.2	HF.2	HF.2.1	HF.2.2	HF.2.3	HF.3	HF.4	All HF
	%	Government schemes and compulsory contributory health care financing schemes	Government schemes	Central government schemes	Ministry of Health schemes	Other ministries schemes	State/ regional/ local government schemes	Provincial government schemes	District government schemes	Compulsory contributory health insurance schemes	Voluntary health care payment schemes	Voluntary health insurance schemes	NPISH financing schemes	Enterprise financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	All financing schemes
HC.1	Curative care	79.8%	72.7%	50.4%	55.5%	26.1%	80.0%	80.0%	80.0%	93.3%	83.4%	79.9%	13.5%	87.7%	64.1%		72.2%
HC.1.1	Inpatient curative care	44.1%	36.5%	23.6%	26.1%	11.5%	40.7%	40.7%	40.7%	58.8%	44.4%	39.4%	1.9%	47.5%	31.5%		37.9%
HC.1.2	Day curative care																
HC.1.3	Outpatient curative care	35.6%	36.2%	26.8%	29.3%	14.7%	39.3%	39.3%	39.3%	34.5%	39.1%	40.4%	11.6%	40.3%	32.6%		34.4%
HC.1.4	Home-based curative care																
HC.2	Rehabilitative care	0.4%	0.5%	2.2%	2.5%	0.6%	0.0%	0.0%	0.0%		0.2%			0.2%			0.2%
HC.1+HC.2	Curative care and rehabilitative care	80.1%	73.3%	52.6%	58.0%	26.8%	80.0%	80.0%	80.0%	93.3%	83.6%	79.9%	13.5%	88.0%	64.1%		72.4%
HC.3	Long-term care (health)																
HC.4	Ancillary services (non-specified by function)	0.2%	0.4%	1.2%	0.5%	4.3%	0.1%	0.1%	0.1%		0.1%		2.3%		7.3%		3.5%
HC.5	Medical goods (non-specified by function)	0.5%	0.8%	0.5%		2.9%	0.8%	0.8%	0.8%		0.3%	2.1%	0.4%		28.1%	5.2%	13.5%
HC.6	Preventive care	13.9%	20.9%	30.7%	26.0%	53.2%	17.7%	17.7%	17.7%	0.3%	2.6%		58.6%	0.0%	0.4%	79.7%	6.6%
HC.7	Governance, and health system and financing administration	5.3%	4.7%	15.0%	15.5%	12.8%	1.3%	1.3%	1.3%	6.4%	13.4%	18.0%	25.2%	12.0%		15.2%	3.9%
HC.8	Other health care services not elsewhere classified (n.e.c.)																
All HC	All functions	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SHA Table A 6. CHE by Financing Schemes and Functions (% of expenditure by Functions), 2014

Functions	Financing schemes	HF.1	HF.1.1	HF.1.1.1	HF.1.1.1.1	HF.1.1.1.2	HF.1.1.2	HF.1.1.2.1	HF.1.1.2.2	HF.1.2	HF.2	HF.2.1	HF.2.2	HF.2.3	HF.3	HF.4	All HF
	%	Government schemes and compulsory contributory health care financing schemes	Government schemes	Central government schemes	Ministry of Health schemes	Other ministries schemes	State/ regional/ local government schemes	Provincial government schemes	District government schemes	Compulsory contributory health insurance schemes	Voluntary health care payment schemes	Voluntary health insurance schemes	NPISH financing schemes	Enterprise financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	All financing schemes
HC.1	Curative care	43.3%	26.0%	4.4%	4.0%	0.4%	21.6%	6.9%	14.7%	17.3%	14.9%	1.9%	0.1%	12.9%	41.8%		100.0%
HC.1.1	Inpatient curative care	45.6%	24.9%	3.9%	3.6%	0.3%	20.9%	6.7%	14.3%	20.8%	15.1%	1.8%	0.0%	13.3%	39.2%		100.0%
HC.1.2	Day curative care																
HC.1.3	Outpatient curative care	40.6%	27.2%	4.9%	4.4%	0.5%	22.3%	7.1%	15.2%	13.5%	14.7%	2.0%	0.2%	12.5%	44.7%		100.0%
HC.1.4	Home-based curative care																
HC.2	Rehabilitative care	84.2%	84.2%	82.6%	78.4%	4.2%	1.6%	0.5%	1.1%		15.8%			15.8%			100.0%
HC.1+HC.2	Curative care and rehabilitative care	43.3%	26.1%	4.6%	4.2%	0.4%	21.5%	6.9%	14.7%	17.3%	14.9%	1.9%	0.1%	12.9%	41.7%		100.0%
HC.3	Long-term care (health)																
HC.4	Ancillary services (non-specified by function)	2.7%	2.7%	2.1%	0.7%	1.3%	0.7%	0.2%	0.4%		0.4%		0.4%		96.9%		100.0%
HC.5	Medical goods (non-specified by function)	1.5%	1.5%	0.2%		0.2%	1.2%	0.4%	0.8%		0.3%	0.3%	0.0%		97.9%	0.3%	100.0%
HC.6	Preventive care	81.8%	81.2%	29.2%	20.4%	8.8%	52.1%	16.6%	35.5%	0.6%	5.0%		5.0%	0.0%	3.2%	9.9%	100.0%
HC.7	Governance, and health system and financing administration	52.6%	30.8%	24.2%	20.6%	3.6%	6.6%	2.1%	4.5%	21.8%	44.2%	7.9%	3.7%	32.6%		3.2%	100.0%
HC.8	Other health care services not elsewhere classified (n.e.c.)																
All HC	**All functions**	**39.2%**	**25.8%**	**6.3%**	**5.2%**	**1.1%**	**19.5%**	**6.2%**	**13.3%**	**13.4%**	**12.9%**	**1.7%**	**0.6%**	**10.6%**	**47.1%**	**0.8%**	**100.0%**

SHA Table A 7. CHE by Financing Agent and Functions (Rp million), 2014

Financing agents		FA.1	FA.1.1	FA.1.1.1	FA.1.1.2	FA.1.2	FA.1.2.1	FA.1.2.2	FA.1.3	FA.1.9	FA.2	FA.3	FA.4	FA.5	FA.6	All FA
Functions	Billion of national currency	General government	Central government	Ministry of Health	Other ministries and public units (belonging to central government)	State/ regional/ local government	Provincial government	District government	Social security agency	All other general government units	Insurance corporations	Corporations (other than insurance corporations)	Non-profit institutions serving households (NPISH)	Households	Rest of the world	All financing agents
HC.1	Curative care	113,572.7	11,519.8	10,482.7	1,037.2	56,640.8	18,070.6	38,570.2	45,412.1		5,005.3	33,910.3	277.5	109,800.3		262,566.0
HC.1.1	Inpatient curative care	62,830.7	5,391.6	4,936.7	454.9	28,832.8	9,198.3	19,634.6	28,606.2		2,471.0	18,339.3	39.1	53,966.8		137,646.8
HC.1.2	Day curative care															
HC.1.3	Outpatient curative care	50,742.0	6,128.2	5,546.0	582.2	27,808.0	8,872.3	18,935.6	16,805.9		2,534.3	15,570.9	238.4	55,833.5		124,919.1
HC.1.4	Home-based curative care															
HC.2	Rehabilitative care	510.2	500.3	474.7	25.6	9.8	3.2	6.7				95.5				605.7
HC.1+HC.2	Curative care and rehabilitative	114,082.9	12,020.2	10,957.4	1,062.8	56,650.6	18,073.8	38,576.9	45,412.1		5,005.3	34,005.8	277.5	109,800.3		263,171.7
HC.3	Long-term care (health)															
HC.4	Ancillary services (non-specified by function)	351.6	267.5	95.8	171.7	84.1	26.8	57.3					47.0	12,470.9		12,869.5
HC.5	Medical goods (non-specified by function)	713.1	114.6		114.6	598.5	190.9	407.6			134.0		8.8	48,138.7	154.7	49,149.3
HC.6	Preventive care	19,725.2	5,378.7	3,265.4	2,113.3	14,199.6	4,528.3	9,671.3	146.9			8.0	1,207.7	769.3	2,390.2	24,100.5
HC.7	Governance, and health system and financing administration	7,475.7	3,198.7	2,688.9	509.8	1,181.7	539.3	642.3	3,095.4		1,128.1	4,632.7	519.7		454.6	14,210.9
HC.8	Other health care services not elsewhere classified (n.e.c.)															
All HC	All functions	**142,348.6**	**20,979.7**	**17,007.6**	**3,972.2**	**72,714.5**	**23,359.2**	**49,355.3**	**48,654.4**	-	**6,267.4**	**38,646.5**	**2,060.7**	**171,179.1**	**2,999.6**	**363,501.9**

SHA Table A 8. CHE by Financing Agents and Functions (% of expenditure by Financing Agents), 2014

Functions	Financing agents / %	FA.1 General government	FA.1.1 Central government	FA.1.1.1 Ministry of Health	FA.1.1.2 Other ministries and public units (belonging to central government)	FA.1.2 State/ regional/ local government	FA.1.2.1 Provincial government	FA.1.2.2 District government	FA.1.3 Social security agency	FA.1.9 All other general government units	FA.2 Insurance corporations	FA.3 Corporations (other than insurance corporations)	FA.4 Non-profit institutions serving households (NPISH)	FA.5 Households	FA.6 Rest of the world	All FA All financing agents
HC.1	Curative care	79.8%	54.9%	61.6%	26.1%	77.9%	77.4%	78.1%	93.3%		79.9%	87.7%	13.5%	64.1%		72.2%
HC.1.1	Inpatient curative care	44.1%	25.7%	29.0%	11.5%	39.7%	39.4%	39.8%	58.8%		39.4%	47.5%	1.9%	31.5%		37.9%
HC.1.2	Day curative care															
HC.1.3	Outpatient curative care	35.6%	29.2%	32.6%	14.7%	38.2%	38.0%	38.4%	34.5%		40.4%	40.3%	11.6%	32.6%		34.4%
HC.1.4	Home-based curative care															
HC.2	Rehabilitative care	0.4%	2.4%	2.8%	0.6%	0.0%	0.0%	0.0%				0.2%				0.2%
HC.1+HC.2	Curative care and rehabilitative care	80.1%	57.3%	64.4%	26.8%	77.9%	77.4%	78.2%	93.3%		79.9%	88.0%	13.5%	64.1%		72.4%
HC.3	Long-term care (health)															
HC.4	Ancillary services (non-specified by function)	0.2%	1.3%	0.6%	4.3%	0.1%	0.1%	0.1%					2.3%	7.3%		3.5%
HC.5	Medical goods (non-specified by function)	0.5%	0.5%		2.9%	0.8%	0.8%	0.8%			2.1%		0.4%	28.1%	5.2%	13.5%
HC.6	Preventive care	13.9%	25.6%	19.2%	53.2%	19.5%	19.4%	19.6%	0.3%			0.0%	58.6%	0.4%	79.7%	6.6%
HC.7	Governance, and health system and financing administration	5.3%	15.2%	15.8%	12.8%	1.6%	2.3%	1.3%	6.4%		18.0%	12.0%	25.2%		15.2%	3.9%
HC.8	Other health care services not elsewhere classified (n.e.c.)															
All HC	All functions	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SHA Table A 9. CHE by Financing Agents and Functions (% of expenditure by Functions), 2014

Functions	Financing agents	FA.1	FA.1.1	FA.1.1.1	FA.1.1.2	FA.1.2	FA.1.2.1	FA.1.2.2	FA.1.3	FA.1.9	FA.2	FA.3	FA.4	FA.5	FA.6	All FA
	%	General government	Central government	Ministry of Health	Other ministries and public units (belonging to central government)	State/ regional/ local government	Provincial government	District government	Social security agency	All other general government units	Insurance corporations	Corporations (other than insurance corporations)	Non-profit institutions serving households (NPISH)	Households	Rest of the world	All financing agents
HC.1	Curative care	43.3%	4.4%	4.0%	0.4%	21.6%	6.9%	14.7%	17.3%		1.9%	12.9%	0.1%	41.8%		100.0%
HC.1.1	Inpatient curative care	45.6%	3.9%	3.6%	0.3%	20.9%	6.7%	14.3%	20.8%		1.8%	13.3%	0.0%	39.2%		100.0%
HC.1.2	Day curative care															
HC.1.3	Outpatient curative care	40.6%	4.9%	4.4%	0.5%	22.3%	7.1%	15.2%	13.5%		2.0%	12.5%	0.2%	44.7%		100.0%
HC.1.4	Home-based curative care															
HC.2	Rehabilitative care	84.2%	82.6%	78.4%	4.2%	1.6%	0.5%	1.1%				15.8%				100.0%
HC.1+HC.2	Curative care and rehabilitative care	43.3%	4.6%	4.2%	0.4%	21.5%	6.9%	14.7%	17.3%		1.9%	12.9%	0.1%	41.7%		100.0%
HC.3	Long-term care (health)															
HC.4	Ancillary services (non-specified by function)	2.7%	2.1%	0.7%	1.3%	0.7%	0.2%	0.4%					0.4%	96.9%		100.0%
HC.5	Medical goods (non-specified by function)	1.5%	0.2%		0.2%	1.2%	0.4%	0.8%			0.3%		0.0%	97.9%	0.3%	100.0%
HC.6	Preventive care	81.8%	22.3%	13.5%	8.8%	58.9%	18.8%	40.1%	0.6%			0.0%	5.0%	3.2%	9.9%	100.0%
HC.7	Governance, and health system and financing administration	52.6%	22.5%	18.9%	3.6%	8.3%	3.8%	4.5%	21.8%		7.9%	32.6%	3.7%		3.2%	100.0%
HC.8	Other health care services not elsewhere classified (n.e.c.)															
All HC	**All functions**	**39.2%**	**5.8%**	**4.7%**	**1.1%**	**20.0%**	**6.4%**	**13.6%**	**13.4%**		**1.7%**	**10.6%**	**0.6%**	**47.1%**	**0.8%**	**100.0%**

SHA Table A 10. CHE by Financing Schemes and Providers (Rp millions), 2014

Financing schemes	Providers / Billion of national currency	HP.1 Hospitals	HP.2 Residential long-term care facilities	HP.3 Providers of ambulatory health care	HP.4 Providers of ancillary services	HP.5 Retailers and other providers of medical goods	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.8 Rest of economy	HP.9 Rest of the world	All HP All providers
HF.1	Government schemes and compulsory contributory health care financing schemes	82,193.3		10,204.3	355.4		35,227.2	13,947.1	421.3		142,348.6
HF.1.1	Government schemes	45,862.9		1,122.8	355.4		35,080.2	10,851.7	421.3		93,694.2
HF.1.1.1	Central government schemes	10,742.4		840.7	111.4		3,323.4	7,865.8			22,883.7
HF.1.1.1.1	Ministry of Health schemes	9,832.6		352.6	111.4		3,301.6	5,313.4			18,911.5
HF.1.1.1.2	Other ministries schemes	909.8		488.1			21.8	2,552.4			3,972.2
HF.1.1.2	State/ regional/ local government schemes	35,120.5		282.0	244.0		31,756.9	2,985.9	421.3		70,810.5
HF.1.1.2.1	Provincial government schemes	11,204.8		90.0	77.8		10,131.7	952.6	134.4		22,591.4
HF.1.1.2.2	District government schemes	23,915.7		192.1	166.1		21,625.2	2,033.3	286.9		48,219.2
HF.1.2	Compulsory contributory health insurance schemes	36,330.5		9,081.6			146.9	3,095.4			48,654.4
HF.2	Voluntary health care payment schemes	27,155.0		12,157.4	40.0	134.0		2,855.6	4,632.7		46,974.6
HF.2.1	Voluntary health insurance schemes	3,541.3		1,464.0		134.0		1,128.1			6,267.4
HF.2.2	NPISH financing schemes	63.0		230.2	40.0			1,727.5			2,060.7
HF.2.3	Enterprise financing schemes	23,550.7		10,463.1					4,632.7		38,646.5
HF.3	Household out-of-pocket payment	89,954.6		31,708.3		49,516.2					171,179.1
HF.4	Rest of the world financing schemes (non-resident)							2,545.0		454.6	2,999.6
All HF	**All financing schemes**	**199,302.9**	**-**	**54,070.0**	**395.4**	**49,650.2**	**35,227.2**	**19,347.7**	**5,054.0**	**454.6**	**363,501.9**

SHA Table A 11. CHE by Financing Schemes and Providers (% of expenditure by Financing Schemes), 2014

Financing schemes (%)		HP.1 Hospitals	HP.2 Residential long-term care facilities	HP.3 Providers of ambulatory health care	HP.4 Providers of ancillary services	HP.5 Retailers and other providers of medical goods	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.8 Rest of economy	HP.9 Rest of the world	All HP All providers
HF.1	Government schemes and compulsory contributory health care financing schemes	57.7%		7.2%	0.2%		24.7%	9.8%	0.3%		100.0%
HF.1.1	Government schemes	48.9%		1.2%	0.4%		37.4%	11.6%	0.4%		100.0%
HF.1.1.1	Central government schemes	46.9%		3.7%	0.5%		14.5%	34.4%			100.0%
HF.1.1.1.1	Ministry of Health schemes	52.0%		1.9%	0.6%		17.5%	28.1%			100.0%
HF.1.1.1.2	Other ministries schemes	22.9%		12.3%			0.5%	64.3%			100.0%
HF.1.1.2	State/ regional/ local government schemes	49.6%		0.4%	0.3%		44.8%	4.2%	0.6%		100.0%
HF.1.1.2.1	Provincial government schemes	49.6%		0.4%	0.3%		44.8%	4.2%	0.6%		100.0%
HF.1.1.2.2	District government schemes	49.6%		0.4%	0.3%		44.8%	4.2%	0.6%		100.0%
HF.1.2	Compulsory contributory health insurance schemes	74.7%		18.7%			0.3%	6.4%			100.0%
HF.2	Voluntary health care payment schemes	57.8%		25.9%	0.1%	0.3%		6.1%	9.9%		100.0%
HF.2.1	Voluntary health insurance schemes	56.5%		23.4%		2.1%		18.0%			100.0%
HF.2.2	NPISH financing schemes	3.1%		11.2%	1.9%			83.8%			100.0%
HF.2.3	Enterprise financing schemes	60.9%		27.1%					12.0%		100.0%
HF.3	Household out-of-pocket payment	52.5%		18.5%		28.9%					100.0%
HF.4	Rest of the world financing schemes (non-resident)							84.8%		15.2%	100.0%
All HF	**All financing schemes**	**54.8%**		**14.9%**	**0.1%**	**13.7%**	**9.7%**	**5.3%**	**1.4%**	**0.1%**	**100.0%**

SHA Table A 12. CHE by Financing Schemes and Providers (% of expenditure by Providers), 2014

Providers % Financing schemes		HP.1 Hospitals	HP.2 Residential long-term care facilities	HP.3 Providers of ambulatory health care	HP.4 Providers of ancillary services	HP.5 Retailers and other providers of medical goods	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.8 Rest of economy	HP.9 Rest of the world	All HP All providers
HF.1	Government schemes and compulsory contributory health care financing schemes	41.2%		18.9%	89.9%		100.0%	72.1%	8.3%		39.2%
HF.1.1	Government schemes	23.0%		2.1%	89.9%		99.6%	56.1%	8.3%		25.8%
HF.1.1.1	Central government schemes	5.4%		1.6%	28.2%		9.4%	40.7%			6.3%
HF.1.1.1.1	Ministry of Health schemes	4.9%		0.7%	28.2%		9.4%	27.5%			5.2%
HF.1.1.1.2	Other ministries schemes	0.5%		0.9%			0.1%	13.2%			1.1%
HF.1.1.2	State/ regional/ local government schemes	17.6%		0.5%	61.7%		90.1%	15.4%	8.3%		19.5%
HF.1.1.2.1	Provincial government schemes	5.6%		0.2%	19.7%		28.8%	4.9%	2.7%		6.2%
HF.1.1.2.2	District government schemes	12.0%		0.4%	42.0%		61.4%	10.5%	5.7%		13.3%
HF.1.2	Compulsory contributory health insurance schemes	18.2%		16.8%			0.4%	16.0%			13.4%
HF.2	Voluntary health care payment schemes	13.6%		22.5%	10.1%	0.3%		14.8%	91.7%		12.9%
HF.2.1	Voluntary health insurance schemes	1.8%		2.7%		0.3%		5.8%			1.7%
HF.2.2	NPISH financing schemes	0.0%		0.4%	10.1%			8.9%			0.6%
HF.2.3	Enterprise financing schemes	11.8%		19.4%					91.7%		10.6%
HF.3	Household out-of-pocket payment	45.1%		58.6%		99.7%					47.1%
HF.4	Rest of the world financing schemes (non-resident)							13.2%		100.0%	0.8%
All HF	All financing schemes	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SHA Table A 13. CHE by Financing Schemes and Financing Agents (Rp million), 2014

Financing schemes	Financing agents / Billion of national currency	FA.1 General government	FA.1.1 Central government	FA.1.1.1 Ministry of Health	FA.1.1.2 Other ministries and public units (belonging to central government)	FA.1.2 State/ regional/ local government	FA.1.2.1 Provincial government	FA.1.2.2 District government	FA.1.3 Social security agency	FA.1.9 All other general government units	FA.2 Insurance corporations	FA.3 Corporations (other than insurance corporations)	FA.4 Non-profit institutions serving households (NPISH)	FA.5 Households	FA.6 Rest of the world	All FA All financing agents
HF.1	Government schemes and compulsory contributory health care financing schemes	142,348.6	20,979.7	17,007.6	3,972.2	72,714.5	23,359.2	49,355.3	48,654.4							142,348.6
HF.1.1	Government schemes	93,694.2	20,979.7	17,007.6	3,972.2	72,714.5	23,359.2	49,355.3								93,694.2
HF.1.1.1	Central government schemes	22,883.7	20,979.7	17,007.6	3,972.2	1,903.9	767.8	1,136.1								22,883.7
HF.1.1.1.1	Ministry of Health schemes	18,911.5	17,007.6	17,007.6		1,903.9	767.8	1,136.1								18,911.5
HF.1.1.1.2	Other ministries schemes	3,972.2	3,972.2		3,972.2											3,972.2
HF.1.1.2	State/ regional/ local government schemes	70,810.5				70,810.5	22,591.4	48,219.2								70,810.5
HF.1.1.2.1	Provincial government schemes	22,591.4				22,591.4	22,591.4									22,591.4
HF.1.1.2.2	District government schemes	48,219.2				48,219.2		48,219.2								48,219.2
HF.1.2	Compulsory contributory health insurance schemes	48,654.4							48,654.4							48,654.4
HF.2	Voluntary health care payment schemes										6,267.4	38,646.5	2,060.7			46,974.6
HF.2.1	Voluntary health insurance schemes										6,267.4					6,267.4
HF.2.2	NPISH financing schemes												2,060.7			2,060.7
HF.2.3	Enterprise financing schemes											38,646.5				38,646.5
HF.3	Household out-of-pocket payment													171,179.1		171,179.1
HF.4	Rest of the world financing schemes (non-resident)														2,999.6	2,999.6
All HF	**All financing schemes**	**142,348.6**	**20,979.7**	**17,007.6**	**3,972.2**	**72,714.5**	**23,359.2**	**49,355.3**	**48,654.4**		**6,267.4**	**38,646.5**	**2,060.7**	**171,179.1**	**2,999.6**	**363,501.9**

SHA Table A 14. CHE by Financing Schemes and Financing Agents (% of expenditure by Financing Schemes), 2014

Financing schemes	Financing agents	FA.1	FA.1.1	FA.1.1.1	FA.1.1.2	FA.1.2	FA.1.2.1	FA.1.2.2	FA.1.3	FA.1.9	FA.2	FA.3	FA.4	FA.5	FA.6	All FA
	%	General government	Central government	Ministry of Health	Other ministries and public units (belonging to central government)	State/ regional/ local government	Provincial government	District government	Social security agency	All other general government units	Insurance corporations	Corporations (other than insurance corporations)	Non-profit institutions serving households (NPISH)	Households	Rest of the world	All financing agents
HF.1	Government schemes and compulsory contributory health care financing schemes	100.0%	14.7%	11.9%	2.8%	51.1%	16.4%	34.7%	34.2%							100.0%
HF.1.1	Government schemes	100.0%	22.4%	18.2%	4.2%	77.6%	24.9%	52.7%								100.0%
HF.1.1.1	Central government schemes	100.0%	91.7%	74.3%	17.4%	8.3%	3.4%	5.0%								100.0%
HF.1.1.1.1	Ministry of Health schemes	100.0%	89.9%	89.9%		10.1%	4.1%	6.0%								100.0%
HF.1.1.1.2	Other ministries schemes	100.0%	100.0%		100.0%											100.0%
HF.1.1.2	State/ regional/ local government schemes	100.0%				100.0%	31.9%	68.1%								100.0%
HF.1.1.2.1	Provincial government schemes	100.0%				100.0%	100.0%									100.0%
HF.1.1.2.2	District government schemes	100.0%				100.0%		100.0%								100.0%
HF.1.2	Compulsory contributory health insurance schemes	100.0%							100.0%							100.0%
HF.2	Voluntary health care payment schemes										13.3%	82.3%	4.4%			100.0%
HF.2.1	Voluntary health insurance schemes										100.0%					100.0%
HF.2.2	NPISH financing schemes												100.0%			100.0%
HF.2.3	Enterprise financing schemes											100.0%				100.0%
HF.3	Household out-of-pocket payment													100.0%		100.0%
HF.4	Rest of the world financing schemes (non-resident)														100.0%	100.0%
All HF	**All financing schemes**	**39.2%**	**5.8%**	**4.7%**	**1.1%**	**20.0%**	**6.4%**	**13.6%**	**13.4%**		**1.7%**	**10.6%**	**0.6%**	**47.1%**	**0.8%**	**100.0%**

SHA Table A 15. CHE by Financing Schemes and Financing Agents (% of expenditure by Financing Agents), 2014

Financing agents / Financing schemes		FA.1	FA.1.1	FA.1.1.1	FA.1.1.2	FA.1.2	FA.1.2.1	FA.1.2.2	FA.1.3	FA.1.9	FA.2	FA.3	FA.4	FA.5	FA.6	All FA
%		General government	Central government	Ministry of Health	Other ministries and public units (belonging to central government)	State/ regional/ local government	Provincial government	District government	Social security agency	All other general government units	Insurance corporations	Corporations (other than insurance corporations)	Non-profit institutions serving households (NPISH)	Households	Rest of the world	All financing agents
HF.1	Government schemes and compulsory contributory health care financing schemes	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							39.2%
HF.1.1	Government schemes	65.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								25.8%
HF.1.1.1	Central government schemes	16.1%	100.0%	100.0%	100.0%	2.6%	3.3%	2.3%								6.3%
HF.1.1.1.1	Ministry of Health schemes	13.3%	81.1%	100.0%		2.6%	3.3%	2.3%								5.2%
HF.1.1.1.2	Other ministries schemes	2.8%	18.9%		100.0%											1.1%
HF.1.1.2	State/ regional/ local government schemes	49.7%				97.4%	96.7%	97.7%								19.5%
HF.1.1.2.1	Provincial government schemes	15.9%				31.1%	96.7%									6.2%
HF.1.1.2.2	District government schemes	33.9%				66.3%		97.7%								13.3%
HF.1.2	Compulsory contributory health insurance schemes	34.2%							100.0%							13.4%
HF.2	Voluntary health care payment schemes										100.0%	100.0%	100.0%			12.9%
HF.2.1	Voluntary health insurance schemes										100.0%					1.7%
HF.2.2	NPISH financing schemes												100.0%			0.6%
HF.2.3	Enterprise financing schemes											100.0%				10.6%
HF.3	Household out-of-pocket payment													100.0%		47.1%
HF.4	Rest of the world financing schemes (non-resident)														100.0%	0.8%
All HF	All financing schemes	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SHA Table A 16. CHE by Financing Agents and Providers (Rp millions), 2014

Providers / Billion of national currency / Financing agents		HP.1 Hospitals	HP.2 Residential long-term care facilities	HP.3 Providers of ambulatory health care	HP.4 Providers of ancillary services	HP.5 Retailers and other providers of medical goods	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.8 Rest of economy	HP.9 Rest of the world	All HP All providers
FA.1	General government	82,193.3		10,204.3	355.4		35,227.2	13,947.1	421.3		142,348.6
FA.1.1	Central government	10,737.9		839.1	111.4		2,294.1	6,997.2			20,979.7
FA.1.1.1	Ministry of Health	9,828.0		351.0	111.4		2,272.4	4,444.8			17,007.6
FA.1.1.2	Other ministries and public units (belonging to central government)	909.8		488.1			21.8	2,552.4			3,972.2
FA.1.2	State/ regional/ local government	35,125.0		283.6	244.0		32,786.1	3,854.5	421.3		72,714.5
FA.1.2.1	Provincial government	11,205.2		91.6	77.8		10,159.1	1,691.1	134.4		23,359.2
FA.1.2.2	District government	23,919.8		192.1	166.1		22,627.0	2,163.4	286.9		49,355.3
FA.1.3	Social security agency	36,330.5		9,081.6			146.9	3,095.4			48,654.4
FA.1.9	All other general government units										
FA.2	Insurance corporations	3,541.3		1,464.0		134.0		1,128.1			6,267.4
FA.3	Corporations (other than insurance corporations)	23,550.7		10,463.1					4,632.7		38,646.5
FA.4	Non-profit institutions serving households (NPISH)	63.0		230.2	40.0			1,727.5			2,060.7
FA.5	Households	89,954.6		31,708.3		49,516.2					171,179.1
FA.6	Rest of the world							2,545.0		454.6	2,999.6
All FA	**All financing agents**	**199,302.9**		**54,070.0**	**395.4**	**49,650.2**	**35,227.2**	**19,347.7**	**5,054.0**	**454.6**	**363,501.9**

SHA Table A 17. CHE by Financing Agents and Providers (% of expenditure by Providers), 2014

Providers % Financing agents		HP.1 Hospitals	HP.2 Residential long-term care facilities	HP.3 Providers of ambulatory health care	HP.4 Providers of ancillary services	HP.5 Retailers and other providers of medical goods	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.8 Rest of economy	HP.9 Rest of the world	All HP All providers
FA.1	General government	41.2%		18.9%	89.9%		100.0%	72.1%	8.3%		39.2%
FA.1.1	Central government	5.4%		1.6%	28.2%		6.5%	36.2%			5.8%
FA.1.1.1	Ministry of Health	4.9%		0.6%	28.2%		6.5%	23.0%			4.7%
FA.1.1.2	Other ministries and public units (belonging to central government)	0.5%		0.9%			0.1%	13.2%			1.1%
FA.1.2	State/ regional/ local government	17.6%		0.5%	61.7%		93.1%	19.9%	8.3%		20.0%
FA.1.2.1	Provincial government	5.6%		0.2%	19.7%		28.8%	8.7%	2.7%		6.4%
FA.1.2.2	District government	12.0%		0.4%	42.0%		64.2%	11.2%	5.7%		13.6%
FA.1.3	Social security agency	18.2%		16.8%			0.4%	16.0%			13.4%
FA.1.9	All other general government units										
FA.2	Insurance corporations	1.8%		2.7%		0.3%		5.8%			1.7%
FA.3	Corporations (other than insurance corporations)	11.8%		19.4%					91.7%		10.6%
FA.4	Non-profit institutions serving households (NPISH)	0.0%		0.4%	10.1%			8.9%			0.6%
FA.5	Households	45.1%		58.6%		99.7%					47.1%
FA.6	Rest of the world							13.2%		100.0%	0.8%
All FA	**All financing agents**	**100.0%**		**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

SHA Table A 18. CHE by Financing Agents and Providers (% of expenditure by Financing Agents), 2014

Providers % Financing agents		HP.1 Hospitals	HP.2 Residential long-term care facilities	HP.3 Providers of ambulatory health care	HP.4 Providers of ancillary services	HP.5 Retailers and other providers of medical goods	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.8 Rest of economy	HP.9 Rest of the world	All HP All providers
FA.1	General government	57.7%		7.2%	0.2%		24.7%	9.8%	0.3%		100.0%
FA.1.1	Central government	51.2%		4.0%	0.5%		10.9%	33.4%			100.0%
FA.1.1.1	Ministry of Health	57.8%		2.1%	0.7%		13.4%	26.1%			100.0%
FA.1.1.2	Other ministries and public units (belonging to central government)	22.9%		12.3%			0.5%	64.3%			100.0%
FA.1.2	State/ regional/ local government	48.3%		0.4%	0.3%		45.1%	5.3%	0.6%		100.0%
FA.1.2.1	Provincial government	48.0%		0.4%	0.3%		43.5%	7.2%	0.6%		100.0%
FA.1.2.2	District government	48.5%		0.4%	0.3%		45.8%	4.4%	0.6%		100.0%
FA.1.3	Social security agency	74.7%		18.7%			0.3%	6.4%			100.0%
FA.1.9	All other general government units										
FA.2	Insurance corporations	56.5%		23.4%		2.1%		18.0%			100.0%
FA.3	Corporations (other than insurance corporations)	60.9%		27.1%					12.0%		100.0%
FA.4	Non-profit institutions serving households (NPISH)	3.1%		11.2%	1.9%			83.8%			100.0%
FA.5	Households	52.5%		18.5%		28.9%					100.0%
FA.6	Rest of the world							84.8%		15.2%	100.0%
All FA	**All financing agents**	**54.8%**		**14.9%**	**0.1%**	**13.7%**	**9.7%**	**5.3%**	**1.4%**	**0.1%**	**100.0%**

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