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Determinant of Health Development Performance after Decentralization and Regional Autonomy Program in West Nusa Tenggara Indonesia

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Abstract
The objective of this study is to verify factors contributing to the improvement of health status in West Nusa Tenggara. In addition, this paper is also intended to analyze dominant factors influencing health development since the initiation of decentralization and regional autonomy program. Data used in the analysis consist of secondary data (time series) over the period of 2000-2011. Data are obtained from various sources and have been documented and published. Several variables identified as variables that affect the performance of health development consist of education, economic, infrastructure, and health resources variable. Each variable is categorized as latent variable in which each variable has its own indicators. Collected data will be analyzed using quantitative analysis by applying structural equation models (SEM) with Partial Least Square (PLS). The result findings indicate that health performance is influenced simultaneously by variables including in the model such as social, economic, infrastructure, and health resources. The dominant factors influencing health development are social and economic factor representing the willingness to pay and the ability to pay for health services.
Keywords: health development performance, decentralization, structural equation modelling, willingness to pay, ability to pay.

1. Background

Decentralization and regional autonomy in Indonesia implemented since 2001 provide opportunities to realize as well as to fulfill the actual needs of local governments and their community. The policies also encourage local governments and other stakeholders to be innovative, especially in planning and budgeting process of regional development. In addition, decentralization and regional autonomy are believed to be able to improve the quality of public services, to enhance the welfare of local people, and to foster participation and democracy at the local level. They will provide huge opportunities for local government to develop natural and human resources existing in each region and to create an atmosphere of competition among regions (Bappeda, 2009).

Decentralization and regional autonomy intended to improve the quality of public services provided by government have apparently shown a good performance. Development in public health in the province of West Nusa Tenggara (WNT) tends to have a positive progress. This is demonstrated by the increasing rate of health indicators including infant mortality rate, maternal mortality rate, life expectancy, birth attended by skilled attendant, malnutrition, and morbidity rate. The infant mortality rate in 2000 was 78.5, but it decreased to 62.62 in 2011. The maternal mortality rate has also declined from 390 in 2000 to 280.5 in 2011. Meanwhile, people enjoyed a longer life, whereas life expectancy in 2000 was 58.4 years and it increased to 63 in 2011. The percentage of birth attended by skilled attendant increased also from 74.88% in 2000 to 76.44 in 2011 (BPS, 2001; Bappeda, 2012). Similarly, the rate of malnutrition and morbidity indicated a better condition during the last decade.The improvement of health status in WNT can be perceived as a success story of development process in the region. Decentralization and regional autonomy intended to accelerate development process provide a wider space to nurture ideas, creation, and innovation. With limited resource, WNT has been striving to achieve its development goals since the launch of decentralization policy. In order the success story could be imitated by other local governments, it is important to investigate as well as analyze factors influencing the success especially relating to health status or health performance indicator. Therefore, the objective of this paper is to verify factors contributing to the improvement in indicators of health development in WNT. In addition, this paper is also intended to analyze dominant factors influencing health development since the initiation of decentralization and regional autonomy program.

2. Framework of Health Performance Assessment

Determinant of health and diseases varies among many scholars. Rose (1985) differentiated the determinant of health and diseases between determinants of individual cases and determinants of population incidence rates. The subject of most epidemiological research is the determinants of individual cases, meanwhile determinants of population incidence rates are much less studied. Determinants of individual cases are measured through relative risk. Besides, they depend on heterogeneity of exposure and may miss most important causes if highly prevalent.

Meanwhile, determinants of population incidence rates are identified through ecologic comparisons of exposure and disease distributions (Victoria, 2002).

In their study of child survival in developing countries, Mosley and Chen (1984) differentiated between social sciences approach and medical sciences approach. There are two basic approaches for understanding child health determination including social science approach and medical science approach. Social sciences approach is used by demographers and many sociologist, meanwhile medical sciences approach is used by medical scientist. The social sciences approach emphasizes on distal determinants, political and ideological structure, and behavioral factors. Biological sciences approach emphasizes on proximate determinants such as water/sanitation, environment, immunity, genetic factors, diseases, malnutrition, infection, etc.

The biological sciences approach has been developing since the last century indicated by the born of some schools of thought (Victoria, 2002). In around 1900, "Unicausality" school of thought believed that one germ caused one disease. During 1930-1940s, the school of thought called Agent/ host/ environment interaction stated that diseases were caused by the interaction between agent, host, and environment. However, the agent alone has limited explanatory power. In 1960s, Multicausality school of thought admitted that each disease may have several different causes. It introduced a so called "web of causation". Meanwhile, the Genomic era (1990s) renewed emphasis on individual susceptibility.

In their study paper, Mosley and Chen (1984) attempted to integrate the social sciences and biological sciences models of child health determination. Socioeconomic determinants (personal illness control including prevention and treatment) together with biological approach (maternal factor, environmental contamination, nutrient deficiency, and injury) are determinant of health and sick. This approach indicates an important development since social-economic determinants are seen as over-determinants, or distal determinants of several of the more proximate determinants that medical scientists and many epidemiologists were concerned about. However, the Mosley and Chen model is still an individual level model (Victoria, 2002).

McMahon (1960) introduced a concept of "web of causation" indicated that he believed on multicausality theory. Web of causation model is a biomedical individualism whereas the solution of at individual level is biomedical interventions. Victoria (2002) commented that web approach gives equal weight to factors that are hierarchically different. However, it does not differentiate between determinants at individual and population level.

Masuy-Stroobant (2001) suggested the usage of maternal factors, environmental contamination, nutrient deficiency, injury, and personal illness control as proximate determinants of health status. They should be measurable in population-based research. Meanwhile, the socio-economic determinants, which are operating through these proximate determinants, are grouped into three broad categories of factors including individual-level factors, household-level factors, and community-level factors.

It can be concluded that studies of determinants of health must address different levels of aggregation including populations, sub-populations, and individuals. Hierarchies between levels and among determinants are important. Furthermore, multiple disciplines are required for a thorough understanding of health determinants. Finally, actions to improve health must address different levels of determination (Victoria, 2002).

This study, however, will use socio-economic and environmental determinants to verify factors or determinants of health status in WNT. The level of analysis is population level due to the limitation of available data and resources owned by author. They comprise social variable (mean year of schooling, literacy rate, and enrollment rate in primary school), economic variable (per capita income, economic growth, real expenditure, and public expenditure), infrastructure variable (household access for clean water, electrification ratio, quality of road, and sanitation), and health resources variable (number of doctor, paramedic, other health personnel, and health facilities in sub-district and village level). Meanwhile, health status or performance will be indicated by infant mortality rate (IMR), maternal mortality rate (MMR), life expectancy, births attended by a skilled attendant (health personnel), malnutrition, and morbidity.

3. Method

3.1 Site of Study

The study is carried out in the province of WNT. The province of WNT is performed by two main islands – Lombok and Sumbawa. The area of Sumbawa island is three times the area of Lombok island or about 15.414,5 km^2. Meanwhile, the area of Lombok island is only about 4.738,65 km^2. In addition to the two main islands, there are about 241 small islands surrounding the main islands. From those small islands only 117 have their own name, while the rest (124 islands) have no name. Only 16 islands are resided by people. There are three major ethnic groups including Sasaq, Samawa, and Mbojo. The last two ethnic groups are living mostly in the island of Sumbawa, meanwhilwe Sasaq ethnic group is residing in the island of Lombok. The three ethnic groups have their own culture including language, tradition, traditional costume, architecture, food, and traditional celebration. Each island has five districts including one municipality and four regencies. The population of WNT reached 4,500,212 inhabitants according to the result of National Population Census 2010. The population

was composed by as many as 2,183,646 men and women 2,316,566 people, with a sex ratio of 106.09.The number of households was 1,248,115 households with an average household size of 3.61.The population in 2000 was 4,008,601 people with the growth rate of 1.17%. The population density was 216 people per square km in 2000, meanwhile in 2010 it became 242 people.

Gross Regional Domestic Product (GRDP) of WNT *at the year 2000 Constant Price was Rp* 20.056 trillion (USD 2.228 billion)[1] in 2010. The economic structure of the province was dominated by mining and quarrying sector with its contribution of 27.32%. The second largest sector composing the economic structure was agriculture sector reaching 22.49% in 2010. The role of industrial sector was relatively low since its contribution was only 4.71%. However, the smallest contribution to GRDP was electricity sector, gas and water accounted for only 0.37%. During the year 2008-2010, the economic growth was fluctuated. In 2008, the growth was only 2.82%, but it increased to 12.11% in 2009. However, the high growth of economic could not be maintained. As a result, the economic growth in 2010 was lower than that in the year 2009 and it was 6.29%. Mining and quarrying was the most contributed sector to GRDP since it grew up to 28.71% in 2009 and 11.71% in 2010.

Meanwhile, the per capita income of population was Rp 6,685,103 at current price in 2010 by excluding Non Oil and Gas Mining Sub Sector. It increased from Rp 4,986,631 in 2008 and Rp 5,738,751 in 2009. District with the highest per capita income in 2010 was Mataram City with Rp 11,987,881, whereas Central Lombok was the lowest per capita income of Rp 5,393,938. The quality of human resources in WNT is increasing indicated by the increase of Human Development Index (HDI) from year to year. However, the HDI of WNT is still in the lowest rank among provinces in Indonesia. However, some indicators of health status have improved indicated by the increase of life expectancy, the decrease of infant and maternal mortality rate, declining of morbidity and malnutrition, and the increase of birth attended by skilled attendant. Although the health status is increasing, malnutrition rate of children under-five is still high and disparity in health status among socioeconomic and gender groups is still wide. In addition, the community health status of WNT is still far behind in comparison to the other provinces in Indonesia.

The education level of community has also increased during the last decade. In 2000, for example, the mean year of schooling was 5.5 years and it increased to 6.8 years in 2011. Similarly, the enrollment rate for all age groups has increased significantly. The enrollment rate of primary school was 89.9% in 2000, and it increased to 99.6% in 2011. The literacy rate has also improved from 74.6% in 2000 to 97.95% in 2011. However, the disparity of education among social groups such as poor and rich group, rural and urban, and gender is still high. In general, the quality of life of women and children in WNT is getting better. Social welfare has also increased due to the efforts of empowerment, service provision, rehabilitation and social protection to vulnerable communities.

3.2. Data Collection

Data have been collected from various official documents from several sources. Central Burro of Statistic (BPS) has issued several kinds of publication including Region in Figures (DDA), Welfare Indicators, Key Indicators of Indonesia, and Trends of the Selected Socio-Economic Indicators. Regional Development Planning Board (Bappeda) West Nusa Tenggara also publishes Gross Regional Domestic Product West Nusa Tenggara and Development Indicators of Medium Term Development Plan (2009-2013). Regional Health Service also reports annual health indicators performance of West Nusa Tenggara. The last source of data is National Team for the Acceleration of Poverty Alleviation (TNP2K) which produces official report called People Welfare Indicators. The report consists of four books including book for health, infrastructure, poverty, and education. The collected data are categorized as time series data starting from the year 2000 until 2011. Those secondary data will be grouped into a new variable consisting of various indicators. The new variable is then identified as variable of health performance, social, economic, infrastructure, and health resources. These variables are referred to as latent variables (manifest). Each latent variable has multiple indicators. Health performance is explained by infant mortality rate (IMR), maternal mortality rate (MMR), life expectancy, births attended by a skilled attendant (health personnel), malnutrition, and morbidity. Indicators of social variables are mean year of schooling, literacy rate, and primary school enrollment. Indicators of economic variable consist of per capita income, economic growth, real expenditure, and public expenditure. Indicators for infrastructure are household access for clean water, electrification ratio, quality of road, and sanitation. The last variable of health resources is indicated by the number of doctor, paramedic, other health personnel, and health facilities in sub-district and village level (public health center/PKM and its auxiliary unit/PUSTU).

3.3. Data Analysis

[1] The exchange rate of USD 1 is Rp 9,000

Data collected have been analyzed by using multivariate analysis. The multivariate analysis uses structural equation model analysis (Structural Equation Modeling/SEM). The model is used since research variables are categorized as unobservable variables and reciprocal (recursive) variables. Moreover, the purpose of the use of SEM models is to obtain a useful structural model for estimation and proving the model which is created. SEM model is an integrated approach between the factor analysis, structural models, and path analysis (PATH) using three activities simultaneously including checking the validity and reliability of the instrument (the equivalent of confirmatory analysis), testing the relationship model between latent variables (equivalent to a path analysis), and getting a useful model to estimation or equivalent to the structural model and regression analysis, (Solimun, 2002). SEM model is then analyzed using software Partial Least Square (PLS).

To answer the research questions, the formulation of model in the research consists of several models since the relationship among variables is reciprocal. Therefore, we have four equations model including:

(i) $Y = f(X1, X2, X3, X4, E)$
(ii) $X1 = f(X2, E)$
(iii) $X3 = f(X2, E)$
(iv) $X4 = f(X4, E)$

Note: Variable Y is health indicator performance.
Variable X1 is education
Variable X2 is economic
Variable X3 is infrastructure
Variable X4 is health resources.

4. Results and Discussion

This section will be divided into three subsections starting from description of variables, relationship among variables in the model, and interpretation of the results. The relationship among variables in the model consists of two types including the relationship between latent variables and their indicators (outer model) and relationships among latent variables (inner model).

4.1. Description of Variables

Variables used in the model consists of five variables called latent variable or variable construct. Each variable construct or latent variable has its own indicators. Indicators of variable construct (latent) (Y) Health Performance Indicators consist of infant mortality rate (IMR), maternal mortality rate (MMR), life expectancy, births attended by a skilled attendant (health personnel), malnutrition, and morbidity. IMR and is measured by the number of infant mortality (death) before its first birthday among 1,000 births, meanwhile MMR is measured by the number of mother death among 100,000 women who get birth.

Table 1: Identification of Variables Used in the Research

Variable	Description of Variables	Mean	Std. Dev
Y	**Health Indicator Performance**		
Y1	Infant Mortality Rate (IMR)	71.00	5.2937
Y2	Maternal Mortality Rate (MMR)	338.86	34.5824
Y3	Life Expectancy (in year)	60.53	1.4496
Y4	Birth attended by a skilled attendant (health personnel) (in percentage)	75.79	3.0488
Y5	Malnutrition (in percentage)	4.299	0.9647
Y6	Morbidity (in percentage)	27.19	5.2338
X1	**Social Variable**		
X1.1	Mean year of Schooling (in year)	6.42	0.4301
X1.2	Literacy rate (in percentage)	82.47	7.1050
X1.3	Pure pupil enrollment rate in primary school (in percentage)	96.16	2.8455
X2	**Economic Variable**		
X2.1	Riel per capita income (in rupiah currency)	3489160	2385412
X2.2	Economic growth (in percentage) (mining is excluded) (in percentage)	4.95	1.3458
X2.3	Purchasing power parity is measured by riel expenditure per month (in rupiah currency)	607988	25264.84
X2.4	Public expenditure of regional government budget	321282500000	203783810229
X3	**Infrastructure Variable**		
X3.1	Percentage of household having access to clean water	57.64	9.6358
X3.2	Electrification ratio	33.33	7.7228
X3.3	Percentage of road in good condition	46.11	2.7376
X3.4	Sanitation (percentage household having access to toilet)	53.92	9.0892
X4	**Health Resources**		
X4.1	Number of doctor	508	96.2972
X4.2	Number of other health personnel	338	146.9255
X4.3	Number of paramedic	4796	753.2007
X4.4	Number of health center service	610.5	58.56853

Latent variable of social (X1) is constructed by three indicators. These indicators are mean year of schooling, literacy rate, and pure pupil enrollment rate in primary school. It is assumed that each indicator has a positive and negative connection or influence over the health performance indicators. It means that the higher value of social indicators the better performance of health indicators. However, the test of significance will verify the meaningfulness of these indicators in explaining the latent variable.

Indicators used to explain economic constructs (latent variable/X2) consist of riel per capita income, economic growth, purchasing power parity, and public expenditure of regional government. These indicators is perceived to have a relatively strong link to public health performance, health resources, infrastructure and social indicators. The relationship between these economic indicators and public health performance indicators can be either positive or negative. Similarly, the relationship between economic indicators and health resources, infrastructure and social indicators can be either positive or negative. The test of significance will verify the form of those relationships between economic indicators and other indicators of the latent variables.

The indicators of infrastructure variable (X3) are clean water, electrification ratio, condition of road, and sanitation. It is assumed that these indicators have significant influence to health performance. Clean water and sanitation are two of other important indicators of environment which are determinant of individual sick and population sick (Rose, 1985). Meanwhile, the availability of good road and electricity can facilitate a healthy and joyful life. Furthermore, good condition of road can accelerate the transportation of sick people to health care facilities without delaying.

Finally, the indicators of health resources variable (X4) are reflected by two categories of resources - human resources and physical resources. Human resources consist of three indicators including number of doctor, number paramedic, and number of other health personnel. Number of doctor is measured by adding all doctor

including general doctor, dentist and specialist. Number of paramedic is represented by the number of nurse and midwife. Other health personnels comprise sanitary, environmental health, nutrition, medical technician, and pharmacologist. Meanwhile, physical resource is represented by the number of public health center services (PKM) and auxiliary public health center (Pustu). The two resources are perceived as the important health determinant in scientific literature (Mosley and Chen, 1983). Furthermore, Mosley and Chen (1983) showed that there were two basic approaches for understanding health determination (especially child) in the scientific literature. The social science approach, used by demographers and many sociologists and the medical science aproach used by medician and biologist.

4.2. Relationship among variables in the model

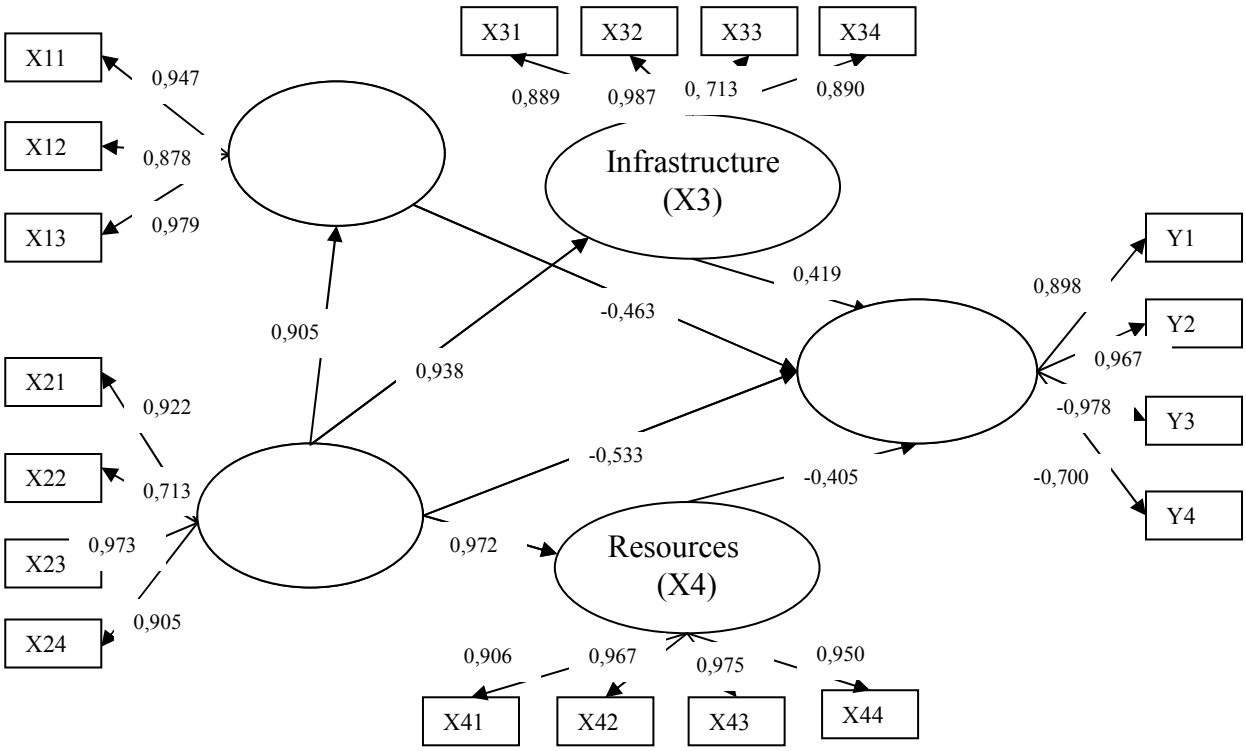
4.2.1. Relationship between Latent Variables and Their Indicators (Outer Model)

The results of data analysis using the model of Partial Least Square (PLS) show that not all indicators (constructs) of the latent variables are included in the model since the loading factor of each construct is less than 0.70. An indicator that has a good reliability should have a loading factor at least 0.70. Using the criteria, indicators with the value of loading factor less than 0.70 are excluded from analysis. Thus, from six indicators for health performance, two indicators are excluded in the subsequent analysis including indicator Y5 and Y6. Those indicators are malnutrition and morbidity.

Based on the criteria, the indicator for the other latent variables that have a loading factor of less than 0.70 will be excluded from further analysis. Since all indicators for social variable (X1) have loading factor more than 0.70, there is no indicator excluded in subsequent analysis. Similarly, indicators for economic, infrastructure, and health resources have loading factor above 0.70 then none of them is removed from the model.

Picture 1

Model Path Diagram Construct



Furthermore, the significance of each indicator of latent variables is determined by statistical t test. Based on the results of t test statistics for each indicator of all latent variables, none of those indicators is not significant at an alpha (α) of 5% or 1.96 of t count since the value of t statistic of all indicator is greater than t count on an alpha of 5%. Therefore, it can be concluded that all indicators are able to significantly explain or indicate latent variable. In other words, all indicators of latent variables (Xi) are valid indicators to measure their latent variables. More detail about the significance latent variable indicators can be seen in the Table 2.

Table 2: Relationship betwen Latent Variables and Their Indicators

Variable	Loading Factor	Standard deviation	T Statistic	Significances
Health Performance				
Y1	0.898	0.025	36.055	Significant
Y2	0.967	0.008	113.924	Significant
Y3	-0.978	0.005	201.653	Significant
Y4	-0.700	0.047	14.857	Significant
Social				
X11	0.947	0.006	151.197	Significant
X12	0.878	0.018	49.882	Significant
X13	0.979	0.003	287.161	Significant
Economic				
X21	0.922	0.022	42.623	Significant
X22	0.713	0.060	11.864	Significant
X23	0.973	0.004	243.530	Significant
X24	0.905	0.016	55.654	Significant
Infrastructure				
X31	0.889	0.015	60.078	Significant
X32	0.987	0.003	364.633	Significant
X33	0.713	0.143	4.989	Significant
X34	0.890	0.040	22.070	Significant
Health Resources				
X41	0.906	0.035	25.905	Significant
X42	0.967	0.008	117.788	Significant
X43	0.975	0.004	218.011	Significant
X44	0.950	0.011	84.711	Significant

4.2.2. Relationships Among Latent Variables (Inner Model)

There are seven relationships among latent variables tested in this study including the relationship between economic variable and social variable, economic variable and infrastructure variable, economic variable and health resources variable, economic variables and health performance variable, social variable and health performance variable, infrastructure variable and health performance variable, and between health resources variable and health performance variable. Economic variable affects all other latent variables, whereas health performance variable is affected by all other latent variables.

Based on the result of analysis, economic variable affects significantly all other latent variables. This is demonstrated by the statistical t value which is greater than t count on an alpha of 5% (1.96). Meanwhile, health performance variable is not significantly affected by all other latent variables. Only two latent variables that affect significantly health performance variable since the values of t statistics of those latent variables are greater than the value of t count on an alpha of 5%. The two other latent variables that do not influence significantly health performance variable are infrastructure and health resources variable. It can be concluded that only social variable and economic variable influence health performance variable significantly.

Table 3: Relationship among Latent Variables in the Model

Variables	Original Sample Estimate	mean of subsamples	Standard deviation	T-Statistic	Significances
Economic -> Social	0.905	0.905	0.018	51.415	Significant
Economic -> Infrastructure	0.938	0.940	0.008	120.618	Significant
Economic -> Health Resources	0.972	0.972	0.005	190.905	Significant
Economic -> Health Performance	-0.533	-0.535	0.080	6.651	Significant
Social -> Health Performance	-0.463	-0.466	0.055	8.456	Significant
Infrastructure -> Health Performance	0.419	0.465	0.247	1.696	Not significant
Health resources -> Health Performance	-0.405	-0.447	0.259	1.564	Not significant

To measure the effect of latent variables on other latent variables simultaneously it is used the value of R-square (R^2). Based on the analysis result, it is obtained that the value of R^2 is 0.946 for health performance variable. It means that health performance variable is affected 94.6% by all variables in the model, while the remainder (5.4%) is the influence of variables beyond the model. Meanwhile, social variable is influenced 81.9% by economic variables. Similarly, infrastructure variable and health resources variable are affected mostly by economic variable with its contribution about 87.9% and 94.4% respectively.

4.3. Interpretation of the Results

Based on the calculations using the PLS model, most indicators have loading factor above 0.70. Only two indicators of health performance variable have loading factor below 0.70 so that they should be excluded from the model. Loading factor value of less than 0.70 indicates that the correlation between indicators and latent variables is weak so it could not adequately explain the latent variable. The result of loading factor calculation shows that all latent variables, except for health performance variable have similar indicators in comparison to the initial model.

Furthermore, to determine the significance of each indicator of latent variables statistical t test is performed. Based on the results of t test statistic for each of the indicators of latent variables all indicators are significant at an alpha (α) of 5% or 1.96 for t count because the t statistics of those indicators is greater than t count. It means that all indicators of latent variables can be used as indicator of their latent variables and those indicators have been a valid indicator to measure latent variables.

The results of the calculations for inner model or relationship between the latent variables show that social variable has significant influence to health performance variable with a regression coefficient of -0.463 and a t statistical parameter of 8.456. It means that there is a significant relationship between social variable and health performance variable. The higher the level of social indicators, the higher the health performance indicators. It is understandable since education could enhance the awareness of people as well as the willingness of people to pay for health facilities.

Three indicators of social variable are mean year of schooling, literacy rate, and enrollment rate in primary school may explain the relationship between the two latent variables. The higher rate of literacy, mean year of schooling, and enrollment rate indicate that communities have a better education. This brings about the better understanding toward health problem so that when a symptom of the disease emerges then people know how to both react and make a decision. Besides, they know to whom they should ask a help.

The high rate of infant mortality or maternal mortality in developing countries is not merely a technical medical aspect but it is far beyond of that. Sociologically, there are three different types of “late”, which are hindered sick people from obtaining immediate medical help (Hadar, 2008). The first “late” is when people make a decision about how to handle the problem. The second “late” is due to the availability of transportation so that they come to the health facility too late. Finally, the last “late” is the late of treatment or handling. This kind of “late” occurs usually in a health facility. Health personnel do not treat or handle the patient such as an emergency case. As a result, the patient’s life could not be saved.

In addition, a survey carried out by Woman Health and Family Welfare (WHFW) in 2002 and 2004 (quoted by Haddar, 2008) concluded that the indirect causes of the high rate of maternal mortality in WNT are acute or chronic disease following the pregnancy, bad nutrition, anemia, and “four too”. The “four too” are too young to be pregnant, too frequent to give birth, too close of pregnancy spacing, and too old to give birth. By having good education or information about health problem, people at least have an ability to protect themselves and avoid bad risk as well. The last cause of maternal mortality indicates that social aspect including education plays a

significant role in influencing health performance in WNT. The results of the study, therefore, prove that good education of community will improve the performance of community's health.

The other latent variable influencing the health performance significantly is economic variable. It is indicated by regression coefficient of -0.533 and a t statistical parameter of 6.651. It means that the higher the level of economic indicators the higher the level of health performance indicators. Indicators of economic variable including riil per capita income, economic growth, purchasing power parity, and public expenditure of regional government may explain the relationship between the two latent variables. The higher level of those economic indicators the better the economic condition of community. Two indicators of economic variable – riil per capita income and purchasing power parity – indicate the economic condition of community in household level. Meanwhile, the other two indicators including economic growth and public expenditure of regional government indicate the economic condition of community in macro level. Both have a significant influence to the health performance indicators. In one side, the better economic condition in household level will increase the ability to pay for health services of household. With their better ability to pay, households have an opportunity to choose certain type or level of health services. On the other side, the capacity of government to provide better health service facilities is also increasing. Government can enlarge the access of community to health service facilities and ameliorate the quality of health services as well. Simultaneously, health performance variable is not only influenced by latent variables having significant t test such as social and economic variable but also all latent variables including in the model. It means that health performance variable is also affected by infrastructure and health resources variable. This is indicated by the value of R^2 at 0.946 which mean that all four latent variables affect health performance with contributions of 94,6%. It means that 94,6% of health performance are influenced by, social, economic, infrastructure, and health resources variable, while the remaining 5,4% are the influence of various variables beyond the model. The results of PLS model shows that the hypothesis indicating social and economic variable affect health performance variable is acceptable. It means that to improve health performance we have to improve the social and economic condition in household and community level. In other word, we have not only to increase the willingness to pay of people by improving their education level but also their ability to pay by improving their economic condition. The significant influence of social and economic variable is incompliance with study of Mosley and Chen (1984) which uses socioeconomic determinant as proximate determinants that in turn influence the risk of disease and the outcome of disease processes (Wiki, 2012).

IV. Conclusion

Conclusions drawn based on the analysis above are:

1. Health performance is influenced simultaneously by variables including in the model such as social, economic, infrastructure, and health resources. The contribution of those variables in influencing health performance variable is 94.6%, whereas the remaining is a contribution of other variables outside the model.
2. Partially, social and economic variable affect health performance significantly since only the two variables have t count greater than t statistic with alpha (α) 5% (1.96). The fact indicates that the better socioeconomic condition of community, the higher the level of health performance.
3. The improvement of social condition of community means the improvement of community willingness to pay for health facilities. With better education, people have capacity to make decision as well as to take action to save themselves from certain diseases. Meanwhile, the improvement of economic condition of community means the improvement of the ability of people to pay for health facilities. With better economic condition, people have an opportunity to choose certain health services suitable with their capability.
4. The better condition of economic will also increase the capability of government to provide better health service facilities. Government can enlarge the access of community to health service facilities and ameliorate the quality of health services as well.

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