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The New Financing Situation and Human Resource Challenges in Puskesmas

'The administration requirement for BOK reporting is too much and can cause the field workers to lose their concentration on providing high quality health services to their communities.'

Head of Puskesmas in Pemalang[1]

Over the past 10 years, the Government of Indonesia has launched a series of reform initiatives aimed at improving health care service delivery across the country. A particular focus has been to strengthen business processes and governance aspects in frontline service units, such as community health centres. The introduction of the health operational assistance (BOK) program and the national health insurance (JKN) program in 2010 and 2014 respectively have influenced the complexity of business processes and governance of health centres throughout Indonesia. Findings obtained during the field work of 22 primary health centres (Puskesmas) across 11 districts, and from in-depth analysis of six Puskesmas[2], suggests the emergence of new challenges and dynamics of human

[i] Focus Group Discussion (FGD) with staff of Puskesmas Banjardawa Pemalang.

[ii] Puskesmas Prajekan and Puskesmas Tegalampel (Bondowoso, East Java); Puskesmas Kota and Puskesmas Baruga (Bantaeng, South Sulawesi); and Puskesmas Suela and Puskesmas Selong (Lombok Timur, NTB).

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resource (HR) related aspects in the health sector. There are at least three HR dynamics in community health centres that may need further attention moving forward: (i) the increased administrative and financial management workload of staff and the lack of adequate competence in these areas; (ii) emerging inequity and effectiveness issues caused by the increased and potentially imbalanced incentive structures; and (iii) the growing numbers of voluntary health workers.

INTRODUCTION

Indonesia created a model of integrated health-service provision of both preventive and curative care, through the establishment of primary health centres (Puskesmas) in 1979. Currently there are 9,754 Puskesmas, of which 3,396 provide in-patient services, and 6,358 provide ambulatory services only. Although the sector has largely achieved the target of Puskesmas-to-population ratio of 30,000, the 2014 Health Sector Review reports that 38 percent of Puskesmas are in moderately to severely damaged condition, while around 2,000 Puskesmas have no physician in place, and 430 sub-districts have no Puskesmas (Kementerian PPN/Bappenas, 2014).

Law No. 17/2007 on the National Long-Term Development Plan (RPJPN) 2005–2025 states that health and education sectors are the core pillars to create competitive and qualified human resources for Indonesia. Subsequently, the central government has introduced several reforms in both sectors in the past ten years. In the health sector, there are two main ongoing reform programs that aim to improve access to primary healthcare: (i) the health operational assistance (BOK) program introduced in 2010; and (ii) the national health insurance (JKN) program managed by BPJS (National Social Security Agency), officially launched in 2014. Both programs have brought significant changes with regard to financing, organisational, business processes, and human resource management aspects of local health agencies (Dinas Kesehatan), hospitals, and in particular Puskesmas. Further, a merit-based human resources management system was introduced in 2014. Regardless of the delay in implementation, Law No. 5/2014 on State Civil Apparatus is widely understood as the umbrella policy for the government to achieve the RPJPN aim of improving the quality of civil servants, with the ultimate goal of achieving high quality public service delivery.

Human resource management in basic service delivery is a complex matter. International literature has shown that both education and health sectors have to deal with variation of workforce size at every level, distribution, specialties, composition and the increasing need to recruit temporary and auxiliary staff (Hdiggui, 2006; WHO, 2010). In the Indonesian health sector, the main policy debate surrounds performance management, incentive structure, and the distribution of qualified health care workers. The government of Indonesia, at both central and local levels, has trialled a wide range of policies and programs to improve the quality, impact, and distribution of health workers, including the Health Act, the Medical Act, and the Hospital Act (Meliala & Anderson, 2014). Despite these efforts, the distribution and service delivery performance of health staff remains unsatisfactory in large parts of Indonesia.

This policy brief generates from a recent KOMPAK[6] study on fund flow and governance arrangements in selected frontline health and education service delivery units, covering 11 districts in five provinces[7]. The objective of this study is to identify conditions that hinder the effectiveness of services in the health service unit, with a focus on public financial management and its impact on governance and human resource management in Puskesmas. The analysis and recommendations presented in this brief are based on both qualitative and quantitative data obtained during the field work of 22 Puskesmas across the 11 districts, and on an in-depth analysis of six Puskesmas, focusing on how these service units manage various sources of funds and increasingly complex procedures with limited staff.

[3] Ministry of Health, 2015.

[4] Health Operational Assistance Funds (BOK) is a central government assistance program to local government that aims to support health program implementation at the Puskesmas level. It aims to improve community health activities, in particular promotion and prevention activities, to achieve targets of priority national health programs (source: Ministry of Health Regulation No. 11/2015 on Technical Guidance of Health Operational Assistance Funds (BOK)).

[5] National Health Insurance (JKN) is part of the National Social Security System (Law No. 40/2004 on the National Social Security System), which aims to provide universal health coverage by 2019. The insurance covers services to every person who has paid the JKN premium or to those who receive government assistance (PBI) (source: http://jkn.kemkes.go.id).

[6] KOMPAK (Kolaborasi Masyarakat dan Pelayanan untuk Kesejahteraan — Community and Service Collaboration for Welfare) is a facility funded by the Australian Government to support a number of Government of Indonesia programs in achieving the National Medium-Term Development Plan 2015–2019 targets of reducing poverty by improving the quality and coverage of basic services and by increasing off-farm economic opportunities for the poor.

[7] Research areas: Lombok Utara and Lombok Timur (Province NTB); Pemalang and Pekalongan (Province Central Java); Pangkajene-Kepulauan and Bantaeng (Province South Sulawesi); Aceh Barat and Bireuen (Province NAD); and Malang, Pacitan, and Bondowoso (Province East Java).

The six Puskesmas were purposely selected for the in-depth analyses, based on the following characteristics: (i) urban or rural; (ii) number of beneficiaries; and (iii) financial capacity.

THE NEW FINANCING SITUATION IN PUSKESMAS

In the past five years, the reform agenda in the health sector has succeeded in significantly increasing the overall central government health budget. Figure 1a provides an overview of the national increases in overall government expenditure and health sector expenditures from 2012 until 2016. While the government spent USD 12 per capita in 2012, by 2016 this had increased to USD 31. The recent increase in funding allocations in the health sector is considered an important part of the ongoing health policy reform agenda, which aims to provide universal and improved access to free or subsidised primary health care.

However, while the increase is significant, the central government expenditures did not meet the required five percent mandatory health spending until 2016. Although for most years, the planned budget figures met the five percent requirement, spending at this level did not follow. While central government only spent 2.7 percent on health in 2012, this figure reached 5 percent in 2016, mainly as the result of BPJS transfers, as illustrated in Figure 1b[8].

In line with the national funding picture, the Puskesmas visited had experienced significant increases in their overall available resources during the same period. The Puskesmas health services are financed mainly through four income sources: (i) District APBD (salary and non-salary); (ii) BOK; (iii) JKN capitation; (iv) JKN non-capitation; and, in some places, (v) service user fees[9]. The contribution from the various funding sources has shifted considerably since the introduction of JKN in 2014, mainly moving from APBD to JKN capitation and non-capitation financing of primary health services. This reliance on JKN capitation and non-capitation funds is expected to further increase as the numbers of JKN members rise, and expenditures are shifted from APBD to JKN financing. In terms of size, BOK funding did not fluctuate significantly during the same period, although it proportionally decreased in terms of its overall contribution to health services, due to the increase in other Puskesmas funding sources[10].

Figure 1a: Historic Perspective of Health Financing in Indonesia 2012–2016

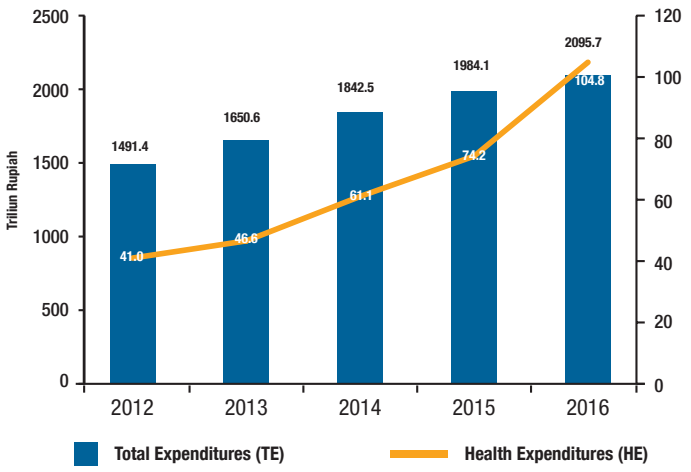
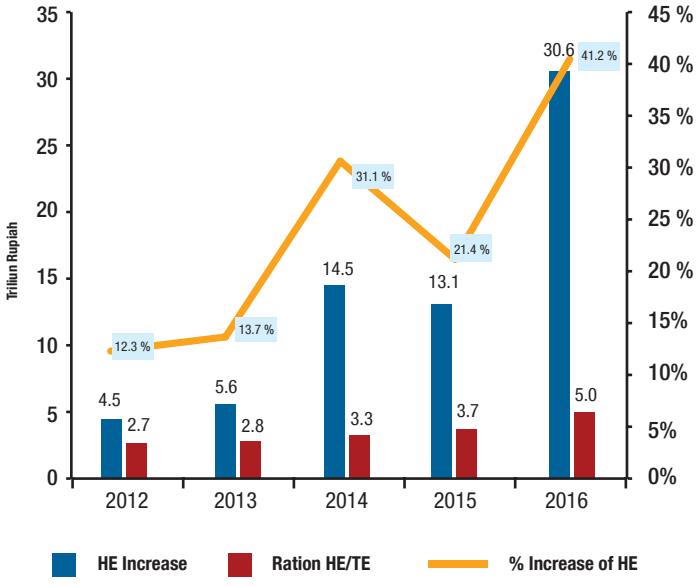


Figure 1b: Health Expenditure Trends in Indonesia 2012–2016



[8] Total Expenditures (TE): Total expenditures are the total central government expenditures outlined by the State Budget (APBN) and approved by the House of Representatives. Health Expenditures (HE): Health expenditures are the total central government expenditures related to health, consisting of spending from the central government, spending as a result of transfers to regional and village funds, and spending through financing of debt related to health. HE Increase: Health expenditures increase is the increase in health expenditures relative to the prior year. Ratio HE/TE: The ratio of HE/TE is the total health expenditures divided by the total expenditures expressed as a percentage. This ratio represents how much of the total central government budget is spent on health as a percentage of the total government budget. % Increase of HE: The percentage increase of HE is the year-over-year increase in health spending expressed in percentage terms.

[9] KOMPAK Policy Brief 2016 on Fund Interplay in Public Health Centres (Puskesmas).

[10] Permenkes No. 21/2016 provides the formula for how to calculate staff incentive points and the distribution of JKN service fee.

The monthly JKN capitation amount is transferred at the beginning of each month to the Puskesmas, based on the actual number of BPJS beneficiaries registered to each Puskesmas and the applicable tariff. According to Regulation No. 2/2015 on BPJS, the system is based on a capitation tariff formula, where the Puskesmas receives between 3,000 and 6,000 per BPJS member. In theory, the amount returned per member should be based on: (i) type of human resources available; (ii) infrastructure and equipment; (iii) scope of services; and (iv) the Puskesmas commitment of service. However, the respondents from the study reported that the amount in reality is only calculated based on types of staff, infrastructure and equipment measures, since the other two criteria are basically intangible and too hard to measure. Unfortunately, by excluding the two last categories from the analysis, the performance element of the Puskesmas and its staff is not taken into account or weighted less than the other two.

Out of the total JKN capitation fund amount transferred to the Puskesmas at the beginning of each month, the Puskesmas is mandated to spend a minimum of 60 percent to pay staff incentives (Jaspel or service fee) to both health workers and non-health workers[11]. The remaining percentage of the capitation fund will then be allocated for purchasing medical equipment and pharmacy supplies through the online e-purchasing and e-procurement system. Out of the six case studies concluded for this study, all six Puskesmas were allocating 60 percent share for staff incentives, and 40 percent for medical equipment and pharmacy supplies and other operational costs from the JKN capitation fund.

INCREASED WORKLOAD AND CAPACITY CHALLENGES

According to non-BLUD (Regional Public Service) Puskesmas staff interviewed, about 80 percent reported that their overall workload had nearly doubled with the introduction of BOK and JKN program implementations. This is the case in particular for midwifes and nurses who are directly involved in BOK program implementation and JKN IT related responsibilities. As reported in the 11 locations selected for the study, only BLUD Puskesmas have dedicated administrative or finance staff to manage these additional responsibilities. Consequently, nurses, midwifes, or other health workers have been forced to take on these functional responsibilities, and have often done so without the required technical competencies to do so.

As part of managing the BOK funds the Puskesmas staff are required to adopt a so-called project cycle management or performance/output-based management approach in terms of planning, execution, monitoring, reporting, and evaluation. During the implementation, monitoring, and reporting phases of BOK activities, the persons-in-charge or the activity coordinators have to manage administrative, financial, and technical responsibilities. For example, due to the lack of administrative and financial support staff in most Puskesmas, health workers are responsible for everything from activity proposals and budgeting, invitations, coordination with village officials, implementing the activity, and finalising the activity and financial report. Field work or outdoor activities are normally conducted eight times per month. Upon return to the Puskesmas, health workers will normally finalise the reporting requirements, while also fulfilling their regular curative/rehabilitative responsibilities in the Puskesmas. With the heavy additional administrative and financial workload, many Puskesmas staff feel that less time is available for actual service delivery activities.

Compared to the APBD and BOK program, the management and reporting of JKN fund expenditures is somewhat less process-heavy, which is surprising when considering that the JKN funds contribute on average a significantly higher proportion of the overall budget envelope compared with BOK funds for individual Puskesmas. For planning purposes, the monthly JKN capitation amount seems to be relatively easy to predict for the Puskesmas staff, primarily because of the use of an IT-based application (Primary Care or P-Care), which shows real-time information. The P-Care system is now also used for non-capitation claims, mainly in-patient treatments and birth deliveries, which allows Puskesmas to submit claims online, which enables them to track the progress of the payment. However, with the move from a manual to an information technology based system, the Puskesmas staff are still finding the financial management and reporting requirements of online BOK reporting and JKN P-Care system challenging. All JKN data management and communication with BPJS requires staff to master the online P-Care system as a precondition for effective and accurate budget forecasting, fund reporting, and JKN non-capitation application claims. In the Puskesmas visited, on average at least 80 percent of Puskesmas patients are BPJS users, and approximately 80 percent of these patients are paid for through

[11] FGD with staff of Puskesmas Kepanjen, 28 October 2015.

government assistance (Penerima Bantuan Iuran/PBI). These numbers provides an indication of how many patients are managed through the P-Care system and subsequent online reporting requirements, thus indicating the overall IT-based workload the Puskesmas staff face on a monthly basis.

For the Puskesmas that have BLUD status, all have dedicated treasurers with sufficient knowledge and skills in finance management and IT. For example, Puskesmas Kesesi 1 in Pekalongan District, which manages a large capitation fund, has nine dedicated administrative and finance officers. Contrary to BLUD Puskesmas, all non-BLUD Puskesmas visited did not have dedicated finance officers or treasurers with qualifications and technical competency in accounting and computer-related fields. To compensate, Puskesmas health workers (midwives, nurses, pharmacists, nutritionists, public health worker, and community health workers) perform functions as treasurers for JKN and BOK funds, in addition to other administrative functions such as operating P-Care and the visits registrar, as confirmed through the interviews. In terms of IT, staff competences are perhaps even less optimal. For example, in Kabupaten Malang and Lombok Timur, the Puskesmas have only one staff member who can operate a computer. To compensate for this lack of knowledge among current staff, some Puskesmas have made use of fresh graduate volunteers to try to overcome the increasingly IT-based workload. In general, less than 20 percent of staff reported that they have sufficient IT (computer and internet) knowledge to effectively operate these systems. Since both BOK and JKN fund management rely heavily on staff member's knowledge and skills in finance management, information technology (computer and internet), and more generic office and management skills, this situation is of great concern.

Further, all purchasing of medical equipment and drugs are currently done through online e-procurement and e-purchasing systems. Similar to the situation for general IT qualifications, nearly all Puskesmas staff are not familiar or feel uncomfortable with this new method of procurement, which may explain the low absorption capacity for the operational budget share of the JKN funds.

In addition to the challenges related to IT competences, another issue is the availability of or poor internet infrastructure and access. A majority of the Puskesmas in rural sub-districts in Pangkajene, Bantaeng, Lombok Timur, Lombok Utara, Aceh Barat, and Bireuen depended on cellular providers such as Telkomsel and Indosat to get internet connection. However, in addition to being costly, these types of solutions are not reliable and often slow down processing and uploading of information in the P-Care system. Thus, staff are often forced to travel to the nearest city centre to update data and submit the online reports.

Unfortunately, most of the Dinas (agencies) only allocate very small or no budget for training and other staff development programs for Puskesmas. For example, in Aceh Barat, the last training staff received was in 2015 on asset and medication management. Interviewees in a majority of the districts reported that BPJS did a two-day training session on JKN fund management in 2014; however, no further training directly linked to JKN funding had been provided. However, a few Dinas Kesehatan had actively invited people from the government auditing agency (BPKP) as resource persons in a workshop on reporting and auditing systems. Although staff interviewed could advise that Dinas personnel provide support in response to requests, in most places Puskesmas staff reported that there was no frequent support, active facilitation, or training provided by Dinas Kesehatan staff, as illustrated by the head administrator of Puskesmas Kepanjen[11].

'It's not easy to do these new tasks. When there is a technical problem with computer software, we do not know where to receive support and immediate answers. Even staff from Puskesmas Pujon from the neighbor Kecamatan has contacted me many times to discuss technical P-Care issues related to computer and internet challenges. We simply do not receive regular technical assistance from Dinas Kesehatan, but sometimes when we ask they may be available solve internet and accounting related problems' (Puskesmas Kepanjen, Kabupaten Malang).

The introduction of the new funding mechanisms for BOK and JKN has clearly increased the overall workload for Puskesmas

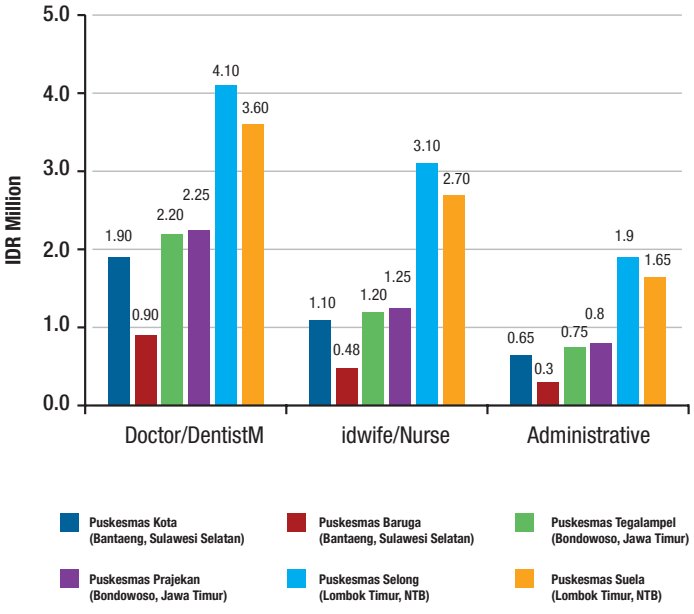
staff. Combined with the lack of competency in accounting, computer/IT and other skills in organisational management in non-BLUD Puskesmas, an insufficiency of IT infrastructure has contributed to low efficiency in financial management and administrative tasks. Considering that these functions in non-BLUD Puskesmas are performed by regular health personnel, the staff concerned are reporting that less time is now allocated for actual health service delivery tasks. Further, resulting from lack of competencies in both accounting and IT, mal-administration cases are being identified by the district auditor, as seen in several Puskesmas in Lombok Timur. One of the heads of Puskesmas concerned blamed the mal-administration on the fact that the 'assigned health workers treasurers' have limited knowledge in accounting and the data entry system, hence mistakes are frequent. Such assigned 'treasures' of BOK and JKN funds in Aceh, East Java, and South Sulawesi made clear statements in the interviews that given a choice they would have refused to become treasurers. Not only do they lack the necessary competences, but it also created double workload with only a small return incentive of approximately IDR 100,000 per month.

INCREASED INCOME: INCENTIVE OR DISINCENTIVE?

There are three kinds of income sources for Puskesmas staff: (i) salary for permanent staff (PNS) and non-permanent contract based staff (PTT); (ii) district performance incentive or tunjangan kinerja daerah (TKD) for PNS only; and (iii) JKN service fee or jasa pelayanan (Jaspel) for PNS and contract-based staff. Following the implementation of JKN capitation financing of Puskesmas in early 2014, all Puskesmas staff interviewed report satisfaction with this arrangement, considering their increased overall income as the result of the service fee incentive payments for staff (jasa pelayanan/Jaspel). Based on Permenkes No. 19/2014, later revised with Permenkes No. 21/2016 on the Use of Capitation Fund, a minimum of 60 percent of the capitation fund is earmarked as incentives or service fee, which is paid out to staff based on three criteria: (i) job level/education background; (ii) presence; and (iii) local variables (seniority, workload, and performance). The calculation and distribution of the Jaspel fee is somewhat complicated and compromised, since most Puskesmas do not have a specialised human resources management staff, and the regulation and performance criteria are quite complex. Without dedicated staff to monitor performance, presence and staff workload, the calculation and decision made about how much individual staff members will receive is often lacking transparency. The final amounts are often simply decided by those who control the access to JKN funds, who are the head of Puskesmas and the JKN treasurer. This area totally lacks oversight and control mechanisms, and unfortunately this loophole can become a new arena of corruption for those who control and access JKN fund management.

Incentive payments for staff vary substantially by staff type and Puskesmas location, as shown in Figure 2. The differences in average incentive payments between staff and particularly between staff in different Puskesmas are significant. On average, in addition to their salary, doctors and dentists received approximately IDR 2.5 million in incentives, while midwives and nurses were rewarded incentives of IDR 1.6 million, and administrative staff received IDR 0.9 million. Doctors and dentists received 1.6 times more incentives than nurses and midwives, and 2.8 times more than administrative staff. However, across the six Puskesmas locations, incentive payments for the same staff type varied considerably. For example, doctors and dentists in Puskesmas Selong received the highest incentives (IDR 4.1 million), which were 4.6 times higher than the incentives awarded to doctors and dentists in Puskesmas Baruga (IDR 0.9 million). Similarly, midwives and nurses in Puskesmas Selong received the highest incentives (IDR 3.1 million), which were 2.8 times higher than the average incentives paid to midwives and nurses in the other five Puskesmas.

Figure 2: Average Incentive Payments by Staff Type in Six Puskesmas (Per Month)

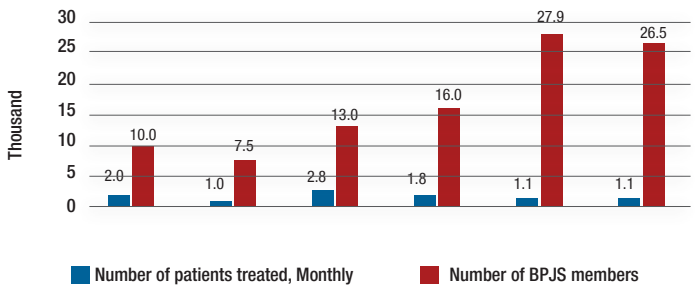


Further, in more rural/remote areas in Lombok Timur, even Puskesmas with a high number of BPJS members (over 20,000) cannot receive full JKN funds of 6,000/capitation due to limited facilities and shortage of medical workers (doctors and dentists). Hence, these health workers with similar number of BPJS members receive a smaller amount of Jaspel compared to those in Puskesmas with a full complement of medical workers (minimum of two doctors and one dentist) and complete facilities (in-patient rooms with air conditioning, comfortable waiting room etc.)

The basic rationale for the calculation formula is that a doctor in a Puskesmas with a high number of BPJS members and with full facility capacity should receive a higher incentive payout since it is assumed that he or she will have a higher workload and potentially treat more complex cases. Although this study was not able to review the complexity and types of medical cases each Puskesmas handled, the patient data collected from the six case studies showed that Puskesmas with higher number of BPJS members are not treating a significantly higher number of patients per month compared to Puskesmas with less BPJS members, as shown in Figure 3.

The new incentive system provided for through the JKN capitation fund for Puskesmas staff is largely seen by most Dinas Kesehatan staff as a good system to improve staff performance, and thus provide better health service delivery to the communities. However, a majority of the Dinas staff interviewed were still questioning a positive correlation between the increased income of the staff and improved performance of staff and the Puskesmas services as a whole. According to heads of Puskesmas and Dinas Kesehatan staff interviewed, their perception is that staff discipline and activity levels have improved in terms of presence and involvement in Puskesmas activities. However, there is less proof of and ability to measure tangible improvements in staff performance.

Figure 3: Number of Patients Treated and Number of BPJS Members



Further, the increased incentive payments to Puskesmas staff are also having another unintended consequence of economic jealousy. While few head Dinas openly criticise the application of the service fee incentive formula for Puskesmas staff, the heads of Dinas Kesehatan in Pemalang and Bantaeng said frankly that the significant increased income received by Puskesmas staff could reduce motivation of PNS in other agencies, especially in Dinas Kesehatan, as expressed by the following question from interviewees:

'How come Dinas Kesehatan staff who supervise Puskesmas staff and have bigger tasks and responsibilities in managing health programs in the district receive smaller income than that of Puskesmas staff?'

Head Dinas Kesehatan

Furthermore, a staff member of Dinas Kesehatan in Aceh Barat complained that after the JKN implementation, Puskesmas staff have become arrogant and less willing to follow instructions from the Dinas:

'In several things, they no longer see us as important as they used to. In Acehnese, we call it "peng keu nempeu ke" (literally meaning right or wrong is my money), because they now can manage Puskesmas fund as they want.'

Staff member of Dinas Kesehatan

The expressions of jealousy not only derived from PNS health workers and general PNS in other government institutions, but also between health workers inside Puskesmas, for example non-medical staff towards medical staff, as well as complaints from non-permanent staff towards permanent staff. It seems like this unequal share of Jaspel fees occurs in all Puskesmas across Indonesia, as confirmed by health workers outside our district samples who have reported issues of what they call unfair distribution of Jaspel fees in and between Puskesmas through the president's official complaint portal at **www.laporpresident.id12**.

What the data indicate are some emerging trends that may lead to several unintended scenarios and service delivery implications if left unnoticed. If the distribution of capitation funds continues to be mainly reliant on number of BPJS membership numbers, without considering actual patient numbers and service delivery performance, what was meant as incentives for improved staff performance may in certain places become a disincentive:

1) As has already been indicated by staff interviewed for this study, staff may seek transfers to Puskesmas with a higher income, hence higher levels of incentive payments. Since the formula already favours urban areas with a higher number of population and potential for paying members, this may add to the current problem of retaining qualified staff in rural areas.

2) Puskesmas with few BPJS members may continue to see low levels of incentive payments for staff compared to Puskesmas with many BPJS members, although actual number of patients may be similar. This may have impact staff morale and provide a disincentive rather than incentive in certain areas in providing high quality service delivery.

3) Increased levels of economic jealousy may occur between Puskesmas staff and Dinas Kesehatan/other service units, between staff within individual Puskesmas, and between staff in different Puskesmas. This situation, if left unnoticed, may interfere with overall service delivery efficiency and effectiveness.

Considering the current trend of Puskesmas becoming more and more reliant on the capitation fund, and as this fund continues to grow in size for all or at least some Puskesmas, the above early warning signs emerging from this study in terms of potential inequity between Puskesmas should be followed up with additional data collection and analysis to enable policy makers to make necessary adjustments in current policies if needed.

INCREASING NUMBER OF VOLUNTARY HEALTH WORKERS

The government Law No. 36/2014 on Health Workers defines three types of legal status for health workers: (i) permanent staff

or pegawai negeri sipil (PNS); (ii) contract based staff (PTT); and (iii) special assignment (final year students with resident status and Diploma III). However, the regulation does not describe a contract modality for voluntary health workers.

With no status recognised by law, volunteer health workers are still being recruited by Puskesmas across Indonesia. In particular, and based on statements made by respondents, it seems that the number of voluntary health workers has increased after the implementation of the JKN capitation fund system came in place, since the Puskesmas now have increased autonomy in managing the capitation fund. It is at the discretion of the head of Puskesmas or head Dinas to recruit staff using the volunteer modality.

Before the voluntary health workers can be officially accepted to work for a Puskesmas, the volunteers need to sign a declaration letter that states the volunteers will not request salary or service fee payments, and that the Puskesmas has no obligation to pay the volunteers. Thus, the volunteers are aware that they will be working for free, and if they will receive some kind of compensation it will normally be between IDR 100,000–200,000 per month. In the Puskesmas visited, the funding source to pay for such compensation fees would normally be generated from individual donations from other staff member's Jaspel fee allocations; hence it will not show in official financial reports. Staff reported that every PNS or contract-based staff member receiving a Jaspel fee has to provide a small donation to contribute towards the volunteers' service fees, which is naturally not always popular among staff:

'The more volunteers recruited, the less Jaspel incentive we (PNS and contract based staff) receive.'

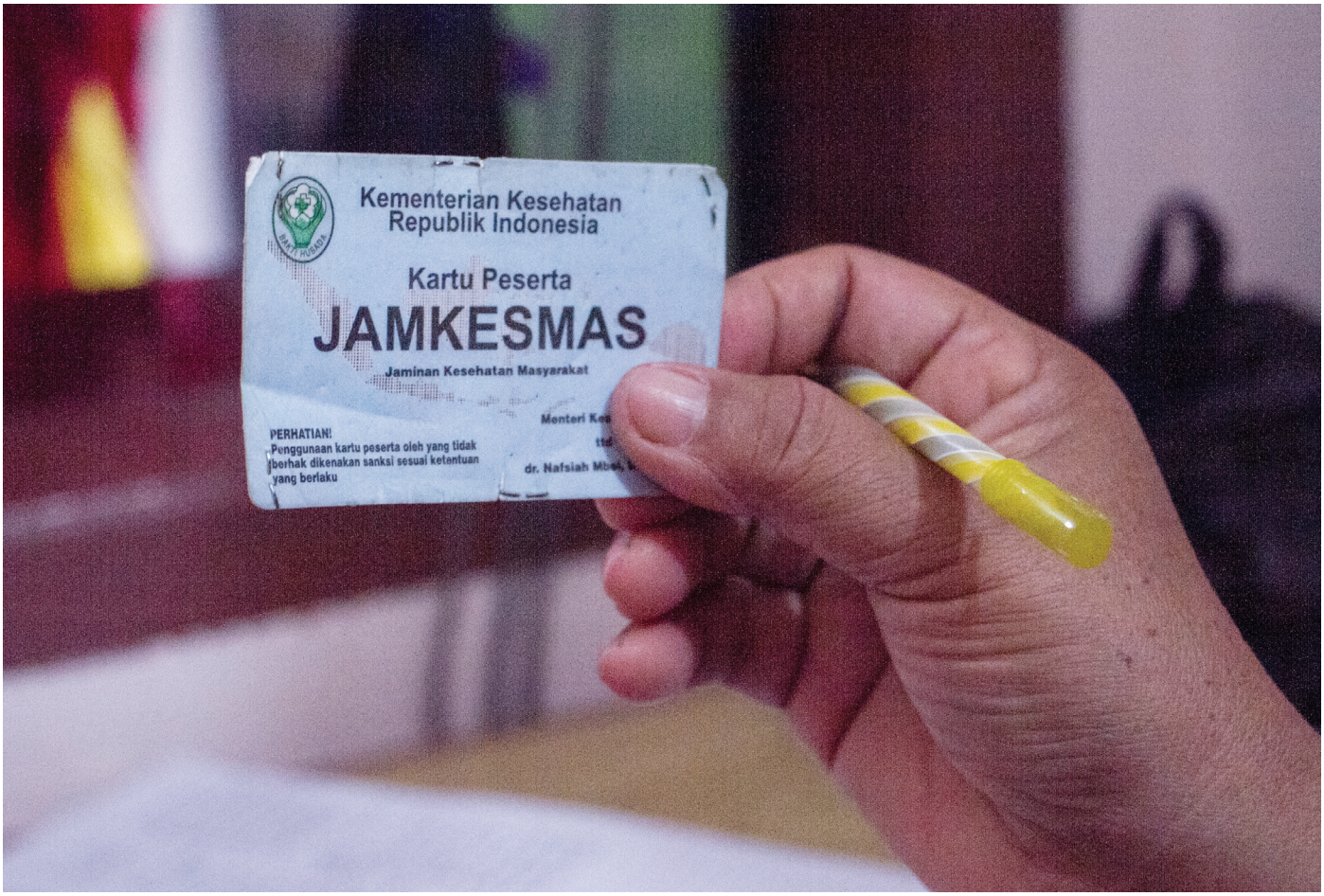
Head of Puskesmas in Bondowoso

As a result, some Puskesmas in Java districts have simply refused to add more voluntary health workers for personal economical reason.

In some Puskesmas in South Sulawesi, NTB, and Aceh, the number of volunteers take up at least 50 percent of the total number of Puskesmas personnel. The phenomenon of a higher ratio of volunteers compared to actual staff is more frequent in districts outside Java. The observed Puskesmas in Aceh Barat, Lombok Timur, Bantaeng, and Pangkep have more than 20 volunteers each, while the Puskesmas Bantimala in a mountainous area in Pangkajene has as many as 31 volunteers. While the total number of volunteers is less in Puskesmas in Java districts, of the two Puskesmas observed in Bondowoso, there were still eight voluntary health workers working for Puskesmas Tegalampel and six for Puskesmas Prajekan, while Puskesmas Banjardawa in Pemalang had 12 voluntary midwives.

There are two types of motivation used to justify the need for recruiting volunteers in the Puskesmas observed. Primarily, the Heads of Puskesmas provide a professional justification that the Puskesmas lack particular professional staff such as pharmacists, lab analysts, public health worker, nutritionists, as well as health workers equipped with IT knowledge and skills in particular. Coincidently, almost all new graduates recruited have IT capabilities. Secondly, a more 'human' justification is provided. Findings in NTB, South Sulawesi, and Aceh reveal that there may be an oversupply of fresh graduate health workers, especially midwives and nurses, in the Puskesmas observed. Every month, Puskesmas and Dinas Kesehatan received job application letters from fresh graduate health workers. Some applicants can be accommodated as volunteers by Puskesmas, but many are turned back. There seems to be some social and political pressure to accommodate local unemployed youth living in the villages around the Puskesmas, or those related to officials in the districts who keep sending job applications to the Puskesmas and Dinas Kesehatan. In the past year, staff in Dinas Kesehatan in Lombok Utara and Lombok Timur admitted that they are overwhelmed with the numbers of application letters every month. The research noted that the challenge of oversupply of fresh graduate health workers in some districts in Nusa Tenggara Barat and Aceh has exploded, as local campuses with new health degrees have increased in recent years.

From the volunteers' perspective, there seem to be two main motivating factors behind their choice to work without pay. Firstly, new graduates normally would like to work and to get practical experience from the medical profession, and such volunteer experiences may provide an entry point or provide an advantage in becoming PNS in the future. Secondly, other volunteers are accepting voluntary assignments while waiting for the enactment of a new government regulation on non-



permanent staff with a government contract basis or Peraturan Pemerintah (PP) on Pegawai Pemerintah dengan Perjanjian Kerja (PPPK). While they are expecting that this government regulation will automatically change their legal status from voluntary basis to contract basis, the actual draft regulation states that to become PPPK, applicants have to follow stages of selection and tests.

CONCLUSION AND RECOMMENDATIONS

In general, health reform programs at the Puskesmas, particularly those related to the financial management of BOK and JKN, have provided some impact on human resources management at Puskesmas. Therefore, to implement the services at Puskesmas optimally, there needs to be serious attention from policy makers in 3 aspects of the findings of this study: the improvement of human resources capacity in financial management, volunteer management and performance-based incentive management.

The emerging issues highlighted in this policy brief with regard to changes in Puskesmas financing, and the subsequent human resources challenges encountered in the Puskesmas, should be noted and further analysed within a larger sample. So far, the Puskesmas are trying to manage the situation as best they can to follow the mandated BOK and JKN procedures and regulations, and considering the lack of training and staff capacities, they have made considerable progress. However compliance is not enough to run and achieve targets of national health priority programs. Therefore, the issues identified are recommended to be reviewed and further discussed by either central or local governments. Based on the sample data analysed for this study and on comments provided by the Puskesmas and Dinas staff interviewed, the following recommendations may be a starting point to consider:

- Regarding issues of increased workload caused by BOK and JKN, the obvious solution will be to recruit dedicated financial officers and/or administrative assistants with qualifications and competency in accounting and IT/ computers to assist with fund implementation and reporting in each Puskesmas. Considering that this may not be an option for budgetary reasons, then at the very least intensive training and mentoring of current staff is needed in the required areas. It is therefore recommended that a functional analysis and training needs assessment

is incorporated into the Dinas and service units' annual program planning processes and subsequent budget be made available for staff capacity development.

- IT infrastructure development in rural areas is rather poor and represents a much larger complicated challenge in many areas. While national authorities may want to consider a much broader strategy to ensure full coverage across Indonesia, local service providers such as Telkom, Telkomsel, and Indosat, as well as satellite based internet providers, should be officially invited by the local government to discuss how to solve the local internet connection problems in rural areas where the Puskesmas operates. If not solved, the already overworked staff will continue to operate an inefficient IT-based system and the administrative workload will not benefit from modern technological solutions and aides.

- The increased amount of incentive payments are currently generating economic jealousy within and among staff in the health sector. Expressions of jealousy seem to be emerging between Dinas Kesehatan staff in relation to Puskesmas staff, between staff from different Puskesmas, and between different categories of staff within each Puskesmas. The general perception is that there is an integral unfairness in the current system, which provides an unequal share of Jaspel incentive payments to certain staff in certain locations. Therefore, an objective review of the JKN service fee distribution since the start of the JKN capitation fund implementation in 2014 and its consequences is urgently needed.

- Lastly, the ever-growing number of voluntary health workers in Puskesmas, especially in non-Java districts will need to be seriously considered by local government. If no action is taken, this number will keep growing and can cause an oversupply of midwives and nurses in particular. The Ministry of Health, the local government, respective Dinas and local campuses should consider reviewing and matching the actual needs and demand for midwives and nurses with the annual intakes and number of graduate students in each area.

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