Australian Government

Policy Brief

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Funds Interplay in Public Health Centres (Puskesmas)

ABSTRACT

Since decentralisation of local service delivery in 2001 to local governments, district governments' expenditure assignments have increased accordingly, and, in total, more than IDR 6,000 trillion has been transferred in inter-governmental fiscal transfers since then. Consequently, health sector budgets have also increased and the roles and responsibilities at the service unit level in managing financing of primary health services have changed significantly. With the introduction of the national health insurance (*Jaminan Kesehatan Nasional*, JKN) in 2014, the financing landscape and the contributions from the different funding sources have shifted considerably. The reformulation of BOK-TP (health operational budgets disbursed directly by Ministry of Health into facility bank accounts) into BOK-DAK (health operational budgets disbursed by Ministry of Finance through district treasury to facility accounts) in 2016 resulted in further major changes to the way this funding is managed. Based on the evidence from a small sample of *Puskesmas*, it seems likely that the majority of funding for *Puskesmas* operations (excluding staffing costs) now derives from JKN capitation payments. In the four *Puskesmas* studied in depth by the KOMPAK team, between 61 and 89 percent of total *Puskesmas* financing in 2015 came from JKN capitation payments. Conversely, funding from district budgets (APBD) and BOK dropped from around 50-90 percent of total Puskesmas funding in 2013, to around 6-20 percent in 2015.

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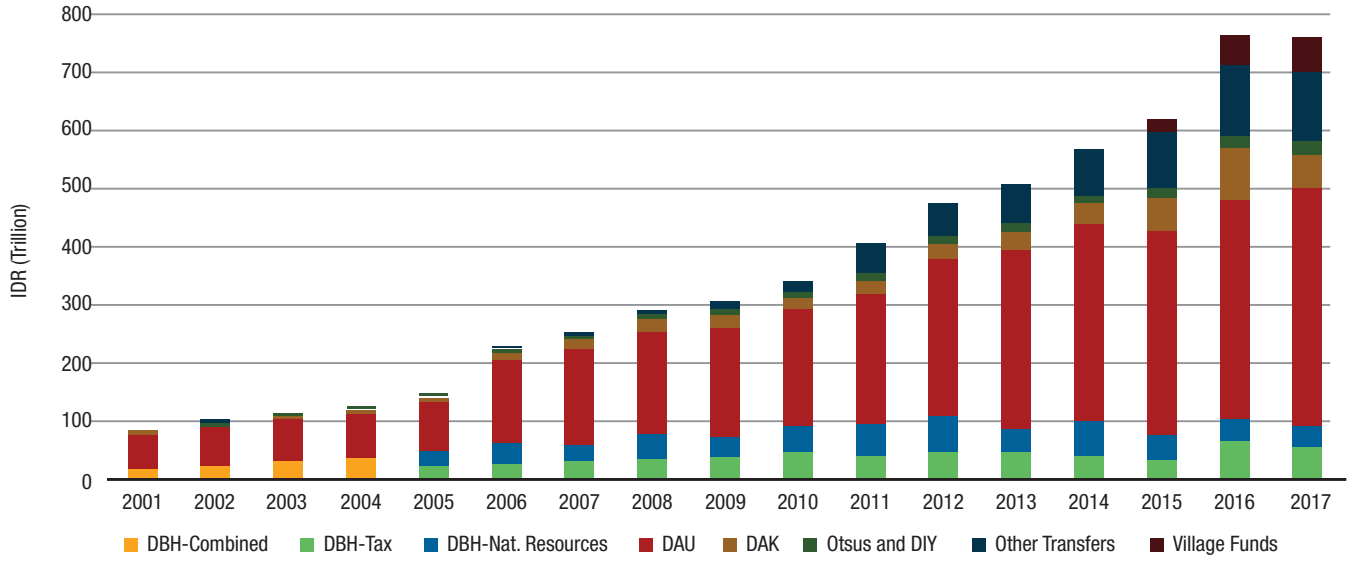
In other words, JKN financing is crowding out districts' allocation of their own budgets to *Puskesmas* financing. While the sample size is very small, the magnitude and consistency of the changes across the different study locations suggests this phenomenon is likely to be happening across Indonesia. Questions about the ability of the district health office to enforce performance improvements and national priorities may arise as districts lose influence as the frontline units become less dependent on district transfers. The shift to JKN also served to significantly increase the allowance payable to *Puskesmas* staff: however, these payments vary considerably across *Puskesmas*, from IDR 900,000 per doctor per month to IDR 4.5 million. The overall amount of these payments, and the variations across *Puskesmas*, are reported to be generating perverse incentives and behaviours that may over time influence service delivery outcomes in certain areas. Finally, the study hints that these new funding arrangements may be leading to more inequitable distribution of funding, which may be self-reinforcing. The capitation payments are based on the number of JKN members registered at the *Puskesmas* and on the level of service offered. *Puskesmas* with more qualified staff and better equipment get more funding, while *Puskesmas* in poorer areas with lower coverage of JKN registration get lower allowances and operational budgets. This situation may become a vicious cycle if left unmanaged, and a review of the current 'formula' for JKN payments and of the composition of *Puskesmas* revenue sources is needed.

INTRODUCTION

In 2001 Indonesia devolved most service delivery responsibilities from central government (CG) to local governments (LGs), and since then primary health services have been mostly managed by district governments.[1] The devolution of health sector responsibilities has been challenging, complicated, and uneven among many districts. These challenges mainly relate to: (i) the transfer of ownership of public health centres (*Puskesmas*) including physical assets and human resources; and (ii) the transformation of the role of district governments and technical agencies from supporting central government ministries to managing and providing services to the people in their jurisdiction, in addition to the districts' ability to drive continuous improvement in service quality.

With the transfer of service delivery responsibilities, expenditure assignments were devolved accordingly. Since the beginning of the decentralisation process, more than IDR 6,000 trillion has been transferred to local governments in Indonesia through various forms of inter-governmental fiscal transfers (IGFT). The increase in IGFT over time is illustrated in Figure 1. However, the increase in transfers to the regions has not necessarily translated into significant improvements in service delivery. While a few local governments have managed to provide high quality and accessible public services, the majority of local governments are still struggling to fulfil this main objective of decentralisation.

Figure 1. Historic Perspective of IGFT in Indonesia 2001–2017



Note: All of the data provided are nominal and derived from audited financial reports, except 2016 (revised APBN) and 2017 (APBN).

[1] All *Puskesmas* and service units below the *Puskesmas* are the district's responsibility, as well as category C hospitals. Category A and B hospitals are normally the responsibility of provincial governments, as well as some larger city authorities. The district is also responsible for coordinating and regulating all private health service providers in their areas.

These shortcomings reflect the institutional, regulatory, and human capacity challenges for both central and local governments in translating the available fiscal resources into services in the frontline service delivery units.

This policy brief is based on a recent KOMPAK[2] study of the flow of funds and governance arrangements in selected frontline health and education service delivery units, covering 11 districts in five provinces.[3] The objective of the study was to identify constraints to effective service delivery in frontline service units, particularly focusing on public financial management (PFM) and other closely-linked governance arrangements. The analysis and recommendations presented in this brief are based on qualitative and quantitative data obtained during the field work of 22 public health centres (*Puskesmas*) across the 11 districts, and on an in-depth analysis of four *Puskesmas*[4] that focused on how these service units manage various sources of funds and increasingly complex procedures with limited staff. The four *Puskesmas* were purposely selected for in-depth analyses based on the following characteristics: (i) urban or rural; (ii) number of beneficiaries; (iii) financial capacity; and (iv) autonomous local government service unit (BLUD) status. Their profiles are described in Table 1.

While other studies have analysed certain aspects of financial management in *Puskesmas*, none have thoroughly reviewed how these funds were managed in practice. Previous Public Expenditure Analysis (PEA) studies, initiated by the World Bank and later adopted by other parties, have focused on provincial and district health spending without 'drilling down' to the service unit level. More specific studies, such as the 2015 study conducted by *Pusat Kebijakan dan Manajemen Kesehatan Universitas Gadjah Mada* (Centre for Health Policy and Management, Gadjah Mada University), reached the service unit-level, but only focused on challenges in financing the health services. Thus, this policy brief aims to provide a comprehensive picture of how *Puskesmas* manage funds that they receive or collect, including their strategies for managing the uncertainty and complicated procedures of the funds. The analysis also covers the three more recent developments related to financing of *Puskesmas* services: (i) the roll-out of JKN in 2014; (ii) the transformation of the health operational assistance (BOK) fund (see Table 3 for more information); and (iii) the emergence of *Puskesmas* with public service unit (BLUD) status.

Box 1. Puskesmas with BLUD status

A community health centre can become an autonomous local government service unit (BLUD). This allows the Puskesmas to:

- receive JKN funds directly from BPJS Kesehatan
- deposit service user fees to the Puskesmas account
- manage their funds based on the annual business plan, rather than the work plan of the district health agency.

BLUD status can only be obtained if a Puskesmas is considered to have good standards, human resources, and financial and asset management systems in place. The assessment is conducted by a team comprising the health, finance, and planning agencies.

Table 1. List of observed Puskesmas

No	Puskesmas	District	Province	Location	Facility	BLUD Status
1	Arjosari	Pacitan	East Java	Rural	In-patient	Non-BLUD
2	Peusangan	Bireuën	Aceh	Urban	In-patient	Non-BLUD
3	Kesesi I	Pekalongan	Central Java	Rural	In-patient	BLUD (from 1/1/16)
4	Santong	Lombok Utara	NTB	Rural	Outpatient	Non-BLUD

[2] 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 RPJMN 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.

[3] The field work was conducted in January to March 2016 and covered the following areas: Lombok Utara, and Lombok Timur (West Nusa Tenggara (NTB) Province); Pemalang and Pekalongan (Central Java Province); Pangkajene-Kepulauan and Bantaeng (South Sulawesi Province); Aceh Barat and Bireuen (NAD Province) and Malang, Pacitan, and Bondowoso (East Java Province).

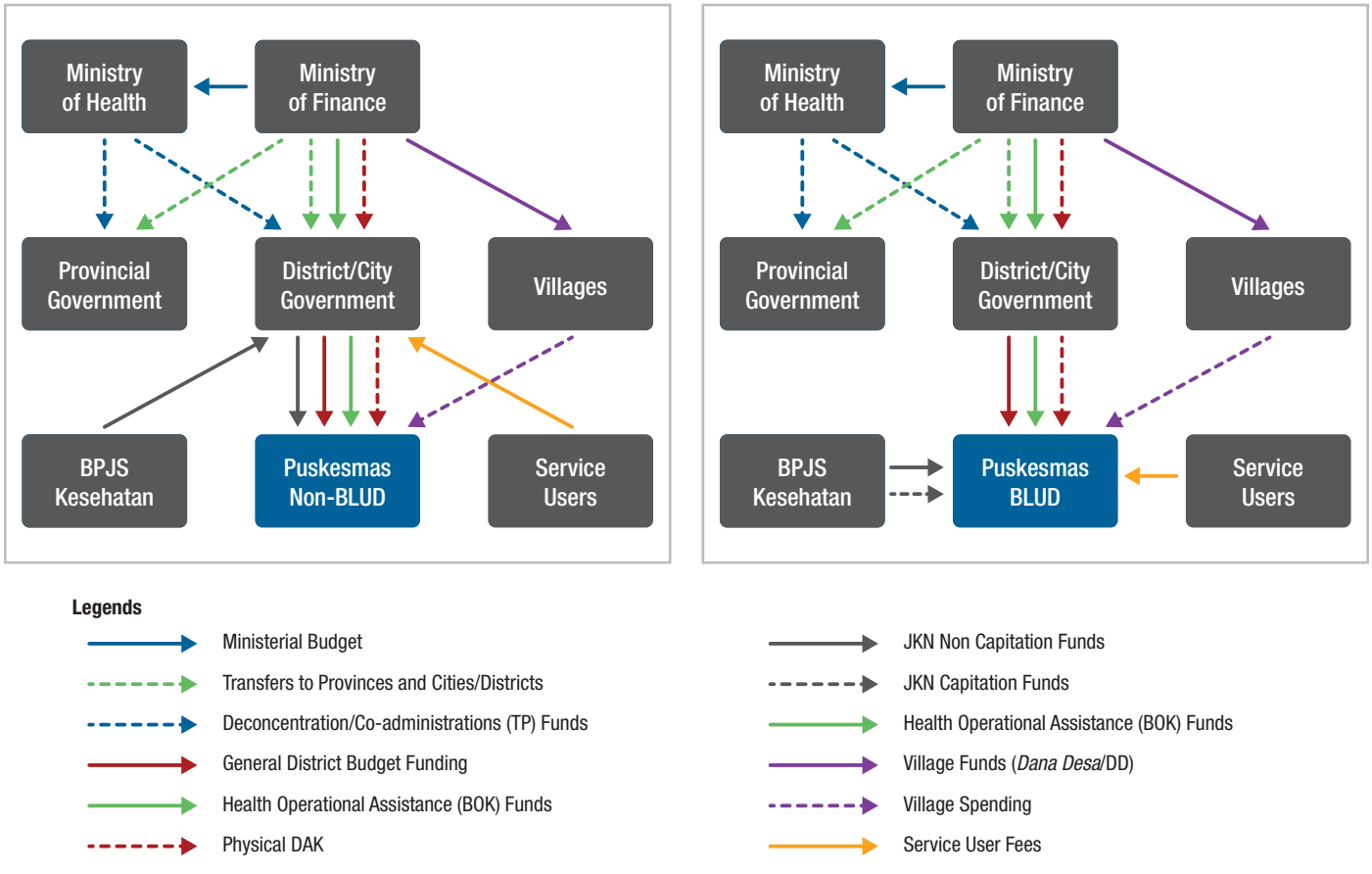
[4] *Puskesmas* Arjosari (Pacitan District, East Java); *Puskesmas* Peusangan (Bireuën District, Aceh); *Puskesmas* Kesesi I (Pekalongan District, Central Java); and *Puskesmas* Santong (Lombok Utara District, NTB).

PUSKESMAS FUND FLOW – WHAT FINANCES PRIMARY HEALTH CARE SERVICES?

Although part of the district government, *Puskesmas* receive funds from various government branches, as well as from non-government sources. In addition to allocations from the district government budget (APBD), *Puskesmas* receive national health insurance (JKN) funds from the National Health Insurance Agency (BPJS Kesehatan) and direct fee payments from service users. Referring to the existing regulatory framework and based on the findings in the 11 visited districts, *Puskesmas* service delivery is financed through up to seven different funds. Moreover, the *Puskesmas* receives the various funds through several different financing mechanisms, as can be seen in Figure 2, which provides a 'simplified' overview of the fund flow mechanisms for financing of *Puskesmas* primary health services.

Prior to 2014, the districts financed *Puskesmas* staff salaries/allowances and contributed towards the operational budget through their annual budget (APBD),[5] while infrastructure investments were financed through the physical Specific Allocation Fund (physical DAK).[6] Public health programs (UKM) were primarily financed through BOK funds. The introduction of the national insurance scheme (JKN) in 2014 and the transition of BOK from TP (co-administration fund) to non-physical DAK in 2016 significantly changed financing of *Puskesmas* service delivery functions. The most substantial change was due to the national health insurance (JKN) scheme. All *Puskesmas* now obtain monthly capitation funds from BPJS Kesehatan. The amount received is based on the number of JKN beneficiaries[7] that are registered in a *Puskesmas*, and the applicable unit value per beneficiary, which ranges between IDR 3,000 and 6,000 depending on number of doctors and dentists in each

Figure 2. Fund Flow Mechanisms for Financing of BLUD and Non-BLUD Puskesmas



[5] Such financing was mainly financed through *Dana Alokasi Umum* (DAU) transfer from the central level, as is the case for most service delivery at the local level. The rest of the *Puskesmas* operational budget is financed through service user fees or *Dana Alokasi Khusus* (DAK).

[6] *Dana Alokasi Khusus* (DAK).

[7] The figure is the number of registered BPJS participants in the *Puskesmas* work areas.

Puskesmas.[8] The monthly transfer is adjusted every month, based on the actual number of beneficiaries registered in the BPJS Kesehatan office.

During the period between 2013 and 2015, all *Puskesmas* visited had experienced significant increases in their overall available resources (as shown in Figure 3).[9] The contribution from the various funding sources also shifted considerably during the same period (see Table 2), mainly moving from general APBD funds to JKN capitation and non-capitation financing of primary health services. Reviewing Figure 3 also shows that the large increase during this period is attributed to the JKN capitation and, to a lesser degree, non-capitation funds. 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. The data collected and used for this analysis is provided in Table 3.

Figure 3. Funding Trends in Four Observed Puskesmas 2013–2015

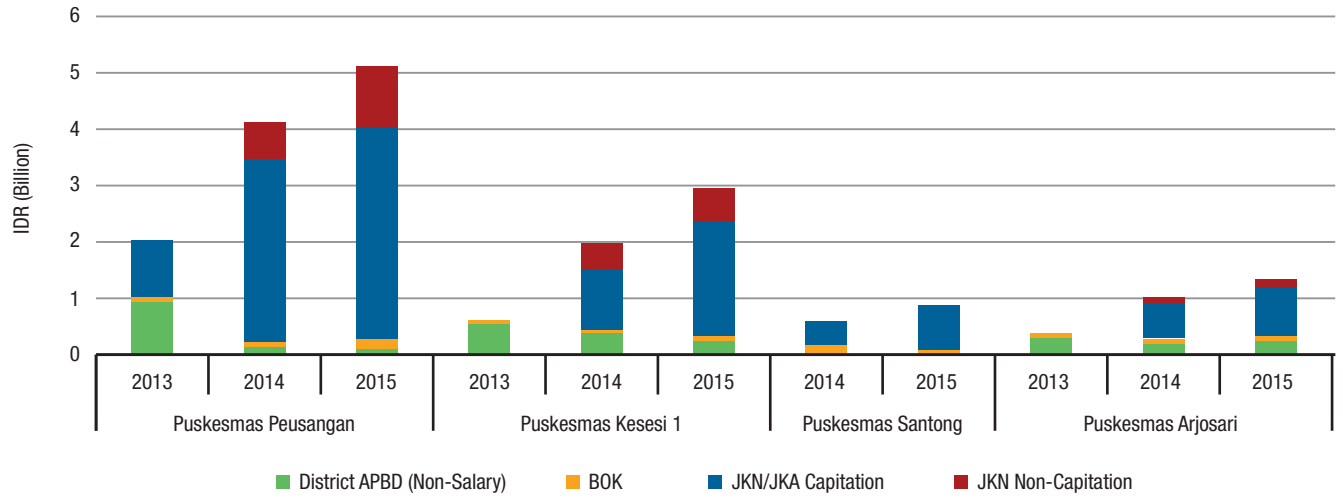


Table 2. Types of Funds that Finance Puskesmas' Spending

No	Funds	Main Funded Items	Fund Manager	Earmarking
1	General APBD funds (non-DAK)	- Salary and allowance for civil servants - Operational funds	- District treasury	No
2	Physical DAK	- Facility construction or renovation - Pharmacy supplies	- District treasury - District health agency	Yes
3	Non-physical DAK (BOK)	- Public health programs (UKM)	- District health agency - Puskesmas	Yes
4	Service user fees	- Operational funds - Medical supplies - Service fees for medical workers	- Non-BLUD: District health agency - BLUD: Puskesmas	No
5	JKN capitation	- Staff remuneration - Pharmacy and medical supplies - Individual health programs (UKP)	- Non-BLUD: District health agency - BLUD: Puskesmas	Partially
6	JKN non-capitation	- Operational funds - Medical supplies - Service fees for medical workers	- Non-BLUD: District health agency - BLUD: Puskesmas	Partially
7	Village funds	- Public health programs in villages	- Village treasurer	Yes

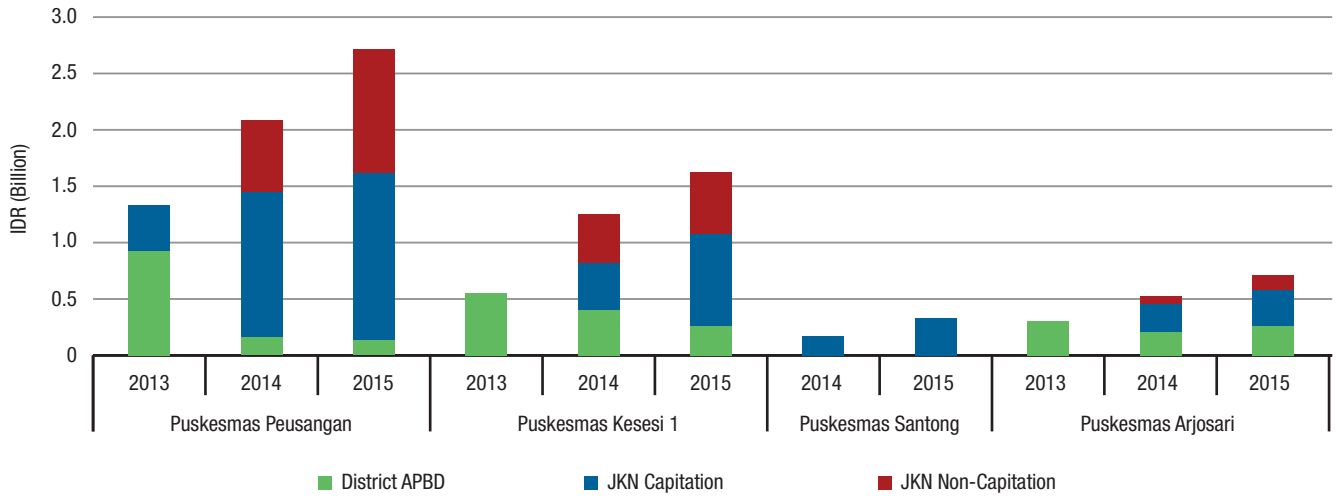
[8] A *Puskesmas* with no doctor or dentist will receive a minimum of IDR 3,000 per month compared to a Puskesmas with at least two doctors and one dentist, which will receive a maximum of IDR 6,000 per month.

[9] Puskesmas Santong in Lombok Utara was only established in late 2013, which may account for the lower level of resources.

Table 3. Funding Composition in Four Observed Puskesmas

Funding Source	Puskesmas Peusangan			Puskesmas Kesesi 1			Puskesmas Santong		Puskesmas Arjosari		
	2013	2014	2015	2013	2014	2015	2014	2015	2013	2014	2015
Total budget (IDR million)	2038.7	4133.2	5129.1	634.6	1970.4	2944.7	623.9	892.4	402.1	1021.6	1344.9
District APBD (excl. salary/ allowance)	46.3%	4.0%	2.8%	86.6%	20.6%	9.0%	1.4%	2.0%	76.4%	20.9%	19.0%
BOK	4.9%	2.3%	3.2%	13.4%	4.6%	3.3%	32.1%	8.6%	23.6%	9.8%	9.3%
JKN capitation	48.8%	78.0%	72.5%	N/A	52.2%	68.2%	66.5%	89.4%	N/A	62.5%	61.5%
JKN non-capitation	N/A	15.8%	21.5%	N/A	22.7%	19.5%	0.0%	0.0%	N/A	6.8%	10.2%

Figure 4. Trends of Puskesmas Operational Budget in 2013–2015



When taking a closer look at actual funds available for operational expenditures for *Puskesmas*, when payments for service fees/ incentives are deducted, the trend with regard to dependency on JKN funds remains the same as illustrated in Figure 4.

In addition to the overall trend, the fund composition also revealed significant differences in the total budget managed by each *Puskesmas*. The analysis of each *Puskesmas* showed that the difference is mainly due to: (i) the number of JKN beneficiaries; (ii) the coverage area of *Puskesmas*; and (iii) the availability of in-patient and birth delivery facilities. *Puskesmas* Peusangan in Aceh has the highest fiscal capacity, because it fulfils all three criteria: a high number of JKN beneficiaries due to the universal health insurance coverage in Aceh[10]; coverage of the whole Peusangan sub-district; and availability of both in-patient and birth delivery facilities in the local health centres. At the opposite end of this spectrum, *Puskesmas* Santong in Lombok Utara has the lowest level fiscal resources; because of the relatively low number of JKN beneficiaries, it covers only two out of five villages in the Kayangan sub-district, and it has no in-patient facility. However, while this rationale for the differences in fiscal resources seems reasonable, the variation between the 'richest' and the 'poorest' *Puskesmas* is perhaps not fully justified if one considers the number of actual patients treated per month and the significant differences in staff incentives. As indicated in the recent KOMPAK Policy Brief *The new financing situation and human resource challenges in Puskesmas* (2017), the incentive payments are not based on actual patient numbers or other performance measures, but are simply the result of a formula based on BPJS membership numbers and technical staff/services available at each *Puskesmas*.

[10] The Aceh provincial government provides health insurance to the whole population in the province. They pay the premiums for those who are not covered by CG or by individual initiatives.

As part of the same KOMPAK study, findings in six different locations indicate that incentive payments for staff vary substantially by staff type and *Puskesmas* location.[11] 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 per month in incentives, while midwives and nurses were rewarded incentives of IDR 1.6 million, and administrative staff received IDR 0.9 million. However, across the six *Puskesmas* locations visited, 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*.

Observations in the *Puskesmas* and district health agencies visited revealed a number of perverse incentives from the increase and distribution of *Puskesmas* additional resources, including:

- Medical workers and administrative staff tend to prefer working in *Puskesmas* with greater resources, as this translates into higher financial incentives for individual staff.
- A number of health agency staff, including division and section heads, are actively trying to relocate to *Puskesmas*, as they are not eligible for any *Puskesmas*-related incentives in current positions.
- Based on answers from the respondents, jealousy between health agency staff and *Puskesmas* staff is emerging, and could potentially disrupt both individual and institutional relationships.
- *Puskesmas* may compete for more JKN beneficiaries, as this would result in greater JKN capitation and non-capitation funds.
- *Puskesmas* situated in areas with few paying members might over time become poorer, unless the total number of BPJS members increases and evens out between the various *Puskesmas*. This could potentially lead to inequities in actual operational budgets for medical equipment and medicine, in addition to less qualified and motivated staff considering staff preferences.

The JKN funds will likely contribute more and more to *Puskesmas*' overall resources in the coming years. With the target of universal JKN coverage across the country by 2019, transfers of JKN funds to *Puskesmas* is anticipated to increase, as more people will become JKN beneficiaries. The Ministry of Health (MoH) and district governments should anticipate this growing number of JKN beneficiaries in certain areas, or lack of such in others, to ensure the provision of accessible, high quality, and equitable health services remains or grows with the increasing numbers.

[11] KOMPAK Policy Brief The new financing situation and human resource challenges in Puskesmas, 2017.

ALLOCATIONS OF FUNDS

District APBD Funds

The allocation of district APBD funds for *Puskesmas* follows the district planning and budgeting cycle.[12] The steps of the cycle related to *Puskesmas* financing are described in Figure 5. Prior to the first step, health agencies are already involved in developing the annual work plan (RKPD) and budget ceiling (KUA-PPAS). A smooth process would enable *Puskesmas* to commence the APBD-funded activities in February of the following fiscal year. This planning and budgeting cycle also affects other central government transfers that are channelled through APBD, such as physical DAK and (since 2016) also BOK financing. JKN fund allocations for *Puskesmas* that do not have BLUD status are also budgeted for in the district APBD.

Physical DAK and Non-Physical DAK (BOK)

The allocation process of physical DAK is described in Figure 6. Since DAK should be budgeted in APBD, the timeline often becomes an issue, because the estimated budget ceilings from the central government are usually only known in November, when the district APBD is nearly or already approved.

Figure 5. District APBD Budgeting Cycle Related to Puskesmas

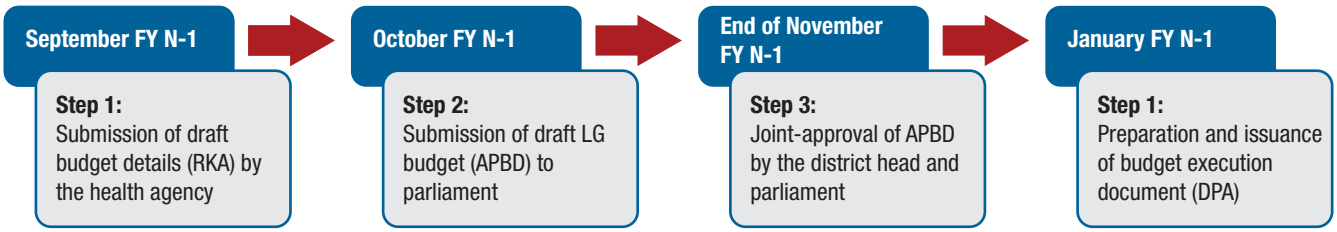


Figure 6. DAK Budget Cycle

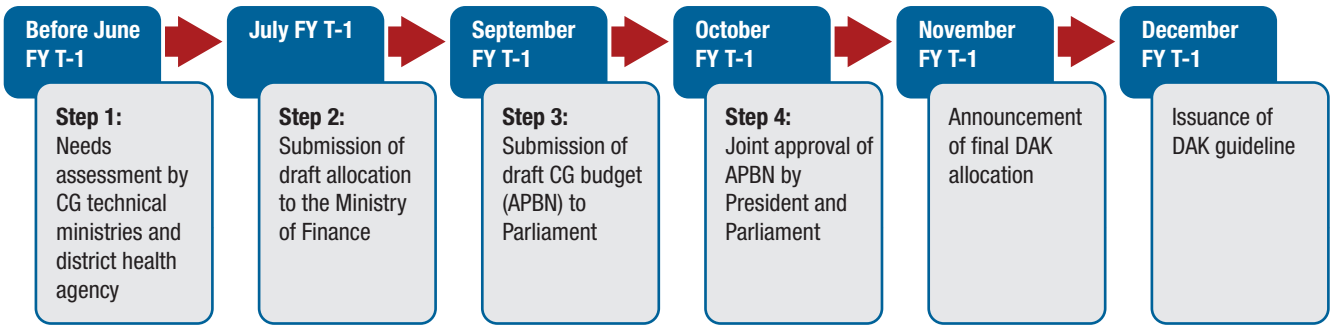


Table 4. Comparison of BOK Before and After 2016

Aspects	2010–2015	From 2016
Type of fund	Co-administration fund (TP)	Non-physical specific allocation fund (DAK)
Legal budget document	Central Government budget (APBN)	District budget (APBD)
Budget execution document	Budget execution document (DIPA) of Ministry of Health	Budget execution document (DPA) of District Health Agency
Tranches	One or more	Four quarterly tranches
Treasury office	National treasury office (KPPN)	District Cash Office (*Kasda*)

[12] Financial year in Indonesia is 1 January–31 December.

After a few years as part of MoH's budget, as of Fiscal Year (FY) 2016 the BOK funding is channelled through the district budget as non-physical DAK. The difference between the two mechanisms is presented in Table 4. This transformation has had an impact on the execution of UKM programs during 2016, because the districts were not informed about the regulatory framework for the new BOK grant until very late in 2015, when the 2016 budget had already been approved. This meant that districts needed to find a way to be able to disburse the BOK funds, because they were not part of the approved budget.

JKN Funds

JKN funds, he newest method for financing *Puskesmas* service delivery come in two forms: (i) a capitation share, which is paid in the beginning of each month as an advance; and (ii) a non-capitation share, which is refunded based on services rendered and claims submitted by the *Puskesmas*. 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), showing real-time information about the actual number of beneficiaries registered to each *Puskesmas*, and thus able to estimate the amount of capitation resources.

The P-Care system is now also used for non-capitation claims, mainly for in-patient treatments and birth deliveries, which allows *Puskesmas* to submit claims online and which enables them to track the progress of the payment. Nevertheless, the *Puskesmas* is still required to submit a hardcopy to the BPJS Kesehatan office for the claim to be processed. While the calculation of the JKN non-capitation fund is relatively simple, estimates related to actual available non-capitation resources and expenditures remain challenging, as the numbers might fluctuate significantly from month to month. Some districts with non-BLUD *Puskesmas*, such as Malang, Pacitan, and Pekalongan, needed accurate estimates because the non-capitation revenues contribute to the overall operational budget of the *Puskesmas*.

Key Challenges

The field review of the allocation processes of each fund in the four *Puskesmas* confirms the analysis above and the challenges the *Puskesmas* have in estimating and budgeting for actual resources during their planning and budgeting processes. Referring to the actual timeline, as shown in Table 5, a majority of the *Puskesmas* were only informed about their estimated budget envelope in December 2015 for planning purposes for FY 2016. In addition, information regarding actual allocations for 2016 of all funds was only provided in early 2016. This situation remains challenging for *Puskesmas*, as the local APBD process is often already in the final phase or completed by the time expenditure limits are advised, which makes it difficult to make adjustments to the plans and budgets. This situation has led to the inability of *Puskesmas* to develop accurate work plans for physical DAK and BOK funded crucial programs, such as infrastructure development, pharmacy supplies, and other specialist public health programs, and this can delay budget execution until budget revisions take place in September.

Table 5. Allocation and Disbursement Timeline for the Four Puskesmas, FY 2016

No	Funds	Allocation information		Disbursement		
		Legal document	Timeline	Legal document	Timeline	Start of disbursement
1	General APBD funding	Local regulation (*Perda*) on APBD 2016	December 2015	Budget execution document (DPA) of district health agency	January or February 2016	January or February 2016
2	Physical DAK	Ministry of Finance regulation (PMK) on transfers to regions in 2016	Early December 2015	DPA of district health agency	January or February 2016	After February 2016
3	BOK			Special DPA for BOK	Various	
4	JKN	Notification from BPJS Kesehatan	Each month	Special DPA for JKN capitation	January or February 2016	January 2016

WHAT CAN THE VARIOUS FUNDS BE USED FOR?

In terms of fund purposes, some of the funds are earmarked, while others are quite flexible. Commonly the allocations from the district APBD, which are non-DAK, can be used to fund all possible spending items. However, physical DAK and JKN capitation funds, on the other hand, are always earmarked and can only be used for certain pre-approved expenditure categories. The eligibility of expenditures against the various funds, as illustrated in Table 6, is quite promising, although complicated. At least four funds are flexible for most spending items: general APBD funding, both JKN capitation and non-capitation funds, and service user fees.[13] Physical DAK is earmarked for facility development and pharmacy supplies, while the health operational assistance (BOK) fund is earmarked for public health programs (UKM). The Village fund (*Dana Desa*) is a new source of funding since 2015, and the fund can theoretically finance UKM programs or co-finance other health-related expenditures benefiting the village communities. However, substantive village contributions towards health service expenditures are yet to materialise.

The JKN capitation and non-capitation funding is widely considered as the most flexible funding source by the *Puskesmas* staff interviewed. Respondents believe it complements the previous two funding sources (APBD and BOK), particularly related to operational spending, and pharmacy and disposable medical supplies. Although the JKN capitation spending was supposed to be for individual health programs (UKP), there seems to be some flexibility within the funding framework to also cover non-JKN members for promotion and prevention activities.

Table 6. Eligible Puskesmas Spending Categories Based on Funding Source

Spending Item	District Budget			JKN		Service User Fees	Village Fund
	Non-DAK	Physical DAK	BOK (TP/ DAK)	Capitation	Non-Capitation		
Personnel expenses							
Civil servants	√			√	√	√	
Honorary staff	√			√	√	√	
Training/capacity building	√				+	√	
General operations (electricity, water, etc)	√			+	√	√	
Facility							
Development	√	√		+	√	√	
Maintenance	√			+	√	√	
Pharmacy	√	√		√	√	√	√
Medical equipment	√			√	√	√	
Public health programs (UKM)	√		√	+	√	√	√
Individual health programs (UKP)	√			√	√	√	

Note: + indicates eligibility in BLUD Puskesmas **only**.

[13] A few districts still applied service fees for non-JKN or *Jamkesda* members, which could later be used for most spending items.

Table 7. Disbursement and Management Mechanisms for Puskesmas Funds

No	Funds	Source of Fund	Disbursement Mechanism	Puskesmas Management Responsibilities
1	Salary and allowance for civil servants	District budget	Monthly transfer to individuals from district account.	Indirectly
2	Operational and administrative	District budget	Direct payment from district account based on budget execution document (DPA) and fund disbursement request (SP2D).	Directly
3	Health operational assistance (BOK)	District budget	Quarterly transfer from district account to Puskesmas BOK account.	Directly
4	Physical specific allocation fund (DAK)	District budget	Direct spending by the district health agency.	Indirectly
5	National health insurance/JKN (including top-up by provincial/ district government) - Capitation funds - Non-capitation funds	BPJS	- Capitation funds: Monthly advance transfer from BPJS Kesehatan to Puskesmas JKN account, based on number of JKN beneficiaries and capitation tariff category. - Non-capitation funds: Monthly transfer from BPJS Kesehatan, based on verified claims to district account (for non-BLUD Puskesmas) or directly to Puskesmas BLUD account.	Directly
6	Service user fees	Service users	Non-BLUD Puskesmas has to deposit the fees collected into the district account and then the funds will be made available to the Puskesmas through the usual disbursement mechanism for operational budgets.	Directly
7	Village funds	Village budget	Direct spending by village administrators.	N/A

Note: + indicates eligibility in BLUD Puskesmas **only**.

DISBURSEMENT AND FUND MANAGEMENT MECHANISMS

The *Puskesmas* have to deal with predictable and less predictable disbursement schedules for the various funds, as shown in Table 5. Further, as seen in Figure 2, the various funds originate from central and district governments with different disbursement mechanisms and schedules. While most funds are managed directly by the service unit, others only indirectly involve the *Puskesmas*, such as salary and allowances for civil servants, physical DAK, and village funds. Table 7 provides a summary overview of the various funds, disbursement mechanisms, and management responsibilities by *Puskesmas*.

The findings from the four *Puskesmas* showed that while the general funds from the APBD and JKN capitation funds were disbursed relatively smoothly, challenges and delays in disbursement of the other three funds have had negative implications on the delivery of health services. While APBD funds are rather predictable, disbursement of APBD depends on the issuance of the DPA. Problems arise if the DPA misses important spending items, as such disbursements will then have to be postponed until the DPA is revised, usually in July. BOK funding, which is the main source for UKM activities, has been known for its disbursement delays due to budgeting, treasury, and administration-related bottlenecks when it was still a TP under the MoH DIPA (see Table 3). Based on interviews with the BOK treasurers and heads of *Puskesmas*, the disbursement delays did not affect the UKM program executions, because they pre-financed them from their personal funds.

Transformed to non-physical DAK starting in 2016, the BOK disbursements faced another set of challenges. In the 11 districts surveyed, none of the districts had initially included DAK BOK funds in their 2016 budgets, because of the uncertainties surrounding the changes to the BOK regulations during the 2015 planning and budgeting processes. The districts have tried to cope with this in different ways. Six of the 11 districts decided

to postpone disbursement of funds until after the budget revision process (APBD-P) is concluded, usually in September; while the other five visited districts in Java were attempting to revise the DPA prior to APBD revision. Hopefully, in two or three years, the BOK can at least mirror the school operational assistance (BOS) practices. This means that the funds are received by the service units in each quarter and the *Puskesmas* staff will 'only' need to pre-finance UKM programs for one or two months.

The physical DAK, which is managed by the district health agency, has its own formidable challenges. The fund, the main funding source for *Puskesmas* infrastructure and pharmacy supplies, is transferred quarterly from MoF to district accounts, similar to BOK. The execution of both spending items usually requires a procurement process, which can take months to complete. The delay in disbursement of funds often results in scarce pharmacy supplies and neglected maintenance of the health facilities.

Interestingly, considering the rather short time JKN capitation funds have been operational, this financing mechanism is considered by the respondents as the most predictable transfer, as it is usually received at the beginning of each month. The claim-based non-capitation funds are also reported as predictable upon completion of documents and claim submission from *Puskesmas* to BPJS. However, payments of JKN non-capitation funds were often delayed in 2014–2015 due to administrative issues. As reported in all 11 surveyed districts, the claim submission through the P-Care application did not significantly streamline the process. As of early 2016, BPJS Kesehatan still conducted rigorous checks on all claims submitted by *Puskesmas*. This often required a back-and-forth process, and a few claims are reported to have taken more than three months to be processed. As the non-capitation claims also included fees for medical workers, midwives and nurses often needed to wait for more than three months before they received the fees.

ABSORPTION CAPACITY

The financial reports in the four *Puskesmas* visited indicate that their absorption capacity of their overall budget is relatively good. While APBD and BOK funds are normally fully spent by the end of the year, JKN funds remain underspent in all but one *Puskesmas*, resulting in budget surpluses.[15] This is consistent with statements made during the interviews, where *Puskesmas* staff indicated that, because of strict APBD and BOK funds eligibility criteria, spending against these funding sources were normally prioritised. As can be seen from Table 8, all four observed *Puskesmas* fully absorbed APBD and BOK funds during 2013–2015, while remaining unspent budget allocations are from JKN capitation fund categories. Reviewing the expenditure figures in more detail, all four *Puskesmas* fully absorbed the service fee share of the capitation funds, while the operational budget for general support, and pharmacy and disposable medical supplies, was underspent by 50 percent or more.[16] This underspending of JKN funds led to surpluses in all of the visited *Puskesmas* by end of 2015. Pekalongan, Malang, Pacitan, Pemalang, and Bondowoso Districts had already decided that the surplus could be spent in the following fiscal years, while the remaining districts were still undecided when interviewed in early 2016.

Table 8. Fund Absorption in Four Selected Puskesmas

Funding Source	Puskesmas Peusangan			Puskesmas Kesesi 1			Puskesmas Santong		Puskesmas Arjosari		
	2013	2014	2015	2013	2014	2015	2014	2015	2013	2014	2015
District APBD (non-salary)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
BOK	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
JKN/JKA capitation	100%	80.2%	79.3%	N/A	87.1%	N/A	60.0%	58.6%	N/A	56.9%	100.3%
Surplus/deficit (IDR millions)	0	637.4	771.4	0	132.7	N/A	166.1	330.25	0	275.4	–2.15
Surplus/deficit (% of budget)	0	15.4%	15.0%	0	6.7%	N/A	0	37.0%	0	27.0%	–0.2%

[15] The absorption of physical DAK and JKN non-capitation funds was not analysed, because the former was not managed directly by Puskesmas and the latter was often combined as APBD funds.

[16] According to the MoH regulation (Permenkes) No. 19/2014, JKN capitation funds should be spent at least 60% on service fees for Puskesmas staff, while the rest is for operational support, and pharmacy and disposable medical supplies.

As all *Puskesmas* and health agencies are still adjusting to the new JKN regime, the underspending on non-service fee items of JKN capitation funds can be explained as follows:

- Pharmacy supplies were usually financed by DAK or APBD funding and distributed to *Puskesmas* by *Dinas* based on request or availability.
- Considering the special circumstances of the finance management procedure of capitation funds, district health agencies may need time to find a proper way to use the funds.
- *Puskesmas*, even those with BLUD status, are not authorised to procure, and thus rely on the health agencies. While district health agencies in Central and East Java have relatively advanced procurement capacities, those in Aceh and NTB tend to be slower in procuring pharmacy and medical supplies. Interviews with health agency officials indicated that this was likely caused by their unfamiliarity with the procurement process through e-catalogue, which is a relatively new practice.
- By end of 2015, none of the observed *Puskesmas* had obtained BLUD status.[17] As a result, they did not have the flexibility to use the unabsorbed capitation funds for other purposes, such as medical equipment and infrastructure.

Combining the revenues and absorption capacity of *Puskesmas*, there is strong indication that *Puskesmas* have sufficient funding for practically all spending items. This is suggested by: (i) the overall operational budget increasing significantly between 2013 and 2015, which has often led to budget surpluses; (ii) the growing number of JKN beneficiaries, and subsequent operational budgets, which has enabled *Puskesmas* to allocate additional funds for UKM programs covering not only JKN members but also non-members; and (iii) despite certain administrative and procurement problems, which have led to significant unspent funds, there seem to be sufficient funds to purchase pharmacy supplies.

MANAGEMENT OF PUSKESMAS OWN-SOURCE REVENUES

Revealed during the field work, districts vary in how they managed *Puskesmas* own-source revenues, which comprise service user fees and JKN non-capitation funds. The main variations are between districts that applied the BLUD and those that applied non-BLUD *Puskesmas*, and between non-BLUD *Puskesmas* in terms of how the district ties or does not tie own-source revenues

[17] Puskesmas Kesesi I obtained BLUD status in January 2016.

[18] Perpres XXXX [insert the relevant perpes].

[19] Achievement of target will add or reduce the APBD allocation for the following fiscal year.

Figure 7. Service User Fees and Flow of JKN Funds in Non-BLUD (Left) and BLUD (Right) Puskesmas

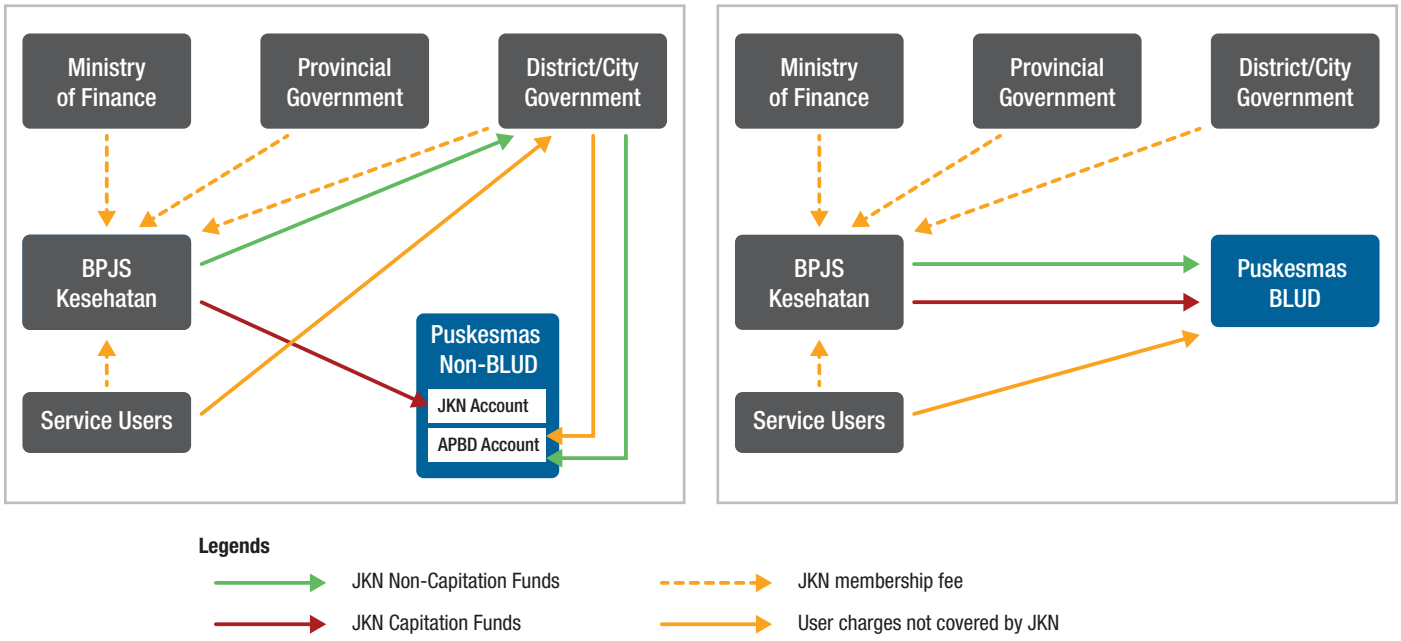


Table 9. Reporting Requirements of Each Fund

No	Funds	Reporting/accountability mechanism	Submitted to
1	General APBD funding	Common financial accountability (SPJ) procedure	District Health Agency
2	Physical DAK	DAK technical and financial report	District Health Agency
3	BOK	Monthly realisation report	District BOK Management Team in the district health agency
4	JKN	Common financial accountability (SPJ) procedure	District Technical Agency
5	Service user fees	Common financial accountability (SPJ) procedure	District Technical Agency

and APBD operational funds. As illustrated in Figure 7, BLUD *Puskesmas* have less complex revenue management procedures than non-BLUD *Puskesmas*. All revenues are managed directly by the *Puskesmas* and can be used according to the needs of individual *Puskesmas*, as per work plan and fund eligibility. The situation for non-BLUD *Puskesmas* is significantly more complex, because all revenues are required to be deposited in the district treasury office before they are 'transferred back' to the *Puskesmas* as part of general district APBD funding. The transfers of such revenue may take months to process, because they are mixed with other APBD funds, excluding DAK. Before the JKN era, this undermined the service delivery provision, as *Puskesmas* relied solely on APBD funds for operational expenditures. In the JKN era, the JKN capitation funds can be used to anticipate such potential delays. Although this also constitutes district revenue, JKN capitation funds are transferred directly from BPJS Kesehatan to each *Puskesmas*, without consideration of their BLUD status.[18] For non-BLUD *Puskesmas*, the usage of the monthly capitation fund still must refer to DPA and requires authorisation by the district health agency office, which was considered as a non-issue in all 11 visited districts.

The second variation is exclusively among districts with non-BLUD *Puskesmas*. This is related to whether or not the *Puskesmas* own-source revenue (service user fees and JKN non-capitation) determines the district APBD allocation of operational funds to the *Puskesmas*. Visited districts in East Java and Central Java tied revenue targets to the APBD allocations, where performing *Puskesmas* can receive up to 80–100% of the total estimated APBD allocation if they meet their set targets of own-source revenue collection. Differently, the districts in Aceh, South Sulawesi, and NTB do not link *Puskesmas* own-source revenues and district allocations, and operational funds are determined

based on estimated actual needs and overall district fiscal capacity. The first option provides stimulation for each *Puskesmas* to achieve a certain target, but might lead to further variation in *Puskesmas* fiscal capacity.[19] The second option seems to equalise the fiscal capacity, but may not motivate *Puskesmas* to raise additional revenues.

REPORTING AND FINANCIAL ACCOUNTABILITY

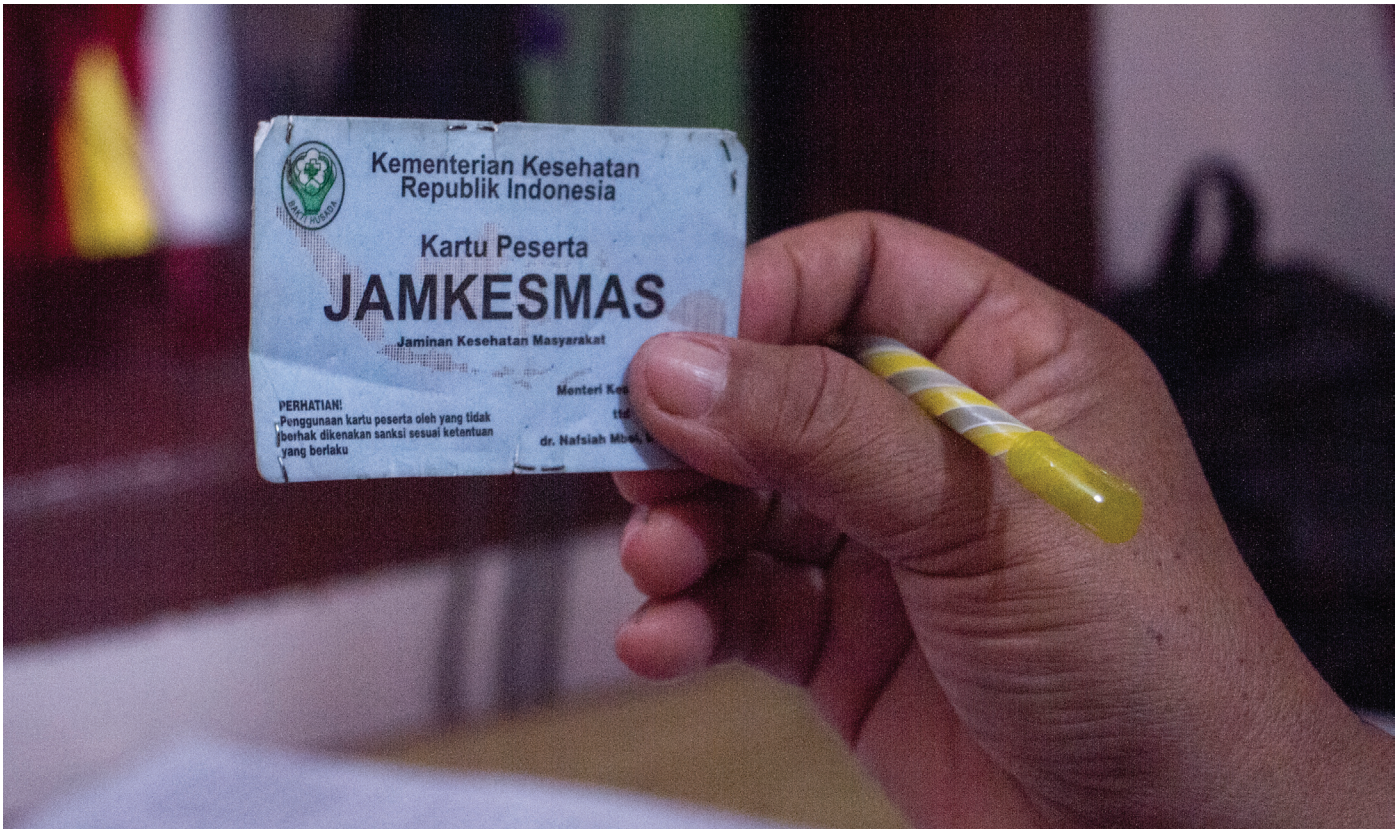
Considering the various sources of funding for *Puskesmas* services, each funding mechanism has separate planning, allocation, disbursement, and reporting requirements, although some follow similar mechanisms and are submitted to the same receiving agency. This often leads to unnecessary confusion and additional work for *Puskesmas* staff. Table 9 provides an overview of these requirements for non-BLUD *Puskesmas*. Remarkably, *Puskesmas* with BLUD status have less complex reporting procedures, as JKN and service user fees can be reported together as part of the BLUD financial reporting.

Further, from 2016 most districts needed to adopt common BOK finance management procedures. Previously, as TP funds, BOK finance management procedures referred to MoH's guideline. However, the new DAK BOK has to follow district finance management rules, which vary among districts. While some districts could accommodate the common BOK practices, some others need to revisit their finance management rules, particularly for issues related to transportation and daily allowance within sub-districts.

According to non-BLUD *Puskesmas* staff interviewed, about 80 percent reported that their overall workload had nearly doubled with the introduction of BOK and JKN program implementations. As reported in the 11 survey locations, 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 perform functions as treasurers for JKN and BOK funds in addition to other administrative and clinical functions.

CONCLUSION

Reviewing all of the various income sources received and managed by the *Puskesmas* surveyed, all four *Puskesmas* have sufficient financial capacity to deliver mandated primary health services. The main challenges for the district health agency and *Puskesmas* are not insufficient resources, but rather related to challenges in how to effectively manage and use the available



funds to deliver equitable, high quality and accessible primary health services. To improve this situation, central government and district stakeholders should respond to emerging issues related to the challenges observed, which concern implementation of JKN, BLUD *Puskesmas*, and BOK transformation to non-physical DAK.

JKN Fund Review

The district health agency should anticipate the implications of the JKN financing mechanisms for primary health services. It seems that the first two years of JKN implementation have provided *Puskesmas* with abundant funds that are far greater than its predecessor Jamkesmas. With the current JKN coverage of around 60 percent of the total population , *Puskesmas* have already a sizable surplus from both JKN capitation and non-capitation funds. This surplus will presumably increase further with the aim of universal coverage. In addition, uneven fiscal resources among *Puskesmas* have led to unhealthy competition and resource distribution among the *Puskesmas*. MoH and the districts may mitigate these problems in the following ways:

- District health agencies should improve the management of procurement and distribution of pharmacy and disposable medical supplies.
- District government needs to review the coverage and facilities of each *Puskesmas*, as the growing number of JKN members may lead to a higher demand for primary health services. Lombok Utara and Pekalongan may provide an example for how to expand coverage and capacity with their solution of one in-patient and one or more out-patient *Puskesmas* per sub-district.
- Review and mitigate the emerging negative trends caused by the current JKN capitation allocation formula with the aimof including actual service performance, and actual number of patients served (rather than only focusing on BPJS members), as well as redistribution of funds or allocating more APBD operational and facility budgets to 'poorer' *Puskesmas*, and allowing *Puskesmas* to hire necessary finance staff as their finance management needs grow in line with the higher income.

Regulate and Expand the Numbers of BLUD Puskesmas

Considering the varied funding sources, *Puskesmas*, particularly those that provide in-patient care, may perform better if they have local public service agency (BLUD) status. Based on the regulatory framework and desk study, BLUD *Puskesmas* may solve the following problems:

- *Puskesmas* with BLUD status have more flexibility in using JKN capitation funds. Unabsorbed funds could be used to improve the facility and to conduct capacity building programs.
- JKN non-capitation funds and service user fees are managed directly by the *Puskesmas*, and are immediately available to cover service costs, and operational or maintenance expenses, as they do not need to be deposited in the district *Puskesmas* account and returned through APBD transfers.
- *Puskesmas* with BLUD status can more easily hire medical workers and finance staff in accordance with actual needs and available funds.

Despite the potential advantages of BLUD status, districts should also be cautious in establishing BLUD *Puskesmas*. The service-unit BLUD is still relatively new and not yet sufficiently regulated. This leaves large and critical issues at the discretion of district governments, the health agency, or even *Puskesmas*. The transformation of BLUD may take the following steps:

1. The health agency and financial management agency may develop a sound understanding of the BLUD *Puskesmas* system and ensure that they have the required capacity to perform the roles.
2. The transformation should start with current in-patient *Puskesmas*, because they usually have greater resources, receive JKN non-capitation funds, and have more complex operations. The out-patient *Puskesmas* may follow later when the system is already running well.
3. The BLUD *Puskesmas* should have a strong financial manager to ensure implementation of a sound financial management system that covers funds from different sources.
4. The health agency and management agency should monitor closely the management of BLUD *Puskesmas* to anticipate and mitigate problems as they occur.

BOK Transformation to Non-Physical DAK Needs Further Consideration

Districts have different responses related to the new status of BOK as non-physical DAK, which might compromise the execution of UKM programs in *Puskesmas*. Observations from the first few months in 2016 revealed that none of the visited districts had incorporated BOK in their APBD. This inevitably led to disbursement delays that may be responded to differently by *Puskesmas* staff, compared to the past BOK delays. While the

previous delays provided assurance that staff could reimburse the pre-financing of BOK activities later, the current BOK does not. Naturally, it would deter the *Puskesmas* staff from conducting any UKM activities financed by BOK. To respond to these issues, MoF and MoH could take the following actions:

- The implementation of this new BOK mechanism needs to be reviewed in 2017, so that the mechanism can be fine-tuned, if necessary, for 2018 and beyond.
- Rather than being channelled through the districts, the DAK BOK may be channelled through the provincial government. Similar to the practice of the school operational assistance (BOS) fund, coordination of the various processes and reporting requirements may be easier, as MoH only needs to deal with 34 provincial health agencies, compared with 512 district agencies.
- To ensure streamlined implementation across the country, MoH may include costing information of UKM programs in its annual DAK guideline.
- To ensure that all districts are well informed about DAK BOK, and also the non-physical DAK, MoH, MoF, and MoHA may work more effectively in disseminating the guideline. The main challenge is that the guideline could only be issued after the Presidential Regulation on APBN execution is signed, which is usually in November or even December. Also, sharing the draft with all districts might not be effective, as the final guideline might differ from the draft and any difference will lead to confusion in districts. Considering these two issues, the three ministries might involve all provincial health agencies from the start. They may be consulted during the formulation and be informed about the initial draft. Once the guideline is finalised, they should be informed and later lead the dissemination to all districts.

In sum, the financing of *Puskesmas* service delivery is complex and each *Puskesmas* needs to manage several funds with separate disbursement mechanisms and procedures. Simplifying and streamlining the many funding sources and requirements should be considered to make financing of the *Puskesmas* more transparent and accountable, in addition to becoming less resource-intensive for the *Puskesmas* staff, and freeing up time for actual service delivery functions.

Table 10. Recommendations

No	Description of Challenges	Suggested Actions	Agency in Charge
1	CG regulations, particularly the DAK guidelines, are often delayed, and so UKM programs in Puskesmas cannot be executed in the first months. Some delays are inevitable because of the wait for parliamentary approval of the CG budget (APBN).	DAK guidelines should be issued for multiple years and published two months before the start of the fiscal year.	MoF-DJPK & MoH
		MoH should brief the provincial health agency one month before the new fiscal year.	MoH
		The provincial health agency should brief the district technical agency two weeks before the new fiscal year.	Provincial health agency
		Establishment of online discussion forums	MoH and provincial health agency
2	A few districts still face major challenges in incorporating additional CG fiscal transfers that are only decided late in the year to APBD, particularly on DAK.	The DAK guideline should also mention how LGs should incorporate it in the APBD.	MoH
		A MoHA circular letter should be issued to give clarity to LGs in incorporating additional fiscal transfers in APBD.	Ministry of Home Affairs (MoHA)—DG Regional Finance
3	There are significant variations in the size and coverage of each Puskesmas in one district, which leads to different remuneration for each individual Puskesmas.	A guideline on the size and coverage of Puskesmas should be formulated.	MoH
		MoH and provincial health agency should monitor districts' policies in managing the Puskesmas.	MoH and provincial health agency

No	Description of Challenges	Suggested Actions	Agency in Charge
4	Despite efforts from CG to address regional disparities, Puskesmas in rural areas have less financial resources, but greater challenges in providing primary health services.	Districts should put more emphasis on APBD allocation to rural Puskesmas.	District health agency
		Physical DAK should be directed for Puskesmas with inadequate fiscal resources.	MoF-DJPK, MoH, and district health agency
5	In the first year of implementation, districts had different responses to the new status of BOK as non-physical DAK, which might compromise the execution of UKM programs in Puskesmas.	The BOK channelling mechanism may be done through provincial government to Puskesmas, similar to BOS practices.	MoF-DJPK and MoH
		The BOK implementation regulation should contain the unit costs of UKM activities to ensure consistencies among Puskesmas.	MoF-DJPK and MoH
6	The BLUD status provides flexibility to Puskesmas, but districts should ensure the readiness of Puskesmas and health and finance agencies before executing the transformation.	MoH and MoHA may develop a guideline on transforming Puskesmas from local technical implementing unit (UPTD) to BLUD.	MoH and MoHA (DG Regional Finance)
		MoF and MoH may develop specific training modules on Puskesmas BLUD.	MoF-DJPK and MoH
		MoF and MoH may train provincial staff on the Puskesmas BLUD training modules.	MoF-DJPK, MoH, provincial health, finance, and training agencies
		Districts should work with the provincial health agency on the transformation plan, particularly in ensuring the readiness of Puskesmas.	Provincial and district health, and finance agencies
7.	Puskesmas with local public service agency (BLUD) status are not well regulated yet, and leave large critical issues to the discretion of LG, the health agency, or even Puskesmas.	MoH should lead in formulating regulations on the management of Puskesmas BLUD.	MoH, MoHA, and MoF (DJPK)
		The district health agency should review in detail the Puskesmas work plan in detail and conduct periodic monitoring.	District health agency
8	JKN non-capitation claims are often delayed, as the overall process is not lean and efficient.	District health agency should reach an agreement with the BPJS office on the claim processing and disbursement procedures.	District health agency
9	No Puskesmas have an integrated annual plan and none have an integrated reporting system.	A national-level regulation needs to be formulated that requires Puskesmas to develop and publish integrated planning and reporting documents.	MoH, supported by MoF-DJPK, MOHA, and BPJS Kesehatan
		Provincial and district health agency should build Puskesmas' capacity to develop and publish integrated planning and reporting documents.	Provincial and district government
10	Despite the significant increase in fiscal capacity of Puskesmas due to the national health insurance (JKN), there is little indication that health services have improved.	BPJS Kesehatan may tie the scale of capitation funds with the service performance.	BPJS Kesehatan
		The district health agency should guide Puskesmas in planning and executing the individual health programs (UKP).	MoH

LIST OF REVIEWED REGULATORY FRAMEWORKS

1. Law No. 33/2004 on Fiscal Balance
2. Law No. 40/2004 on National Social Security System
3. Law No. 24/2011 on Social Security Administration Agency (BPJS)
4. Law No. 5/2014 on State Civil Apparatus
5. Law No. 6/2001 on Village
6. Law No. 23/2014 on Local Government
7. Government Regulation (PP) No. 58/2005 on the Guidelines of Local Financial Management
8. PP No. 43/2014 and PP No. 47/2015 on the Implementation of Village Law
9. PP No. 60/2015 and PP No. 22/2015 on Village Funds from CG Budget
10. Presidential Regulation (Perpres) No. 12/2013 on Health Insurance
11. Perpres No. 111/2013 on the Revision of Perpres No. 12/2013
12. Perpres No. 32/2014 on the Management and Utilisation of JKN Capitation Funds on LG Primary Health Facilities
13. Minister of Home Affairs (MoHA) Regulation (Permendagri) No. 13/2006 on Local Financial Management (and its revisions)
14. Permendagri No. 61/2007 on Local Public Service Body (BLUD)
15. Minister of Health (MoH) Regulation (Permenkes) No. 69/2013 on the JKN Service Costs
16. Permenkes No. 71/2013 on Health Services under JKN
17. Permenkes No. 19/2014 on the Utilisation of JKN Capitation Funds for Health Service Provisions and Operational Funds on LG Primary Health Facilities
18. Permenkes No. 27/2014 on Technical Guidance of INA-CBG
19. Permenkes No. 28/2014 on JKN Implementation Guideline
20. Permenkes No. 59/2014 on JKN Tariffs
21. Permenkes No. 82/2015 on the Technical Guideline of Specific Allocation Fund (DAK) in the Health Sector in 2016
22. Ministry of Finance (MoF) Regulation (PMK) No. 22/2016 on Disbursement of the Health Operational Assistance (BOK) and Family Planning Operational Assistance (BOKB) Funds.

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To request a copy of this policy brief or for more information, please contact KOMPAK Communications Team (communication@kompak.or.id). This policy brief is also available on the KOMPAK website.

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