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Planning and Priority Budget for Health Sector Minimum Service Standards at Community Health Center in Indonesia

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Abstract: Puskesmas as the main implementer of Minimum Service Standards' achievement in the health sector, needs support to achieve the expected achievements. Puskesmas need to be studied to add to the discourse as one of the ingredients in decision-making in Indonesia's health sector. This research is qualitative research with a case study approach. The collecting technique is secondary data in the form of documents, primary data through in-depth interviews, observations, and/or focus group discussions (FGD) with triangulation. The results showed that the planning used the bottom-up, top-down, and community participation approaches. Budget sources are quite good, but budgets for the MSS program have not been specifically segregated in the two districts. It is hoped that there will be flexibility in prioritizing budgets for SPM, UKM, and other regional needs programs. This study's objectives (1) determine priorities for planning and budgeting for minimum service standards in the health sector in public health centers. (2) the right priority in planning the minimum service standard steward in the health sector at the health center.
Keywords: planning, priority, budget, SPM Health.

印度尼西亚社区卫生中心卫生部门最低服务标准的规划和优先预算

摘要：公共卫生中心作为卫生领域最低服务标准成就的主要实施者，需要获得支持才能实现预期的成就。需要研究猫科动物以将其添加到讨论中，作为印度尼西亚卫生部门决策中的要素之一。本研究是采用案例研究方法的定性研究。收集技术是文档形式的辅助数据，通过深度访谈，观察和/或带有三角剖分的焦点小组讨论（烟气脱硫）形成的主要数据。结果表明，该计划使用了自下而上，自上而下和社区参与的方法。预算来源相当不错，但是 MSS 计划的预算并未在两个地区中明确分开。希望可以灵活地确定 SPM，英国和其他区域需求计划的预算优先级。这项研究的目标（1）确定公共卫生中心卫生部门最低服务标准的计划和预算重点。 （2）在医疗中心，在卫生部门规划最低服务标准管理员的正确优先事项。
关键词：规划，优先级，预算，SPM 运行状况。

1. Introduction

The health sector needs to be a development priority, which should receive primary and sustainable attention from central and local governments. The central government, DPR, and local governments (pemda), up to the community health center, need to work together r in increasing the health status of Indonesia to the highest.

In Law Number 23 of 2014 concerning Regional Government, article 18 states that regional government administrators prioritize implementing mandatory government affairs related to basic services. The implementation of basic government affairs services

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must be guided by the minimum service standards set by the Central Government [1]. In Law No. 36 of 2009 concerning Health, article 171 paragraphs 1 and 2 regulates the health sector's budget through the APBN at a minimum of 5% and APBD of 10% [2]. The basis of this constitution has shown that the health sector has actually become one of the priority sectors for the country's development.

In its realization, there are still several problems in health budget policies in Indonesia. The low commitment to the total budget for the health sector. Indonesia has allocated around 3.1% of Gross Domestic Product (GDP) for the health sector [3]. On the other hand, some local governments are not ready to manage the health budget properly. Different factors in budget allocations and revenues among regions may influence the formulation of the SPM health budget. Factors such as conflict of interest between one sector and another affect the health budget's priority in each region. On the other hand, there are allegations that the policies of the central government, local government, and community health centers are not synchronized as well as the SPM health budget in several regions and community health centers in Indonesia.

This research was conducted at community health centers in two regencies: Sleman Regency, Yogyakarta Special Region, and Magelang Regency, Central Java Province. Sleman Regency, according to the Regulation of the Minister of Finance of the Republic of Indonesia No 54/2014, has a fiscal capacity of 0.1239 where such value is in a low category. From the point of view of the regional economy, it is considered unstable and may impact health conditions. One of the factors, including the source of health funds after the JKN era, was an increase through funds from capitation [4]. Magelang and Sleman regencies have close proximity to each other, but they are two regencies originating in two provinces and have different characteristics. In achieving the SPM in the health sector in Magelang Regency, around 16.67% is included in the low category in the province of Central Java [5].

Achieving the MSS targets requires a budget policy commitment at the central and local government levels. Good development planning is based on priority problems based on accurate, accountable data and information. Data on the previous period's development or baseline data results is the main material for planning the budget, programs, and activities of the next period. Planning and budget priorities for health sector MSS are important for study, especially to develop better policies in the future.

2. Health Sector SPM Budget Planning Process

In general, the community health center in this research location refers to the Minister of Health Regulation No. 44 of 2016, which uses a step-by-step scheduled management cycle. The basic data report for the previous 2 years is implemented in the following year. According to the acknowledgment from the informants that basically in community health center planning uses the following principle of problem analysis steps and preparation of the following activity proposal plan (RUK):

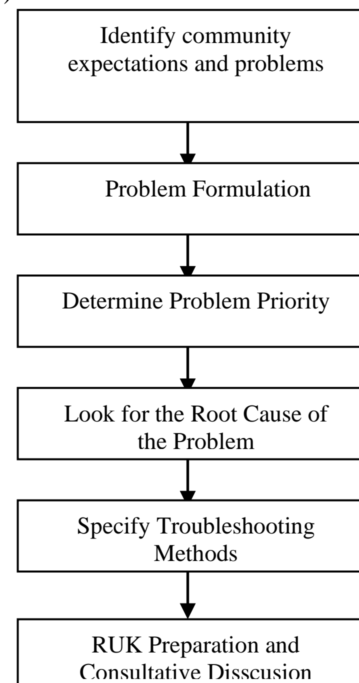

Fig. 1 Flow of steps for preparation of proposed activity plans at the community health center

Meanwhile, the source of material in the preparation of activity proposal plans and community health center budgets. Cross-sector work and participation in increasing service coverage, therefore it is expected that the SPM-BK will reach 100%. The Indonesia Healthy Family Approach Program (PISPK) data can be used as a basis for consideration in preparing the SPM-BK budget plan. In its implementation, community health center management noted the phenomenon of multiple program duties and responsibilities. Lack of human resources in program implementation is still complained of at the Magelang community health center. In general, the preparation of activity proposal plans (RUK) and the Community Health Center budget uses a bottom-up, top-down approach and community participation.

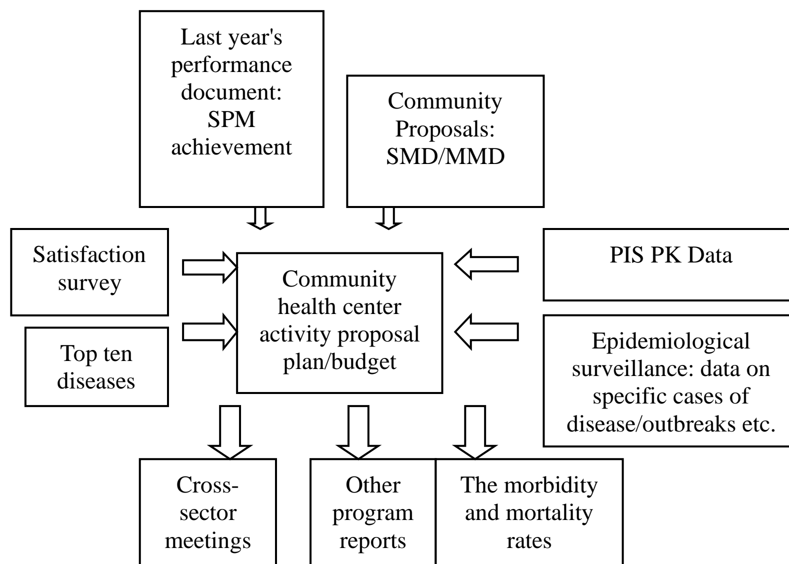

Fig. 2 Resources for community health center activity plans and budget formulation

3. Health SPM Budget Priorities

Since 2016, the local government health budget realization has exceeded 10% of the total APBD, a significant increase compared to previous years. The community health center's health budget has increased after JKN. According to the informants, the budget allocation per sector varies every year, depending on the community health center's conditions and problems. Management decisions can determine program priorities. To save budget, related activities can be carried out together. The recognition of one head of the community health center is based on his experience that the budget is only supportive of the program, the funds are only supportive, the program must continue. Another finding regarding budget priorities in these two regencies' community health centers is that there is no specific policy on separating the SPM program budget from those that are not SPM. Several source persons estimated that the SPM program budget allocation so far was around 35% if it was separated. In general, the community health center's budget allocation has not been seen to prioritize public health program programs (UKM).

The results of this study, in implementation at community health centers, SPM budget policies are often associated with barriers to human resources (HR) and BLUD management. There are different types of workers in the community health centers in the Sleman Regency and Magelang Regency. There is no BLUD staff in the community health center in Magelang Regency because there is no clear regulation to regulate BLUD personnel recruitment. The following is a quote from one of the head informants of the community health center:

"... in 2018 we actually wanted to recruit employees of the health office, but the technique was not clear so the local government asked to change it again…," (informant).

In Sleman Regency, it is different. The community health center in Sleman Regency is given the authority to recruit outsourcing employees. This workforce comes from a collaboration between a community health center and a company that provides labor, such as security personnel and cleaning personnel. BLUD employees are recruited by the Health Office according to the workforce requirements proposed by the community health center.

4. Potential Regional Health Budget for Community Health Center

The health budget allocation for the two regencies is increasing. After JKN exceeded 10%, according to the mandate of the law. According to the informants, they admitted that it was sufficient to carry out the program. The regional health budget comes from various sources, namely: (1) the State Revenue and Expenditure Budget (APBN); (2) District and provincial Regional Revenue and Expenditure Budget (APBD); (3) deconcentrating funds, and (4) other legitimate sources. APBN is the annual central government budget plan approved by the House of Representatives of the Republic of Indonesia (DPR RI). Meanwhile, the APBD is an annual regional government financial plan discussed and agreed upon by the regional government, Regional DPR, and stipulated by regional regulations [7]. The results of this study, particularly in Sleman Regency, can be classified into five sources of the health budget, namely: (1) Special Allocation Fund (DAK), (2) Health Operational

Assistance (BOK), (3) operational subsidies for community health center (SOP), (4) matching funds from APBD, (5) Community health center income funds.

Community health centers are the main implementers of SPM achievement in local governments. Sleman Regency policy, SOP funds are funds to finance UKM activities to strengthen the promotive and preventive sides. Matching funds are taken from the APBD to assist in physical health development. Since the National Health Insurance (JKN) implementation, a significant additional source of funds is community health center income. Funds obtained from capitation funds, owned resources, general patients, and others. The source of funds for the community health center in Sleman Regency is obtained from SOPs, BOK, and regional public service agencies (BLUD), while in Magelang, there is no SOP. Community health centers in these two regencies have status as BLUD. BLUD income has increased every year because community health centers have always been trying to improve health services. This fund is meaningful for community health centers because it adds around 60% of community health center funding sources before JKN.

5. Discussion Topics

5.1. Issues in SPM Budget Planning at Community Health Center

Community health centers in these two regencies have been established as regional public service agencies (BLUD), meaning that community health centers have flexibility in planning and implementing programs, especially in budget management. However, there are differences in policies related to the flexibility of the appointment of health human resources (HRK) needed by the community health center. In the research conducted by Shofiah et al. [8] regarding HRH planning in the community health center in Jember Regency, there is a policy from the local government that does not allow community health centers to recruit any personnel, thus hampering the fulfillment of needs in planning. In a Bogor study, there were health costs that had not been absorbed due to the lack of quantity and quality of human resources in community health centers. The need to increase the allocation of health funds, health financing does not directly improve performance because it needs to be supported by human resources who can manage it appropriately [6, 9]. In researching financial management patterns, the community health center BLUD has provided flexibility in the use of the budget, especially for improving human resources [10].

The results of a research carried out by Widianto, in Sleman, found that there was no guideline to calculate the Unit Cost of activities, especially SMEs, causing difficulties for officers to determine the actual cost needs of the planned activities [11]. This becomes a note in planning the actual budget requirements. The problem in other research on planning is by assessing the performance of the community health center (PKP) that there is no balanced accommodation for each community health center function [12]. Synchronization of each assessment component is required for each function, for example, in the community health service function, which is the most dominant in the community health center program component. Not much has been regulated regarding indicators of service quality and management activities in PKP. This will reflect later in budget planning and community health center programs.

5.2. Health Budget Priority Issues in Community Health Centers

Service standards indicate whether the performance of regional heads is considered successful or not, as stipulated in Law Number 23 of 2014 [1]. In Thailand, three agencies plus local governments share a major funding role for health promotion and prevention services: the Ministry of Public Health (MOPH), the National Health Security Office, the Thai Health Promotion Foundation, and the Tambon Health Insurance Fund. Total spending on prevention and public health in 2010 was 10.8% of total health spending, more than most middle-income countries, which averaged 7.0–2.2%. MOPH was the largest contributor at 32.9%, the second universal coverage scheme with 23.1%, followed by local government and Thai Health at 22.8 and 7.3%, respectively. Thailand's health financing system for promotion and prevention is strategic and innovative because of the three complementary mechanisms in operation [13].

WHO, health promotion activities need to be increased in health systems around the world. Governments should pursue universal coverage of programs that address the most important risk factors in their countries. To achieve this, they must secure adequate funding and focus on implementing a multi-faceted strategy that is cost-effective. To support the recommended approach then they should explore existing and innovative financing options for health promotion. The analysis is based on a health system financing framework [14]. The allocation for public health efforts (UKM), including community empowerment activities, increases [15]. The allocation for individual health efforts (UKP), including funding for the National Healthcare Fund, facilitating regional health insurance, medicines, and support services, is still high, still above 50%. Simultaneously, the allocation for health system support programs (PSK), including management, facilitation, infrastructure, and medical devices, was 32.28 in 2015.

An interesting conclusion in this study is that there is a significant correlation between the percentage of SME budget allocation and district health offices' performance with r = 0.998 (strong correlation) and p-value = 0.038. Whereas the higher the percentage of PHE budget allocation, the higher the performance of the health office [15]. Based on changes in national health system administrators' structure in 2014–2019, district/city health offices have an absolute responsibility to organize Public Health Efforts (UKM) activities in their regions financed by APBD.

5.3. Decentralization Issues in Regional Health SPM Budget

Initially, the regional government's financial dependence on the central government meant that the regional government did not fully feel the delegated authority. Since the era of decentralization, the flow of budget has mostly flowed to the regions. Thus the current source of financing is more dependent on the district budget. This is in line with the enactment of Law no. 32 of 2014 concerning local government 1. With decentralization, there will be a transfer of authority or power-sharing in government planning, management, and decision-making from the national to the regional levels [9]. In fact, power tug-of-war still occurs in this era of decentralization, making local governments unable to freely make policies independently in accordance with local aspirations and needs. This is still found in various urban districts in Indonesia. At the time of planning, the central government still determines the menu options for policies and programs for local governments, including the volume and unit cost of each activity [16]. The SPM achievement plan in the regions refers to the time limit for achieving the SPM, the capacity, and the region's potential.

The leadership and governance factors of the Indonesian health system, through policy evaluation, planning must be strengthened by prioritizing health service delivery, health workforce, and financing to improve health system performance at the district level [17]. According to Le Gargasson et al. [18], in the budget policy process at the adoption stage, the leadership's involvement affects how much the proposed budget can be approved. The commitment of the regional head directly influences this process. This is confirmed in writing by Bojar that the formulation of this budget will follow a cycle and is greatly influenced by the background of the leader [19]. So, it is necessary to have policy advocacy that needs to be done well. Advocating for the SPM program's budget interests is an important part of the work of health offices, related agencies, or universities as public representatives. Improved management means solving various budget system problems because management is important [20].

6. Methodology

Research in this study uses a case study approach. Data collection techniques include documentation, observation, in-depth interviews, and/or FGD.

This research was conducted for 6 months in the early to mid-2019 in the work area of puskesmas in Sleman and Magelang regencies. The data used are primary and secondary. The selection of sources in this study was carried out using purposive sampling. Resource persons were determined based on criteria, namely those who had more control over information and authority in policies to fulfill the two district health centers' MSS health budget.

7. Conclusion

In preparing activity proposal plans (RUK) and community health center budget using a bottom-up, top-down approach and community participation, including increasing work across sectors. There are no specific budget priorities to support the SPM program, especially UKM and the human resource needs of the community health center in Magelang Regency. Potential sources of SPM funds in the community health center of Sleman Regency, DAK, BOK, operational subsidies for the community health center (SOP), matching funds from the APBD, community health center income. Magelang Regency has no SOP funding policy. Community health center advice on flexibility in prioritizing SPM program budgets, UKM, and other local needs. It is necessary to encourage SPM allocation planning to be integrated into the community health center planning documents.

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References

[1] PRESIDENT OF THE REPUBLIC OF INDONESIA. *Law of the Republic of Indonesia Number 23 of 2014 concerning Regional Government.* Indonesian Government, 2014. https://pih.kemlu.go.id/files/UU023201pdf

[2] STATE GAZETTE OF THE REPUBLIC OF INDONESIA. *Law of the Republic of Indonesia Number 36 of 2009 concerning Health,* No. 5063. Jakarta, 2009.

[3] MINISTRY OF HEALTH, REPUBLIC OF INDONESIA. *Indonesia Health Profile 2019*. Jakarta. https://www.kemkes.go.id/resources/download/pusdatin/profil-kesehindonesia/Profil-KHealth-Indonesia-2019.pdf

[4] NINGSIH P. W. *Analysis of Government Sourced Maternal and Child Health Financing Using a Health Account Approach Before and After JKN in Sleman.* Thesis. Library of the Faculty of Medicine, UII Jogjakarta, 2017.

[5] CENTRAL JAVA HEALTH OFFICE. *Achievement of SPM in the Health Sector District Cities in Central Java Seemster 1 in 2018, Semarang,* 2018. https://www.dinkesjatengprov.go.id/v2018/dokumen/spmsmtr12018/mobile/index.html#p=44

[6] ALMASKARI M. S. N. S., & MARNI N. B. Human Resource Management Role in Improving Employees' Performance in the United Arab Emirates' Health Sector. *Journal of Southwest Jiaotong University,* 2020, 55(3). http://jsju.org/index.php/journal/article/view/622

[7] GOVERNMENT OF INDONESIA. 2004. https://www.indonesia.go.id/

[8] SHOFIAH, R., PRIHATINI D., and VIPHINDRARTIN S. Perencanaan Sumber Daya Manusia Kesehatan (SDMK) Puskesmas Di Kabupaten Jember. *Jurnal Bisnis dan Manajemen,* 2019, 13(3): 181–188. https://jurnal.unej.ac.id/index.php/BISMA/article/view/11633/7397

[9] HANDAYANI T., & NADJIB M. Analysis of Public Sourced Local Health Financing: Case Studies at the Bogor District Health Office 2012, 2013 and 2014. *Journal of Health Economics,* 2016, 1(2).

[10] SOAKAKONE M., *et al.* Study of Financial Management Patterns of Regional Public Service Bodies of Pekalongan Health Center with a Holding System. *Indonesian Health Policy Journal,* 2019, 8(1).

[11] WIDIANTO K., TRINANTORO L., and PADAMASIWI R. Implementation of Public Service Agency (PPK-BLU) Financial Management Patterns in the Community Mental Health Program at Community Health Centers in Sleman Regency. *Indonesian Health Policy Journal,* 2015, 4: 44-49.

[12] PUTRI N., ERNAWATY E., THINNI NURUL R., and MEGATSARI H. The Ability of Public Health Center Performance Appraisal Instrument Accommodating the Implementation of Public Health Center Functions. *Media Kesehatan Masyarakat Indonesia,* 2017, 13(4): 337-346. https://journal.unhas.ac.id/index.php/mkmi/article/view/1061/pdf

[13] WATABE A., WONGWATANAKUL W., THAMARANGSI T., PRAKONGSAI P., and YUASA M. Analysis of health promotion and prevention financing mechanisms in Thailand. *Health Promotion International*, 2017, 32(4): 702–710. https://doi.org/10.1093/heapro/daw010

[14] BAYARSAIKHAN D., & MUISER J. *Financing health promotion.* World Health Organization, Geneva, 2007. https://www.who.int/health_financing/documents/dp_e_07_4-health_promotion.pdf?ua=1

[15] ULYA F., & PUTRI N. Association between the Percentage of Public Health Efforts Budget Allocation and District Health Office Performances in Depok, 2013-2015. *KnE Life Sciences,* 2017, 4(10): 391–400. https://doi.org/10.18502/kls.v4i10.3810

[16] PURNAMASARI C. D., AYUNINGTYAS D., and KUSUMAWHARDANI R. Decentralization and Policy Decision Making on Improving Toddler Nutrition in Depo City and Bogor City, West Java Province, 2014.

[17] RAKMAWATI T., HINCHCLIFF R., and PARDOSI J. F. District level impacts of health system decentralization in Indonesia: systematic review. *International Journal of Health Planning and Management*, 2019, 34(2): e1026-e1053. https://doi.org/10.1002/hpm.2768

[18] LE GARGASSON J. B., MIBULUMUKINI B., GESSNER B. D., and COLOMBINI A. Budget process bottlenecks for immunization financing in the Democratic Republic of the Congo (DRC). *Vaccine*, 2014, 32(9): 1036–1042. https://doi.org/10.1016/j.vaccine.2013.12.036

[19] VEIGA F. J., VEIGA L. G., and MOROZUMI A. Political Budget Cycles and Media Freedom. *Electoral Studies,* 2017, 45: 88–99. https://doi.org/10.1016/j.electstud.2016.11.008

[20] SCHIEBER G. J., GOTTRET P., FLEISHER L. K., and LEIVE A. A. Financing global health: Mission unaccomplished. *Health Affairs*, 2007, 26(4): 921–934. https://doi.org/10.1377/hlthaff.26.4.921

参考文:

[1] 印度尼西亚共和国总统。印度尼西亚共和国关于区域政府的 2014 年第 23 号法律。印尼政府，2014。https：//pih.kemlu.go.id/files/UU023201pdf

[2] 印度尼西亚共和国公报。印度尼西亚共和国 2009 年第 36 号法，涉及卫生，第 5063 号。雅加达，2009。

[3] 印度尼西亚共和国卫生部。印度尼西亚卫生概况 2019。雅加达。https://www.kemkes.go.id/resources/download/pusdatin/profil-kesehindonesia/Profil-KHealth-Indonesia-2019.pdf

[4] NINGSIH P. W. 在斯莱曼的 JKN 之前和之后使用健康账户方法对政府提供的母婴健康融资进行的分析。论文。UII 日惹，医学学院图书馆，2017。

[5] 中央爪哇卫生局。 2018 年，三宝垄，中爪哇省西姆斯特 1 卫生部门地区城市实现 SPM. https：//www.dinkesjatengprov.go.id/v2018/dokumen/spmsmtr12018/mobile/index.html#p=44

[6] ALMASKARI M. S. N. S. 和 MARNI N. B. 人力资源管理在提高阿拉伯联合酋长国卫生部门员工绩效中的作用。西南交通大学学报，2020，55（3）。http://jsju.org/index.php/journal/article/view/622

[7] 印度尼西亚政府。 2004。https://www.indonesia.go.id/

[8] SHOFIAH，R.，PRIHATINI D. 和 VIPHINDRARTIN S. 詹伯摄政区卫生人力资源规划。法律杂志，2019，13（3）：181–188。https://jurnal.unej.ac.id/index.php/BISMA/article/view/11633/7397

[9] HANDAYANI T. 和 NADJIB M. 公共来源的地方卫生筹资分析：在茂物地区卫生局的案例研究，2012 年，2013 年和 2014 年。卫生经济学杂志，2016，1（2）。

[10] SOAKAKONE M. 等。具有控股系统的北加隆安卫生院区域公共服务机构财务管理模式研究。印尼卫生政策杂志，2019，8（1）。
[11] WIDIANTO K.，TRINANTORO L. 和 PADAMASIWI R. 在斯莱曼摄政社区健康中心的社区心理健康计划中实施公共服务局（PPK-蓝光）财务管理模式。印尼卫生政策杂志，2015，4：44-49。
[12] PUTRI N.，ERNAWATY E.，THINNI NURUL R. 和 MEGATSARI H. 适应公共卫生中心职能实施的公共卫生中心绩效评估工具的能力。印尼公共卫生媒体，2017，13（4）：337-346。https://journal.unhas.ac.id/index.php/mkmi/article/view/1061/pdf
[13] WATABE A.，WONGWATANAKUL W.，THAMARANGSI T.，PRAKONGSAI P. 和 YUASA M。对泰国健康促进和预防筹资机制的分析。国际卫生促进组织，2017，32（4）：702-710。https://doi.org/10.1093/heapro/daw010
[14] BAYARSAIKHAN D. 和 MUISER J. 为健康促进筹资。世界卫生组织，日内瓦，2007。https://www.who.int/health_financing/documents/dp_e_07_4-health_promotion.pdf?ua=1
[15] ULYA F. 和 PUTRI N. 2013-2015 年德波公共卫生工作预算分配百分比与地区卫生办公室绩效之间的关联。知识量生命科学，2017，4（10）：391-400。https://doi.org/10.18502/kls.v4i10.3810
[16] PURNAMASARI C. D.，AYUNINGTYAS D. 和 KUSUMAWHARDANI R. 关于改善西爪哇省德波市和茂物市的幼儿营养的权力下放和政策决策，2014。
[17] RAKMAWATI T.，HINCHCLIFF R. 和 PARDOSI J. F. 印度尼西亚卫生系统权力下放对地区的影响：系统评价。国际卫生规划与管理杂志，2019，34（2）：e1026-e1053。https://doi.org/10.1002/hpm.2768
[18] LE GARGASSON J. B.，MIBULUMUKINI B.，GESSNER B. D. 和 COLOMBINI A. 刚果民主共和国（刚果民主共和国）的免疫融资预算过程瓶颈。疫苗，2014，32（9）：1036-1042。https://doi.org/10.1016/j.vaccine.2013.12.036
[19] VEIGA F. J.，VEIGA L. G. 和 MOROZUMI A. 政治预算周期和媒体自由。选举研究，2017，45：88-99。https://doi.org/10.1016/j.electstud.2016.11.008
[20] SCHIEBER G. J.，GOTTRET P.，FLEISHER L. K. 和 LEIVE A. A. 为全球卫生筹资：任务未完成。卫生事务，2007，26（4）：921-934。https://doi.org/10.1377/hlthaff.26.4.921