

Utilization of Deconcentration Health Funds in Planning, Budgeting, and Implementation in Indonesia

Gurendro Putro¹, Ristrini¹, Tumaji¹

¹Center for Humanities Research, Development and Health Management, Ministry of Health, Indonesia

Abstract

Background: Deconcentration funds are funds that given to regions in achieving the target echelon 1 indicator of the main units in the ministry of health with program performance indicators, then translated into echelon 2 targets with the achievement of activity performance indicators. This deconcentration fund is one for health financing in achieving the National Medium-Term Development Plan (RPJMN) in the health sector.

Aim: to examine the allocation of deconcentrated funds in planning, implement, monitoring and evaluating.

Method: the secondary data document was analyzed for the allocation of deconcentrated funds, from the center in each division of the program. This research was conducted for 4 months from September to December 2018.

Result: the highest deconcentration funds from 2016 to 2017 were highest in the North Sulawesi provincial health department of 75.68% and 98.64%, while the lowest in the North Kalimantan provincial department was 39.25% and 68.03%. Whereas for 2018 the highest realiation was in the Southeast Sulawesi provincial health department at 97.36% and the lowest in the Aceh provincial health department was 72.86%.

Conclusion: the deconcentration fund planning it is done top down and a menu of programs or activities has been determined. The amount of fund allocation has also been determined by the center, the regions only make and implement what has been made by the center. Activities in the area need to be monitored and evaluated both in substance and financial programs.

Keywords: *deconcentrated funds, planning, monitoring and evaluation.*

Introduction

Health is a basic human need to be able to live properly and productively, therefore it is necessary to conduct cost-controlled and quality-controlled health services¹. Indonesia Sehat Program is implemented with 3 main pillars, namely the healthy paradigm, strengthening health services and national health insurance: 1) the pillar of the healthy paradigm is carried out with health mainstreaming strategies in development,

strengthening preventive promotive and community empowerment; 2) strengthening health services is carried out with strategies to improve access to health services, optimize the referral system and improve the quality of health services, using a continuum of care approach and health risk-based interventions; 3) meanwhile the national health insurance is carried out with a strategy of expanding targets and benefits as well as quality control and cost control^{2,3}.

The health budget allocation managed by the Ministry of Health in 2014 amounted to 50.35 trillion rupiahs with the realization of 47.58 trillion rupiahs. Large allocation and the realization of the budget has increased compared to 2014, namely the allocation of 38.64 trillion rupiah with the realization of 35.42 trillion rupiah. In terms of budget size, the increase also occurred

Corresponding Author:

Gurendro Putro

Email : gurendro.01@gmail.com

Johar Baru, Jakarta Pusat, Daerah Khusus

Ibukota Jakarta Indonesia

in the percentage of realization in 2014 compared to 2013, which was 91.66% in 2013 to 94.49% in 2014⁶. The highest allocation of deconcentration funds in 2017 in West Java Province was Rp. 84,894,996,000 (6.2%) followed by East Java Province in the amount of Rp.83,610,717,000. (6.1%). While the fewest in the Province of DIY is Rp. 24,346,179,000. (1.8%).

In this study the emphasis is placed on an analysis of the use of deconcentration funds provided by the central government (Ministry of Health of the Republic of Indonesia) to Provincial Governments. Also seen in the process of planning, budgeting and implementation or use of deconcentration funds^{7,8}. The purpose of this study is to know the process of planning, budgeting, implementing and utilizing deconcentrated funds in health development. Besides knowing the allocation and realization and monitoring and evaluation of deconcentrated funds.

Method

In this study, a secondary data document was analyzed for the allocation of deconcentrated funds, from the center in each division of the program and information echelon 1 of the republic of indonesia’s ministry of health main unit, except for the health research and development agency and the inspectorate general,

because the institution did not have deconcentration funds. besides conducting interviews with 78 planning officers of the Provincial Health Office in Indonesia. The implementation period is 4 months from December to December 2018. The ethical approval was taken from Health Research and Development Agency (Balitbangkes) of Ministry of Health Indonesia (No: LB.02.01/2/KE.231/2018).

Results

Deconcentration Fund Allocation

In general, the allocation has increased each year in each province from 2016 to Rp. 2,113,059,057,000, - decreased in 2017 by Rp. 1,066,701,376.00, then in 2018 it increased to Rp. 1,102,942,700 .000, -.

Deconcentration Fund Planning

The results of the study on the regional planning team from various provincial health department regarding the deconcentration fund planning process are as follows. According to respondents who were asked questions about the planning process stated that at most 61.0% was a combination of top down and bottom up, then followed by a top down of 28.6% and those with the least amount of bottom up was 10.4%.

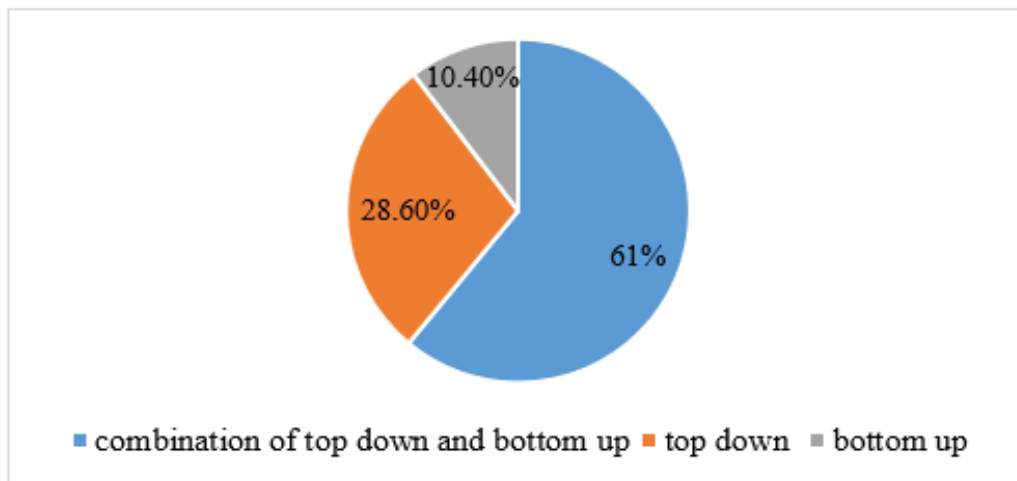


Figure 1: Deconcentration Fund Planning Process

Synchronizing Planning

From the results of interviews with the provincial department planning team, regarding synchronization of planning it was found that the majority were synchronous or matching with the Regional Budget (89.6%) and some were out of sync with the Regional Budget by 10.4%.

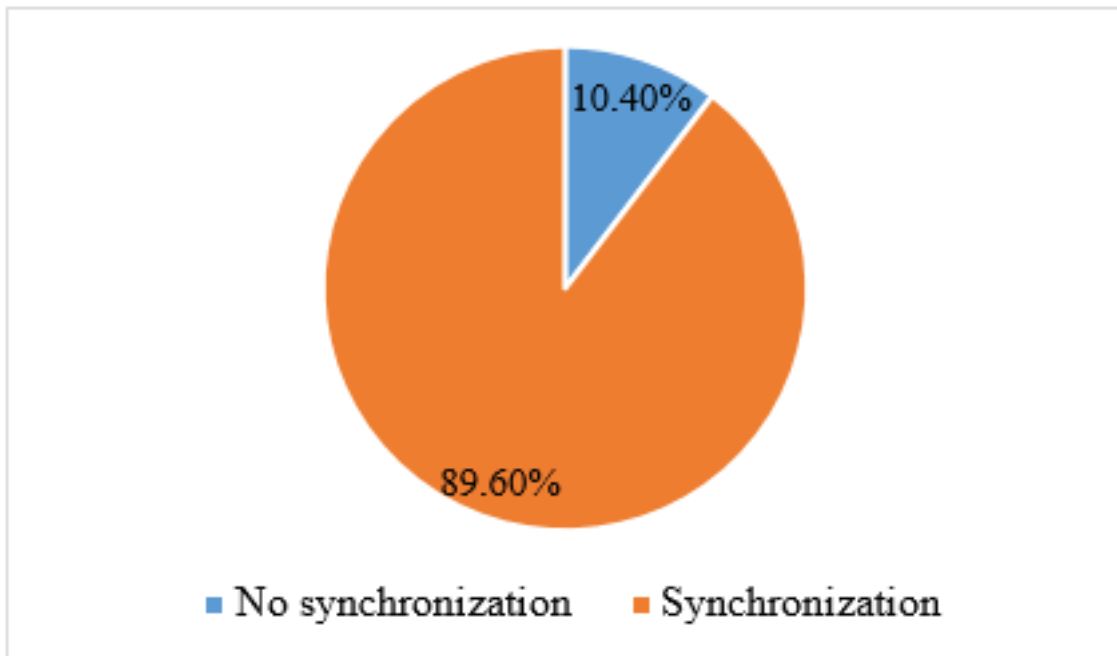


Figure 2: Synchronizing Planning with the Regional Budget

Budget Changes After Desk

In the deconcentration fund planning, after a desk with Echelon 1 Main Unit, according to the Provincial Health Service planning team as follows:

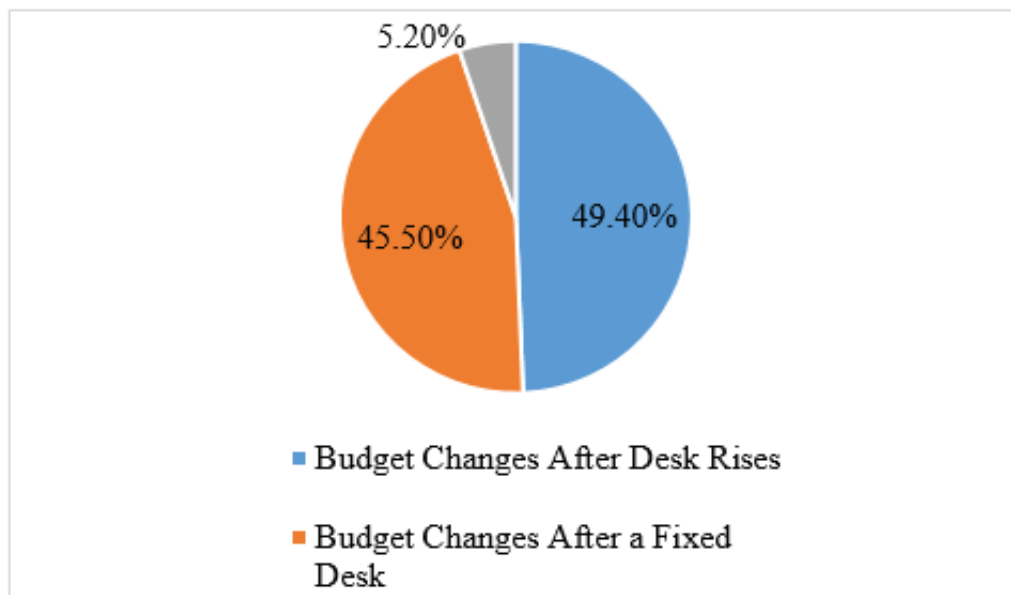


Figure 3: Budget Changes After Desk

Realization of the Use of Deconcentration Funds

The realization of deconcentration funds from 2016 to 2018 per Province in Indonesia can be seen from the following figure.

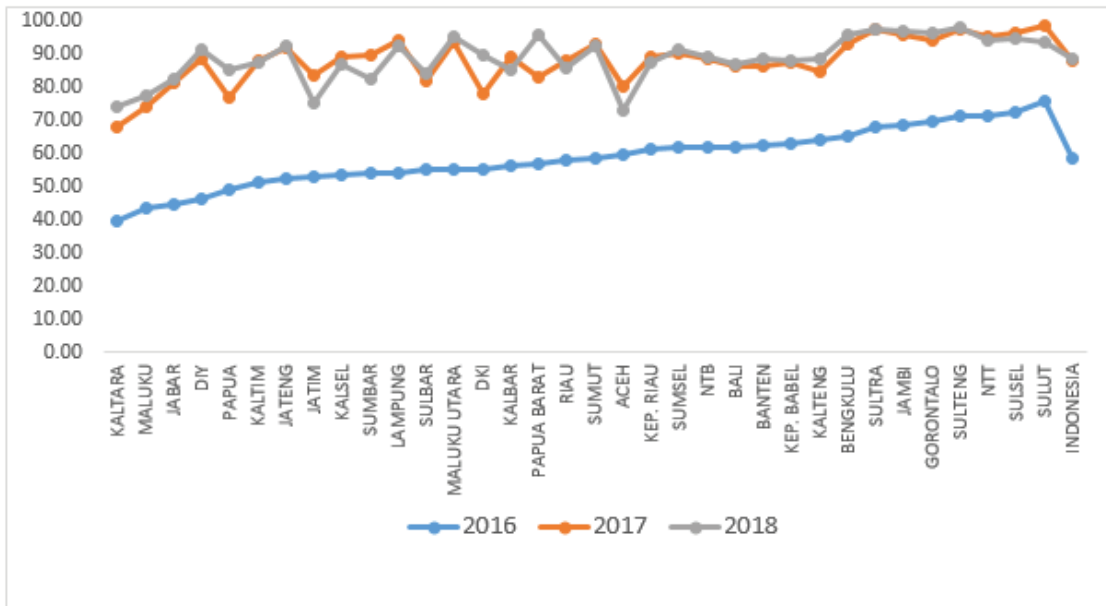


Figure 4: Realization of the Deconcentration Fund

Deconcentration Fund Monitoring and Evaluation

Those who answered 26.8% were not monitored and evaluated, while 71.2% responded to it. From those who answered, monitoring and evaluation were carried out in one year as many as 67.7% with frequencies 1-2 times and 3.7% with frequencies 3-4 times.

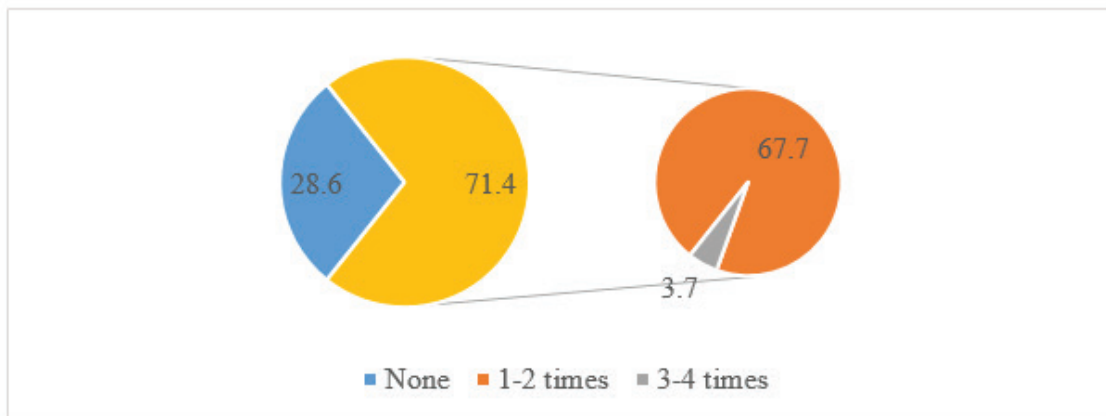


Figure 5: Monitoring And Evaluation

Discussion

In planning the deconcentration fund from the center to the regions, it is always done using the top down method, meaning that the center has determined the menu of programs and activities, the region only follows and fills in the volume and amount that has been provided in the program menu⁹. In the deconcentration fund planning there was no inclusion of APBD funds,

but in the form of activities from other sections, for example the Health Promotion section by riding on health promotion socialization activities. The Provincial Health Office did not determine the program menu, but only had to carry out decisions from the center, although it could not be carried out at all. In the planning of deconcentrated funds, programs are not synchronized based on other funding sources, for example with the Regional Budget (APBD).

Deconcentration fund planning, correspondence and requests for documents needed to the center, then documents sent from the center. An internal meeting is held at the Farmalkes section, then by the center of each fund amount in each work unit, and this is permanent and cannot be changed¹⁰. So that the menu does not match the needs of programs in the region, because there are too many programs from the central government but many cannot be implemented because the budget is insufficient, it seems to only pursue realization but does not guarantee program needs. The program holders are accustomed to referring to standard activities issued by the central government, so they forget the specific needs of the region. Even though the specific needs of the regions are different from those of the central government. This approach must be contextualized to the needs of the region even to the puskesmas through a system approach¹¹.

In the implementation of training activities sourced from deconcentrated funds, can not be on time, often late because the program implementers from the provincial health office must adjust to the schedule of resource persons from the Center, while in the Province there are other activities that are more priority. Determination of the management of deconcentrated funds by the Governor (Decree of Deconcentration Fund Managers) is often late, so the implementation of deconcentrated funds also experiences delays in achieving performance indicators both IKP and IKK. Even in the implementation of deconcentration funds, some are not in accordance with the needs of activities in the region, so what can not be financed by deconcentration funds will be allocated in planning by the provincial health office^{9,12}.

In the implementation of activities that use deconcentrated funds, for health human resource training activities, they have used standards created by the Center both the competency of the speaker / trainer, curriculum, participants, requirements, and certificates¹². The Provincial Health Office only implements programs or activities. In the implementation of deconcentration fund activities, absorption can be up to 70.0%, because there are other activities carried out by the Governor's Office that must be carried out first, but the Central Government stipulates that if the funds can be absorbed 85.0% it can be said to be good¹³.

Now facing the problem of accreditation of Puskesmas and Hospitals, all are required to be accredited, but deconcentration fund support is not

in accordance with the accreditation target. BPJS will even break the cooperative relationship with hospitals that have not been accredited. Puskesmas accreditation is also being pursued, but with the highest accreditation status (Paripurna) it has not yet increased capitation from BPJS to puskesmas. This in-depth study was carried out, including the readiness of puskesmas and hospitals in achieving Universal Coverage (UC)¹⁴. During this time there are training activities, in which the Center trains to the puskesmas which should not occur, meaning the Center conducts training at the Provincial level (master trainer), then the training is continued by Provincial master trainers at the Regency / City level, to the District and village. The central government conducts Norms, Standards, Guidelines and Decisions (NSPK) and conducts monitoring and evaluation after training both in substance and training mechanism¹⁵. The implementation of the Kotamobagu City Government policy in the South Kotamobagu sub-district in free health services cannot be carried out optimally, this is due to the limited resources available, both medical personnel, and infrastructure facilities at the center Kotamobagu Selatan sub-district health services^{16,17}.

In monitoring and evaluating the use of deconcentration funds from the Central to the Province there are instruments used, and this is done once a year (annually), also seen from the realization of finance and output. There is a note, can also be seen the achievements for each health center that can be visited, the activities carried out with deconcentration funds¹⁸. Also noted is the compatibility between program planning and implementation, for example the Farmalkes program menu in the Riau Islands, that from the Center monitoring and evaluation is conducted in 7 districts / cities (10 puskesmas and 10 pharmacies), but can only be done in 1 district with 3 puskesmas and 2 pharmacies, because the funds are insufficient. Report why and sent to the Center.

There is a monitoring and evaluation document for deconcentration funds at the central and provincial levels, there is a follow-up from monitoring and evaluation of the center to the regions, that is, the results will be processed whether the following year the activities listed in the menu are still feasible or not¹⁹. Deconcentration funds can support the achievement of Minimum Service Standards (SPM), for example the use of high rational drugs, the use of antibiotics will go down, this can be budget efficiency (in accordance with programs and activities) but also to support the

activities of the Healthy Indonesia Program with the Family Approach (PIS- PK). For example: in the Riau Islands Province there is a cermat careful germa 'which is "the movement of intelligent people using drugs", this has been carried out in districts/cities, accompanied by cross-sector and cross-programs, the aim is to promote preventive and healthy community. In monitoring and evaluation it is necessary to prepare instruments and implementers in exploring problems until they find the root of the problem, then look for a solution to improve future programs. The monitoring and evaluation implementation is supported by quantitative data, which can provide strength and depth of analysis²⁰.

Conclusion

The Study on the use of deconcentration funds in the planning, budgeting and implementation of the health sector is very important to determine the amount of ceiling, the planning menu and regional potential in carrying out activities that originate from deconcentration funds.

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