AN ANALYSIS ON THE PREPAREDNESS FOR IMPLEMENTING THE MINIMAL STANDARDS FOR SERVICE IN THE HEALTH FIELD AT DEPOK CITY IN 2017

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Abstract. Health is one of the fundamental rights for every person, therefore it must be provided by the government. To guarantee the quality and type of health services, the Minimal Standards for Services (SPM) must be established. This includes the SPM for the productive age healthcare services (SPM BKUP). This type of healthcare is important since it covers about 60-70% of the current population. In this research, we analyzed the discrepancy between the reality and the ideal in the implementation of the SPM BKUP qualitatively through in-depth interviews, focus group discussions, and studying the related documents. We discovered that in Depok City 10 of the 13 indicators for implementation were incomplete. These were the Noncommunicable diseases (NCDs) risk factor counseling, technical trainings for the screening officer and web-based surveillance, NCDs integrated services, recording and reporting, monitoring and evaluation, communication, the attitude of the implementer, manpower, facilities, and funding. And that the other three indicators, incentives for the implementers that reached the target, standard operational procedures for the implementation of the SPM BKUP, and a specialized team for the implementation. Therefore, Depok City was only minimally prepared to implement the SPM.

Keywords: Preparedness Analysis, Regional Government Performance, Productive Age Healthcare Services, NCDs Control, Minimal Standards for Services.

INTRODUCTION

Health is one of the fundamental human rights. Therefore, the government is obligated to guarantee that all of their citizens would receive equal quality and standards of healthcare. However, each capacity of each regional government in Indonesia varies widely. To provide healthcare at a certain standard, the Minimal Standards for Services (SPM) was established. The SPM for Health is regulated by Health Minister Regulation no. 43/2016. Amongst the 12 indicators mentioned in the regulation, we will discuss the SPM for Productive Age Health (SPM BKUP) for citizens aged between 15-59. This SPM regulates the early detection of obesity, hypertension, diabetes, mental emotional and behavioral disorders, sight and hearing disorders, and early detection for breast cancer and cervical cancer in women between the ages of 30-59 years old.

To establish the SPM, there are necessary steps that
must be taken, i.e. screening and counseling for the risk factors (RF) of non-communicable diseases, mental, emotional, and behavioral disorders; technical trainings for the health screening officer; provision of the facilities and equipment for screenings; RF NCDs surveillance trainings; case referral services; recording and reporting; and monitoring and evaluation (monev). According to Edward III, there are four aspects that influences whether a policy would reach its goals, those are communication, disposition, bureaucratic structure, and resources, this includes human resources, facilities, and funding. Therefore, to implement the SPM for health screening successfully, good communication, adequate resources, supporting disposition, and bureaucratic structure is necessary and must be prepared sufficiently.

According to the 2013 Basic Health Research or Riset Kesehatan Dasar (Riskesdas) in West Java, Depok City was one of the cities with a high rate for NCDs risk factors and had the highest rate for NCDs of all the Districts/Cities in West Java. The proportion of residents in the productive age (age 15-59) was 68.5%. If not prepared adequately, the 100% target coverage would not be accomplished and it would influence the performance of the district, possibly increase the morbidity and mortality rate caused by NCDs, and increase the economical and diseases burden in the area. Therefore, it is necessary to evaluate the preparedness of the implementation of SPM in the health field, particularly among the productive age residents.

METHODS

This qualitative research was meant to discover the preparedness of the implementation of the SPM BKUP at Depok City in 2017. To obtain valid results, we performed a triangulation of the data gained from in-depth interviews, focus group discussions (FGDs), and observations by also researching the related documents.

RESULTS AND DISCUSSION

This research evaluated the steps in the implementation of the SPM BKUP and the four aspects of policy implementation, i.e. communication, disposition, resources, and the bureaucratic structure based on the current performance and the 13 indicators that would be able to measure whether the city was prepared to implement the SPM BKUP. The results of that evaluation is described in the following sections.

SPM BKUP Performance

Until November 2017, less than 1% of the targeted group visited the Puskesmas and NCDs Posbindu. However, the visits was limited to the detection of obesity (through measuring their Body Mass Index (BMI) and their waist size), hypertension, diabetes, breast cancer, and cervical cancer. The detection of mental, emotional, and behavioral disorders; sight disorders; and hearing impairments was not included.

According to Strong et al., failure to perform health screenings would delay the diagnosis of a disease and achieving it would reduce the risk for the development of chronic diseases. Disease screenings would only be beneficial if it was done in time. Failure to detect a fast progressing disease would render its management more complicated. This lead time was vital not only for the target groups visiting the Puskesmas or Posbindu, but also for those that did not visit the Puskesmas and its network, which includes school age children, university students, formal and informal workers, prospective haj pilgrims, and other members of the target group that did not have access to the Puskesmas. However, currently, there is no specific method available to ensure that all the citizens gain standardized healthcare. This was exacerbated with inadequate cross-program coordination for screenings at High-Schools, occupational health, prospective haj pilgrims, and inadequate cross-sectoral coordination with private healthcare facilities.

Counseling for Non-Communicable Diseases Risk Factors

At the time of the research, the counseling activities was still limited to the patient’s current risk factors, other diseases not included in the screening was not included in the counseling. These included the risk factors for mental, emotional, and behavioral disorders; sight and hearing disorders. The Puskesmas also has limited media for counseling, there were only breast cancer and IVA flipcharts, and health brochures from the Health BPJS.

Technical Trainings for Screening and Web-Based Surveillance Officers

There were technical trainings for Puskesmas staff that were responsible for screenings, but not for the staff at private healthcare facilities, such as hospitals, clinics, and General Practitioner Practices. The cadres also has not received any training. A similar finding was found in the web-based surveillance trainings for the staff, where only Puskesmas staff has been trained.

Referral Services

Referrals through the integrated healthcare services or pelayanan terpadu (PANDU) for NCDs were not optimal. According to the PANDU NCDs guidelines, any findings of any risk factors of any NCDs for productive ages at the NCDs Posbindu and other UKBM would be referred to the Puskesmas and be managed according to its management protocols and level, and would only be referred if considered
necessary. However, we discovered that there were staff that were not trained in PANDU NCDs, there were Puskesmases that did not have the facilities for PANDU NCDs, such as ECGs, X-ray machines, Peakflowmeter, IVA Kit, dan Ophthalmoscopes, and laboratories. Therefore, the patients had to be referred to facilities with those equipment.

Recording and Reporting

We discovered that the recording and reporting process was still inadequate, even though the monitoring and evaluation process has been performed since 2015 at the Puskesmas and hospitals. The staff at the Puskesmas has also received training in web-based surveillance, but it was rarely used, because they were busy with the other health programs at the Puskesmas. Of the 35 Puskesmas that have received training, only 5 Puskesmas has completed the recording and reporting through the Ministry of Health’s NCDs web portal. Meanwhile, the staff at the private healthcare facilities and the cadres have not been trained, and therefore, have not used the web portal to record and report the results of an activity. This might be caused by the lack of commitment from the implementer to record what was done and perform what was recorded, therefore activities that supported the SPM BKUP was not sufficiently documented. This can be used as a basis for the improvement of the program.

Monitoring and Evaluation

The monitoring and evaluation of the activities in the prevention and management of NCDs at the primary healthcare facilities were to discover the level of awareness in the community, the level of Puskesmas usage as the center for managing NCDs, and intermediate referral center; to discover their capabilities in managing emergency/complicated cases; and to obtain the data for planning the following year. According to the informant, the Health Office has performed monev process to all the Puskesmases and hospitals using the monev instrument based on the NCDs web portal. The process at the Puskesmas was more focused in completing the NCDs web portal, while at the hospitals it was more focused on how the hospital was used as a screening and referral center for NCDs. However, there were no monev processes for the private clinics, private doctor practices, and NCDs Posbindu.

Communication

According to Edward III, effective communication is consistent, clear, and accurate.\(^3\) However, we discovered that only the City level implementers, i.e. the Health Office, its Head of Sections, and its Head of Departments; the Head of the Puskesmas and several of Puskesmas Staff Members has been socialization from the Ministry of Health. There was no socialization to the community and therefore no one in the community knew about the program. In addition, the method used for the socialization was a lecture, which is not very effective. Among the reasons for this was because there was no legislation for the SPM.

The Implementers Attitude

We discovered that a positive attitude from the implementers would enormously support the program. This type of attitude would reduce the number of patients that visit the Puskesmas, reduce the number of referrals to the hospitals (therefore, hospitals would become a larger Puskesmas), reduce the cost for treatment (because the cost for treating NCDs is extremely large for all parties, whether it was the government or the patients and their families), that was supported by the Health Office and the Head of the Puskesmas, which was evident in the revision of the Health Offices’ Strategy Plans (Renstra), the Puskesmas’ Business Strategy Plans, its inclusion in the Public Health Unit (UKM) performance indicators, and the submission of activity plans in accordance to the technical guidelines of the Minister of Health’s Regulation no. 43/2016 on the SPM for the Health Field.

Incentive

As for the incentives for the implementers, what we measured was whether there was a plan to provide incentives for the program or has it already been delivered to the implementers at the City and Health Offices. According to the data that we have obtained, the NCDs program holders at the Puskesmas and the NCDs Posbindu cadres has not received any rewards or incentives after the screenings. There were awards for the best health staff or Puskesmases with certain achievements, but there was no specific awards for completing the SPM in Health even when the SPM was set as one of the accreditation criteria.

Human Resources

In this research, the Human Resources (HR) aspect was evaluated based on the number (quantity) and the quality of the current HR. Without adequate support from a sufficient number of staff with a certain level of quality, the implementation of the policy would not be successful. We discovered that there were not enough manpower in Depok City to implement the SPM BKUP, because there was a lack of manpower in almost of all the types of Healthcare HR. The number of healthcare personnel available in the city is stated in the following table.
Therefore, we conclude that the provision of healthcare facilities and equipment are important factors for the implementation of a policy. Provision of the proper facilities required – i.e. buildings, land, and office supplies – would support its implementation and its success. However, healthcare facilities involved in this program were the Puskesmases, Hospitals, Clinics, Private Doctor Practices, and NCDs Posbindus weren’t spread evenly, some areas had more healthcare facilities than others. This information is summarized in the following table.

**Facility**

Facilities and equipment are important factors for the implementation of a policy. Provision of the proper facilities required – i.e. buildings, land, and office supplies – would support its implementation and its success. However, healthcare facilities involved in this program were the Puskesmases, Hospitals, Clinics, Private Doctor Practices, and NCDs Posbindus weren’t spread evenly, some areas had more healthcare facilities than others. This information is summarized in the following table.

**Table 1. Number and Ratio of Doctors, Midwives, Nurses, and Nutritionist in Depok City in 2016**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Doctor</th>
<th>Midwife</th>
<th>Nurses</th>
<th>Nutritionist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puskesmas</td>
<td>134</td>
<td>182</td>
<td>146</td>
<td>29</td>
</tr>
<tr>
<td>Hospital</td>
<td>234</td>
<td>424</td>
<td>2,250</td>
<td>32</td>
</tr>
<tr>
<td>Private Clinic</td>
<td>282</td>
<td>77</td>
<td>167</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>650</td>
<td>683</td>
<td>2,563</td>
<td>69</td>
</tr>
</tbody>
</table>

Ratio per 100,000 citizens: 31, 32.5, 122, 3.3
Target ratio per 100,000 citizens: 40, 100, 158, 10
HR needed: 190, 1,417, 755, 141

**Table 2. Number of Healthcare Facilities and Community-based Healthcare Units at Depok City in 2017**

<table>
<thead>
<tr>
<th>No</th>
<th>Sub-Districts</th>
<th>Hospitals</th>
<th>Major Clinics</th>
<th>Fasilitas Kesehatan</th>
<th>Doctor Practices</th>
<th>Puskesmas</th>
<th>NCDs Posbindu</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cinere</td>
<td>1</td>
<td>2</td>
<td>12</td>
<td>11</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Beji</td>
<td>1</td>
<td>1</td>
<td>17</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Limo</td>
<td>1</td>
<td>1</td>
<td>19</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Tapos</td>
<td>0</td>
<td>2</td>
<td>11</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>Kecamatan Maja</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Cilingan</td>
<td>1</td>
<td>2</td>
<td>15</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Cilodong</td>
<td>1</td>
<td>1</td>
<td>15</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Ben</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>Tuh</td>
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<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>Cilodong</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>Cinere</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>22</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>23</td>
<td>27</td>
<td>140</td>
<td>233</td>
<td>35</td>
<td>35</td>
</tr>
</tbody>
</table>

Source: Primary Healthcare Section, Referral Healthcare Section, Healthcare Workers and Regulations Section, 2017, after data processing.

According to table 2, not all sub-district had the same number of hospitals, clinics, private doctor practices, Puskesmases, and Community-based Healthcare Units. Some had all the types of healthcare facilities, some didn’t have all of them. Therefore, access to healthcare facilities differ at each sub-district.

Another problem was the number of available equipment of each facility, at the Puskesmas and the NCDs Posbindu. According to the Health Office, in 2017, Screening Kits funded by the Ministry of Health were available at 35 Puskesmases. However, only 11 Sub-District Puskesmas Technical Implementary Units had IVA Kits and was not available at any Kelurahan Puskesmas Functional Implementary Units.

As for the NCDs Posbindu Kits, the amount and types of the kits were below standards and those that were available were not in good condition. The funding for the equipment and facilities were from the DPAPMK. The equipment provided were blood glucose measurement tools, sphygmomanometers, stethoscopes, and adult weight scales. Even now, the Posbindus have difficulties in obtaining funding for laboratory examinations, because the DPAPMK only provided the tools, without the necessary strips or consumables. Of the 691 Posbindus in the area, 450 (65%) Posbindus have all of those tools, while 241 (35%) Posbindus do not have adequate tools, although they do have an adult scale, microtoise, and sphygmomanometer, it was either broken or damaged. The equipment and facilities that must be present at a NCDs Posbindu is regulated in the NCDs Posbindu Guidelines. Therefore, we conclude that the provision of equipment and facilities for screenings at the NCDs Posbindus (or NCDs Posbindu Kits) was not ideal, because 35% of Posbindus did not have adequate tools.

**Funding**

According to the Health Office and the supporting documents, the percentage of the regional government budget (APBD) allocated for health expenditure has increased. In 2013, 6.5% of the Depok City APBD was...
allocated for the health sector, which continued to increase until it reached 11.34% by 2016. However, the amount allocated for the NCDs Section of the Health Office was only Rp 318,054,000,00, about 14% of the total budget allocated to the Depok City Health Office.

However, the larger allocated budget to the Puskesmas was not offset with an adequate allocation to screening programs, as regulated by the SPM BKUP. According to the Health Office, most of the Business and Budget Plan for the Regional Public Service Agency (RBA BLUD) funds were spent on paying their employees and capital, screenings were not a priority. According to the RBA BLUD documents, Budget Implementation Documents (DPA) for Health Operational Assistance (BOK) and DPA for Basic Healthcare and In-patient Care at the Puskesmas in 2017, the budget allocated for the activities of the SPM BKUP only reached 2.19% of the total funds allocated to the Puskesmas and some Puskesmas did not allocate it. Therefore, the amount was extremely limited.

According to the Posbindu cadres and the DPAPMK, some Posbindus – not all – received 1.5 million rupiahs/year in financial aids from the regional government to cover their operational costs. This was because some of the newer Posbindus were not registered during the budget planning process. The size of the funds were also too small to cover the total costs, because there were other costs, such as the cost for referring a patient, to perform a meeting, purchase consumables, etc. in addition to the operational costs. For the moment, in addition to the funds from the regional government, the Posbindu obtained funds from the local residents and donations. This was exacerbated by the poor absorption of the Non-Physical BOK Special Allocation Fund. Since 2016, where the mechanism for funding changed from a Co-Administration Task (TP) to the APBD, the absorption of funds continued to fall until it reached less than 75%, as compared to when it used the TP mechanism. According to the Puskesmas Informants, this reduction was caused by its technical steps. The funds from the DAK had to be transferred into the regional budget and, therefore, had to use the APBD mechanism in its liquidation. Which is why the Puskesmas had difficulties in obtaining the funds quickly to fund the activities of the UKM. As a result, the funds for activities that support the SPM BKUP, such as technical trainings for the cadres and visits to the NCDs Posbindus would not be able to be funded by the Non-Physical BOK DAK.

According to a key informant that calculated the costing for the SPM BKUP in Depok City, the operational expenditure for the SPM BKUP of 1 (one) person in their productive age living in Depok City between 2016-2020 was less than Rp 5,000,00. That was the minimal price unit used by the regional government to cover the operational costs of SPM BKUP activities. Compared to the amount of the total APBD and the APBD for Health of Depok City, the amount set aside for the operational costs of the SPM BKUP was extremely small. According to a key informant, it only amounted to 2.75% of the total APBD for the Health Field Direct Expenditures (Non-Salary) of the City, or 0.28% of the Depok City Direct Expenditure (Non-Salary).

Standard Operating Procedures

We evaluated whether the implementation procedures have been included in the technical guidelines and the Standard Operating Procedures (SOP) for the implementers at the Health Office and Puskesmas. According to the data obtained through FGDs with the NCDs program holder at the Puskesmas and NCDs Posbindu cadres, there was no technical guidelines and SOP for healthcare services in the productive age based on the SPM. In addition, at accredited Puskesmases, the Elderly Posbindus did have an SOP and the NCDs Posbindus had Technical Guidelines for their Posbindu. Although none of these were found at unaccredited Puskesmases.

Bureaucratic Fragmentation

In this research, we discovered that that there was no specific team assigned to implement the program. The task to implement the SPM BKUP was distributed to several work units at the Health Office, mostly in the Health Office’s PEP Sub-Division (for recording and reporting). However, according to an informant in the Ortala Division, per the Depok City Mayor’s Regulation no. 52/2010, the Mayor is responsible for the implementation of the SPM for the Health Field, but its organizing was coordinated by the Health Office and they were allowed to establish a City Team that comprised of the various elements needed, including an Inspectorate to monitor its accomplishment.

CONCLUSIONS

Although the program has gained the support from its implementers, evident in the revision of the city and Puskesmas indicators, there were still many problems that cause ineffective implementation of the program. This might be caused by the ineffective communication between the implementers and the targets, lack of resources, and lack of regulations. Because 10 of the 13 indicators were incomplete, the program implementation was ineffective. While the lack of resources was caused by the inadequate human resources (both in quality and quantity), lack of cross sectoral coordination for the provision of screening Kits and Posbindu Kits, and the lack of an integrated budget planning system. In addition, there we also discovered that there was no plan to provide incentives.
and disincentives for the program. The lack of a specific team for its implementation and too coordinate the program at the City and the lack of an SOP would also influence the cross-sectoral coordination process.

REFERENCES


