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Capitation Management Through Performance-Based Capitation Mechanism of Primary Health Care in Malang, Indonesia

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Abstract

Primary health care (PHC) has one of the largest funding sources, capitation, which BPJS Healthcare Security transfers monthly. Capitation fund receipts were frequently insufficient due to failure to meet performance-based capitation/*Kapitasi Berbasis Kinerja* (KBK) targets, including for PHC in Malang City, Indonesia. This study aimed to examine the management and utilization of capitation funds through a KBK mechanism. This descriptive study used a qualitative approach supported by quantitative data. This study was conducted from July to August 2023 and purposely selected nine informants from BPJS Healthcare Security, the local health office, and PHC. The interviews were transcribed verbatim and analyzed using a thematic analysis approach. Three themes were identified from data analysis: revenue allocation, utilization allocation, and budget expenditure appropriateness. The use of capitation follows the Mayor's regulations, which allocate service and operational costs. However, remaining capitation funds always occur due to unavoidable conditions. Separating accounts between capitation and other funding sources is necessary to track capitation utilization. Therefore, BPJS Healthcare Security needs to participate in capitation reporting and monitoring.

Keywords: capitation, management, performance-based capitation, primary health care

Introduction

Indonesia is a middle-income country that has implemented reforms to achieve universal health coverage (UHC) through the National Health Insurance (NHI) since January 1, 2014.[1] The goal of UHC, according to the World Health Organization, is that countries must provide access to essential health services to the public without financial hardship, and strengthening primary health care (PHC) is the most effective way to address it.[2] PHC plays a role as the gatekeeper, which is the first-level health facility to control the referral system in healthcare.[3] The fundamental duties of gatekeeping are regulating health expenditures, lowering the need for hospitalization and specialized treatments, and enhancing the quality of life and satisfaction of patients.[4,5]

Over half of the PHC budget was funded by the BPJS Healthcare Security, almost entirely through capitation.[6] Prospective capitation payments for PHC providers and organized referral systems were intended to promote efficiency and effectiveness in service delivery as well as access to health care.[7] Capitation payment is based on the number of patients registered to PHC without considering the type and amount of health services provided.[8] BPJS Healthcare Security issues a regulation on instructions for implementing performance-based capitation/*Kapitasi Berbasis Kinerja* (KBK) payments to ensure PHC continues to perform optimally.[9,10] The KBK mechanism is tied to three performance indicators: contact rate, non-specialist referral ratio, and controlled Chronic Disease Management Program/*Program Pengelolaan Penyakit Kronis* (Prolanis) participant ratio, with targets of ≥150%, ≤2%, and ≥5% respectively, affecting the amount of capitation.[9]

The contact rate reflects the proportion of NHI enrollees who receive individual services and community health appointments outside the PHC, and the number must be at least 150 per million people in a month.[9] The non-specialist

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referral ratio determines the percentage of patients referred for non-specialistic cases. This indicator means to ensure that the referral system is implemented according to medical indications and competence.[9] The threshold of the non-specialist referral ratio was a maximum of two non-specialist referral patients per month. The last indicator, the controlled Prolanis participant ratio, depicts the number of patients involved in the program with stable conditions according to the medical examination.[9] Prolanis addresses NHI enrollees with hypertension and type 2 diabetes mellitus, as these two diseases are considered the major causes of mortality and disability in Indonesia and have the largest burden of disease covered in the NHI.[11,12] The threshold of this indicator was at least 5 per 100 patients.[9]

A previous study found that PHC in Malang did not consistently meet the KBK performance indicator targets.[13] Consequently, the capitation rate was lower than the stated minimum standard capitation rate. In contrast, granting higher capitation payments did not compensate the First Level Health Facilities/*Fasilitas Kesehatan Tingkat Pertama* (FKTP) for exceeding the targets.[14] Each PHC received a different amount of capitation funding. According to the financial data from Malang City Health Office, the amount of capitation funding for each PHC varies substantially, with the difference between the PHCs getting the lowest and greatest capitation being nearly two to three times bigger. However, the realization of capitation fund expenditure in 2021 was only around 34 to 78% based on PHC financial data obtained from preliminary interviews.

A prior study regarding capitation management only discussed the comparison of capitation management between PHC, private general practitioners, and private primary clinics.[15] However, no qualitative study has been conducted on managing capitation funds associated with the KBK mechanism, especially using PHC-level data. To fill this gap, this study aimed to examine the capitation fund management and utilization through the KBK mechanism on PHC in Malang City, Indonesia.

Method

This study was conducted in July–August 2023 and selected purposively three PHCs: Janti, Dinoyo, and Cisadea PHCs, to represent PHCs in different subdistricts in Malang City, Indonesia. Qualitative data were collected through semi-structured interviews. Two key informants from Janti PHC were the assistant expenditure treasurer and the NHI treasurer. Three informants from Cisadea PHC were interviewed: the assistant reception treasurer, assistant expenditure treasurer, and Technical Activity Executive Officer/*Pejabat Pelaksana Teknis Kegiatan* (PPTK). PPTK is a position at the PHC responsible for controlling the implementation of activities, reporting the progress of implementing activities and preparing budget documents for the costs of implementing activities. Two informants from Dinoyo PHC, the assistant reception treasurer and PPTK, were interviewed. Quantitative data were collected from BPJS Healthcare Security regarding the achievement of the KBK among the three indicators from 2021 to 2022. Realization of capitation income, expenditure (service and operational cost), and excess of budget calculations/*sisa lebih penghitungan anggaran* (SiLPA) were also gathered from PHC. Since this study examined the use of capitation funds during the COVID-19 pandemic, the contact rate indicators were seen based on face-to-face services and telemedicine.

Results

This study included nine informants involving the Head of the Benefit Guarantee and Utilization Section of BPJS Healthcare Security of Malang City (Informant-1), the Head of the Finance Sub-division of the Malang Local Health Office (Informant-2), the Activities Technical Implementation Officer of Cisadea PHC (Informant-3), Expenditure Treasurer of Cisadea PHC (Informant-4), Revenue Treasurer of Cisadea PHC (Informant-5), Expenditure Treasurer of Dinoyo PHC (Informant-6), Activities Technical Implementation Officer of Dinoyo PHC (Informant-7), Expenditure Treasurer of Janti PHC (Informant-8), Revenue Treasurer of Janti PHC (Informant-9). All informants were engaged in managing capitation funds from diverse stakeholders. Therefore, the information acquired was sufficiently thorough to determine how capitation funds were managed. Three themes emerging from in-depth interviews included revenue allocation, utilization allocation, and budget expenditure appropriateness.

Theme 1: Revenue Allocation

Registered Participants

The number of participants registered at the PHC varied from one to another. The size of the population in coverage areas of the PHC influenced the number of registered participants, impacting the amount of capitation received. The PHC

stated they could not determine the number of participants, especially for the non-subsidy beneficiaries' membership, because they could change their FKTP every three months. Therefore, the quality of services the PHC provides could influence participants to move their FKTP to attain a greater volume of capitation revenue.

"*We actually cannot determine the number of participants... We ask for a lot, it's impossible because it's the patient's rights. Patients can move every three months…*" (Informant-4)

Capitation Rates

The availability of doctors influenced the capitation, with a doctor-to-participant ratio of 1:5000. The fewer doctors, the lower capitation rates would be received, and vice versa. Problems arose due to frequent transfers of doctors. Malang City Health Office redistributed doctors to meet the need for the number of doctors in every PHC.

"Now it has been balanced, according to the position map. If the primary health care lacks the number of officers, at least it has been filled with the position map. Oh, this is not enough [of officers], oh it needs [some officers], oh this also needs [some officers], we are then rolling [their position]. Besides, one of them wants to be promoted [to a higher position]. The rolling [is done] to those who need it. Well, now almost all of the PHCs have completed their accreditation; so, at least, administratively, they are in compliance." (Informant-2)

Performance-Based Capitation

BPJS Healthcare Security has amended the regulations governing capitation. The interviews revealed that the PHC treasurer did not know how to calculate the results of the indicators in detail. The degression of capitation funds mattered for PHC, especially for them with high capitation funds. For example, if the contact rate indicator was not achieved, it could lose more than 10 million in capitation revenue.

"*KBK will encourage each FKTP to have optimal KBK performance so that the capitation obtained is greater than FKTPs that have fewer performance reports. The Performance Report will improve the quality of FKTP services for National Health Insurance participants*" (Informant-1)

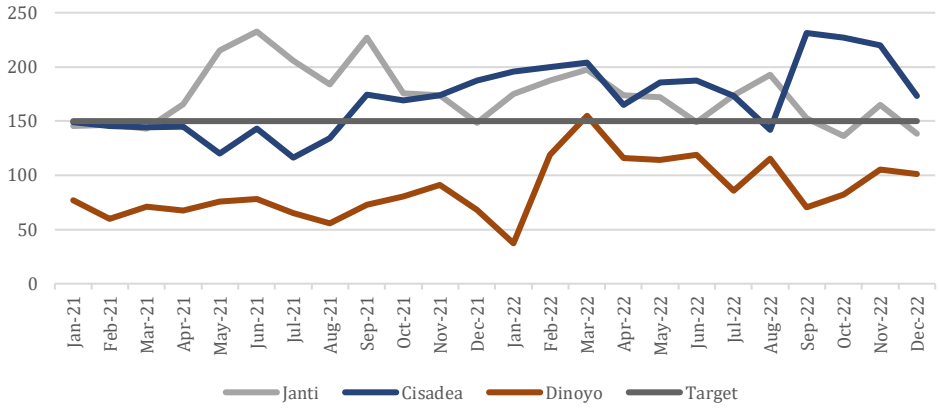

Figure 1. The Achievement of the Contact Rate Indicator in 2021 and 2022

To better understand the contact level indicators, Figure 1 shows the achievements of three PHCs from 2021 to 2022. Janti PHC mostly exceeds targets but experiences a decline at the end of the second year. This was also a reason why the Janti PHC's capitation revenue was reduced in December 2022. The Cisadea PHC tends to be below the target at the start of the first year but then increases. Meanwhile, the Dinoyo PHC has not achieved its target, especially in the first month of the second year. However, it starts to increase until it exceeds the target in March 2022 and falls.

"*Yes, services [provided] outside the building [is] like integrated health care. We do input the BPJS Healthcare Security numbers. That is why we get a lot from integrated health care. Every time we have an activity or a home visit, we note down the BPJS Healthcare Security guarantee program.*" (Informant-4)

According to all PHCs, the contact level indicator was intended to provide services to participants, even if they did not visit the PHCs. Services can be provided through home visits, community group activities, and online consultations. If the contact rate indicator is only measured in the form of patient visits, then the indicator target will be difficult to achieve.

To improve service delivery in the building, the PHCs carry out internal referrals, such as visits to pregnant women and nutritional counseling.

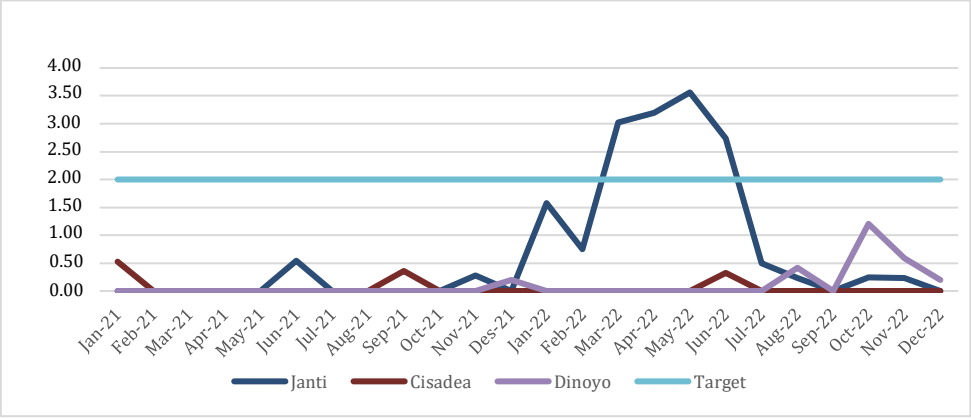

Figure 2. The Achievement of Non-specialist Referral Ratio in 2021 and 2022

In contrast to the previous indicators, Figure 2 illustrates the achievement of a non-specialist referral ratio below the target. All the PHCs tended to maintain their performance within two years. They were aiming for a zero non-specialist referral ratio within a few months. Even though there had been an increase, it was still below the threshold. Janti PHC exceeds the threshold from March to June 2022 but can still pass the limit.

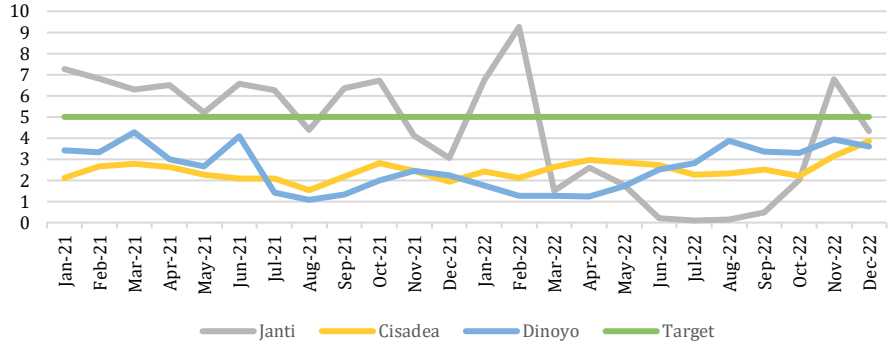

Figure 3. The Achievement of the Last Indicator of Performance-based Capitation in 2021 and 2022

Cisadea and Dinoyo PHCs did not reach their targets for two years, resulting in them not reaching 100% of capitation income. Janti PHC experienced fluctuations in achieving a controlled ratio of Prolanis participants. Apart from not achieving the contact rate indicator, the controlled ratio of Prolanis participants is also the reason why Janti did not receive full capitation in December 2022. In their interview, they said that deflation at the end of the year was due to busy activities.

Theme 2: Utilization Allocation

The three PHCs in this study have been registered as Regional Public Service Agency for Primary Health Care (RPSAPHC) since 2019, and their capitation payments are referred to funds because capitation is one of their funding sources. Following Malang Mayor Regulation Number 4 of 2016, capitation income is combined with other levy funds in one account.[16]

"*It is not purely for capitation itself. It is because capitation is one of the sources of the Regional Public Service Agency for Primary Health Care funding*." (Informant-4)

"*...what is capitation called, it is recognized as Regional Public Service Agency for Primary Health Care income, so it is spent for activities under the Regional Public Service Agency for Primary Health Care*." (Informant-6)

Utilization Allocation for Service Cost

The use of capitation funds for service costs is regulated in the Indonesian Ministry of Health Regulation Number 6 of 2022.[8] The service payment quota is at least 60% of the capitation fund receipts. The allocation of costs for PHC services for the current year is based on capitation estimates for the previous two years. Service fees for each officer vary. Factors determining the amount of service include the type of staff or position and their presence.

"*So, this is a bachelor's degree, [this is] a master's degree, each has its own points. The head of PHC owns points, the treasurer owns points, new civil servant owns points. Later, there will be a period of work. There is also a presence there. It is all there, at that service cost point*" (Informant-2)

Table 3. Utilization Allocation for Service Cost of the Primary Health Care in 2021-2022

PHC	2021			2022		
	Revenue	Service Cost	%	Revenue	Service Cost	%
Janti	USD 174,475.89	USD 74,048.61	42	USD 155,269.91	USD 166,896.50	75
Cisadea	USD 87,768.52	USD 48,059.60	55	USD 82,010.42	USD 51,140.42	62
Dinoyo	No record			USD 132,585.73	USD 76,510.75	58

Notes: PHC = primary health care, USD = United States Dollar (1 USD = IDR 16,230.20)

In accordance with the Indonesian Ministry of Health Regulation Number 6 of 2022 concerning the use of capitation funds, a PHC allocates a minimum of 60% of capitation revenue.[8] The table above shows that the PHCs used capitation funds under the provisions in 2021. However, the use of capitation funds at the Janti and Cisadea PHCs exceeded the threshold (≥60%) in 2022. The variables of officer's type and attendance influence the increase in the use of capitation funds for service costs. The transfer and addition of health personnel at the PHC affect the cost of services.

Utilization Allocation for Operational Cost

Allocation of capitation funds to support operational costs for health services, including medicines, medical devices, consumables, and health service operational activities. The allocation for operational cost support was a maximum of 40% of capitation revenue. PHC allocated more of these funds to operations and maintenance. Expenditures in this allocation were divided into expenditure on goods and services for purchasing current assets and capital expenditure for purchasing fixed assets. Promotional and preventive activities did not use capitation funds because they were limited.

"[It takes] 40% for operations. There are various operations for routine payments, electricity, water, and telephone. Specifically for cleanliness, we use cleaning service; and for security, we also use a professional third party with the same staff. Since we did not have a driver with civil servant status, we finally recruited one person from a third party. The biggest expense is for maintenance. Our pharmacy turned out to be no longer suitable for us to maintain, so we finally moved it. This means it already exists. You just have to repair it according to pharmacy standards. Then, in the end, I could not buy anything." (Informant-7)

Table 4. Utilization Allocation for Service Cost of the Primary Health Care in 2021-2022

PHC	2021				2022			
	Revenue a	Medical device, medicine, consumable goods b	Operational Cost c	% (b+c)/a	Revenue a	Medical device, medicine, consumable goods b	Operational Cost c	% (b+c)/a
Janti	USD 174,475.89	USD 79,897.28	USD 79,897.28	92	USD 155,269.91	USD 61,294.42	USD 61,294.42	79
Cisadea	USD 87,768.52	USD 8,123.22	USD 16,215.43	28	USD 82,010.42	USD 9,895.72	USD 3,988.34	17
Dinoyo	No record				USD 132,585.73	Other funding sources	USD 37,405.65	28

Notes: PHC = primary health care, USD = United States Dollar (1 USD = IDR 16,230.20)

Cisadea PHC expenditure allocation was in accordance with provisions (<40%) in 2021 and 2022. Dinoyo PHC used capitation payments solely for operational purposes (i.e., 28% of the total money allocated); additional funding sources were used to cover costs associated with consumables, medications, and medical equipment. Janti PHC spent much more than the maximum amount on medical equipment, medicines, consumables, and operations.

Obstacles

There were several obstacles to the use of capitation funds at PHCs. The first was related to human resources. PHC lacked human resources as they also carried out service duties to patients. Second, in carrying out procurement, the PHC

must go through a procurement service agency. The agency recommends prioritizing domestic purchases. Meanwhile, more medical goods are being produced overseas. PHCs were uncertain about taking risks and worried about the quality of service. Therefore, they continued to try to buy foreign products even though it takes a long time.

"*The problem is that [the number of] our team is insufficient since we also provide care to patients. Our main task is [all about] services. From medical personnel, from finance [staff], we lack the human resources*." (Informant-9)

Third, PHC still used one account for several RPSAPHC funding sources. Using one account made it difficult to track the realization of expenditures. Last, regulations of Malang Mayor concerning the use of RPSAPHC funds are still limited. While the scope of RPSAPHC funds is quite broad, several areas have yet to be regulated.[16]

"We have one obstacle: we do not have all the Regional Public Service Agencies for Primary Health Care requirements yet. There is only one thing: the use of Regional Public Service Agencies for Primary Health Care funds. Even though there are around 13 regulations that have to be made this year, starting last year, we have started making them in installments." (Informant-7)

Theme 3: Appropriateness of Budget Expenditures

The use of capitation funds does not always conform with initial plans. The flexibility of RPSAPHC enables changes in budget use. However, the use of capitation invariably left SiLPA behind.

The Flexibility of Regional Public Service Agencies for Primary Health Care

All PHCs in Malang have been registered as RPSAPHC. The funding cannot be differentiated, making it easier for the PHC to manage it. In accordance with existing regulations, PHC can choose which activities or expenses will be paid for and which financial sources will be used. Even though they are flexible in handling finances, all the PHCs stated that they had not completely switched to the RPSAPHC since some expenses were still borne by the local Health Office and were reported. Meanwhile, BPJS Healthcare Security advised that capitation should be used to improve the quality of services through improving infrastructure and adding medical personnel.

"So, that is why we say it is not yet full because there are some costs still covered by the local Health Office." (Informant-8)

SiLPA

SiLPA is the excess difference between the realization of budget income and expenditure during one budget period. The first reason SiLPA ended was that health facilities had to provide medical equipment and medicines to treat health problems that had not arisen for a long time, so the planned medicines and medical devices could not be absorbed. The second reason was the difference in market prices. Market prices are usually lower than those budgeted by the Regional Government Information System. Purchases of goods and services can still be used to increase the number of goods, but not for purchasing capital goods. The use of SiLPA funds must follow the allocation in the previous year.

"*Once the budget absorption process begins, suppliers may get offers, and the price will undoubtedly fall. It is impossible to buy above price. You can still buy goods and services in large quantities. Yes, the volume can be increased a little, but not for capital expenditure. That is what SiLPA is asking for*." (Informant-3)

Discussion

Capitation is the monthly payment paid in advance to PHC based on the number of registered participants without considering the type and amount of health services provided. The amount of payment to the PHC is determined based on an agreement between BPJS Healthcare Security and regional health facility associations regarding standard rates set by the Health Minister.[8] If no agreement is reached regarding the amount of payment as intended, the Health Minister shall determine the amount of payment for the health insurance program provided.

By implementing a capitation payment system at PHCs, the health service system aims to promote cost-effective services, improve preventive and proactive management, advance coordination for services, and optimize public health outcomes. The system encourages health professionals to take a holistic approach to patient care and manage resources efficiently to achieve better health outcomes for the enrolled population. However, capitation has weaknesses that could be detrimental to participants, leading to underhandling of primary services, underutilization, and referral of non-specialist cases to hospitals.[17]

KBK has a domino effect on the progress of PHC. Quality is demonstrated by comparing the quality index values achieved by the PHC group with and without CBC. The performance of PHCs implementing the KBK is superior to that of non-KBK PHCs in increasing participant access. In 2016, the number of registered participants per mile at the KBK PHCs who made contact was 54 people; while, at the non-KBK PHCs, it was only 44 per mile.[18] This study showed a difference in contact rates between Janti and Cisadea PHCs that reached 10 per mile. In addition, there was efficiency due to a decrease in referral rates by 1.4%, thereby reducing outpatient and inpatient admissions. BPJS Healthcare Security data for 2019-2020 also shows an increase in primary service performance after the implementation of the KBK. Compared to 2017, there was an increase in the utilization rate of primary health services by 12.5% in 2019. In addition, there was an improvement in the referral system, as seen by a decrease in the number of referrals to hospitals by 2.3% from 2018 to 2020.[19]

The contact rate is an indicator showing a commitment and concern for PHC for the NHI participants' health. The contact rate was measured based on the ratio of registered participants contacting PHC, with the total number of registered participants in PHC multiplied by 1,000. Actions to increase the number of contacts between primary services and NHI participants can be carried out in various activities, both outside and inside the building, offline and online.[9]

The success in achieving contact numbers at the Janti and Cisadea PHCs was due to the availability, commitment, and innovation of their human resources. The availability of human resources has an important role in achieving contact rates since most contact rate activities are carried out outside regular medical services. Human resources must also be supported with adequate facilities, such as transportation and field equipment.[20] Innovation by the Janti and Cisadea PHCs to increase the number of contacts in the building is by making internal referrals for participants deemed to need other services.

Meanwhile, to increase the number of contacts outside the building, the PHCs actively contacted participants through Integrated Health Care activities, home visits, and school visits. The digital technology also enabled telemedicine services for participants with limited PHC access. The role of administrative staff was also crucial in increasing the contact rate because, without good data collection, the contact rate would not be recorded in the P-care system. Therefore, officers who understand the P-Care system well and carried out regular records will greatly contribute to achieving contact rates.

The influential factor in the failure to achieve the contact numbers was the use of capitation funds for operational costs on health services, which did not fully support outside-of-the-building services. Also, they were part of small and medium enterprises, including promotional and preventive activities.[21] This was experienced by the Dinoyo PHC, which did not reach the contact number target since the operational funds originating from capitation were used for pharmacy maintenance, making them unable to buy other needs.

Several factors cause a high ratio of non-specialist referrals in PHC.[22] The first factor was the lack of PHC efforts to foster confidence in PHC's competence in handling non-specialist cases and participants coming to ask for hospital referrals. Support for doctors to handle non-specialist services optimally also influenced the number of non-specialist referrals. Due to a shortage of human resources, a PHC often assigns doctors to other services. Therefore, doctors could not fully focus on providing non-specialist curative services. Procurement of medicines and medical equipment for non-specialist services is also affected because patients prefer to ask for hospital referrals if medicines and medical equipment for non-specialist services are unavailable.

The three PHCs were able to meet the non-specialist referral ratio below the maximum limit required by BPJS Healthcare Security because they could resolve the above obstacles well. This obstacle could be resolved by special team monitoring programs that could reduce non-specialist referrals. Hence, communications with the community, human resources, and the availability of medicines and medical equipment can be fulfilled and carried out well.

Based on BPJS Healthcare Security data, most PHC services in Indonesia have not reached the target indicator of controlling the ratio of Prolanis participants, as experienced by the three PHCs in this study.[19] Based on a study by the Bantul District Government, the target of controlled Prolanis participants that was not achieved was the participants' discipline in carrying out routine treatment and taking medication regularly. Indiscipline in routine control and treatment is caused by not feeling the symptoms and being busy with work.[23]

Seeing these obstacles, it is necessary to have a different approach to encourage participant discipline in carrying out consultations and taking medication regularly. One of the successful efforts made by the Mlati III PHC in Sleman District is by providing a special waiting room and integrated services from patient entry to exit, providing advice on consultations

outside of working hours and reminder notifications for participants to carry out monthly consultations and take medication reminder.[24]

However, the importance of the controlled Prolanis participant ratio is that participants had stable conditions. This was proved by the result of monitoring health status.[25] Accordingly, PHC should be more thorough in putting the data into the P-care system.[25] However, the problem was the lack of staff for data entry into the P-care system. Another study showed that entering the data was hindered by a server that frequently had errors and was slow.[26]

Three main obstacles were found in the utilization of capitation funds. First, the capitation account was the same as other fund accounts, making it difficult to track the allocation of fund flows. Second, providing capitation objects with civil servant status was detrimental to PHC due to limited human resources. Third, procurement of goods must prioritize domestic purchases, while most health products needed were produced abroad. Separation of accounts between capitation funds and other funds must be carried out immediately so that recording and reporting of capitation funds can be done better.

The use of capitation funds and Health Operational Assistance must not overlap. Referring to the implementation of capitation fund management at the Bajulmati PHC, Banyuwangi District, not only are the accounts separate, but the treasurers are also differentiated based on their funding sources.[27] Therefore, each treasurer can focus on recording and reporting their own funds. This can be done by fulfilling financial and accounting human resources in accordance with the needs of the PHC. The obstacles faced in managing capitation funds are limited resources, inadequate understanding of planning, less guidance support from the local Health Office, and the absence of applicable implementation instructions.[28]

The policy for using domestic medical devices must be supported by the availability of domestic medical equipment providers. Currently, 70% of the medical equipment supply in Indonesia is still filled with imported medical equipment, and the domestic industrial market currently only reaches 10%.[29] Flexibility in regulations regarding the procurement of medical equipment needs to be implemented to optimize capitation funds to improve health services to the community. The utilization of capitation funds has not been maximized due to the unclear regulations that need to be developed.[30]

Conclusion

The capitation funds vary due to various factors, such as the number of registered participants, doctor-patient ratio, and performance-based capitation outcomes. However, the absorption of capitation funds each year is not optimal due to unavoidable conditions which cause the SiLPA to occur. Budget absorption is an indicator of health facility performance. This study implies that BPJS Healthcare Security, as the sole purchaser, needs to be more involved in reporting and monitoring capitation funds. The management of capitation funds is still hampered by regulatory limitations, so further regulations are needed to regulate the capitation management.

Abbreviations

UHC: universal health coverage; NHI: National Health Insurance; PHC: primary health care; KBK: *Kapitasi Berbasis Kinerja*/Performance-based Capitation; Prolanis: *Program Pengelolaan Penyakit Kronis/*Chronic Disease Management Program; FKTP: *Fasilitas Kesehatan Tingkat Pertama*/First Level Health Facilities; PPT: *Pejabat Pelaksana Teknis Kegiatan/*Technical Activity Executive Officer; SiLPA: *sisa lebih perhitungan anggaran*/excess of budget calculations; RPSAPHC: Regional Public Service Agency for Primary Health Care.

Ethics Approval and Consent to Participate

Ethical approval for this study was obtained from the Health Research Ethics Commission of Poltekkes Kemenkes Malang (No.DP.04.03/F.XXI.31/1086/2023). Informed consent was acquired prior to data collection and guaranteed confidentiality.

Competing Interest

The authors declared no conflict of interest to be disclosed.

Availability of Data and Materials

The availability of data and materials are available upon request.

Authors' Contribution

ATP designed the study. ATP, HDN, and AA conducted data collection. ATP and AHZ interpreted the data and wrote the manuscript.

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