



World Health
Organization

Indonesia

POLICY BRIEF

Public financial management for effective financing of Puskesmas services in Indonesia

Summary of review and policy insights

Acknowledgement

This policy brief was prepared by Feby Oldfisra (WHO Country Office for Indonesia), Roderick Salenga (WHO Country Office for Indonesia), Jayendra Sharma (WHO South-East Asia Regional Office), and H el ene Barroy (WHO Headquarters).

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Summary

The Government of Indonesia has identified growing concerns about fragmented financing sources for primary care services, which have contributed to inefficiencies in spending and service delivery. In response, it is exploring options to streamline its public financial management (PFM) system to better support primary care.

At the request of the Ministry of Health, and to help guide the reform direction and process, the WHO Country Office for Indonesia working in close collaboration with the regional office and headquarters commissioned a PFM review to identify key opportunities and challenges in budget formulation, execution, and oversight for primary care services delivered through Puskesmas.

Drawing on this review, together with complementary assessments, data analysis, and extensive consultations, WHO has developed a set of policy recommendations aimed at improving the effectiveness and efficiency of public spending to strengthen primary care outputs in Indonesia.

This policy brief summarizes the main findings and recommendations. It is intended to inform stakeholders including the Ministries of Health and Finance, as well as subnational authorities and facility managers as they consider PFM adjustments to make the system more agile and better aligned with the financing needs of primary care services.

Background

Indonesia is undertaking major reforms to its primary care system under Law No. 17 of 2023 on Health and Ministry of Health Regulation (PMK) No. 19 of 2024¹ on PHC implementation. These reforms aim to strengthen service delivery and ensure equitable access to essential health services across the country.

Despite this momentum, financing for primary care services remains fragmented and underutilized². The public financial management (PFM) system faces persistent challenges in channeling funds effectively and efficiently. Multiple funding sources—each governed by distinct and sometimes conflicting rules—complicate budget allocation, execution, and monitoring. This fragmentation reduces clarity over available resources, contributes to misaligned spending, and results in low budget absorption (1). For many primary care centers

(Puskesmas), these constraints translate into gaps in service coverage (2).

Financial data are dispersed across several monitoring platforms and often require manual consolidation, increasing the risk of errors and weakening transparency and accountability (3). At the national level, complex budget information systems and delays in issuing technical guidelines further hinder fund management and reporting. Subnational governments face additional administrative bottlenecks and limited capacity for effective oversight.

Recognizing these challenges, the Ministry of Health has prioritized efforts to streamline PFM rules and processes. In 2023, it partnered with WHO to conduct a comprehensive review of the PFM system. The objective was to identify

1 Law: <https://www.kemkes.go.id/id/undang-undang-republik-indonesia-nomor-17-tahun-2023-tentang-kesehatan>.

2 This brief focuses on primary care service financing and does not include the two other pillars of a PHC approach as defined by WHO and UNICEF (<https://www.who.int/publications-detail-redirect/WHO-HIS-SDS-2018.15>). (4)

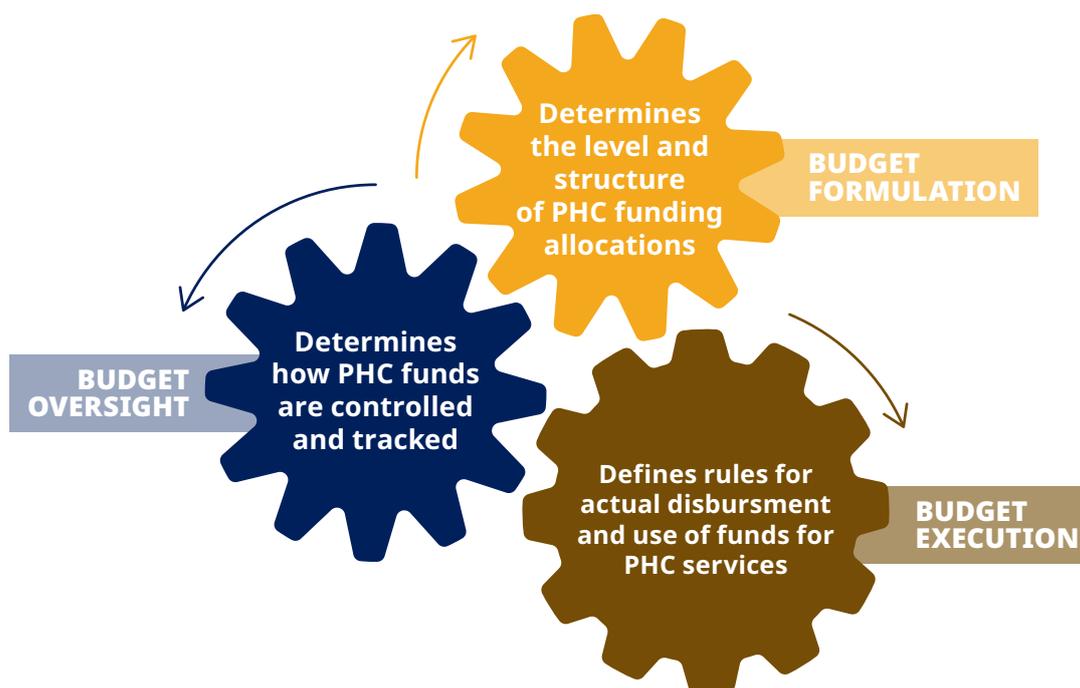
key bottlenecks and develop actionable recommendations to better align PFM practices with Indonesia's primary care reform agenda.

As illustrated in figure 1, identifying PFM bottlenecks across the three phases of the

budget cycle is essential for improving the financing of primary care services. This study applied that framework to systematically diagnose constraints and outline practical steps to unlock public funding for stronger primary care performance.

FIG. 1

Mapping budget cycle stages to primary care service financing



Key findings from the PFM review

WHO commissioned an in-depth study to PFM bottlenecks and challenges affecting the financing of primary care services. The study was carried out by the Center for Health Policy and Management at Universitas Gadjah Mada (UGM), using WHO's established methodology for identifying PFM bottlenecks (5).

A mixed-methods design was employed, integrating both quantitative and qualitative approaches. The review included a qualitative assessment of budget allocation, execution, and expenditure tracking processes, complemented by a data envelopment analysis to evaluate the

efficiency of health spending. Qualitative insights were gathered through focus group discussions and in-depth interviews with stakeholders across administrative levels, including national policymakers, subnational health authorities, and financial managers at Puskesmas.

The study was conducted between September 2024 and February 2025 and covered 12 Puskesmas across four districts selected for their diverse fiscal capacities, geographic contexts (urban, semi-urban, and rural), and varying levels of operational autonomy.

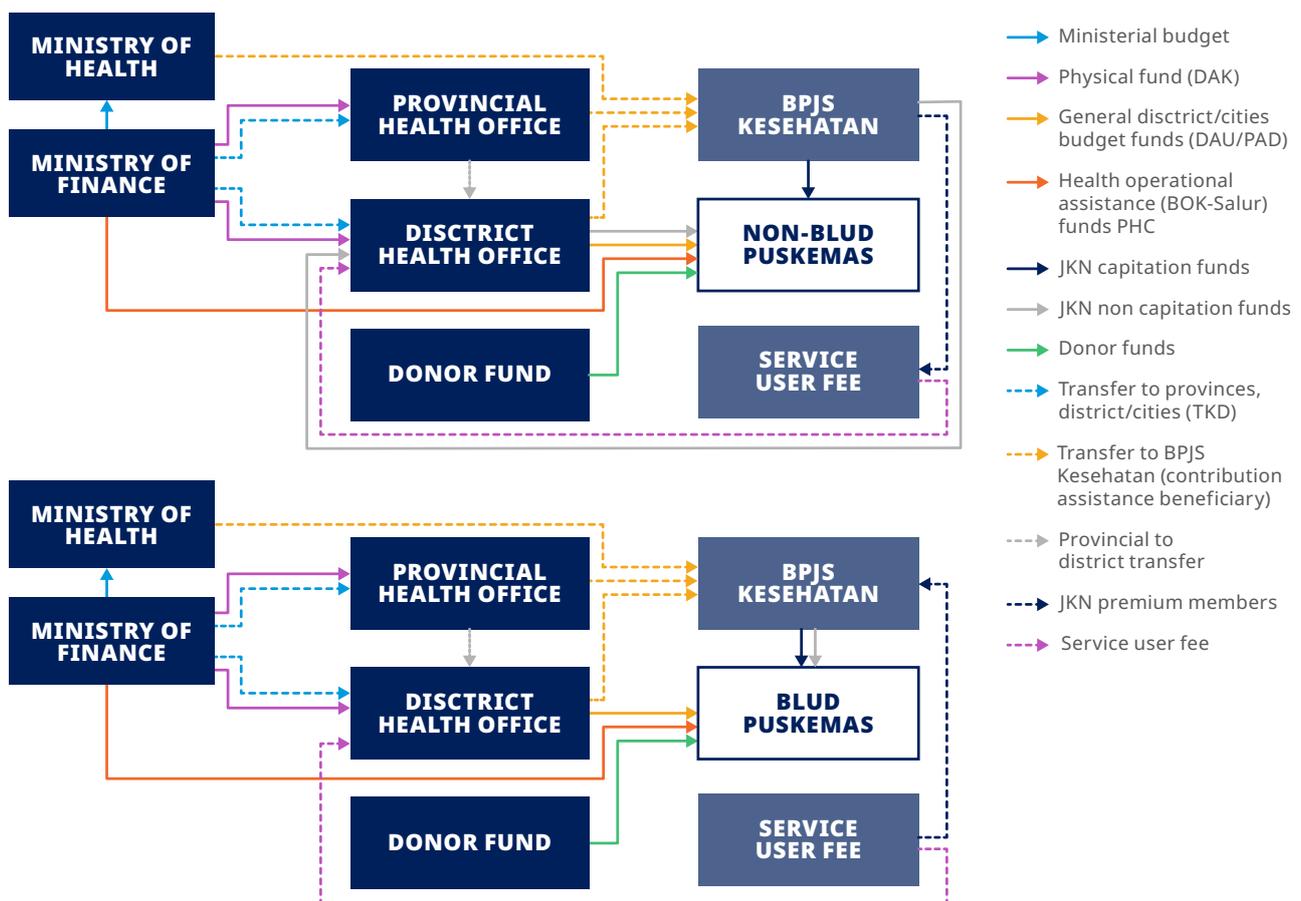
1. Fragmentation in Puskesmas financing

The review identified a complex and fragmented financing landscape for Puskesmas. These facilities receive funding from multiple sources, including ministerial budgets, Health Operational Assistance (Bantuan Operasional Kesehatan, BOK), National Health Insurance (JKN) capitation and non-capitation payments, and local government allocations (see figure 2). Facilities with Badan Layanan Umum Daerah (BLUD) status also receive funding through BLUD grants and are permitted to retain user fees at the facility level.

Each funding source is planned and costed differently, and disbursement schedules and mechanisms vary across streams, adding further complexity to implementation. Most sources are earmarked for specific spending categories, limiting flexibility in how funds can be used. Flexibility also varies by facility status: BLUD facilities generally have greater discretion over certain funding flows than non-BLUD facilities (see table 1).

FIG. 2

Mapping of funding flows for Puskesmas in Indonesia



Source: (6)

TABLE 1

Rules for funds allocation and use for Puskesmas financing

| BOK (health operational assistance) | JKN capitation | JKN non-capitation |
|--|---|--|
| ALLOCATION RULES Based on population and health indicators. | ALLOCATION RULES Based on number of active enrollees and utilization. | ALLOCATION RULES Based on claims for specific services. |
| FOCUS <ul style="list-style-type: none"> • Immunization; • stunting; • maternal-child health; • disease prevention. | FOCUS <ul style="list-style-type: none"> • Health worker incentives; • Patient transport; • Chronic disease programs. | FOCUS <ul style="list-style-type: none"> • Essential emergency obstetric and neonatal; • Antenatal care; • Family planning; • Contraceptive services. |
| DISBURSEMENT <ul style="list-style-type: none"> • Triannual; • Scheduled by MoH. | DISBURSEMENT <ul style="list-style-type: none"> • Monthly in advance; • Based on registered population. | DISBURSEMENT <ul style="list-style-type: none"> • Based on verified service claims; • Disbursement may be delayed. |
| FLEXIBILITY IN USE Low <ul style="list-style-type: none"> • Restricted to specific activities; • Requires MoH approval. | FLEXIBILITY IN USE Moderate Regulated by internal technical guidelines. | FLEXIBILITY IN USE Low <ul style="list-style-type: none"> • Limited to reimbursable services; • Strict verification. |
| APBD (regional government budget) | Out-of-pocket (OOP) expenditure | BLUD revenue |
| ALLOCATION RULES <ul style="list-style-type: none"> • Varies by district; • Influenced by local planning. | ALLOCATION RULES Collected directly from patients. | ALLOCATION RULES Based on internal business plan (RBA). |
| FOCUS <ul style="list-style-type: none"> • Infrastructure; • Salaries; • Routine programmes. | FOCUS <ul style="list-style-type: none"> • Service payments; • Fuel; • Basic operations. | FOCUS Equipment procurement, unexpected expenditures. |
| DISBURSEMENT <ul style="list-style-type: none"> • Quarterly or semi-annually; • Aligned with regional budget cycle. | DISBURSEMENT At point of service. | DISBURSEMENT <ul style="list-style-type: none"> • Flexible; • Guided by RBA and regional policies. |
| FLEXIBILITY IN USE Low (non-BLUD) High (BLUD) BLUD Puskesmas have greater autonomy. | FLEXIBILITY IN USE Low (non-BLUD) High (BLUD) Puskesmas can retain revenues. | FLEXIBILITY IN USE High Allows reallocation based on needs |

2. PFM bottlenecks for Puskesmas financing at all stages of the budget cycle

The budget cycle was used as an analytical framework to identify PFM bottlenecks affecting primary care financing. Key issues uncovered through the study are summarized in [table 2](#).

TABLE 2

Key PFM bottlenecks for Puskesmas financing by stage of the budget cycle

Budget formulation and allocation

|  CHALLENGE AREA |  DESCRIPTION |
|--|---|
| Multiple funding sources | Each source (ministerial budget, BOK, JKN capitation/non-capitation and local government funds) has different rules and timelines and leads to fragmented planning. |
| Diverse allocation rules | Allocation criteria and planning indicators vary across sources and government levels, complicating harmonized budgeting. |
| Inconsistent costing methods | Inconsistent application of approaches (line-item, output-based and capitation) across funding streams limits comparability and coherence. |
| Uncoordinated budget timelines | Different budget cycles and submission timelines across funding streams hinder integrated planning. |
| BLUD vs. non-BLUD disparities | BLUD facilities enjoy greater flexibility in fund use, while non-BLUD ones face rigid constraints, contributing to inequities across regions. |
| Lack of integrated budgeting at facility level | The lack a consolidated budget plan that incorporates all funding sources in many Puskesmas reduces strategic resource allocation. |
| Unstable allocation rules | Annual changes in allocation formulas reduce predictability and hinder long-term planning. |
| Incomplete ILP budgeting | Budget allocations for integrated local planning (ILP) are often partial or delayed, affecting implementation. |
| Limited emergency fund access | Cumbersome administrative procedures slow access to emergency funds. |
| Weak national-subnational coordination | Misalignment between government levels in budget formulation, including indicators and priorities, impede coherence. |

Budget execution

|  CHALLENGE AREA |  DESCRIPTION |
|--|---|
| Disbursement delays | Procedural bottlenecks (e.g., budget implementation document (DPA) guidelines) often delay funds, disrupting services, especially early in the fiscal year. |
| Varying disbursement calendars | Different timelines across sources complicate synchronised planning and execution at facilities. |
| Unclear guidelines | Technical guidelines for fund use are often vague or inconsistently interpreted at the Puskesmas level, leading to uncertainty and delays. |
| Limited flexibility for reallocation | Fund reallocation across or within sources often requires higher-level approval, even in emergencies. |
| Restrictions on fund use | JKN capitation funds use restrictions and frequent delays in service fee payment affect operations. |
| Procurement constraints | E-catalog limitations and rigid procurement rules hinder timely procurement. |
| Uneven absorption capacity | Budget execution rates vary widely across Puskesmas, reflecting disparities in capacity and efficiency. |
| Low emergency responsiveness | Limited flexibility and slow fund release reduce responsiveness to urgent health needs. |

Budget oversight

|  CHALLENGE AREA |  DESCRIPTION |
|--|--|
| Fragmented reporting systems | Separate reporting platforms (e.g., SIPD, e-Renggar and Krisna) increase burden and prevent consolidated tracking. |
| Multiple budget accounts | Each funding source operates through its own account, complicating financial consolidation and monitoring. |
| No unified tracking system | The absence of an integrated platform for financing from all sources limits transparency and oversight. |
| Inconsistent reporting quality | Varying standards for compliance and reporting affect financial data reliability and comparability. |
| Limited real-time oversight | Facility staff lack access to real-time data on financial flows and performance, reducing responsiveness and accountability. |
| Weak data integration | Financial and service data are not systematically linked, hindering performance-based analysis and decision-making. |
| Multiple audit processes | Separate audits of funding sources duplicate efforts, create inefficiencies and raise administrative burden. |

3. Rigidities in funds utilization leading to budget under-execution

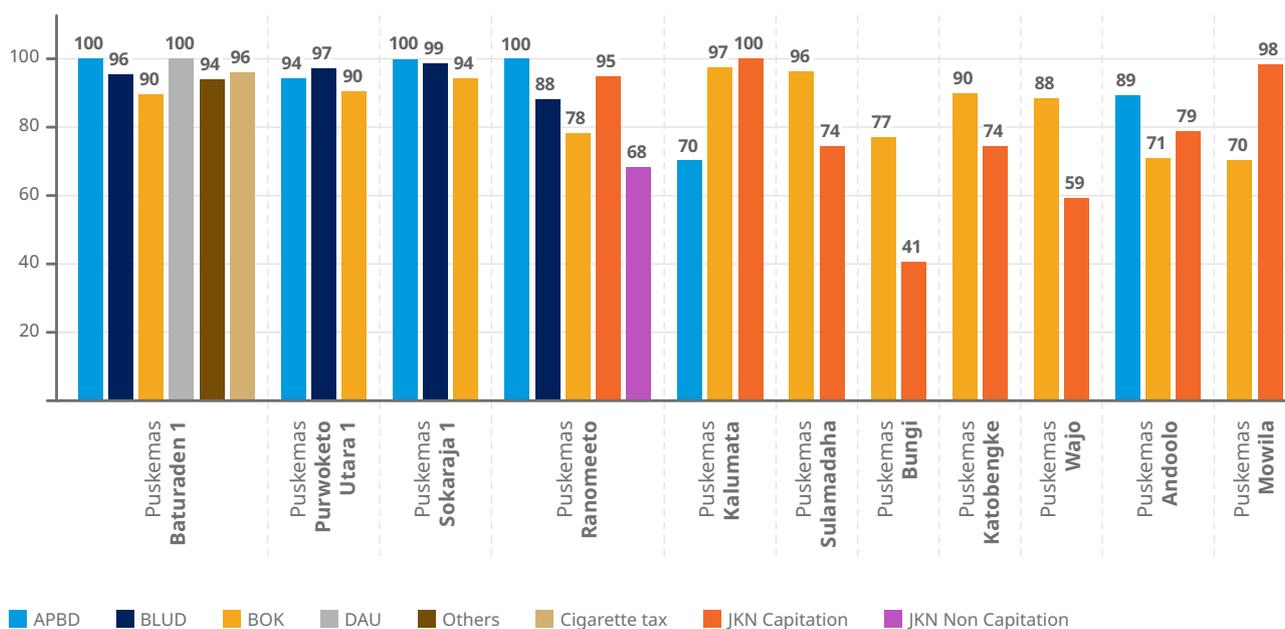
Budget execution data show varying levels of execution across funding streams, which can result in revenue losses since reallocation between sources is not permitted. Some sources—such as JKN capitation—appear to be more underutilized than others across the puskesmas sample (see figure 3).

sources to maximize resource use and, over time, enable reallocation through a more unified budgetary framework. In the immediate term, while fully merging funding sources may not be feasible, establishing a virtual pool of resources could improve visibility over available funds and support more strategic and efficient utilization (see figure 3).

These findings underscore the need to harmonize utilization rules across funding

FIG. 3

Budget execution rate by source of funding in sampled Puskesmas, 2023 (%)



Source: (6)

4. Implications of BLUD status for flexibility in spending

As of September 2025, 6,878 (66,8%) of the 10,300 Puskesmas in Indonesia had BLUD status³. The review examined the features of BLUD status to clarify the scope of discretion available to these facilities. The differences are substantial and have a significant impact from a facility financial management perspective (table 3).

TABLE 3

Key attributes of BLUD and non-BLUD status

| | ✓ BLUD PUSKESMAS | ✗ NON-BLUD PUSKESMAS |
|---------------------------|--|--|
| Revenue management | Directly manage and use revenues | Revenues go to local treasury and require approval |
| Expenditure | Flexible use based on business and budget plan (RBA) | Use tied to APBD and requires approval |
| Procurement | Uses e-catalog/tender, with flexible internal purchasing | Regular procurement through e-catalog/tender |
| Borrowing | Can borrow or delay payments | No borrowing; upfront payments |
| Fee setting | Can adjust service fees for non-JKN services | Fees set by government regulations |
| HR management | Have flexibilities to hire/fire for non-government | Staffing and salaries determined by government regulations |
| Partnerships | Can directly engage partners | Partnerships require government approval |
| Investment | Can reinvest surplus | Investments allocated via APBD |
| Remuneration | Can provide performance incentives | Limited to standard entitlements |
| Surplus/deficit | Can retain and manage funds | Unspent funds returned annually |

³ Data on Puskesmas in Indonesia, Directorate of Primary Health Care Governance, Ministry of Health Indonesia, 2025.

5. Differences in spending efficiency by facility status

The study examined the spending efficiency of health facilities and found notable differences between BLUD and non-BLUD Puskesmas in terms of per capita spending. BLUD facilities tend to serve larger catchment populations at lower costs. While further research is needed to validate these findings across a broader sample, initial interviews suggest a possible link between the level of flexibility and discretion over fund use and overall efficiency.

Qualitative findings from the review indicate that BLUD status may contribute to higher

efficiency because facilities can make quicker operational decisions, adjust spending based on real time needs, and reinvest revenues directly at the facility level. BLUD Puskesmas face fewer administrative restrictions in procurement, can reallocate funds more easily within their business plan (RBA), and have greater control over cash flow management. These flexibilities allow BLUD facilities to manage routine operations more predictably, respond faster to service delivery needs, and minimize delays that often affect non-BLUD facilities.

TABLE 4

Population served and spending per capita in selected facilities

| PUSKEMAS TYPE | NAME OF PUSKEMAS | CATCHMENT POPULATION | HEALTH SPENDING PER CAPITA (Rp) |
|---------------|------------------------------|----------------------|---------------------------------|
| BLUD | Puskesmas Sokaraja 1 | 60.300 | 59.488 |
| BLUD | Puskesmas Kalumata | 56.370 | 62.435 |
| BLUD | Puskesmas Batarudean 1 | 30.943 | 80.618 |
| BLUD | Puskesmas Purwokerto Utara 1 | 24.444 | 81.272 |
| BLUD | Puskesmas Ranoemeto | 22.821 | 98.804 |
| Non BLUD | Puskesmas Siko | 37.530 | 68.006 |
| Non BLUD | Puskesmas Katobengke | 16.490 | 92.235 |
| Non BLUD | Puskesmas Andoolo | 11.148 | 94.156 |
| Non BLUD | Puskesmas Mowila | 13.470 | 120.729 |
| Non BLUD | Puskesmas Bungl | 6.719 | 129.753 |
| Non BLUD | Puskesmas Wajo | 15.592 | 153.450 |
| Non BLUD | Puskesmas Sulamadaha | 9.109 | 164.122 |

Source: (6)

Policy recommendations

Based on these findings, WHO and national authorities propose a set of policy options to address key bottlenecks in primary care service financing. These recommendations are organized by stage of the budget cycle and include cross-cutting measures to support system-wide improvements.

Budget planning and allocation

Adopt a ‘one budget’ approach: implementing a “virtual pooling mechanism”⁴ that consolidates funding sources into a single budget framework would enhance transparency, enable comprehensive tracking, and support strategic resource use. Assigning a single treasurer per facility and transitioning toward multiyear budgeting could further reinforce this approach.

Front-load fund disbursement: applying front-loaded disbursement models that already used for JKN capitation can reduce financial stress caused by delays, improve predictability, and ensure continuity of services.

Introduce Conditional Grants: conditional grants tied to predefined performance indicators and disbursed through provincial governments could incentivize results-oriented spending, strengthen accountability, and complement increased funding.

Budget execution and utilization

Streamline spending authorization: shifting to quarterly or semi-annual approval cycles, particularly for APBD and BOK, would reduce delays and improve spending efficiency and responsiveness.

Harmonize fund use guidelines: developing harmonized guidelines would reduce rigidity and inconsistencies, allowing for more flexible, needs-based spending. This could also enable reallocation across budget lines and, where appropriate, across funding sources.

Align procurement procedures: standardizing procurement processes especially for essential supplies such as medicines and vaccines would reduce administrative burden and improve timeliness.

Financial and performance reporting

Establish consolidated financial reporting: a unified reporting mechanism for primary care spending would improve transparency and accountability. Enhanced interoperability across platforms could support more integrated reporting.

Link financial and health information systems: systematic linkages between financial and health data systems would strengthen accountability and support evidence-based decision-making. Facility-level dashboards for PHC performance could enable real-time monitoring.

Strengthen performance analysis capacity: improved data integration would allow for more robust performance analysis. Building Ministry of Health capacity to interpret and use performance data is essential for informing future budget allocations.

Cross-cutting enhancements

Expand BLUD status to all Puskesmas: BLUD status provides greater flexibility in fund management. A phased national rollout, supported by clear guidelines and capacity building, could enhance financial autonomy and efficiency across all facilities.

Invest in PFM capacity building: targeted PFM training for Puskesmas managers and dedicated finance staff would strengthen financial management functions. Development partners can play a key role in supporting these efforts.

Promote consistency in financial practice: scaling up best practices can help standardize procedures, improve efficiency, and foster greater accountability.

⁴ By “virtual pooling mechanism”, we refer to the establishment of a consolidated, unified budgetary framework that would encompass all sources of funding for Puskesmas. This approach would provide greater visibility into the total available funding for the fiscal year. Importantly, this consolidation does not require a physical pooling of funds—hence the term “virtual” — as we recognize that such integration may not be feasible in the short to medium term. Instead, it functions as a consolidated budgetary envelope, or a “one budget approach,” for each facility, replacing the current practice of budgeting by individual funding source.

Way forward: priority actions

The Ministry of Health and WHO have jointly identified priority actions for 2025–2026 to address most pressing PFM bottlenecks and to strengthen primary care service financing. These actions will be led by national authorities, with technical support from WHO and collaboration from key development partners, including a new targeted World Bank operation⁵.

| 📍 AREA | ▶ IMMEDIATE ACTIONS | 📄 RATIONALE |
|--|---|---|
| Budget formulation & allocation | <ul style="list-style-type: none"> Expand puskesmas-led budgeting beyond BOK to include APBD, JKN, DAK and BLUD revenues. Develop national guidance to operationalize a “one budget” approach at the facility level. | <p>Limited engagement of puskesmas in budget planning leads to misaligned resource allocation. A unified budgeting approach would consolidate all funding sources, improve visibility and support efficient resource use.</p> |
| Budget use | <ul style="list-style-type: none"> Revise JKN capitation guidelines to allow cross-financing for eligible activities. Update spending authorization procedures to enable faster disbursement and consider front-loading mechanisms. | <p>Lags in disbursement of APBD, BOK and JKN non-capitation funds create financial stress. Front-loading and direct disbursement to puskesmas accounts would improve liquidity and service continuity.</p> |
| Budget monitoring | <ul style="list-style-type: none"> Roll out a unified digital reporting platform for primary care spending, integrating all funding sources into a single account. | <p>Fragmented reporting systems hinder consolidated tracking. An integrated account would facilitate monitoring, evaluation and performance-based analysis.</p> |
| BLUD implementation | <ul style="list-style-type: none"> Define and implement a phased national rollout plan to institutionalize BLUD status as the standard for all puskesmas. | <p>BLUD status provides greater flexibility in fund use. Scaling this model nationally would enhance autonomy and responsiveness at the facility level.</p> |
| Cross-cutting capacity building | <ul style="list-style-type: none"> Strengthen financial management and reporting capacity of puskesmas treasurers through targeted training and deployment of finance staff. | <p>Many treasurers lack formal financial training. Building capacity is essential for effective budget execution and accountability.</p> |

⁵ World Bank - Indonesia Health Systems Strengthening Project 2023 – 2030 (<https://documents1.worldbank.org/curated/en/099111723114093413/pdf/BOSIB0fdfe176800908ac8043df4bf6fcfb.pdf>).

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**Health Financing, Health System Strengthening Unit
WHO Country Office Indonesia**

5th Floor, Gama Tower
Jl. HR Rasuna Said Kav. C-22
Jakarta Selatan 12940
Indonesia

Email: wpwhoindonesia@who.int

Website: <https://www.who.int/indonesia>