POTENTIAL FOR FRAUD IN THE MANAGEMENT OF JKN FUNDS AT COMMUNITY HEALTH CENTERS
(Case study at Community Health Centers in "Hastinapura" District)

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ABSTRACT

The purpose of this study is to assess the potential for fraud in the management of the National Health Insurance (Indonesian: Jaminan Kesehatan Nasional /JKN) funds at Community Health Center. The research is conducted using qualitative method with case study design in Hastinapura District. The methods of data collection used are documentation, unstructured interviews and observations, which are then analyzed based on interpretation recorded by researchers. The informants consisted of 2 treasurers of JKN Health Center, 1 member of JKN team of Health Department, and 1 medicine manager of Health Center. The results of this research show that the potential for fraud in JKN funds at Health Center includes: the utilization of capitation fund which is not in accordance with the provisions of legislation, the division of service is potential for moral hazard, the operational cost of the Health Centers is colored by the entrusted activities from health department, and the excessive medicine stocks in remote Health Centers. The additional cost occurs because the Health Center is running out of medicine stock so that the patient has to increase the cost for the purchase of the medicine. The potential for fraud in non-capitation funds is that participants have to pay for actual family planning services that actually can be claimed, due to the prolonged disbursement process.

INTRODUCTION

National Health Insurance (*Indonesian: Jaminan Kesehatan Nasional / **JKN***) Program is part of the National Social Security System (SJSN) organized through a social insurance mechanism. This program is aimed at achieving

Universal Health Coverage as WHO (2005) requires that each country provide universal health insurance. This is realized by the government of Indonesia through the JKN program in order to meet the basic health needs provided to every person who has paid contributions or whose contributions are paid by the government.

Along with the implementation of JKN, many current issues are rolling out in the community related to the JKN program, including the implementation of JKN which has the potential dishonesty causing the Indonesian National Health Insurance Agency (BPJS) to experience a budget deficit of IDR 6.7 trillion at the end of September 2016 (Jawa post, 2016). Masland, et.al (1996) states that in the capitation system, health care providers have a greater risk of fraud because they receive a fixed payment regardless of the amount of service performed or the cost per service. The Audit Board of the Republic of Indonesia (BPK) has also discovered the misuse of JKN capitation funds at Health Centers. The total receipt of JKN capitation funds at Health Centers that should be allocated for services and operational support costs only is in fact also allocated for remuneration for Health Department staff. This obviously deviates from the provisions. In addition, the issuance of the Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2015 concerning the Prevention of Fraud in the Implementation of the Health Insurance Program indicates the need for supervision in the JKN program. In terms of handling insurance, the supervision is carried out by BPJS, and in terms of health services, the supervision is carried out by the regional government.

According to Mulyana (2015), fraud in health services is a form of irregularity carried out by various parties in the health service chain to obtain personal benefits exceeding the benefits derived from normal practice. Related to insurance fraud, Ilyas in Nurbona (2015) states that in some states in the United States, insurance fraud is a criminal act, but the charges are rarely a priority for law enforcement. In Indonesia, fraud in the insurance sector does not include criminal acts because it has not been investigated and dealt legally. Ilyas also states that insurance fraud can be done by anyone, such as hospitals as providers, participants and insurance companies. Thronton (2013) in his research reveals that efforts to identify fraud in health will never end. However, by using structured data model, analytical techniques, and ongoing feedback, fraud that causes greater losses can be detected and prevented.

On the other hand, the Corruption Eradication Commission (Indonesian: Komisi Pemberantasan Korupsi / **KPK**) on its website reveals the weaknesses of the management of JKN funds thoroughly. It is suspected that regulatory aspects have the potential to cause moral hazard and irregularities in the distribution of medical services and operational costs. In addition, the rules for using capitation funds also do not fully accommodate the needs of the Health Center. Furthermore, in terms of financing, the KPK discovered the potential for fraud by allowing the transfer of contribution recipient participants (PBI) from the Health Center to private First Level Health Facilities (FKTP). From here the KPK discovered the fact that a certain Health Center officer had established private FKTP. When patients come to the Health Center, they are sometimes not served well for various reasons, and then they are directed to his private FKTP or those that are affiliate with his.

Several weaknesses in the aspects of governance and resources include: 1) the lack of understanding and competence of health workforces in the Health Center in carrying out regulations; 2) complexity of participatory verification process in FKTP; 3) irregular implementation of tiered referral mechanisms; 3) greater potential for mistreatment by FKTP officers, 4) vulnerability of the Health Center

officers to be victims of extortion by various parties; and 5) the unequal distribution of health workers. One of the potential irregularities can be seen from the perception that capitation funds must be spent in the same year. This causes Health Center officers to try to spend all the capitation funds received even if they are not needed. There is an indication of manipulation in the transactions and accountability for the use of the capitation funds. Another aspect is the absence of a budget for supervision of capitation funds in the regions. This is also exacerbated by the absence of monitoring and control tools for capitation funds by BPJS.

Based on the above background and problems, the potential for fraud is alleged to occur at the Health Centers. Therefore, the researchers are interested in examining whether the potential for fraud occurs in the management of JKN funds at the Health Centers in Hastinapura District.

LITERATURE REVIEW

Fraud

Literally, fraud is interpreted as an act of cheating. Kurniawan (2014, 7) explains that fraud is a tangible form of cunning committed by a person or group of people to get benefit by manipulating data or information. Furthermore, according to the Association of Certified Fraud Examiners (ACFE) in Kurniawan (2014), fraud is the use of one's opportunity for personal interest through the intentional misuse of organizational assets or resources. The elements of fraud, as explained by Kurniawan (2014, 10), consist of the desires and intentions to commit fraud and other unlawful acts carried out in the form of fraudulent activities and manipulation of material data and information by utilizing their position and trust given by others for personal gain.

Tunggal (2010, 196) defines fraud as a form of fraudulent crime committed by an individual or a group of people, both in the public sector and in the private sector. According to Tunggal (2010), the elements of fraud include committing a crime to achieve a goal that is not in accordance with legal or public policy, disguising the purpose by falsifying data and reports, the dependence of the perpetrator on the carelessness of the victims, voluntary action done by the victims to help the perpetrators as a result of fraudulent practices committed, and the closure of criminal acts.

The Management of JKN Capitation Funds at Health Centers

Community Health Center is one of the First Level Health Facilities (FKTP) owned by the government that organizes public health efforts and first-rate individual health efforts by prioritizing promotive and preventive efforts to achieve the highest level of public health in its working area (the Regulation of the Minister of Health of the Republic of Indonesia No 75 of 2014). Based on the Regulation of the Minister of Health of the Republic of Indonesia No 28 of 2014, Health Center is an FKTP paid by BPJS through capitation and non-capitation systems.

In the capitation payment system, The Health Center is paid based on the number of participants registered at the Health Center according to BPJS data. FKTP payments are made in advance every month. The capitation funds management system and procedures have been regulated in Presidential Regulation No 32 of 2014 as a reference for Health Centers that have not implemented PPK-BLUD, including a) budgeting which is carried out by the Head of FKTP by submitting income and expenditure plan for capitation funds that is subsequently budgeted in the RKA-SKPD Health Department; b) implementation and administration; c) accountability where the Head of FKTP is formally and materially responsible for the income and expenditure of JKN capitation funds and d) supervision of the acceptance and utilization is carried out by the Head of the Health Office and the Head

of FKTP in stages. Functional supervision of the management and utilization of capitation funds is carried out by Government Internal Supervisory Apparatus (APIP) of Regency / Municipality

In detail, the use of capitation funds at non-BLUD Health Center has been regulated in the Regulation of the Minister of Health of the Republic of Indonesia number 21 of 2016. The funds are used entirely for payment of health services and support for operational costs for health services at the Health Center. Based on the Regulation of the Minister of Health, the allocation for health services at Health Centers has been set at least 60% of the receipt of capitation funds. While the rest is for the payment of operational support for health services that can be used for medicines, medical devices, and consumable medical materials and other health service operational activities which include:

a) Expenditures for operational goods consist of health services in the building, health services outside the building, operation and maintenance of vehicles for mobile health centers, printed materials or office stationery, administration, coordination of programs and information systems, improvement of the capacity of health human resources; and / or maintenance of facilities and infrastructure;

b) Capital expenditure for facilities and infrastructure, in which the implementation is in accordance with the provisions of the legislation;

c) Procurement of medicines, medical devices, consumable medical materials and procurement of goods / services related to the support of other health service operational costs.

The Management of JKN Non-Capitation Funds at Community Health Centers

In addition to capitation funds, Health Center also has the right to get non-capitation funds which are the amount of claim payments to the BPJS based on the type and amount of health services provided. Services that can be claimed on non-capitation funds are ambulance services, drug referral services, referral service support checks, certain health screening services including cryo therapy services for cervical cancer, first level hospitalization according to medical indications, midwifery services and neonatal care performed by midwives or doctors, according to their competence and authority, and Family Planning services at the first level health facilities (FKTP).

The management of non-capitation funds is different from that of capitation funds, especially in the disbursement. The management and utilization of JKN non-capitation funds at Health Center must follow the provisions of the legislation in the area of regional financial management. Non-capitation funds are transferred by BPJS to the health office and entered as income in the regional treasury, so disbursement follows the disbursement mechanism that applies in the region. The Health Center claims its non-capitalized service to the health office. Next, the Minimum Service Standards (SPM) is made and Warrant for Disbursement of Funds (SP2D) is issued and new funds can then be disbursed.

Potential for Fraud in the Implementation of JKN Program

The Regulation of the Minister of Health of the Republic of Indonesia number 36 of 2015 explains that fraud in the implementation of the JKN program is a deliberate action taken by participants, BPJS Health officers, health service providers, and providers of drugs and medical devices to obtain financial benefits through fraudulent acts that are not in

accordance with the provisions. Fraud can be done by health care providers, that is, by first-level health facilities (FKTP) and advanced referral health facilities (FKRTL). FKTP can be in the form of Health Center, doctor's practice, dentist practice, Pratama clinic and Pratama class D hospital, while KRTL can be in the form of main clinic, public hospital and special hospital. At the FKTP, BPJS uses the capitation and non capitation payment mechanisms.

More specifically, the Regulation of the Minister of Health of the Republic of Indonesia No. 36 of 2015 describes the JKN fraud that can be done at FKTP, such as utilizing capitation funds not in accordance with the provisions of the legislation, manipulating claims on services that are paid non-capitation, receiving commissions for referrals to FKRTL, charging fees from participants, in which the fees have actually been guaranteed in capitation and / or non-capitation funds in accordance with the established tariff standards, making referrals to patients that are not in accordance with the purpose for obtaining certain benefits.

The potential for capitation fund fraud at Health Center is explained by Setiaji (2015) with the fraud triangle theory. Pressure can be done by increasing the budget for the income and expenditure plan of the capitation funds of the Health Center and increasing the points for the number of services. Opportunity arises due to the weak detection of fraud or due to weak sanctions and inability to assess the quality of work. This is done by marking up the cost of purchasing goods to support the operations of the Health Center, doing collusion with third parties related to the procurement of health center assets from Health Center operational assistance fund, buying unnecessary items, fictitious spending on puskesmas assets, cheating on reporting the use of capitation funds at Health Center, and cheating in reporting drug supplies, medical devices and consumable medical materials.

Meanwhile, from the aspect of rationalization, it can be done by adding points for Health Center officers who perform double duty, using Health Center operational assistance funds which are also funded by Health Operational Costs (BOK) funds and Regional Budget (APBD), and utilizing the remaining capitation funds into the service fund.

RESEARCH METHOD

This research is included in qualitative research. The research design used is a case study in "Hastinapura" District. Case study design was chosen because the researchers wanted to find out the potential for fraud in the implementation of JKN funds at Health Centers in "Hastinapura" District through interpretation of various information sources. The types and sources of data used in this study are primary and secondary data. Primary data are in the form of interviews and observations. Unstructured interviews were carried out on informants consisting of 2 treasurers of JKN Health Center, 1 member of the health department JKN team, and 1 medicine manager of Health Center. Observation made is in the form of observations from the results of interviews which are then interpreted. Whereas secondary data in this study are in the form of regulations, laws, articles and data related to the management of JKN funds.

DISCUSSION

A. Potential for Fraud in the Management of JKN Capitation Funds

Service Distribution is Potential for the Emergence of Moral Hazard

The Regulation of the Minister of Health of the Republic of Indonesia No. 21 of 2016 describes that the workforce that can receive services from this capitation fund includes civil servants, government employees with work agreements and temporary employees. In East

Java, at the beginning of JKN implementation in 2014, the Governor of East Java issued a circular letter number 440/11167/031/2014 which explained that employees who were entitled to receive health services from JKN capitation funds were official employees who received salaries from the National Budget / Regional Budget.

In fact, in "Hastinapura" District there are still personnel outside Government employees, that is, Honorary Workforce and Temporary Employees who are called volunteers. These volunteers are actually contract workers who have a decree of the Head of the Health Service, but in the decree it is explained that the volunteers concerned will not demand salary from the regional government. These volunteers are scattered throughout the Health Center with a considerable number. They are actually really needed by the Health Center because of various educational backgrounds such as midwives, nurses, administration and cleaning services. Therefore, the capitation fund is used as a solution by all Heads of Health Centers in providing welfare for the volunteer workers. This is done by cutting the capitation funds from government employees, honorary workforce and temporary employees to be distributed to volunteer personnel. Roy as the Head of Health Center "Kalingga" strengthens with his statement;

> *"Normatively, it is those who have decree who can get, 38 people, yes, but internally, all employees can get 68 people, starting from volunteer to janitor, all can get because I think they also help friends who have rights, like janitor, drivers. Without them, who will sweep and clean the office? ... and that is also the need for the health center ... more over it is not only in my Health Center, but also in all Health Centers, but how much they are paid, it depends on the head ... "*

Normatively, the Health Center only provides services to employees who are paid by the APBN and APBD, but the head of the Health Center has full authority in allocating services at the Health Center. He provides services to all employees at his Health Center. The head of the Health Center thinks that all of these employees contribute to the services at the Health Center both directly and indirectly. This is done by cutting the services of government employees, honorary employees and temporary employees to be distributed to the volunteers.

> This was acknowledged by Mr. Roy; "I had already discussed this in the meeting ...and all friends agreed to share. I also told them that if they wanted, it would be divided based on the existing rules and the actual performance of our friends. They would not get full ... so because all this time they are assisted by the volunteers. So, I take the middle path that part of their rights is given to the volunteer ..."

The deduction of health center staff services by the Head of the Health Center is delivered openly at the Health Center meeting and approved by the participants concerned. This is because all employees realize that their performance has not been maximized and helped by volunteer workers. This service cut is basically a local policy taken by the Head of the Health Center and does not include fraud as long as there is no indication of personal gain (Kurniawan, 2014). However, it needs attention because the potential for fraud will occur if there is an opportunity to commit fraud. Cressey in Kurniawan (2014, 8) explains that someone can betray the trust of others when he experiences financial problems, and he realizes that his problem can be solved by taking advantage of his position. This needs to be reviewed that when there is no rule that regulates the percentage of the service

deduction given to the volunteer workers, it is possible that the deduction is carried out disproportionately and not transparently and potential for fraud may occur.

Health Center Operational Costs are colored by activities from the Health Office

In utilizing operational costs, researchers found that the Health Center got pressure from several parties to carry out activities or programs beyond their needs. This was reinforced by Mrs. Nancy as treasurer of the JKN of Health Center "Kutai":

> *"In previous years, cataracts were entrusted activities from the Health Office, but in the next year no proposal for cataracts..."*
> *"Based on BPKP's findings ... for circumcision ... this is actually not under capitation, so we are confused, you know, it is not in capitation, but we are required to carry out a mass circumcision. But to overcome community complaints ... yes we still do that every year. Like mass treatment, why there is still mass treatment (it can be carried out at the Health center), why is it not treated at the Health Center. It turns out that the community request for it, usually requests from NGOs, like NU.."*

In small a Health Center, such as Health Center "Kutai", activities from health office, like cataract surgeries, are required by the health office and must be implemented even though these activities are not a mandatory program. This causes operational activities that are really needed to be ruled out and cannot be implemented. This pressure is not only from the health office, but also from NGOs that demand mass treatment activities or mass circumcision which is juxtaposed with organizational activities. Services, such as mass treatment and circumcision, can be done at the Health Center, so there is no need to operate outside the Health Center. This needs to get attention that the function of Health Center as the First Level Health Facility (FKTP) is to provide non-specialist services and there are 144 diagnoses which become its authority in accordance with the Regulation of the Minister of Health of the Republic of Indonesia No. 75 of 2014.

Confusion to Deplete Medicine

Setiaji (2015) explains that one indication of fraud is buying unnecessary goods. In the use of medicines and consumables, Thomas, the manager at the Health Center "Kalingga" admitted that the medicines purchased by the Health Center were unused. This is reinforced by Thomas's statement;

> *"You know, most of my friends complain, confused and do not know what they are used for, especially at the Health Center with a big capacity. What is that much medicine for? "*

Procurement of medicine is determined by the percentage of JKN capitation funds set by District Head, while capitation funds are determined by the number of participants registered at the Health Center. So, the health centers, with a great number of participants, have large JKN capitation funds including the procurement of medicine that follows the capitation budget limit. In reality, this is not in line with the real visit of participants to the Health Center, especially those located in remote areas and have large capitation funds. In this Health Center, the visits of BPJS patients are very low. This is due to the traditional factors of the village community who rarely visit if they are only mildly ill. The community will just come to the Health Center if the illness is severe and requires referral to the hospital, so that the medicines provided by the Health Center are not optimally used.

This condition causes abundant and unused medicines at the Health Center especially those in remote areas. The distribution of medicines has actually been distributed to all health workers in the village, but on the other hand, the villagers assume that the medicines provided by the Health Center are ineffective and cheap medicines, as conveyed by Mr. Thomas as follows,

> *"By the rules, health facilities are actually not allowed to procure medicines outside of the medicines planned here, but there are demands from the public to ask for good medicines, finally, our friends provide them. It is based on the community's suggestion ..."*

In addition the large size of the medicine limit, the abundance of medicine in the Health Center is also caused by public perception that the medicines provided by the Health Center, especially after they who know the price of the medicines on the market, and they ask for better medicines, or patented medicines. Even they are not reluctant to pay for medicines at a higher price. Therefore, inevitably health workers also provide medicines outside the medicines available at the Health Center. This condition has caused the abundance of medicines and the unused medicines provided from JKN capitation funds, especially in remote Health Centers. This needs to get attention because there is an indication that the medicines are unused, especially at the Health Center with high capacity of capitation funds but low patient visits. So, to spend the medicines, the Health Center in remote areas hold mass treatment activities at certain moments.

Confusion of the Running out of Medicine Stocks

As explained earlier, in the Health Centers with high capitalization funds but low real participant visits, they are confused to spend medicine stocks. But conversely, at the Health Centers with high patient visits but low capitation funds, they often experience medicine shortage, because they have to meet not only outpatient medicines but also inpatient medicines for JKN participants. Here is the explanation from Mrs. Nancy when confirmed about the lack of medication at her Health Center;

> *"we have to replace with other similar medicines, ... We are servants, and business must exists ... if we buy them ourselves, we will be asked where we get the money from,, what money is taken for the purchase of medicines, but we still have to do it,, plus non-capitation medicines, at least better injection, ranitidine or cefotaxim ... those are mandatory medicines ... "*

Health services at the Health Centers need adequate medicines both in quantity and quality. In Health Centers that experience medicine shortage, it is acknowledged that officers seek the availability of medicines independently. This condition indicates that in some cases, the community must increase costs for purchasing medicines, because the Health Center is experiencing medicine shortage. This is reinforced by the results of the monitoring and evaluation conducted by the Health Office which states that several Health Centers directly refer to hospitals due to unavailability of medicine. The unavailability of medicine at the Health Center is followed up by referring the patients to the hospital, or the patients can buy medicine at the officer.

The shortage of medicine stocks may occur when the procurement of medicines has not been carried out or late in delivery, as explained by Ms. Nancy as follows:

> "*Before the medicines arrived, we used medicines from PKD because of the policy of the Department Head. BPJS is allowed to use PKD,*

but PKD is not allowed to use BPJS ... when we are running out of medicines, we have to borrow, and it is only the managers who know about this.»

The unavailability of medicine occurs not only at the Health Centers with the low capacity funds but high participants visit, but also at the beginning of the fiscal year where the procurement of medicines cannot be done due to delays in APBD approval. Medicines at the Health Center consist of two sources of funding, namely PKD (Basic Health Services) which comes from Special Allocation Funds (DAK) and BPJS drugs that come from JKN capitation funds.

As explained that when JKN medicines experience a vacuum, the policy taken by the Health Office is by allowing to borrow from Village Health Polyclinic (PKD) medicines, but if PKD medicines suffer from deficiencies, PKD is not allowed to borrow JKN medicines. This policy was recognized by the medicine manager at the Health Center due to the tight supervision on JKN capitation funds by the BPK and BPKP. However, this should be further analyzed on how to address the shortage of drugs at the Health Center with high visit but small capitalization funds, because the task of the Health Center is to ensure health services for JKN participants, including medicines.

B. Potential for Fraud on JKN Non-Capitation Funds

Referring to Health Center 36 of 2015, the potential for fraud is also suspected to occur on a non-capitation basis, which can be in the form of manipulation of claims on the services that are paid using non-capitation funds. The same thing is stated by Sholihah and Prasetyono (2016) that the most common fraud in the public sector is the manipulation of accountability report and supporting documents, which has an impact on the invalidity of the financial statements prepared. However, this has not been found at the Health Center in "Hastinapura" District. This is reinforced by the statement of Mrs. Mariah as treasurer of JKN at the Health Center "Kalingga";

"The non-capitation funds are actually not absorbed well every month... because sometimes there are inpatients, but sometimes there is not ... then it's too bad ... {it is difficult to make claim, if the number of patients is small ... it doesn't match with its complication ... "

In the management of non-capitation funds, no manipulation of claims has been found. This is based on information from the treasurer of JKN Health Center stating the difficulty of the process of claiming inpatient fees because the validation process carried out by BPJS is quite long. This is reinforced by the statement of Mrs. Christina as treasurer of JKN in the Health Office:

"The problem is that claim approval from the BPJS takes a very long time, so the Health Center is lazy to convey the claims ... here there are only 4 health centers that go in... we just leave the others"

Non-capitation funds are transferred to the treasurer of JKN in the health department, which are then deposited to the regional treasury. From the regional treasury office, the funds are then absorbed by the Health Center. Before the disbursement process, every month the health centers must report the number of patients claimed for non-capitation services. Furthermore, after having feedback from BPJS related to the number of claims approved, the health centers send accountability report which

is accompanied by all supporting data using the disbursement mechanism in accordance with regional provisions, that is, through Minimum Service Standards (SPM) and Warrant for Disbursement of Funds (SP2D). The cost of hospitalization that can be claimed is in the form of staff services fees according to the medical actions taken. Besides, from the non-capitation funds, the Health Center must set aside to be deposited as regional revenue in accordance with the applicable regional regulations. This also causes JKN treasurers to be rather lazy to claim hospitalization at their health centers, especially if there are only a few inpatients. In reality, the potential for fraud that arises is that some services, that can actually be claimed, are not claimed because of the long process, for example unclaimed family planning services. This resulted in participants still having to pay for the services that actually could be claimed.

CONCLUSION

Along with the implementation of JKN, many current issues are rolling out in the community related to the JKN program, including the potential for fraud which is supported by the issuance of the Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2015 concerning Fraud Prevention. Fraud in the implementation of the JKN program is a deliberate action taken by participants, BPJS Health officers, health service providers, and providers of drugs and medical devices to obtain financial benefits through fraudulent acts that are not in accordance with the provisions. The fraudulent acts can be carried out by health care providers, that is, by the first level health facilities (FKTP) including the Health Center.

Based on the results of interviews and observations, some potential for fraud in JKN funds at the Health Center is the use of capitation funds that are not in accordance with the provisions of the law with the findings of the distribution of services fees that have the potential to cause moral hazard, the operational costs of Health Center are colored by intervention activities from the Health Department and procurement of excess medicines at remote health centers. In addition, there are additional costs due to the condition of the Health Center that are out of stock of medicines so that patients have to increase the purchase of medicines that are carried out independently or provided by the officers. Running out of stock of drugs also results in high referral rates for patients who actually can be handled by the Health Center. In non-capitation funds, the potential for fraud that arises is that participants have to pay for family planning services that can actually be claimed, due to the prolonged disbursement process.

The weakness of this study is the limited time of the researchers to examine the suitability between claims for hospitalization and real inpatients at the health center. The researchers also have not linked the referral data and patient data served at the Health Center. Therefore, further research can investigate the potential link between fraud and service performance at the health center. Based on the findings above, it is necessary to regulate the distribution of services for volunteer workers at the Health Center so that the cut which is carried out by the head of the Health Center can be controlled. In the management of drugs, the Health Office should analyze the availability of drugs with the number of real patients visiting the health center, so that there is no health center that experiences shortage of medicine while on the other hand there is no Health Center that wastes the medicine. In non-capitation funds, the Health Center can impose a capitation return on participants, in which the Health Center can charge fees especially for ongoing maternal and child services such as birth process and family planning, after the claim is made and paid, the payment can be made to the participants.

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