PUBLIC SERVICE COMPENSATION MECHANISM: LESSON FROM COMMUNITY HEALTH CENTERS PRACTICES

Laode Rudita[1], Asep Cahyana[2]
[1]Universitas Indonesia, Depok, Indonesia
[2]Universitas Gadjah Mada, Yogyakarta, Indonesia
Email: laoderudita@ui.ac.id

Abstract

The fulfillment of the community's right to obtain decent health services and public facilities remains an unmet challenge for the government. The readiness of public health service providers to ensure all service recipient rights, as mandated by law, is relatively inadequate. As one unresolved policy issue in Indonesia, public service delivery is regarding provision of compensation to service recipients for service failure or unfulfilled service standards, it is also highly urgent for health service related to ensure patient safety dan convenience. However, the mandatory Presidential Regulation regarding public service compensation mechanisms, mandated more than a decade ago, has not yet been established, leaving service providers without implementation guidelines. Therefore, this study aims to explore the urgency, attributes, and "street-level practices" of compensation mechanism policies, particularly in public health services to realize healthy cities through quality public services. This research utilizes a qualitative approach involving descriptive, analytical, and socio-legal methods, gathering primary data through literature reviews, regulatory document analysis, and in-depth interviews with two of Community Health Center (CHC or Puskesmas) heads chosen purposively based on the result of Ombudsman Assesment of Compliance (Penilaian Kepatuhan) year 2023. The findings demonstrate significant good practices and policy initiations for providing compensation by the Puskesmas Kretek in Bantul Regency, Yogyakarta Special Region and the Puskesmas Kebondalem in Pemalang Regency, Central Java. These findings provide a foundational reference for broader national policy formulation of service compensation mechanism. Expecting adoption of the CHC's compensation practices in national context, this study recommends for prioritizing compensation implementation in fully accredited health centers and outlines specific financial and non-financial compensation forms.

Keywords: *Health Service, Service Compensation, Community Health Center, Service Standard, Service Failure Recovery.*

A. INTRODUCTION

The right of every citizen to obtain health services and the state's responsibility for providing decent services are guaranteed by the Constitution (People's Consultative Assembly of the Republic of Indonesia, 2020). However, fulfilling this basic right remains a challenge for countries worldwide, including Indonesia (Japar et al., 2024). The National Long-Term Development Plan (*Rencana Pembangunan Jangka Panjang Nasional* or RPJPN) 2025-2045 identifies that health development faces challenges of demographic transition, urbanization, epidemiological changes, and unhealthy behaviors that increase the burden of communicable and non-communicable diseases, including elderly and mental health (Law 59 to 2024 concerning RPJPN 2025-2045). Therefore, the health system must be responsive to changes, technology, pandemic threats, and inequality in access to health facilities, medical personnel, and medicines, while strengthening financing through innovation and resource mobilization.

In the National Medium-Term Development Plan (*Rencana Pembangunan Jangka Menengah Nasional* or RPJMN) 2025-2029 (Presidential Decree 2025 concerning RPJMN 2025-2029), the Government of Indonesia (GOI) established 20 Super Priority Transformation Efforts (Game Changers) divided into five transformation sectors: Social, Socio-Cultural and Technological, Economic, Governance, and Legal, Stability, and Leadership. Transformation in the health sector falls under Social Transformation, specifically the restructuring of health management (Super Priority Transformation 3) and investing in primary health care (Super Priority Transformation 4). This shows the government's great attention to resolve problems in the health sector as soon as possible, especially alleviating stunting, communicable diseases, and neglected tropical diseases such as tuberculosis and leprosy. To realize Superior Indonesian Human Resources, health sector transformation is placed in Phase 1 (2025-2029), indicating that health transformation is fundamental, serving as a foundation for subsequent phases. If Phase 1 is not successfully achieved, it will be difficult to realize the next phases as a prerequisite for Golden Indonesia 2045.

To achieve social transformation in the health sector, policies are needed that lead to an increase in health efforts, alongside a resilient and responsive health system. Improving health efforts emphasizes increasing public health initiatives, expanding comprehensive primary health investments to the village level, and fulfilling the quality of health services responsive to community needs, including reducing waiting times (Ministry of National Development Planning/Bappenas, 2024). This must be implemented comprehensively across Village, Sub-district, District, and Regency/City levels.

Furthermore, as affirmed in the *Asta Cita* (the Eight Ideals of the President of the Republic of Indonesia) outlined in the RPJMN 2025-2029, health development is included in the 4th ideal and the 7th Priority Program: "guaranteeing the availability of health services for all Indonesian people." In addition, one of the eight Quick Wins established relates to health services, namely free medical check-ups. This free health screening program is provided to all Indonesian people on their birthdays and is carried out at Community Health Centers (hereafter referred to as CHC or Puskesmas) (Muhawarman, 2024). This affirms that improving the quality of health services at the Puskesmas, as the primary health facility closest to the community, is crucial in realizing the *Asta Cita*.

Realizing the vital position of the Puskesmas, the Government issued Minister of Health Regulation Number 19 of 2024 concerning the Implementation of Community Health Centers. In this regulation, the Puskesmas serves as the first-level health facility closest to the community and the first point of contact for health services, tasked with organizing and coordinating promotive, preventive, curative, rehabilitative, and/or palliative services. As primary health care, the Puskesmas has three integrated goals: fulfilling health needs in every phase of life, improving health determinants (social, economic, commercial, and environmental), and strengthening individual, family, and community health. Health services at the Puskesmas have transitioned from being Polyclinic-based to Cluster-based, consisting of the Management Service Cluster, Maternal and Child Service Cluster, Adult and Elderly Service Cluster, Communicable Disease Control and Environmental Health Service Cluster, and Cross-Cluster Service Support. The regulation also emphasizes the importance of improving health service quality at the Puskesmas, both internally and externally, continuously and sustainably. This requires quality indicators for measuring and reporting quality over time.

Health services, including those provided at the Puskesmas, are fundamentally part of public services. According to Health Law Number 17 of 2023, obtaining safe, quality, and affordable health services is a universal right. This aligns with Public Service Law Number 25 of 2009, which categorizes health services at hospitals and health centers as public services. The Public Service Law mandates that providers deliver quality services in accordance with established service standards.

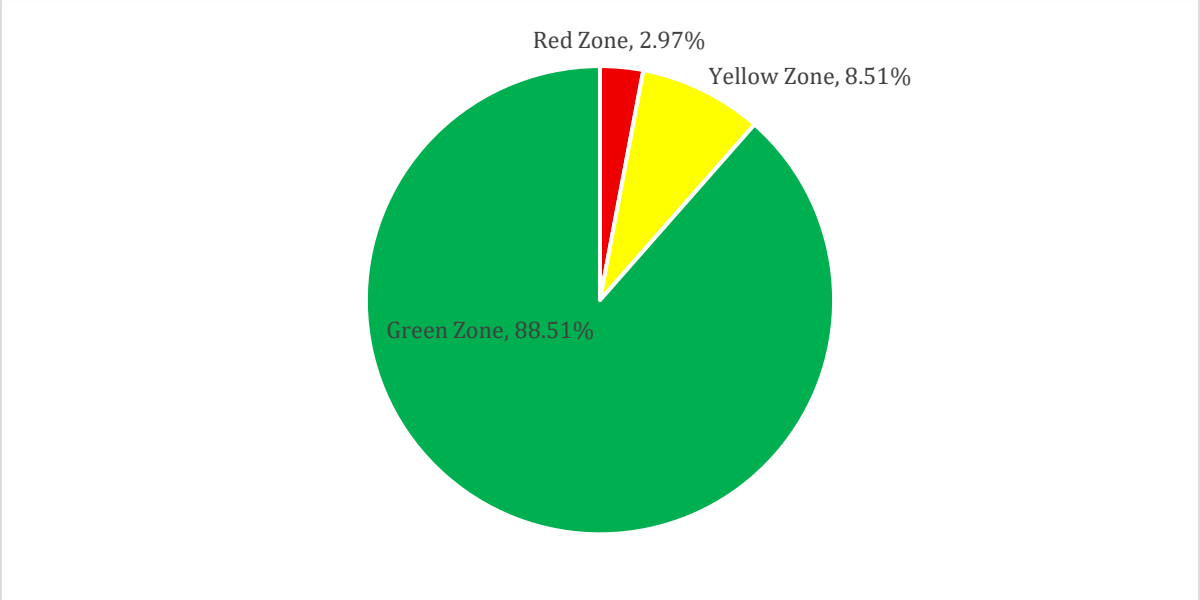

Figure 2. Distribution of Puskesmas Compliance Assessment Zoning
Source: ORI (2024)

The fulfillment of service standards by the Puskesmas is reflected in the Puskesmas Compliance Assessment results by Ombudsman of the Republic of Indonesia (ORI, 2024). In 2024, out of 1,013 Puskesmas assessed, 814 (88.51%) entered the Green Zone, 86 (8.51%) entered the Yellow Zone, while 30 (2.97%) were in the Red Zone. Based on dimension fulfillment weights, the average input dimension was 87.46%, process dimension 90.15%, output dimension 90.59%, and complaint dimension 87.93%. This data shows that, generally, the Puskesmas have successfully provided required service standards. The crucial next step is ensuring this service quality continually improves. Therefore, it is important to examine the relevance of applying compensation for unfulfilled services at the Puskesmas.

In public sector, the services received by citizen as user are sometimes not in accordance with the standard. It reflects the occurrence of service failures in public services in accordance with predetermined norms or standard, resulting loss experienced by the user both economically (time, money) and socially (status, self-esteem) in various types and levels (Thomassen et al., 2017; Van de Walle, 2016). As an instrument of control and evaluation to maintain continuous quality, the Public Service Law includes a policy of compensation for services that fail to meet standards (Gelbrich, 2015, 2016). This feature is essentially the service provider's response to user complaints and a recovery effort for service failures (Hocutt and Bowers 2005; Thomassen et al, 2020; Bae et al., 2020).

Service compensation could be in finansial and/or nonfinancial forms, including apology and philantropy (Gelbrich, 2016; Thomassen et al, 2020). The compensation in any forms provides several benefits: it increases distributive and interactional justice, generates user satisfaction, improves the provider's image, and strengthens partnerships between providers and users (Thomassen et al., 2017; Bae et al., 2020; Yu et al., 2019). Provision of compensation signals to users that the provider takes complaints seriously, while indicates the providers that service improvements are necessary (Innovative Public Services Group, 2008).

Theoretical and practical references internationally demonstrate that service compensation features are vital for ensuring standard implementation and quality. However, the implementation of this policy feature in public services delivery context, particularly in public health service of developing country remains underexplored. In Indonesia context, although the Law Number 25 of 2009 mandated a Presidential Regulation on compensation mechanisms more than a decade ago, it remains unestablished, hindering compensation implementation for poor services (Rudita, 2023). Principled issues emerging in the draft

Presidential Regulation discussions include which providers need to enforce it, the types of services and standard components involved, and the form and value of the compensation (Cahyana, 2022). A 2020 letter from the State Secretary to the Ministry of Administrative and Bureaucratic Reform stated the need for criteria identifying which providers can enforce compensation and simulations of its implementation (Cahyana, 2022). Consequently, good practices developed at the provider level must be identified for policy adoption.

Therefore, this study aims to explore urgency, attributes, and "street-level practices" of compensation mechanism policies, particularly in public health services to realize healthy cities through quality public services. The existence and role of the Puskesmas are crucial in providing universal health services for citizen and realizing healthy cities/regencies. Providing a compensation feature for standard fulfillment as mandated by the Public Service Law and Health Law is a critical step to ensure continuous quality improvement of the public health service. However, this obligation lacks adequate "top-down" procedural and technical policy guidelines by the government, resulting a potential opportunity to recommend some policy alternatives through "bottom-up approach" based on street-level practices.

This study aims to examine and formulate an appropriate compensation mechanism for public health services in Indonesia, particularly in *Puskesmas*. Specifically, the study seeks to explore how compensation mechanisms are understood and implemented in *Puskesmas* services, identify which services should adopt such mechanisms based on accreditation level, service type, and components of service standards, and determine the most relevant forms of compensation in terms of types, values, procedures, and implementation. Based on the empirical findings, the study also aims to develop evidence-based policy recommendations for the implementation of service compensation mechanisms in *Puskesmas* to strengthen service quality, accountability, and patient satisfaction.

B. METHOD

This research utilized a qualitative approach. According to Creswell (2014), qualitative research is an approach to exploring and understanding the meaning that individuals or groups ascribe to a social problem. This qualitative research applies descriptive, analytical, and socio-legal methods. The goal is to deepen and enrich the results of previous data. Data were collected through literature studies, document analysis, laws and regulations, and in-depth interviews Laws and Regulations analyzed consist of Law Number 25 of 2009 concerning Public Services, Law Number 17 of 2023 concerning Health, Regulation of the Minister of Health Number 43 of 2019 concerning Community Health Centers, and other related policies such as the National Long-Term Development Plan (RPJPN 2025-2045).

Primary data were collected through depth-interviews using open-ended questionnaires. Interviews were conducted in December, 2024 - Januari, 2025 to the informants from Health Service Providers at the Puskesmas, consisting of the Head of the the Puskesmas Kretek in Bantul Regency, Yogyakarta Special Region and the Puskesmas Kebondalem in Pemalang Regency, Central Java. The informants were chosen purposively based on the result of Ombudsman Assesment of Compliance (Penilaian Kepatuhan) year 2023. Qualitative data analysis was carried out using a Framework Analysis approach, adjusting the data to the predetermined research framework (Matson, 1981; Srivastava & Thomson, 2009).

C. RESULTS AND DISCUSSION

The study reveals paradox of "stuck" in national policy of compensation mechanism in one side, and the policy initiatives and implementation in the street level of public healthcare service in other side. Although the Presidential Regulation acting as the implementing regulation of the Public Service Law which regulates the compensation mechanism for unfulfilled service standards has not yet been issued, there are existing good practices in

applying compensation policies by service providers, particularly in public healthcare. Awareness of the importance of providing compensation due to unfulfilled health service standards does not merely arise from statutory obligations; rather, it stems from the providers' awareness of their duties as service providers and their empathy towards the community requiring health services. This awareness and empathy foster a high sense of responsibility in service delivery. For example, the Kretek Puskesmas in Bantul Regency realizes the importance of apologizing and providing explanations for health service delays, viewing this as a standard courtesy for service providers (Interview, 2024). Additionally, the push to provide service compensation policies in the Puskesmas has also been advocated by the Ombudsman RI for several years through Ombudsman Assesment of Compliance (Penilaian Kepatuhan) program (Interview, 2024; ORI, 2023).

Based on this awareness and encouragement, service compensation at the Kretek Puskesmas was first formalized in 2023 through the Decree of the Head of Kretek Puskesmas Number 440/0119/Kapus/V/2023 dated May 20, 2023, concerning Compensation for Service Delays at Kretek Puskesmas. Through this policy, there are three categories of compensation provision at Kretek Puskesmas:

a. Category I: Service delay of < (less than) 30 minutes; compensation is provided in the form of an apology and an explanation to the service user.
b. Category II: Service delay of 30 to 60 minutes; compensation is provided in the form of drinking water.
c. Category III: Service delay of > (more than) 60 minutes; compensation is provided in the form of drinking water and a souvenir.

With this relatively simple policy, the compensation provided by Kretek Puskesmas is currently limited to service delays. Furthermore, compensation is only provided if there are complaints from the community. Complaint handling team formed by the Puskesmas head has an authority to decide whether or not the compensation are awarded after conducting analysis and assesment to the complaint.

The Kebondalem Puskesmas in Pemalang Regency, Central Java, also has a Health Service Compensation Policy. Through the Decree of the Head of Kebondalem Puskesmas Number 083 of 2023 concerning the Provision of Compensation for Service Recipients Not in Accordance with Kebondalem Puskesmas Service Standards, the health center provides compensation in the following forms and categories:

a. Apologizing for services that do not comply with applicable service standards. This is done if officers do not apply the 5S principles (*senyum, sapa, salam, sopan, santun* - smile, greet, salute, polite, courteous) or if officers do not arrive on time due to official duties.
b. Providing priority service on the next visit by issuing a Priority Card from Kebondalem Puskesmas. This can be given if a patient is dissatisfied and complains via the suggestion box, or if a team meeting determines the patient is entitled to priority service.
c. Providing drinks on the next visit. This is given if officers do not apply the 5S, officers are late due to duties, the patient experiences a near-miss incident, or officers are absent due to Force Majeure while the patient urgently requires service that day.
d. Home delivery of products. This is done if officers do not apply the 5S, officers provide service exceeding intolerable time limits while the patient (or family member) complains due to other urgent matters, or if the patient experiences a near-miss incident.

Judging by the forms of compensation available, the Kebondalem Puskesmas policy appears slightly more comprehensive than that of Kretek Puskesmas. However, compensation is still largely reactive provided only when service recipients submit complaints and the policy has not been socialized to the public, leaving the community unaware of their rights when service standards fail.

The initiation of these compensation policies by both Puskesmas is highly commendable, despite existing shortcomings that require rectification, such as limiting compensation primarily to service delays, requiring formal complaints prior to compensation, and lacking public socialization. These deficiencies can be improved through policy evaluation. On the other hand, the strengths of these initial policies include providing compensation that goes beyond mere physical goods (water or souvenirs) to include priority services or home delivery of service products.

Based on these findings, the implementation of the Health Law must adopt compensation features to encourage continuous health service quality improvement. This includes Puskesmas services as the spearhead of public health services, as affirmed in the RPJPN 2025-2045 and the President's *Asta Cita*.

Prioritizing which Puskesmas implement compensation can be based on location (urban, rural, remote, highly remote), accreditation level (*Paripurna*, *Utama*, *Madya*, *Dasar*), and service standard readiness. The types of compensated services can also be adjusted to the Puskesmas's accreditation level, focusing on individual service clusters (Maternal and Child, Adult and Elderly, Cross-Cluster Support) and/or the most frequently accessed services, whether goods, services, or administrative. Standard components eligible for compensation should be limited to non-compliance with requirements, procedural deviations, delays, cost discrepancies, and service product damage. Compensation should primarily be non-financial, tailored to local wisdom, violation types, and accreditation levels. Limited financial compensation may be included for highly accredited Puskesmas based on impact scale, accompanied by rewards and cross-stakeholder support. The compensation mechanism should align with the violation type whether provided spontaneously by the provider or via user complaint supported by a dedicated team and community empowerment. The success of compensation implementation can be measured gradually: increased initiatives (Years 1-3), decreased requests (Years 4-8), and sustainable service quality (Years 9-10).

As the government belongs to its citizens, public administrators must serve and empower citizens through the proper management of public organizations and the implementation of public policies. Therefore, citizens should be at the forefront, and the government's emphasis should be placed on building public institutions that possess integrity and responsiveness (Denhardt & Denhardt, 2000). The Puskesmas is tasked with organizing and coordinating promotive, preventive, curative, rehabilitative, and/or palliative Health Services, prioritizing promotive and preventive efforts within its working area. In carrying out these duties, the Puskesmas functions as the primary health care provider closest to the community. These primary health services are integrated to meet health needs in every phase of community life (Minister of Health Regulation No. 19/2024).

a. Criteria for Puskesmas Organizing Compensation

To ensure health services operate effectively, efficiently, and equitably according to regional needs and geographical conditions, the government classifies the Puskesmas. Based on Permenkes 19/2024, the Puskesmas are categorized by working area characteristics (non-remote, remote, highly remote) and service capabilities (non-inpatient, inpatient), where non-remote health centers consist of rural and urban health centers.

As an integral part of primary health care facilities, the Puskesmas must address the main challenge of basic health services: providing and maintaining service quality continuity. According to Minister of Health Regulation Number 34 of 2022, one effort to improve Puskesmas service quality is through accreditation. Accreditation aims to: a) improve and guarantee service quality and safety for patients and the community; b) increase protection for health human resources and institutions; c) improve organizational and service governance; and d) support government health programs.

According to the Decree of the Minister of Health No. Hk.01.07/Menkes/165/2023

concerning Community Health Center Accreditation Standards, standards are grouped by essential organizational functions. They focus on patient care provision (good care governance) and creating safe, effective (good corporate governance), well-managed organizations. Accreditation Standards consist of 5 Chapters:

1). Puskesmas Leadership and Management: Planning and access, organizational governance, human resource management, facility and safety management, financial management, supervision, control, and performance assessment.
2). Implementation of Public Health Efforts (UKM): Integrated planning, access, mobilization, coaching, strengthening via PIS-PK, essential and developmental UKM implementation, and performance assessment.
3). Implementation of Individual Health Efforts (UKP), Laboratory, and Pharmacy: Clinical services, assessment/care plans, emergency services, local anesthesia, nutrition, discharge/follow-up, referrals, medical records, laboratory, and pharmaceutical services.
4). National Priority Programs: Stunting prevention, reducing maternal/infant mortality, improving immunization coverage/quality, tuberculosis control, and non-communicable disease control.
5). Puskesmas Quality Improvement (PMP): Continuous quality improvement, risk management, patient safety goals, incident reporting, and infection prevention/control.

The accreditation levels, from highest to lowest, are: *Paripurna* (Plenary or Fully Accredited), *Utama* (Main), *Madya* (Intermediate), *Dasar* (Basic), and Not Accredited.

In practice, compensation has been implemented at Kebondalem Puskesmas in Pemalang (urban, non-inpatient) and Kretek Puskesmas in Bantul (rural, inpatient). Both have achieved *Paripurna* Accreditation and the Highest Compliance (Green Zone) in the Ombudsman RI Assessment.

While compensation can theoretically be implemented at any Puskesmas to guarantee quality, practical execution depends heavily on the facility's readiness to meet service standards. Therefore, prioritization is necessary. This study recommends:

1). Service compensation should be prioritized in urban and rural Puskesmas, then gradually rolled out to remote and highly remote Puskesmas, both inpatient and non-inpatient.
2). Compensation should be prioritized by accreditation level: mandatory for *Paripurna* and *Utama*, and optional for *Madya* and *Dasar*.
3). Compensation should align with Ombudsman RI Compliance Assessment results (Green, Yellow, Red Zones) or alternative institutional assessments indicating standard readiness.

b. Types of Services Provided with Compensation

According to the Public Service Law, service types include goods, services, and administrative services. Under Permenkes 19/2024, Puskesmas services include Management, Maternal/Child, Adult/Elderly, Communicable Disease/Environmental Health, and Cross-Cluster Support. While compensation can theoretically apply to all clusters, considering direct community benefits and provider capabilities, this study recommends that Puskesmas compensation policies:

1). Focus on the Maternal and Child, Adult and Elderly, and Cross-Cluster Support Clusters, as these relate directly to individual patients, making compensation recipients easier to identify.
2). Focus on the most frequently accessed services, such as goods (medicine availability, inpatient rooms), services (doctor examinations, lab sampling), and

administrative tasks (referral letters, sick notes).

3). Exclude the Management Cluster (internal focus) and Communicable Disease/Environmental Health Cluster, as disease response often involves Force Majeure characteristics or systemic (non-individual) environmental health interventions.

4). Scale with accreditation; higher accreditation levels should offer compensation for a wider variety of services.

c. Components of Service Standards Provided with Compensation

The Public Service Law outlines 14 mandatory service standard components. Six must be published according to PANRB Ministerial Regulation No. 15 of 2014: 1) requirements, 2) systems/mechanisms/procedures, 3) service duration, 4) costs/tariffs, 5) service products, and 6) complaint handling.

Beyond delays, compensation is also practically applied for arbitrary service denial, ignored procedures, unfriendly staff (lacking 5S), equipment failure, uncomfortable infrastructure, queue discrepancies, and damaged service products (Cahyana, 2022). Kretek Puskesmas limits compensation to delays, while Kebondalem Puskesmas includes lack of 5S, officer tardiness (duty/force majeure), exceeded time limits, patient dissatisfaction, or near-miss incidents. Therefore, recommended standard components for compensation include:

1). Requirements: When providers impose unwritten or unauthorized requirements.

2). Mechanisms/Procedures: When staff fail to apply procedures, such as disorganized queuing or "ping-ponging" patients without clarity.

3). Duration: Unreasonable waiting times or staff tardiness without legal cause.

4). Costs: Charging unauthorized fees for ostensibly free services.

5). Service Products: Damaged medication, data errors on referral letters, etc.

d. Types, Values, and Forms of Compensation

Service compensation can be financial and/or non-financial, including apologies, staff empowerment, or social contributions. Citizen Charter practices in Spain, the Netherlands, and Estonia include gift coupons, home delivery for delayed services, flower coupons, priority queues, donations, bicycle light repairs, theater tickets, and formal apologies (Cahyana & Rudita, 2025). In India, compensation includes apologies, explanations, guarantees of non-repetition (backed by monitoring), corrective actions, and financial payouts. In the UK healthcare sector, financial compensation follows the "putting things right" principle restoring the affected person to their rightful position. The Parliamentary and Health Service Ombudsman developed a six-level compensation scale based on severity (Ombudsman UK, 2025).

Table 1. Financial Compensation Levels in UK Health Services

Level	Severity Level	Compensation
Level 1	Low-impact injustice such as annoyance, frustration, worry, or inconvenience	£0 / Apology
Level 2	Errors with relatively low impact on the affected person, resulting in mild distress, inconvenience, or pain	£120 - £550
Level 3	Moderate impact on the affected person (e.g., regarding distress, worry, or inconvenience)	£600 - £1,200
Level 4	Significantly affected and/or long-lasting impact affecting their ability to live a relatively normal life	£1,250 - £3,700
Level 5	Marked and detrimental effect on the ability to live a relatively normal life	£3,750 - £12,450
Level 6	Most serious impact, involving profound, devastating, or irreversible effects on the affected person	£12,500 or more

Domestic practices are grouped into four clusters: material, immaterial, additional

services, and priority services (Cahyana, 2022). Material compensation includes money, equivalent-value goods, free product replacements, snacks/drinks, and souvenirs (pens, mugs, t-shirts). Immaterial compensation includes apologies, written explanations, special attention, staff evaluation, and appreciation (cards or social media shoutouts). Additional services involve free re-services, queue-free re-services, free product delivery, after-hours service, bonus time, or free medical check-ups. Priority services include priority parking, queuing, seating, and timing on subsequent visits.

The current forms at the Puskesmas are relatively basic. Kretek offers apologies, explanations, water, and pens for delays. Kebondalem offers apologies, priority cards, drinks, and home delivery based on specific violations. Therefore, this study recommends that Puskesmas compensation should:

1). Be primarily non-financial (material, immaterial, additional, or priority services) drawing from best practices.
2). Be tailored to local wisdom and the provider's financial capabilities, as the Puskesmas generally have limited financial resources.
3). Align with the specific violation and its impact, ensuring relevance to restoring user satisfaction.
4). Scale with accreditation; higher-accredited Puskesmas should offer greater compensation value/variety.
5). If financial compensation is implemented, it should:
    a). Be restricted to highly accredited Puskesmas that have successfully managed non-financial compensation.
    b). Utilize a central Government-designed scale based on recipient impact.
    c). Involve financial rewards for successfully implementing Puskesmas.
    d). Involve cross-stakeholder support (Central/Regional Gov, BPJS Health) since FKTP revenues rely on APBD and BPJS Capitation Funds.

e. Compensation Provision Mechanism

Service compensation benefits the recipient, the provider, and the overall service system. Theoretically and practically, it can follow user complaints or be a proactive provider initiative to maintain quality. Both approaches are utilized globally and at Kretek and Kebondalem Puskesmas. Therefore, regarding the mechanism, this study recommends:

1). For visible violations (e.g., delays), compensation should be spontaneous and proactive, without requiring a complaint.
2). For violations requiring proof, compensation can follow a verified complaint from the recipient or their proxy.
3). The Head of the Puskesmas must establish a dedicated team to manage compensation, potentially integrated with complaint or quality assurance teams.
4). Community empowerment is essential to support the compensation feature through socialization, education, advocacy, and affirmation.

f. Measurement/Evaluation of Compensation Implementation

Compensation serves three goals: guaranteeing rights/recovering losses for the public, establishing provider accountability, and continuously improving systemic quality. Therefore, this study recommends measuring success across three levels:

1). Level 1 (Years 1-3): An increase in compensation initiatives/processed requests indicates positive implementation from the user's perspective.
2). Level 2 (Years 4-8): A subsequent decrease in necessary initiatives/requests indicates improved accountability and reduced service failures.
3). Level 3 (Years 9-10): Minimal compensation requests, accompanied by a robust service culture and continuous quality improvement.

g. Compensation Scheme in non healthy service (as Comparison from private)

While there are various compensation schemes in the private and semi-public domains, these are less common in Indonesia's core public organizations. Public organizations also differ in whether they explicitly promise to compensate for service failures (Thomassen et al., 2017). However, the new public management (NPM) reforms in Indonesia have required public service organizations to adopt similar good practices as in the private sector. The NPM paradigm requires that public organizations implement laws and regulations and provide maximal service satisfaction to consumers or citizens (serving rather than steering) (Denhardt & Denhardt, 2000).

In Indonesia, among the public services that provide compensation to service recipients for losses arising from failure to meet service standards is air transportation services, especially in terms of service delays. However, the losses experienced due to delays in air transportation services are not as great as the potential losses from delays in health services which pose a risk to life safety.

Aircraft public services in Indonesia have exemplary compensation schemes for passengers experiencing losses from flight delays that do not require a complex complaint-handling procedure. Based on the Minister of Transportation Regulation Number 89 of 2015 regarding "Delay Management in Commercial Air Transport Business Entities (Article 6)," air transport business entities are responsible for all flight delays resulting from airline management factors and must compensate the passenger for losses from the non-fulfillment of service completion standards related to airline management, including:

1). Pilots, co-pilot, and cabin crew delays;
2). Catering service delays;
3). Handling delays on land;
4). Passenger delays related to late check-in, transfers, or connecting flights; and
5). Aircraft unpreparedness (Article 5 (2))

However, aviation business entities are not responsible for delays or losses arising from non-management related factors or Force Majeure, such as the weather (heavy rain, flooding, lightning, storms, fog, smoke, visibility below the minimum standard, or wind speeds that exceed the maximum standard that interferes with flight safety), operational technical factors caused by airport conditions at the time of departure or arrival, or other factor such as riots and/or demonstrations in the airport area (Article 5 and Article 6 (2)). To ensure that compensation is paid, airlines must provide executive officers (managerial level) with the full authority to make decisions in the field to deal with passengers who experience flight delays (Article 8). Officers must be highly responsive, empathetic, attentive, and caring and must assist passengers to rearrange their travel plans before they complain.

To more easily determine the compensation types, the compensation schemes are divided into six categories, as follows:

1). category 1: for 30–60-minute delays, the compensation is a soft drink;
2). category 2: for 61–120-minute delays, the compensation is drinks and a snack box;
3). category 3: for 121–180-minute delays, the compensation is drinks and a heavy meal;
4). category 4: for 181–240-minute delays, the compensation is drinks, a snack box, and a heavy meal;
5). category 5: for a delay of more than 240 minutes, the compensation is 300,000 rupiahs (three hundred thousand rupiahs);
6). category 6: if a flight is canceled, the airlines must assign the passengers to the next available flight or refund the entire ticket cost (refund ticket); and
7). for delays in categories 2–5, passengers can be also transferred to the next

available flight or the entire ticket cost refunded (refund ticket).

These categories provide legal certainty for both the service providers who provide the compensation and the citizens who are harmed by these various circumstances. These arrangements also minimize injustices or abuses of authority when providing compensation. The compensation must be provided without question by officers on behalf of the airlines (Article 3 and Article 9 Regulation of the Minister Transportation No. 89 of 2015) When a flight is delayed and meets one of these six categories, the officer mustactively and directly compensate the passenger and must not wait for the passenger to complain. Rather than waiting for customers or citizens to complain, this type of active, responsive, compensation mechanism should apply to all public service providerswhen citizens suffer losses from the non-fulfillment of service standards.Scheduled commercial air transport business entities must have Standard Operating Procedures (SOPs) in the Indonesian language43for delay management to ensure that the community understands the procedures when service standards are not met. All public service providers should also have SOPs in their service standard sections to actively deal with citizen losses from the non-fulfillment of service standards.

Public service compensation from service delays or cancellations of the above services, can be emulated by community health centers (Puskesmas), especially in relation to the compensation mechanism which does not require complaints from service recipients who experience losses, where the initiation of compensation must be given immediately when there is a delay in service. Moreover leveling of compensation, and types of compensation which can be financial or non-financial. The compensation given should be commensurate with the loss experienced, or at least close to it.

D. CONCLUSION

Citizens' rights to health services and the state's responsibility to provide decent services are constitutionally guaranteed. The role of the Puskesmas is critical in providing universal health services for citizen and realizing healthy cities and regencies. In accordance with the Public Service Law and Health Law, compensation mechanisms are essential features needed to ensure the continuous improvement of Puskesmas service quality, encouraging providers to deliver proactive and maximized care. Despite of inadequate “top-down” procedural and technical policy guidelines by the national government, the opportunity to recommend some policy alternatives through “bottom-up approach” comes from street-level practices. The study finds significant good practices and policy initiations for providing compensation by the Puskesmas Kretek in Bantul Regency, Yogyakarta Special Region and the Puskesmas Kebondalem in Pemalang Regency, Central Jawa, as well as a comparison of compensation mechanism from privat service (aviation). These findings provide a foundational reference for broader national policy formulation of service compensation mechanism. Expecting adoption of the CHC’s compensation practices in national context, this study emphasizes the urgency of establishing these compensation policies and offers concrete recommendations covering Puskesmas criteria, service types, compensated standard components, compensation forms and values, delivery mechanisms, and evaluation metrics for success. It recommends for prioritizing compensation implementation in fully accredited health centers and outlines specific financial and non-financial compensation forms.

REFERENCES

Bae, G., Lee, S., & Kim, D. Y. (2020). Interactions between service recovery efforts and customer characteristics: Apology, compensation, and empowerment. *Journal of Quality Assurance in Hospitality & Tourism*, 22(2), 218–244.

Cahyana, A. (2022). *Analisis Multiple Streams Approach Terhadap Penghambat Agenda*

Kebijakan Ganti Rugi Pelayanan Publik di Indonesia (Doctoral Dissertation, Universitas Gadjah Mada).

Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*. SAGE Publications Inc.

Denhardt, R. B., & Denhardt, J. V. (2000). The new public service: Serving rather than steering. *Public Administration Review*, 60(6), 549.

Gelbrich, K. (2015). How much compensation should a firm offer for a flawed service? An examination of the nonlinear effects of compensation on satisfaction. *Journal of Service Research*, 18(1), 107–123.

Gelbrich, K. (2016). How a firm's best versus normal customers react to compensation after a service failure. *Journal of Business Research*, 69(10), 4331–4339.

Japar, M., Semendawai, A. H., & Fahruddin, M. (2024). Hukum kesehatan ditinjau dari perlindungan hak asasi manusia. *Jurnal Interpretasi Hukum*, *5*(1), 952-961.

Keputusan Kepala Puskesmas Kebondalem Nomor 083 Tahun 2023 tentang Pemberian Kompensasi Bagi Penerima Layanan Tidak Sesuai Standar Pelayanan Puskesmas Kebondalem.

Keputusan Kepala Puskesmas Kretek Kabupaten Bantul Nomor 440/0119/Kapus/V/2023 tentang Kompensasi Keterlambatan Pelayanan Pada Puskesmas Kretek.

Matson, M. C. (1981). Policy implementation and policy failure: a framework for analysis applied to the case of the community land scheme (UK). *Leeds Polytechnic, School of Planning and Environmental Studies, Planning Papers*, *25*.

Peraturan Menteri Perhubungan Nomor 89 Tahun 2015 tentang Penanganan Keterlambatan pada Badan Usaha Angkutan Udara Niaga.

Peraturan Menteri Pendayagunaan Aparatur Negara dan Reformasi Birokrasi Nomor 15 Tahun 2014 tentang Pedoman Standar Pelayanan.

Peraturan Menteri Kesehatan Nomor 43 Tahun 2019 tentang Pusat Kesehatan Masyarakat.

Peraturan Menteri Kesehatan Nomor 34 Tahun 2022 tentang Akreditasi Puskesmas, Klinik, Laboratorium Kesehatan, Unit Transfusi Darah, Tempat Praktik Mandiri Dokter, dan Tempat Praktik Mandiri Dokter Gigi.

Keputusan Menteri Kesehatan No. Hk.01.07/Menkes/165/2023 tentang Standar Akreditasi Pusat Kesehatan Masyarakat.

Ministry of National Development Planning/Bappenas. (2014). *Ringkasan Rancangan Awal RPJMN 2025-2029*. Ministry of National Development Planning/Bappenas.

Muhawarman, A. (2024). *Kemenkes Cek Kesiapan Quick Win Pemeriksaan Kesehatan Gratis di Puskesmas Sumba Barat Daya*. Retrieved from: https://kemkes.go.id/id/kemenkes-cek-kesiapan-quick-win-pemeriksaan-kesehatan-gratis-di-puskesmas-sumba-barat-daya

Ombudsman of the Republic of Indonesia. (2024). *Hasil Penelitian Kepatuhan Puskesmas 2024*. Jakarta: Ombudsman of the Republic of Indonesia.

Ombudsman UK, Parliamentary and Health Service Ombudsman. (2025). *Financial remedy*.

Srivastava, A., & Thomson, S. B. (2009). Framework Analysis : A Qualitative Methodology for Applied Policy Research. *Journal of Administration & Governance*, *4*(2), 72–79.

Thomassen, J. P., Leliveld, M. C., Van de Walle, S., & Ahaus, K. (2017). Compensating citizens for poor service delivery: Experimental research in public and private settings. *Public Administration*, 95(4), 895–891.

Undang-Undang Dasar Negara Republik Indonesia.

Undang-Undang Nomor 25 Tahun 2009 tentang Pelayanan Publik.

Undang-Undang Nomor 59 Tahun 2024 tentang Rencana Pembangunan Jangka Panjang Nasional Tahun 2025-2045.

Walle, S. Van de. (2016). When Public Service Fail: A Research Agenda on Public Service

Failure. *Journal of Service Management*, *27*(5).

Yu, W. H., Chiu, S. K., & Tung, C. M. (2019). The study of evolution among logistic service quality, service compensation and long-term cooperation commitment. *Procedia Manufacturing*, 39, 1493–1500.