INDONESIA IMPLEMENTATION RESEARCH
UNIVERSAL HEALTH COVERAGE

POLICY BRIEF

Strengthening Primary Care as the Foundation of JKN

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Introduction

Central to the vision of JKN and the Government of Indonesia's commitment to enhancing the health of all of its citizens is strengthening the role of primary care to prevent, treat and manage health conditions. How it is working, what the challenges are, and where might changes to regulations or operationalization of JKN contribute to strengthening the system so that JKN can achieve its goals. This brief focuses on JKN regulations at the primary care level, and shares insights into whether regulations are effective and how they are being implemented in a range of Indonesian contexts.

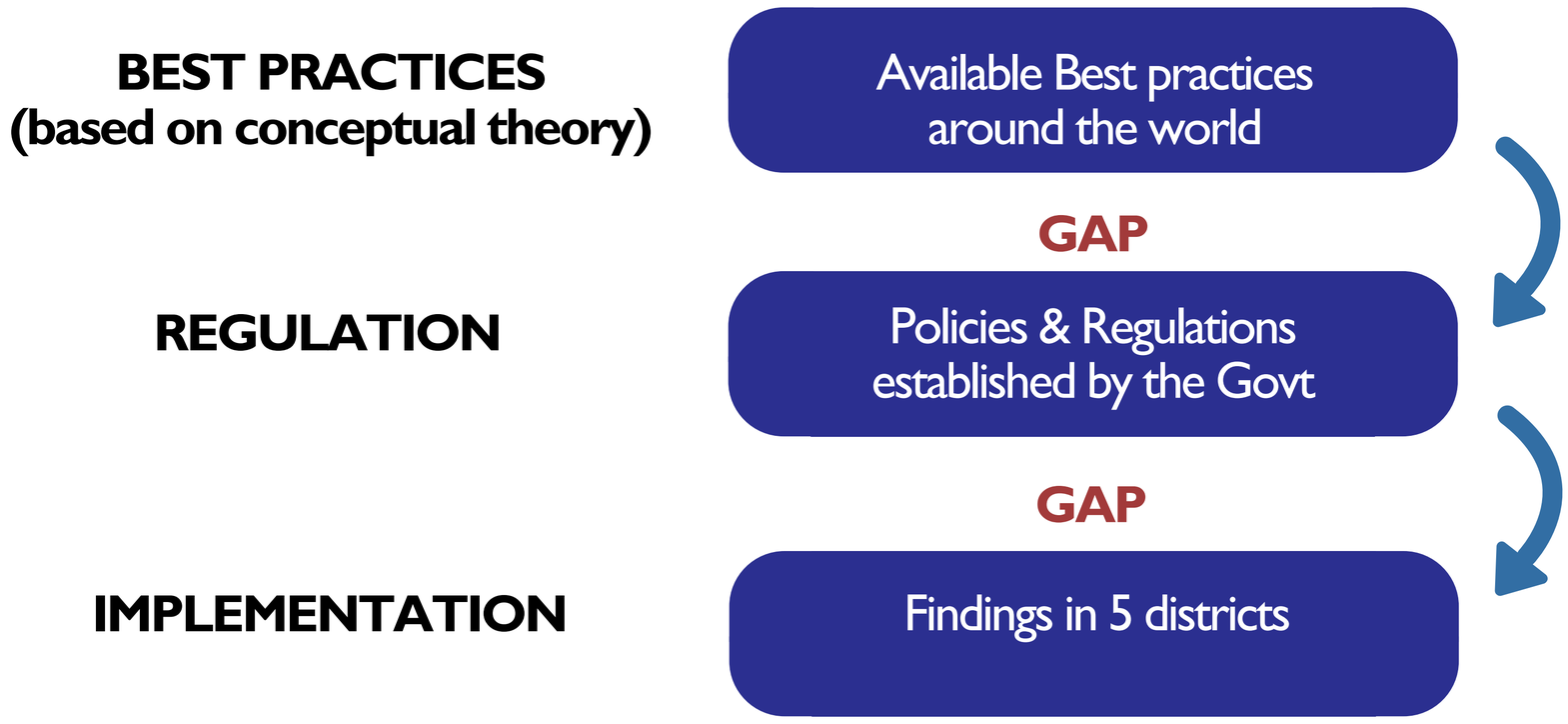
Implementation research to strengthen primary care under JKN

CHPM UGM in collaboration with Center of Health Financing and Insurance, Ministry of Health, supported by USAID's Health Finance and Governance Project, conducted implementation research to understand how JKN regulations on primary care are being implemented at the district level. The aim of the research is to help ensure an effective role for primary care as gatekeeper for JKN, and to support Indonesia's progress toward universal health coverage.

CHPM and its university partners from the Indonesia Health Policy Network carried out the research in five districts in four provinces: Tapanuli Selatan (North Sumatera), Jakarta Timur (DKI Jakarta), Jember (East Java); Jayapura City and Jayawijaya (Papua). The research team mapped the various JKN and other regulations affecting primary care; interviewed more than 100 respondents in 88 primary health care facilities, and conducted focus group discussions among representatives of the District Health Office, Financing Office and Inspectorate, and Health Social Security Agency (Badan Penyelenggara Jaminan Sosial – Kesehatan/ BPJS Kesehatan) in each district. Consultations with national and district-level stakeholders were held to confirm the findings and their implications.

Main findings and their implications

This brief seeks to contrast the ideal intention of JKN policy with the actual implementation. It highlights the need for collaborative effort to narrow or close these policy-implementation gaps.



1. Capitation payment system has little impact on improving performance

The capitation payment system for primary health care was developed to increase efficiency by improving organizational and individual performance. According to JKN policy, capitation payment is applied at the primary care level, in which the majority of this fund is allocated as an incentive to health workers to motivate them and improve their performance (Presidential Regulation 32/2014).

However, in three years of implementation, this has not been the result. This study shows a high referral rate for both specialized and non-specialized cases. Except in Jayapura city, a pilot site for pay-for-performance capitation (KBK), the capitation has reduced the non-specialized referral rate to below 5% in most Primary Health Center (limited to 96 diagnosed cases).

Findings from respondent interviews indicate that the additional incentive revenue from capitation has helped to incentivize staff to be more disciplined in terms of attendance and working hours, but there is no evidence of improved quality of their performance. This might be due to staff feeling overwhelmed by high workload.

> *"Staff incentives do not make staff performance better because the workload is also multiplied along with it." (DHO staff)*

In addition, the distribution of staff incentives is based on the level of education and attendance, which does not encourage staff to improve their performance. Disparity in staff incentive revenue has caused inter-professional envy that in turn demotivates certain categories of health workers.

> *"Staff incentives do not have much impact on performance quality. They come to work every day, but it doesn't mean they become more diligent. Lazy people remain lazy." (Head of Puskesmas)*

> *"The years of service and level of education have been a variable in the payroll system. I think incentive should be more focused on rewarding performance." (Head of DHO)*

Another finding indicates that there are no standards or guidelines for an acceptable range of income for health workers, particularly doctors. The differences in income between medical doctors in East Jakarta and in Papua are shown in the table below.

Location	Salary	Regional Allowance	Staff Incentive from Decapotation	Total
Jakarta	X	19.620*	Not Allowed	x +19,620
Jayawijaya	X	5,000*	6,200*	x +11,200

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*Allowance for functional doctor with first level expertise according to Pergub DKI Jakarta 108/2016

**Doctor's incentive capitation mean from study result

The gap in staff incentives also occurs within districts (except East Jakarta). As an example, in Jayawijaya, one of its Puskesmas has 70.000 participants and the service incentive is ± Rp. 400.000.000 for 4 medical doctors; while another Puskesmas with 3.500 participants and one medical doctor receives only ± Rp. 24.350.000. Beyond the income gap, the findings also indicate that the doctor-participant ratio has resulted in an imbalance in workload distribution.

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1 Strategic purchasing: a payment mechanism or purchases where there is a sorting process of any intervention needs to be purchased, how the intervention will be purchased and obtained. In strategic purchasing there is employment contract between

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The table below shows the range of staff incentives to medical doctors in four of the study districts. This data suggests that the implementation of capitation policy does not sufficiently offset differences in medical doctors' income to have an impact on individual and group performance.

District	Incentives		
	Mean (Rp)	Lowest (Rp)	Highest (Rp)
Tapanuli Selatan	1.037.782	517.013	1.486.800
Jember	2.824.533	831.029	6.727.266
Jayapura	4.134.731	678.473	10.355.973
Jayawijaya	6.193.963	2.626.302	11.377.989

This study also revealed that there is a sizeable unutilized capitation fund in two districts, because the operational fund is not optimally utilized. For example, in 2015, 36% of the total capitation fund in Jember, and 17% in South Tapanuli was unutilized. The back-referral program, which was initiated by BPJS, has not yet been implemented in the five study districts. Findings also indicate that capitation has not had impact on increasing the number and quality of health workers.

2. The importance of strengthening the role of the District Health Office to ensure effective individual health

To achieve Universal Health Coverage, many countries adopt strategic purchasing approach. According to this concept, ideally the government has a role as the principal who mandates BPJS (as the agent) to obtain the greatest benefit for the people relative to the cost incurred in achieving health status outcomes. The district government, which in the Indonesian health context is represented by the DHO, should have the authority to ensure that resources are spent to produce desired health outcomes.

MOH regulation no 19/2014 (and MoH regulation no 21/2016) specifies the role of DHO in implementing JKN, namely: advocacy to local leaders regarding the proportion of capitation allocated for operational cost and staff incentives; procurement of drugs, medical equipment and consumables; developing guidelines for utilizing capitation; and supervision. Act no. 23/2014 states the duties and authority of SKPD Kesehatan (PHO and DHO) to manage individual health efforts (in addition to their role in managing community health).

On other hand, BPJS regulation No. 2/2015 states that BPJS has the duties and authority to evaluate the contact rate, referrals and Prolanis visits (the pay for performance indicators). Thus, there is a tension between BPJS regulation and the role of DHO – as the extension of local government – in ensuring that JKN improves individual health service outputs and outcomes.

The study indicates that DHO and Puskesmas staff perceive that BPJS, and not DHO, has the authority to evaluate service utilization outputs (according to BPJS regulation No. 2/2015).

> *"We already have our own criteria to evaluate Puskesmas. It is similar to SPM, i.e. K4 achievements, health workers, and many more. You could see the entire guideline. We also know number of referrals and visits. But we do not monitor these things, because the concept of Puskesmas is territorial [relating to the community health and catchment area]" (Former Chief of Department in DHO)*

In Jayapura, the pilot site for pay for performance capitation (KBK), DHO states that they do not know how BPJS evaluates the performance of Puskesmas. DHO also does not receive the report on KBK indicator achievements.

> *"Now the contact rate in the KBK program is available ….. there is a system which should accumulate them all. As far as I know, there are reports from P-care, but I do not know how to evaluate it … because the contact rate is not only in Puskesmas, there are Posyandu contacts, home visits, etc. We asked for the data, including Prolanis data. So, there are no reports that have direct link to DHO. So if we need information, we have to send a letter to BPJS and ask for the data" (DHO)*

This study reveals that the monitoring of service utilization outputs is already in line with the BPJS regulation 2/2015. However, it is in conflict with Act no. 23/2014 that states that DHO has the authority to monitor the individual health effort.

3. BPJS has centralized structure, operating in a decentralized health system

The goal of Indonesia's laws on decentralization has been to empower local governments to take responsibility for their own development based on their individual needs and priorities. Health is one of the sectors that has been decentralized. In our initial analysis of JKN regulations affecting primary care, we found an incompatibility between the national regulations of BPJS as a financial institution with centralized structure and function (SJSN Law and BPJS Law), and health decentralization policies (Governance Law and Health Law).

For example, BPJS Regulation No. 2/2015 regarding the determination of capitation payment based on physician and dentist availability, as well as MOH Regulation 19/2014 about distribution of staff incentives from capitation, is decided at the national level with little consideration to different conditions at the provincial and district level.

Instead of supporting the policy to distribute doctors to remote areas, the current capitation payment system (which is calculated based on doctor and dentist availability) has resulted in lower amounts of revenue from capitation for primary care facilities in remote areas. At the same time, there has been little additional investment for new health facilities and infrastructure in these areas.

Some respondents stated that the capitation rate should be determined based on local factors such as geography, access to transportation and telecommunications as well as the number and type of health personnel available.

> *"Maybe the people from the ministry (of health) see that all service must be provided by doctors, but it's different for us in Eastern Indonesia. Moreover, not all Puskesmas have a doctor, thus the nurses' workload is different from outside Papua. Even though there is doctor, there is usually only one and sometimes has another duty. The doctor workload is then transferred to the nurse..." (Head of Puskesmas)*

In the implementation of JKN, the research found that the BPJS branch offices do not have the flexibility to work with local governments and health authorities to formulate a capitation scheme that reflects health issues and priorities at the provincial and district level.

Another example relates to the data required for policy formulation, planning and budgeting for local governments. The current MoH Regulation 99/2015 requires BPJS to report only to health facilities that have joined the BPJS network. There is no mechanism for the Puskesmas, private health centers, and even DHO to access the identity of their registered JKN members. Moreover, the detailed hospital utilization data for JKN members (information on diseases and claims) is also not shared with the PHO/DHO. As a result, this important health data has not been used in policy formulation and planning and budgeting at the local level.

The results of interviews with the authorities in the districts suggest that this information asymmetry negatively impacts the role and authority of local government and health authorities because of insufficient information to monitor the performance of health facilities. At the same time, BPJS as a purchaser of services from health facilities also acts as an evaluator through the Performance-Based Capitation program and has the right to reduce the amount of capitation to health facilities.

Although local governments and health authorities can and sometimes do ask for data from BPJS, DHO has not routinely carried out data analysis under JKN. Respondents also explained that BPJS does not have accountability towards local governments. BPJS use its P-care data for its own needs, and not for the needs of health system improvement in the province or district. This was the case in all of the study districts.

"BPJS often takes the shortcut (of communication) directly to Puskesmas, not through us anymore. Do they know who is responsible to manage the Puskesmas in this district?" (Head of DHO)

"There is information that is delivered directly to Puskesmas, for example (we don't know that) IVA examination can be claimed. We just know when the fund has been transferred." (DHO staff)

The results of the implementation research show that the regulations on and issued by BPJS are centralized. Policies regarding BPJS do not provide opportunities for local governments to participate in making better district health policy based on geographic conditions, availability of human resources, as well as the standard price of goods and services in each region. The findings differ in Jakarta, which has its own distinctive system. The centralized BPJS system is in accordance with BPJS Regulation No. 2/2015, but it bypasses the authority of local governments in managing health in their areas as stated in Law No. 23/2014.

The attempt to close the gap

The gaps outlined above have implications for the implementation of health policies. Efforts to minimize or close these gaps fall into two categories: (1) policy gap minimization; and (2) implementation gap minimization. Various possibilities for these efforts will be discussed during the Dissemination Meeting of JKN Implementation Research Results on 20-21 October 2016 in Jakarta.