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Commitment-based capitation as Indonesia's model for performance-based payment system for primary care providers: Resolving the challenges of implementing the KBK Scheme in Indonesia's National Health Security Program

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Summary

*After a year of implementing the National Health Insurance program (*Jaminan Kesehatan Nasional – *JKN), the Social Security Administering Body for the Health Sector* (*BPJS Kesehatan*) *instituted in 2015 a Pay for Performance (P4P) scheme in the capitation system for primary care providers. P4P or* Kapitasi Berbasis Komitmen Pelayanan *(KBK) is commitment-based capitation that aims to measure the commitment of primary care providers to deliver primary care services comprehensively. Unfortunately, resistance from primary care providers hindered its full execution. It was then agreed that KBK would be postponed until 2016 and applied only to state primary care providers or state health community centers* (Puskesmas) *in provincial capitals. Since 2017, all* Puskesmas *have been applying the KBK except those in remote areas. In 2018, all private primary care providers are to implement the KBK. Three main indicators are used to monitor the KBK system, namely, contact rate, percentage of active Disease Management Program (DMP) member visits, and non-specialized referral ratio. The three indicators reveal improvements from January to December 2017 thus showing an improvement in the role of primary care providers as gatekeepers and care coordinators. Nevertheless, challenges still emerge and continuing improvements are essential*.

The issue or challenge

What was the issue or challenge addressed by your good practice? Please provide a short description.

The implementation of a commitment-based capitation system faced several challenges.

First, the effectiveness of a capitation system was an issue in the initial period of the JKN program. No regulation on P4P existed. BPJS Kesehatan had to pay all primary care providers in the same norm, regardless of how they perform their commitment to optimum primary services. Indonesia's Corruption Eradication Commission (*Komisi Pemberantasan Korupsi* – KPK) alerted BPJS Kesehatan of potential capitation-income misuse, suggesting the urgency of a P4P mechanism. In 2015, BPJS Kesehatan enacted P4P through a BPJS Kesehatan regulation. The P4P scheme or KBK is a commitment-based capitation aimed to measure the commitment of primary care providers to deliver primary care services comprehensively.

Second, challenges emerged due to the immense resistance from primary care providers. The fear of capitation-income reduction and transparency issues were highlighted. This stopped the full implementation of the KBK, thus forcing BPJS Kesehatan to postpone the implementation to 2016 and only through the Puskesmas or state health community centers in provincial capitals.

Third, another major issue also arose on whether BPJS Kesehatan was authorized to regulate the payment system. Hence, in 2017, a joint resolution was issued by the Ministry of Health and BPJS Kesehatan to regulate the KBK scheme and its roadmap to full implementation for all primary care providers in 2018. Through this regulation, payment compensation is only for Puskesmas, while private primary care providers will be compensated in 2018. Compensation ranges from 2.5 per cent to 10 per cent of the capitation received.

Addressing the challenge

What were the main objectives of the plan or strategy to resolve the issue or challenge? List and briefly describe the main elements of the plan or strategy, focusing especially on their innovative feature(s) and expected or intended effects.

Strategies to resolve the issues above:

- Construction of a legal guideline: Since BPJS Kesehatan was a new body in 2014, all stakeholders were apparently unfamiliar with it to regulate the payment compensation system. Despite regulation constraints, a legal guideline must be accepted by all to fully implement the KBK scheme.
- A fully implemented KBK scheme to all primary care providers: The scheme must be implemented by all primary care providers, both state and private-owned providers, through a roadmap accepted by all.
- Indicators to measure achievement: As commitment-based capitation was a new concept, indicators must assess the outcome of the scheme in accountable and transparent means.

Targets to be achieved

What were the quantitative and/or qualitative targets or key performance indicators that were set for the plan or strategy? Please describe briefly.

The implementation targets of the compensation scheme were:

- by all Puskesmas at the provincial capital level in 2016;
- by all Puskesmas in 2017;
- by all private primary care providers in 2018;
- primary care providers were given more time for adaptation. This smoothened the execution by less rejection.

There are three quality indicators for the KBK scheme. The indicators are derived from four elements of primary care: first-contact care, comprehensive care, continuity of care and care-coordination. The indicators are:

- Contact rate: Measures how primary care providers act as first contact care for JKN members. The minimum target is 150 visits per one million members.
- Percentage of active DMP-member visits: This identifies comprehensive care especially for JKN members suffering from chronic diseases (diabetes and hypertension). Primary care providers must meet at least 50 per cent of this indicator.
- Non-specialized referral ratio: The ratio describes how primary care providers function as gatekeepers, referring patients only when specialized medical treatment is required. Only 5 per cent of non-specialized referrals are permissible.

The three indicators are measured through P-Care, a software application developed by BPJS Kesehatan for primary care providers. The data is accessible to all stakeholders thus ensuring the accountability and transparency. Qualitative aspects include improvement of primary care providers as gatekeepers and care coordinators, or in more specific terms, their commitment to comprehensive primary care.

Evaluating the results

Has there been an evaluation of the good practice? Please provide data on the impact and outcomes of the good practice by comparing targets vs actual performance, before-and-after indicators, and/or other types of statistics or measurements.

Since BPJS Kesehatan regulation was widely resisted in 2015, a joint resolution between BPJS Kesehatan and the Ministry of Health was issued in 2017. It affirmed the roadmap of implementation and guidelines for measuring the indicators. By the joint regulation, routine monitoring and evaluation are conducted among all stakeholders in local and central levels, the independent Quality Control and Cost Containment Team (*Tim Kendali Mutu Kendali Biaya* – TKMKB) is a key player in the monitoring and evaluation process.

The implementation of KBK has been in line with the roadmap stated in the joint regulation as follows:

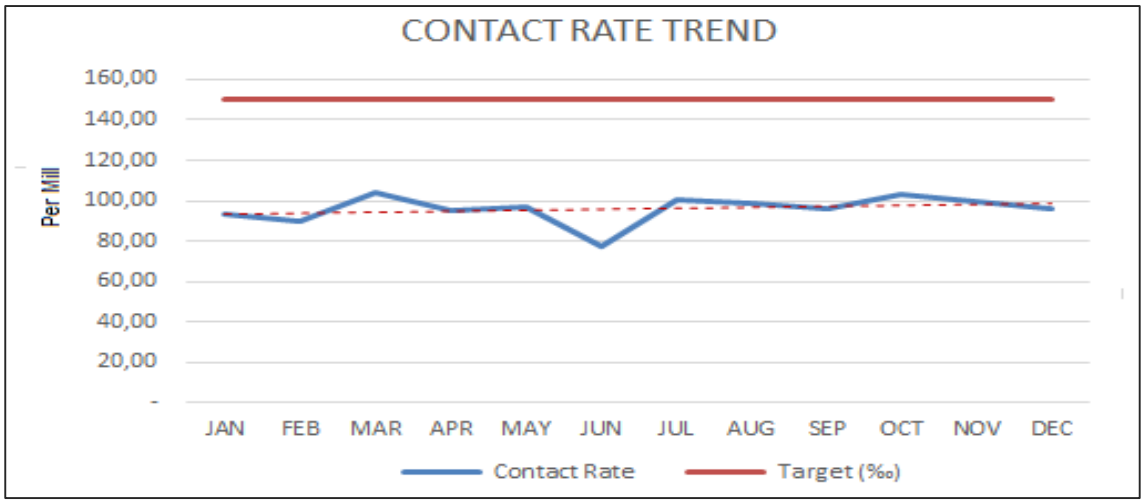
- In 2016 all Puskesmas in provincial capitals have implemented KBK.
- In 2017 there were only 12.4 per cent of Puskesmas (1.220 of 9.863) which have not yet implemented the KBK scheme, due to their location in isolated and remote areas.
- As of March 2018, 7.2 per cent of private primary care providers (336 of 4.687) have been willing to be compensated through KBK scheme; the other 92.8 per cent are expected to comply with the payment compensation in July 2018 in accordance with the joint regulation.

All primary care providers implementing the KBK scheme have utilized P-Care to record patient-related data. Analysis of the P-Care data show improvements in the three quality indicators:

- Contact rate

  There has been a rise of contact rate from 93.16 visits per one million members in January 2017 to 95.99 in December 2017 as shown in Figure 1.

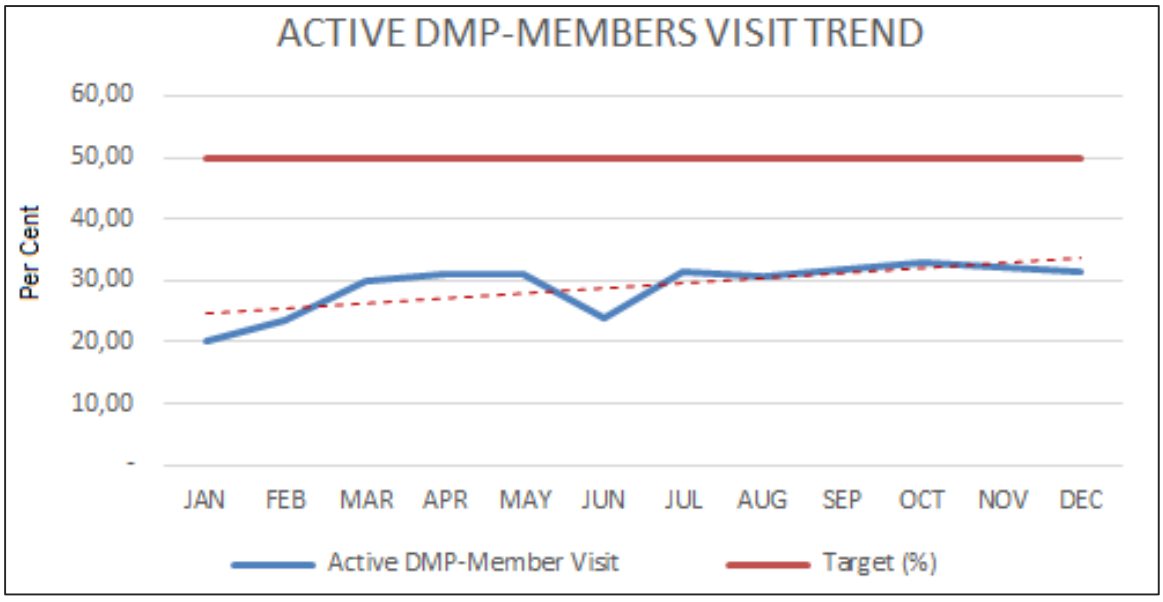
Figure 1. *Contact Rate Trend Year 2017*



- Active DMP-member visits

  Active DMP-member visits showed an increase in percentage, from 20.23 per cent in January to 31.33 per cent in December 2017, revealing that primary care providers strive to make DMP members active in the program. This is shown by Figure 2.

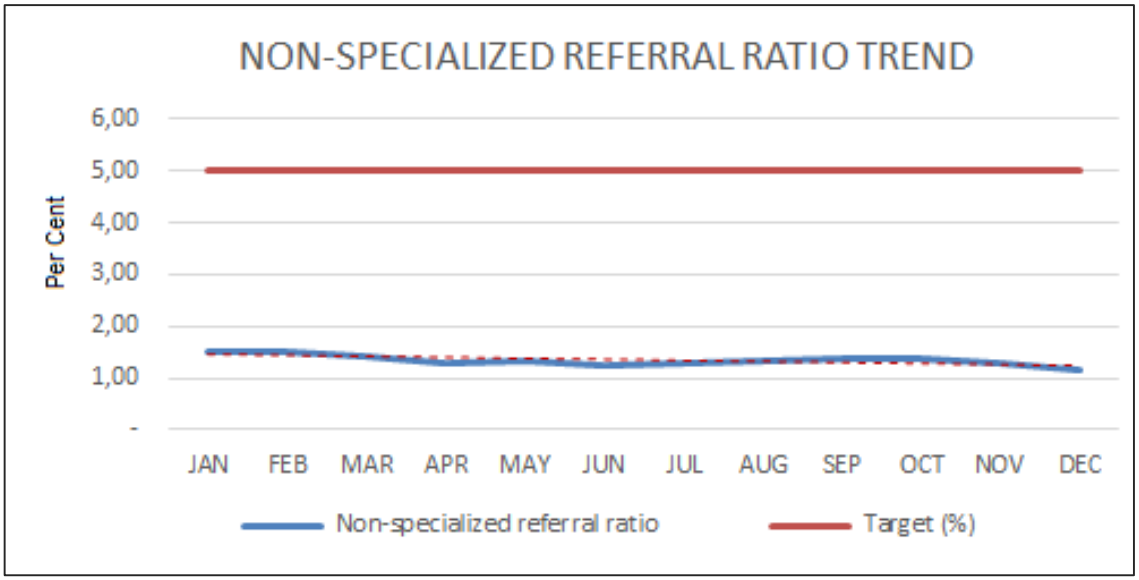
Figure 2. *Active DMP-member visits in 2017*



- Non-specialized referral ratio

  Non-specialized referral ratio has decreased from 1.51 per cent in January to 1.18 per cent in December, showing that primary care providers are becoming more cognizant of their role as gatekeepers, referring patients only when specialized medical treatment is required. The data is described by Figure 3.

Figure 3. *Non-specialized referral ratio in 2017*



Even if the payment compensation had not yet been implemented in 2017 for private clinics, they achieved the highest average of contact rate (132.4 visits per one million members), a significant increase in active DMP member visits (from 17.6 per cent in January 2017 to 24.8 per cent in December 2017) and a significant decrease in non-specialized referral ratio (from 2.1 per cent in January 2017 to 1.7 per cent in December 2017). This shows the readiness of private primary care providers for payment compensation in 2018.

Lessons learned

Based on the organization's experience, name up to three factors which you consider as indispensable to replicate this good practice. Name up to three risks that arose/could arise in implementing this good practice. Please explain these factors and/or risks briefly.

Three major factors enabled the enactment of the commitment-based capitation:

- Active coordination with stakeholders especially with the Ministry of Health

  As most primary care providers are state owned (*Puskesmas*), getting the support of the Ministry of Health was crucial.

- A clear legal guideline

  This is a major factor for implementation success. The immense resistance of primary care providers in 2015 became a priceless experience in the attempt to regulate the payment system. Eventually, a joint regulation issued by the BPJS Kesehatan and the Ministry of Health was the preferred mitigation.

- Well prepared health information system

  All patient-related activities must be recorded on the software application (P-Care) in order to evaluate the performance of primary care providers. This information system,

which is accessible to all stakeholders, enables the successful implementation of the KBK program.

The major risks in implementing the KBK scheme were:

- Resistance of primary care providers

  Active coordination reduces resistance, as stated above.

- Potential act of fraud mainly in the form of phantom records

  In order to counter this, the evaluation team (TKMKB, BPJS Kesehatan and municipal health offices) assesses the commitment of primary care providers on a monthly basis.

- Accountability and transparency of evaluation for compensation
  With the P-Care software application, primary care providers are able to monitor their monthly achievements. All stakeholders are also provided access to the data. Routine monitoring by all, especially by the independent TKMKB team, resolves accountability and transparency issues.

In implementing commitment-based capitation through the KBK program, BPJS Kesehatan faced various challenges. Nevertheless, it strives to resolve each issue through strategic actions thus allowing the sustainability of the program.