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POLICY BRIEF

Strengthening Primary Care Through Performance - Based Incentive System

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The policy brief presents recommendations to Ministry of Health, Ministry of Administrative and Bureaucratic Reform, National Social Security Board (Dewan Jaminan Social Nasional/DJSN), Indonesian Social Security Agency for Health (Badan Pelaksana Jaminan Sosial Kesehatan/BPJS Kesehatan), National Civil Service Agency (Badan Kepegawaian Negara/BKN), Regional Civil Service Agency (Badan Kepegawaian Daerah/BKD), Province Government and Regency/ Municipality Government in order to strengthen primary care in Primary Healthcare Facilities (Puskesmas).

Introduction

Jaminan Kesehatan Nasional (JKN/National Health Insurance) implementation in primary care has several specific characteristics:

1. The benefit package is comprehensive, including the provision of preventive, promotive, curative and rehabilitative services.
2. The curative service package in primary care consists of at least 144 types of services in accordance with the stipulated guidelines (Regulation of Minister of Health no. 514/2015);
3. The payment is conducted by BPJS to PHCs through capitation and non-capitation payment process (Regulation of Minister of Health No. 52/2016);
4. The implementation of KBKP (service commitment-based capitation) stipulates that the amount of capitation depends on accomplishing specified targets including: contact rate with the BPJS covered population and proportion of non specialist referral and screening of people with chronic conditions. The indicators represent the performance of PHC in reaching the covered population and performing the important function as a gatekeeper in Indonesian Health care System, as well as preventive-promotive function (Joint Regulation No. 2/2017).
5. In addition, BPJS pays unit fees for some services (incl. ANC), directly to primary care facilities bank accounts. These fees are intended to stimulate utilization of essential services that reduce maternal mortality.
6. The use of capitation funds in government-owned PHC that is regulated in the Regulation of Minister of Health No. 21/2016, states a minimum of 60% is distributed to health workers in the form of remuneration, and 40% is allocated to support operational fund of service providers. Capitation Fund in private-owned PHC is fully under the private sector management discretion.

To understand how primary care is responding to the new payment system, implementation research was conducted in five Regencies/ Cities, namely South Tapanuli Regency, Jember Regency, Jayawjaya Regency, East Jakarta Municipality, Jayapura Municipality. The research was divided into 2 Cycles. The first cycle looks at how the regulation of JKN at the primary care level is being implemented. The second cycle aims to understand the incentive system in JKN with the goal of informing how the payment system could be refined/revised.

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The 1st Cycle: (2016)

The research was conducted during June – November 2016, using mixed methods involving qualitative data and secondary quantitative data, interviews with 86 respondents (head of PHC) in 86 PHCs (including private-owned clinics), 5 health offices, 5 DPPKADs, 5 inspectorate offices, and 5 BAPPEDAs as well as 5 focused group discussions with a total of 52 participants.
The research shows the following results:

1. Revenue from capitation was not yet able to give leverage toward the performance of PHC as the gatekeeper of healthcare system. There was variation in the number of non-specialist referral in different regions, some remain stagnant or increased, while others start declining.
2. The new payment systems appear to be associated with performance of the facilities in terms of increased numbers of health contacts with the population (more people are getting into the primary care systems) and enhanced promotive-preventive activities particularly the non-communicable disease (hypertension and diabetes).
3. Remuneration allocated from capitation does not yet motivate the individuals of health workers to improve their performance since the remuneration distribution system does not yet consider individual performance.

The results of the first cycle shows that health workers are not motivated by the new payment system. For the system to achieve its desired goals of providing coverage of quality services that enhance the health of Indonesia's population, the payment system needs to motivate health workers to work as teams as well as individuals. Therefore, it is very important to identify which incentives motivate both team and individual performance in primary care facilities so that together they generate better health for Indonesians. Cycle 2 research does not yet explore team incentive, and future research should examine this aspect of the incentive system.

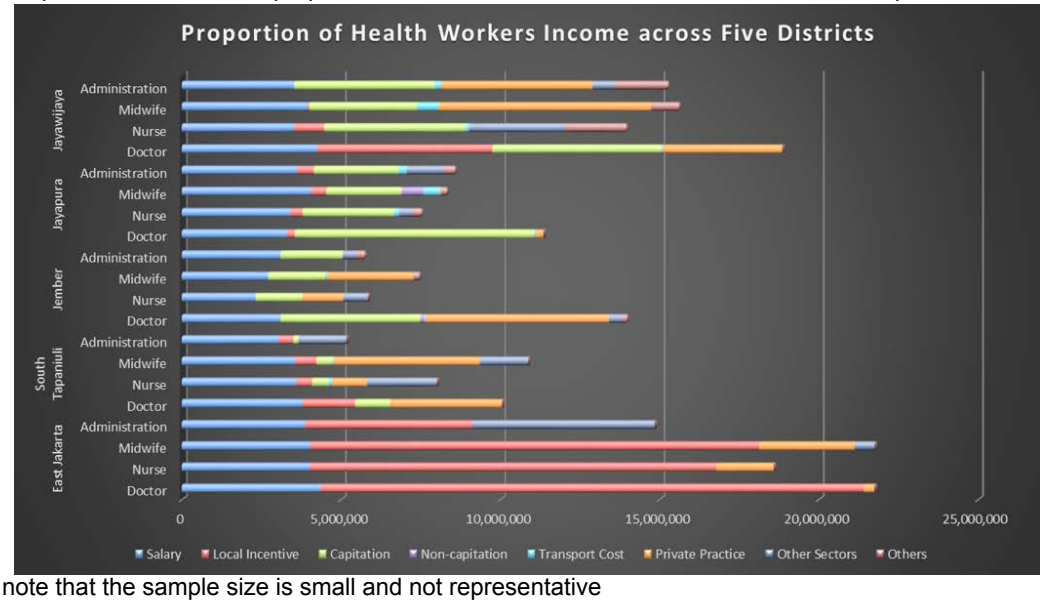
The 2nd Cycle

The research was conducted during July – November 2017, using mixed method involving qualitative data and secondary quantitative data, interviews with 70 respondents in 32 PHCs (including private-owned clinics), 5 hospitals, 5 health offices, 5 BKDs, as well as 23 focused group discussions with a total of 173 participants.

The Amount of Income of Health Workers in PHCs: How much is from BPJS?

The proportion of income for doctor, nurse and midwife from BPJS capitation funds varies widely in the five districts (see Graph 1). This indicates the relative power of BPJS and local government over how they are paying for services and, potentially, quality.

Graph 1: The variation of proportion based on sources of income for different health professions



*) Please note that the sample size is small and not representative

Sources of income include salary, capitation, local incentive/regional allowance, non-capitation, transport cost, private practice, other sectors, and other sources. Note that in some districts such as Jayawijaya, Jember, and South Tapanuli, health workers earn a significant portion of their income in dual practice while in other districts, East Jakarta and Jayapura, dual practice is insignificant. Local government payment for health varies widely and is a significant source of income in some districts such as East Jakarta and Jayawijaya (especially for doctors).

Table 1. Income by Source: Doctors in Puskesmas in Five Districts

Source of Income	Jayapura (n=2)	Jayawijaya (n=4)	South Tapanuli (n=2)	East Jakarta (n=8)	Jember (n=8)
Salary	3,300,000 (29%)	4,248,750 (22%)	3,800,000 (38%)	4,359,333 (20%)	3,095,313 (22%)
Regional Allowance	250,000 (2%)	5,500,000 (29%)	1,637,500 (16%)	17,050,000 (78%)	0
Capitation	7,500,000 (67%)	5,300,000 (28%)	1,111,254 (11%)	0	4,392,156 (32%)
Non Capitation	0	0	0	0	125,000 (1%)
Other income (BOK, overtime pay, etc)	0	0	0	0	108,863 (1%)
Private Practice	250,000 (2%)	3,750,000 (19%)	3,500,000 (35%)	333,333 (2%)	5,762,500 (42%)
Other business (Non Healthcare)	0	0	0	0	400,000 (3%)
Total	11,100,000 (100%)	18,798,750 (100%)	10,048,754 (100%)	21,742,666 (100%)	13,883,831 (100%)
Minimum	9,500,000	10,100,000	7,075,000	12,000,000	6,000,000
Maximum	13,200,000	25,799,000	13,022,508	28,278,800	23,700,000

Providers who are responsile for HIV, TB and MCH programs receive additional salary for taking those roles, but our respondents indicated that they did not feel it was adequate for the level of responsibility. The additional salary was not tied to program targets. Although they felt professionaly responsible for meeting program targets, there was no direct financial reward for it.

Table 2. Average Income of Doctors in Private-owned PHCs (*)

	Salary	Regional Allowance	Capitation	Non-Capitation	Total Income	Income from other Practice Place	Other Business (Non Health Care)	Total
5 Regencies/ Municipal-ities	2,833,333	-	4,366,667	83,333	7,283,333	1,666,667	3,333,333	12,283,333
East Jakarta	4,000,000	-	6,550,000	125,000	10,670,000	0	0	10,675,000

(*)Average salary for all respondents

Table 2. shows that income from capitation in private-owned PHCs make a large contribution to doctors' total income. Capitation to private doctors has potentially two benefits: on the one hand it can reduce the burden on the public doctors which could free up resources to provide better public care. However, on the other hand, with dual practice doctors and other health workers may charge extra payments to see people in their private clinic as a way of "double dipping". This could also lead to a system where the poor receive worse services. Wide variation in capitation payments is driven by the composition of primary care staff, the numbers of enrolled population, and the accomplishment of Performance-Based Capitation (KBK). For example, puskesmas in remote areas that are not able to attract doctors receive lower per capita payments than puskesmas in non remote areas with more doctors and other health staff.

> "Let's look at doctors in some of new districts. Doctors in those areas receive huge amount of incentive, about 30 million (rupiah). However, it is the nurses who do the work for them. (non-doctor, Jayapura)

In addition to capitation and salary from the government, there are various sources of income for health workers, namely:

Non-capitation income:

In addition to capitation, health workers can also receive income from remuneration claim which is paid by non-capitation fund. The amount depends on the quantities of the following services that are provided, and how this non capitation remuneration is distributed among health workers. In Jember, for example, there is a regional regulation that stipulates that 40% of capitation claims are distributed as remuneration. A part of the 40% is distributed to the Heads of Puskesmas and doctors, whereas the rest is distributed for the team involved in the service being claimed. However, in other districts, the distribution is based on the head of Puskesmas discretion.

Table 3. The Amount of Non-Capitation Payment for Health Workers across Five Districts

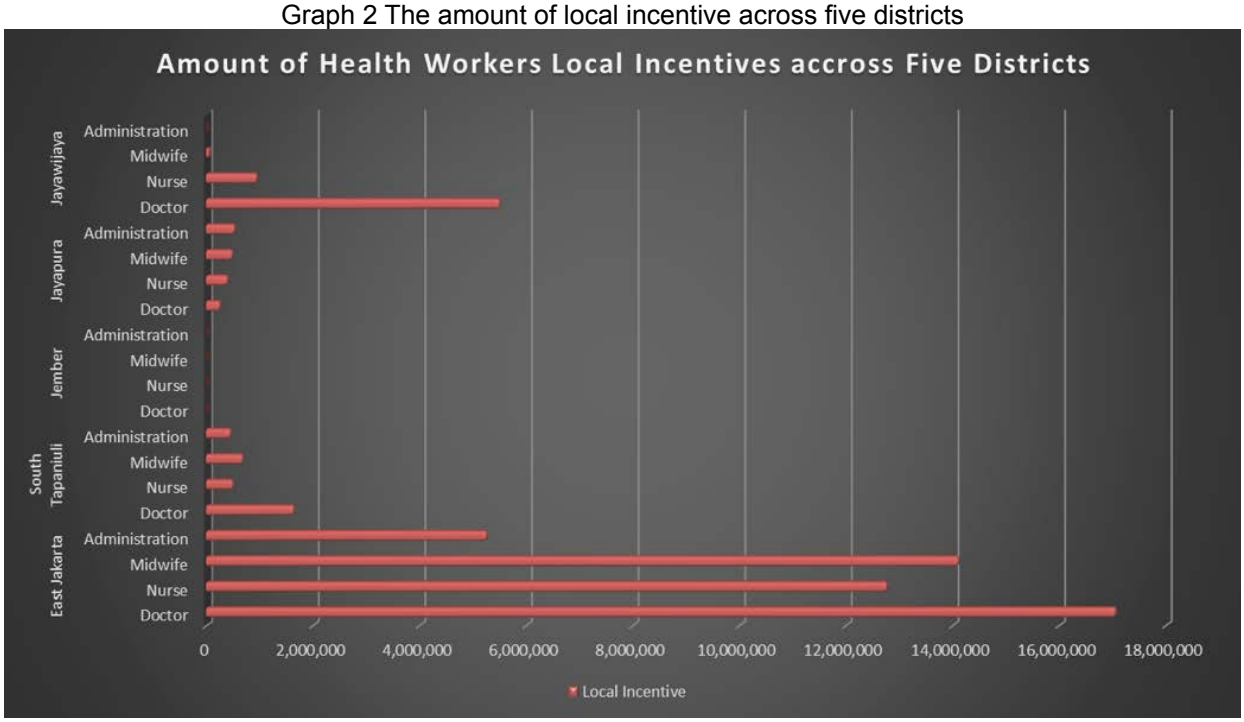
Service Type	Tariff for Non Capitation
Antenatal Care	Rp. 200.000 (or Rp.50.000 per visit)
Normal Delivery	Rp. 700.000 (midwive) Rp. 800.000 (doctor)
KF1 - KN1, KF2-KN2, KF3, KN3	Rp. 250.000/visit
Pre-referral for Obstetric and Neonate Complications	Rp. 125.000
Post Partum Service at BEONC facility	Rp. 175.000
Implant	Rp. 100.000
FP Injection	Rp.15.000
Post Partum FP Complications	Rp.125.000
KBMOP, Vasectomy	Rp.350.000

Table 3 shows that the amount of non-capitation payment for different services may have potential perverse incentive associated with paying less for a referral for a complicated delivery than for managing a normal delivery. Notably, not all health workers are fully aware of these fees, so the potentially perverse incentives may not be a problem at this point.

Income from regional government

Allowance given by regional government is determined by regional resources and priorities given to health versus other sectors. The average proportion of regional allowance toward income of health workers in Puskesmas per month varied between 2% in Jember up to 78% in East Jakarta.

Graph 2 The amount of local incentive across five districts



*) Please note that the sample size is small and not representative.

Graph 2 shows that there is also gap among health workers, such as in East Jakarta the amount of regional allowance for general practitioners is Rp.23,300,000 compared to administration officers (non-health professional) is Rp.6,500,000.

Income from private practice

There are three sources:

- Private practice in which patients directly pay.
- From double contract practice with BPJS. For example, in Jember, BPJS Kesehatan purchases healthcare service from the same doctors through collaboration with Puskesmas and private-owned PHCs.
- Income from other insurance providers.

Income from other revenues sources

> Doctors are like gods. Other professions are considered as nothing… we, who are in the administration, sometimes feel sad, very sad. I feel like, this is not fair (non-doctor, Jayapura).

Some health workers obtain income from other sources that may come from the non-healthcare sector. For example, health workers who have side business, family business, and others.

From the above explanation we can observe that the role of regulations of Central and Regional Government is considerably significant in determining the income of health workers, meanwhile the role of BPJS regulation is relatively minimal.

How is the currently applied incentive system for health workers associated with performance assessment system?

There is also a variation of what is so called as “incentive system” and performance assessment system. In private sector, “incentive system” is truly determined by management’s policy, therefore it varies. Performance assessment depends on the evaluation of the head of private-owned primary care facilities, whereas in government sector:

- East Jakarta municipality, Jayapura municipality, and Jayawijaya Regency give additional income for all the workers from Regional Budget and it is assessed based on the attendance and work performance. However, in reality, the final assessment in Jayapura city is only based on attendance, and the attendance-based allowance distribution in Jayawijaya is abolished because there is no means to monitor attendance.
- In East Jakarta, performance assessment is already designed in such a way to calculate the activities performed, for example: community visits, coordination meetings, medical procedures. However the greatest points are based on attendance.
- As illustrated in Image 1 on the left, the officers state that the indicators of individual performance are implementing main duties and functions, providing services and accomplishing targets. Meanwhile indicators that are generally calculated in the allowance distribution are attendance, education and activities conducted (for example: the transportation fund for the officers to go to field). Therefore, a major distinction is seen between what is assessed and what is actually valued in the “incentive system”. It seems that “process” is valued, whereas in health care service there is an urgent need to drive performance towards quality. Performance assessment in Puskesmas is conducted by Heads of Puskesmas and Head of Administration. The difference in income which is determined more by non-performance factors generates the sense of inequality and envy among health workers.

What is being rewarded?

What should be rewarded?

According to respondents, indicators that are implemented should consider what are the achievement of Puskesmas officers: “*The score is already determined, everything has its own score, work tenure, bachelor degree, education, position, attendance. Our accomplishment is not scored instead. Accomplishment should be the target. It should be scored and made into points.*”

Based on the results of discussion and interviews, there are several inputs related to incentive and disincentive which is considered worthy, as well as performance indicator that should be incentivized. Those inputs are summarized in Table 4.

Table 4. Recommendations by respondents on indicators of performance, incentive and disincentive

Performance	Incentive	Disincentive
• Geographic area of Service • Frequency of health promotion activities • The use of promotion media • Cross-sectors cooperation improvement • Preventive services to meet Minimal Service Standard • Work risk	• Remuneration considered as fair • The addition of remuneration • Capacity improvement (internal and external) • Training – workshop • Benchmark • Available equipment • Scholarship for further study • Religious trip	• Reprimand • Promotion postponement • Rank degradation • Relocation • Suspension • License revocation • Non Job • Allowance reduction • Allowance revocation • Dismissal

This is an opportunity to revise the payment system to align it with the objectives of the health system and with the performance of health workers who work within it.

Conclusion

1. "Incentive system" and allowance for health workers is determined by variables which are not directly associated with individual performance. The determinant variables are factors such as attendance percentage, education, working period, and position. There are feelings of envy and inequality among health workers.
2. The absence of disincentive system (except in East Jakarta) that either penalizes or reduces payment to teams and health workers that under-perform or fail to meet targets.
3. In Puskesmas, there is significant distinction between the method of allowance calculation in Puskesmas of non PPK BLUD (South Tapanuli, Jember, Jayapura, and Jayawijaya) and Puskesmas of PPK BLUD (East Jakarta). However, the Special Region of Jakarta has Regional Performance Allowance system that is actually specific compared to other regencies/cities, not an initiative of Puskesmas as PPK BLUD.
4. Individual incentive system and individual performance assessment in private sector are extremely determined by management/owner's policy. Dual practice may burden the system by 'double dipping'.
5. Non capitaion is not yet directed to pay for quality

Implication

1. If the motivation of health workers is not supported by incentive system that appreciates the individual and team performance, as well as insufficient disincentive system, then it is difficult to improve quality of care. Ignoring internal envy and inequality will also decline work motivation, individual performance and in the end the performance of health care facilities.
2. Incentive system which is less anticipating the distinctions of regional resources may increase the gaps of health workers availability among regions with high fiscal capability and regions with low fiscal capability.

Recommendations

1. BPJS Kesehatan should know the amount of money obtained by health workers from capitation and non-capitation payment to primary healthcare institution. By knowing the amount of money, it is expected that BPJS Kesehatan can influence payment mechanism to health workers so that capitation and non-capitation fund paid to primary care facility may give impact to individual and team performance and service quality which is purchased by BPJS Kesehatan.
2. MoH and Regional Government agree on incentive proportion (excluding salary from government) for health workers based on the amount of income feasible obtained by health workers. Incentive proportion is based on capitation fund and regional government fund. Central government can make 'matching grant' policy to encourage regional government designing attractive regional allowance and incentive. Professional organization is involved in the discussion on the stipulation of remuneration system for each profession.
3. Developing remuneration system in primary care which is comprehensive and inclusive, by doing the following:
   a) Identifying various components of financial incentive resources (regional allowance, capitation, non-physical DAK, and others)
   b) Agreeing on additional variables as well as the amount of point and calculation method, scoring and reporting the additional variables in financial incentive calculation system. Additional variables such as work load and working risk (i.e. risk of infection, risk of transportation to remote areas)
   c) Identifying various non-financial incentive and the funding resources, as well as the distribution mechanism.
   d) Translating the targets of Minimum Service Standard or targets of Commitment-Based Capitation into targets of individual and team performance.
   e) Agreeing and stipulating the expected individual and team performance indicators and individual and team accomplished target, and ensure that the performance to be assessed covers curative, rehabilitative, promotive and preventive service performance.
   f) Ensuring that remuneration system is designed to meet health sectors purposes, which are health status improvement, service quality and equity.
4. The government (Ministry of Health, BPJS Kesehatan, DJSN) perform adjustment of capitation distribution with certain adjuster to help regions in difficulties to be able to perform better service and government should contribute in determining how they will "purchase" service and quality. BPJS should also be perceptive to avoid "double-contract" in primary care.
5. There is also a need to review the non capitation payment amount and what it is being paid for to ensure that the right kind of services and quality is rewarded.

Questions for Future Research

This research entails the need to further explore some unanswered questions that can be followed up by future research, such as:

- How can incentives be structured to reward team based health care?
- Do financial incentives have more continuous impacts than non-financial incentives?
- How professional associations could play a role to advocate an acceptable and fair incentive system for their respective professions, and with regard to other profession?
- How capitation, non capitation, and other funds can be leveraged to improve promotive/preventive?
- Is there a relation between PPK BLUD Puskesmas (flexibility in financial management) status with improvement in Puskesmas performance?

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