



**ANALYSIS OF FAIRNESS DISTRIBUTION OF CAPITATION SERVICE
BETWEEN HEALTH CENTERS**

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ABSTRACT

This article discusses the analysis of fairness distribution of capitation services between health centers in Bogor 2019. Objective: to conduct a fairness analysis of distribution of capitation service between health centers in Bogor 2019. Method: This research is a qualitative study with a case study design. The Population of this study was all workers in 101 health centers in Bogor, the sample was selected using Purposive Random Sampling and 5 health centers were selected, that is Tajur Halang, Leuwiliang, Cirimekar, Parung Panjang and Bojong. The data in this study were obtained from in-dept interviews with 18 informants, capitation data in 2017, 2018 and data on the realization of distribution capitation services at health center based on the regulation the Minister of Health Number 21 of 2016. The data is processed by going through several stages, that is data reduction, data display dan conclusion drawing. Results: The study show that there is external injustice related to services in capitation fund of Bogor district in 2019. Conclusions: There is a need for further research related to risk adjustment based on age, gender and geography to determine the amount of capitation between health centers. This research contributes to reviewing the establishment of Civil Servants Income Allowances, so that there is no disparity between health centers.

Keywords: bogor district in 2019; distribution of capitation services; fairness external in health centers

INTRODUCTION

JKN is a health protection guarantee so that participants receive health care benefits and protection to meet basic health needs, given to everyone who has paid dues or whose contributions are paid by the government (Presidential Regulation of Republic Indonesia Number 12 in 2013 Concerning Health Insurance, 2013). Furthermore, JKN is organized by all health facilities in collaboration with BPJS Kesehatan, which consists of First Level Health Facilities (FKTP) and Advanced Level Referral Health Facilities (FKTRL). Health facilities in collaboration with BPJS Kesehatan are expected to provide comprehensive health services. (Regulation of the Minister of Health The Republic Indonesia Number 71 in 2013 Concerning Health Services in the National Health Insurance, 2013). Therefore, the standard tariff for health services is set for FKTP and FKTRL in collaboration with BPJS Kesehatan. (Regulation of the Minister of Health the Republic Indonesia Number 69 in 2013, 2013). As quality control and health payments in the JKN era, a capitation payment system was applied to FKTP.

Capitation is a payment method in health insurance where the health care provider receives a predetermined payment for each registered patient. Health care providers will agree to provide health services to each participant in health insurance for a certain time based on a contract with the contributor (Telykov, 2001). Capitation is the amount of monthly payment paid in advance by BPJS Health to FKTP based on the number of registered participants without taking into account the type and number of health services provided. (Regulation of the Minister of Health the Republic Indonesia Number 69 in 2013, 2013). Capitation payments will expand access to care, limit physician spending that is not as needed, reduce medical costs, are an important source of income for health care providers and will increase promotive services to reduce drug

costs. (Andoh-Adjei et al., 2017; Telykov, 2001). In addition, capitation payments will increase incentives for providing basic health services at Health Center (Yang et al., 2016).

Incentives are part of the benefits received by health workers in addition to compensation for health services that have been carried out. Incentives are very important in the payment system because they will have an impact on overall performance. However, determining the amount of incentives is very complicated, because there is an element of the need for fairness in the determination of incentives (Dessler, 1997). The important factor in determining incentives is that incentives must be fair (Dessler, 1997).

Fairness is the main concept in the accuracy of incentive formation. Fairness will be seen from two aspects, that is Internal Fairness and External Fairness. Internal Fairness is a comparison between the work done and received between employees. Internal Fairness can also be understood as a review from the inside of one position and another. Usually, to fulfill Internal Fairness is to establish a performance evaluation. While externally fair is a comparison between what is received with the suitability of the prevailing labor market level. For example, with certain positions and salaries in one organization compared to certain positions and salaries in other organizations. Establishing External Fairness is generally verified by salary surveys. There are 3 important aspects that influence the opinion of Fairness, (1) the opinion on the results (*outcome fairness*) is the results received with the contribution they have made to the organization. (2) The opinion on the determination of the amount of incentives (*procedural Fairness*) and (3) the opinion on the distribution of incentives (*distributive Fairness*). (Dessler, 1997; Koss, 2008; Smither, 1998).

The distribution of the capitation amount received by each health centers is determined based on human resources, completeness of facilities and infrastructure, scope of service, service commitment and performance of the health centers. The procedure for determining the amount and distribution of capitation funds among health centers has been established based on the Minister of Health Regulation no. 59 in 2014 concerning Standard Tariffs for Health Services in the Implementation of the Health Insurance and a Joint Decree between the Secretary General of the Ministry of Health and BPJS Kesehatan no. 2 in 2017. However, the uncertain nature of illness and health, will put health service providers at risk of experiencing excess expenditure from capitation payments that have been paid in advance, equating the amount of capitation to all health care providers will burden health service providers who are in the environment high risk population (Telykov, 2001). Therefore, health centers located in high-risk areas will receive lower incentives than health centers located in low-risk areas. This will affect Fairness between Health centers or External Fairness

Kurnia 2015 stated that the capitation rate would be high in the 0-4 and > 50 years group. It is known that the Pancasan Health Center, Gang Aut Health Center, DPP dr. Siti Robiah DPP dr. Sri Danuwati and Pelitas Sehat 4 Clinic get higher capitation funds when compared to the capitation value calculated based on age risk (Kurnia & Nurwahyuni, 2015). Anel et al, 2016 also stated that paying capitation according to high-risk populations will increase equality of access to services (Pope et al., 2004). The fairness of incentives will be related to performance. If the opinion of health workers on fairness is not fulfilled, they will feel that something promised has been withheld or not recognized so that it will have an impact on job dissatisfaction (Timpe, 1992). The potential for unfairness in terms of results, determination and distribution of capitation in external aspects will have an impact on the performance of health services. Thus, it is necessary to look at the opinion of health workers regarding fairness. Therefore, the researcher wants to research on the analysis of fairness distribution capitation

services with the performance of health workers

This research will be conducted in Bogor, it is based on a preliminary study conducted, it is known that the distribution of the amount of capitation funds between health centers is uneven where there are those who get up to 4 billion while the lowest is 300 million, besides that Bogor has urban and rural areas. The distribution of health workers at health centers in Bogor also varies, some are appropriate, less and more, besides that in Bogor there are no health centers that have become PPK-BLUD. So that research in Bogor will be able to adequately describe external fairness. This research was conducted to carry out Analysis of Fairness Distribution of Capitation Service Between Health Centers.

METHOD

The research has received a recommendation from the Ethics Review Team of the Faculty of Public Health, University of Indonesia number 71/UN2.F10/PPM.00.02/2019. This research was conducted using a design *case study* with a qualitative method approach. This research was conducted at the Bogor Regency Health Center from January 2019 to April 2019. The population in this study was all workers in 101 health centers Bogor Regency. The sample selection in this study was carried out using *purposive random sampling* that is the selection of health centers is determined based on research needs with inclusion criteria (1) Obtaining capitation funds above the average value, being in urban areas and having various types of employment. (2) Obtaining capitation funds above the average value, residing in rural areas and having various types of employment. (3) Obtaining capitation funds below the average value, residing in urban areas and having various types of employment. (4) Obtaining capitation funds below the average value, residing in rural areas and having various types of employment. (5) Health centers that experienced an increase in capitation funds in 2017.

Five health centers were selected in Bogor Regency, namely, Tajur Halang Health Center, Leuwiliang Health Center, Cirimekar Health Center, Jampang Health Center and Suliwer Health Center. The informants in this study were selected by purposive sampling that met the knowledge and experience and had a direct relationship with the research topic consisting of (1) Head of Health Centers, (2) Head of Administration of Health centers, (3) Treasurer of JKN, (4) Health Workers, (5) Non-Health workers. Primary data in this study were obtained from the results of in-depth interviews with informants. The secondary data of this study are 2017 capitation data, 2018 data on the realization of capitation funds in 2017, 2018 at each health centers and service distribution data based on Ministry of Health regulation No. 21 of 2016. The method of collecting data is by reviewing documents, interviews, and then analyzing the data. by performing the following steps (1) descriptive informants, (2) making field notes, (3) transcripts, (4) organizing and organizing data, (5) coding data, (6) summarizing data into a matrix, (7) identify variables and relationships between variables, (8) draw conclusions.

RESULTS

Due to time constraints, this study was limited to government health centers. The research was conducted from April to May 2019. Located in the Bogor Regency area, in order to achieve the research objectives, 5 health centers were selected to be informants in this study. However, in practice there was 1 health center that refused to conduct research and 2 health centers who refused to continue research. In the end, with consideration from the health Office, 2 more health centers were added, to replace the health center that received capitation funds below the average and were located in rural areas, namely the Jampang Health Center, which was continued by the Bojong Health Center. The health center that received above average capitation funds and was located in a rural area, namely the Tajur Halang Health Center, was

continued by the Parung Panjang Health Center. Meanwhile, to replace the health center that experienced an increase in capitation funds in 2018, the Suliwer Health Center, there were no more health centers that had these criteria, so they were finally excluded from the study. The reason most health centers refuse is because of objections to requests for data on the realization capitation services in accordance with Minister of Health Regulation no. 21 in 2016. Therefore, the Health Office advises researchers to request the data without the nominal amount obtained by each health worker. Thus, other health centers do not object to continuing their research, but for health centers that have previously refused the research, it is recommended to be replaced with other health centers that have research inclusion criteria. Informants in this study are as follows:

Table 1.
Research Informants (n= 18)

Name of Health Centers	Informants	Education	Code	Total
Tajur Halang	Head of Health Center	Doctor	D1	1
Jampang	Employee	Midwife	B1	1
Leuwiliang	1. Head of Health Center	1. Dokter	1. D2	4
	2. Treasurer	2. Bachelor of	2. B2	
	3. Head of administration	Midwife	3. SKM1	
	4. Administration	3. Master of Public Health	4. ADM1	
		4. High School		
Cirimekar	1. Head of Health Center	1. Doctor	1. D3	5
	2. Treasurer	2. Doctor	2. D4	
	3. Head of administration	3. 1 st Diploma	3. GZ1	
	4. Administration and Treasure of Health	4. Healthcare assistant	4. ADM2	
	5. Administration Operational	5. Non-Health Education, under 3 rd diploma	5. ADM3	
Parung Panjang	1. Head of Health Center	1. Doctor	1. D5	4
	2. Treasurer	2. Bachelor of	2. P1	
	3. Head of administration	Nurse	3. Kesling1	
	4. Nutrition program manager	3. Bachelor of Environmental Health	4. GZ2	
		4. 1 st diploma		
Bojong	1. Head of administration / Treasurer of JKN	1. Nurse	1. P2	3
	2. Midwife	2. 3 rd Diploma of Midwife	2. B3	
	3. Sanitarian	3. 3 rd Diploma of Environmental Health	3. SN1	

Table 1. it is known that the informants have various types of education levels, have different types of positions and several people in charge of the program.

External Fairness Between Health Centers in Bogor Regency.

The amount of capitation funds received by each health center varies, depending on the number of participants whose contributions are paid by the government (PBI) and doctors. This has been determined in the Minister of Health Regulation no. 59 in 2014 concerning the standard tariff for health services in the implementation of the health insurance program. The capitation rate at the health center has a range between Rp. 3,000 – Rp. 6,000. The determination of the amount depends on the ratio between the number of PBI and doctors at the health center. The PBI and doctors in the health center, the greater capitation funds received each year

In addition, the Joint Decree between the Secretary General of the Ministry of Health and BPJS Kesehatan no. 2 in 2017 concerning Performance-Based Capitation, which consists of several achievement indicators to determine the amount of capitation received at each health center. When all indicators are met, the health center will receive 100% of the capitation norm, but if any of the indicators are not achieved there will be a reduction in the capitation norm to 95% until the lowest is 90%. Based on the description of the capitation value in Bogor, it is known that the highest capitation value in 2018 was 4.6 billion while the lowest was 300 million rupiah with an average value of 1.6 billion.

Outcome Fairness

The results of this study indicate that the receipt of capitation funds that have been received annually is unfair. Most of the informants stated that the results were unfair.

“...It's not fair, it's just a fortune, isn't it?...” (SKM1)

“...It's not fair, we have a small capitation, but because it's in the city, so our visits are still high, but in rural areas the capitation is big but the visits are few...” (ADM2)

“...It's not fair, most of the small capitations are health centers in the city, because the PBI are few ...” (DK1)

This unfairness is supported by data showing that the difference between the largest and the smallest can be up to 3-8 times.

Procedural Fairness

The amount of capitation received at each health center is determined by the Minister of Health no. 59 of 2014. In addition, it is also regulated in the joint decree between the secretary general of the Ministry of Health and BPJS no. 02 of 2017 concerning Performance-Based Capitation. Therefore, when the health center is able to fulfill all the requirements in the regulation, they will receive a 100% capitation but if they are not able to fulfill all the requirements, the health center will have their capitation reduced by 95% to 90%. Most of the informants who feel that it is unfair is because of the distribution of participants whose contributions are paid by the government.

“...For example, here there are 11 thousand participants, then the area over there is only 5 thousand participants, for example, we move the 11 thousand participants over there to increase participation, is that possible?...” (DK1)

“...there is an imbalance in the distribution of PBI...” (DK2)

“...because the system is a quota of PBI ...” (ADM3)

Apart from the fact that the number of PBI in health center causes the amount of capitation received, the difference in rates between private clinics and health center is also a reason for unfairness. In the Regulation of The Ministry of Health number 59 there is a difference in rates

between health center and private clinics. The regulation states that the tariff for private clinics or individual doctors in collaboration with BPJS Kesehatan is Rp. 8,000 – Rp. 10,000, while the tariff for health center is Rp. 3,000 – Rp. 6,000.

“...It's not fair, the health center has a heavy burden because there are preventive and curative services, providing counseling, immunization and measuring the baby's weight every month, but private clinics don't do that. ...” (DK2)

“...It's not fair, the ones who do the 4 services are the health center, private clinics don't do it ...” (SN1)

“...It's not fair,, this private clinic doesn't do 144 services like at the health center...” (B3)

‘...there is a gap between health center and private clinics, when compared to private clinics they do not carry out 4 efforts, they are only curative, while in health center it is curative and preventive ...’ (P2)

The results of the interview show that the number of PBI and the difference in rates between government-owned health centers and private clinics or individual doctors are the reasons for unfairness procedure.

Distributive Fairness

The results of the interviews showed that most of them said that the inequality in the distribution of participants whose contributions were paid by the government was due to the access factor and the availability of other health center in the working area of the health center.

“...we are located in the city, there are already many health centers so that the participants are divided and each health center has a few participants, then our health center is also in the middle of the city PBI are few too...” (D4)

“...right here in the city how do you want to make participants whose contributions are paid by the government?... because this is a city so there are rarely poor people ...” (ADM3)

“...If in rural areas there are many PBI but not necessarily they go to the health center for treatment, they mostly choose not to seek treatment because the cost of going to the health center is more expensive than the cost of treatment ...” (D3)

“.... It's just good luck, according to the quota of PBI so that there are many participants, some have few participants even though the work is the same between health centers...” (SKM1)

“....there is no equal distribution of participants, what about the health center that have a few PBI? ...” (GZ2)

“...unequal distribution of participants, if it is calculated, there is paid after providing services for 1 patient, it can be 3 million, while here, participants are at most 80 thousand each time they provide services. ...” (P2)

However, the unequal distribution is not without reason. It is not possible to transfer participants to another place because it is far from their area just to divide the number of participants equally at each health center.

“...For example, here there are 11 thousand participants, and in the area over there, there are only 5 thousand participants, those for 11 thousand have their home addresses here, so they must be registered with the nearest FKTP, then we will move the 11 thousand participants to that area to increase membership, is it possible? ? can't right, because of what? They just don't necessarily come here, especially if the health center is far away...” (DK1)

“....if it's not that bad, it's not necessarily treatment unless they go to a place that's close, coming there is free but the cost from home to the health center can cost a lot of money”

(DK1)

“...because the working area of the health center has been determined, for example in a rural area there are many working areas so there are many participants, different from those in the city, the working area is a bit because there are already many health centers ...” (DK2)

Inequality in the distribution of PBI also creates an imbalance in the distribution of health workers in Bogor

“...because it causes piling up and shortages, for example here, here it means piling up, right, imagine that there are 15 midwives here even though our poned is born only 2 times a month...”(GZ2)

“...there is a trend of shifting health workers between health centers, look for health centers that receive large capitation...”(ADM2)

These results illustrate that the distribution of PBI and health workers to determine the amount of capitation services is still not fair. So there needs to be an intervention to fix it.

DISCUSSION

External fairness is a comparison between what is received with the appropriate level of the prevailing labor market. For example, with certain positions and salaries in one organization compared to certain positions and salaries in other organizations. Establishing external fairness is generally verified by salary surveys (Koss, 2008). The fairness opinion is to assess the outcome, procedures and distribution of incentives.

Outcome Fairness

Most of the informants said that there was no external fairness of results in the distribution of capitation services in Bogor. The variation in the capitation value in the districts makes the income of each type of worker at each health center different. Those who are in health center with large capitation will get greater results compared to others. This is also supported by Hasan, 2017 which states that the allocation of capitation between health centers is very varied and has a high disparity, this disparity will affect the income received by the same type of workforce at each health center differently with the smallest value being IDR 213,993 and maximum IDR 3,033,108 (Hasan & Adisasmito, 2017).

Procedural Fairness

The fairness of the procedure, most of the informants stated that it was unfair. Most of them said the injustice was related to the distribution of PBI participants. The amount of the PBI will affect the amount of income received by the health center. The amount of the capitation norm at each health center is regulated in the regulation of the minister of health no. 59 in 2014 and a Joint Decree between the Secretary General of the Ministry of Health and BPJS Kesehatan no. 2 in 2016 which regulates the amount of acceptance of the capitation norm between health center based on selection and credentialing at each health center.

Minister of Health Regulation no. 59 of 2014 states that the capitation rate at government-owned health centers is Rp. 3,000 – Rp. 6,000, taking into account the number of participants in the health center and the number of doctors. The more participants, the greater the capitation norm received, the capitation norm will also increase when there are many participants accompanied by a large number of doctors in the health center. Meanwhile, the joint agreement letter between BPJS Kesehatan and the Secretary of the Ministry of Health No. 2 in 2016 stated that BPJS Kesehatan would pay the capitation norm set in the Minister of Health Regulation number 59 in full 100% or reduced according to the success of the existing Commitment-Based

Capitation indicator.

Equalizing the amount of capitation for all health care providers will be burdensome for health services that are in a high-risk population environment (Telykov, 2001). This research is also supported by Kurnia, 2015 which states that there are 4 FKTP whose capitation norm is paid greater than the capitation norm which is calculated based on the age risk adjustment of the participants (Kurnia & Nurwahyuni, 2015). Using the risk value in determining the amount of capitation will be able to redistribute funds to existing providers, according to the provider's risk (Langenbrunner et al., 2009). Risk adjustment in Indonesia may be appropriate if it is based on the age and sex distribution of participants registered in each health center because in Indonesia these two things are the main reasons for using the service. (Zahroh et al., 2019).

Distributive Fairness

The results of this study indicate that most of the informants said the distribution of services between health center was unfair. This is due to the unfair distribution of PBI. The distribution of PBI participants was unfair due to city and village access and the availability of health center in one area. The more health center in the city, the fewer PBI participants at each health center. In addition, PBI participants in cities tend to be fewer than PBI participants in rural areas. This is also supported by Hasan, 2017 which states that the distribution of PBI participants in Bogor has a high disparity, PBI participants are at least 4,057 participants and the highest are 42,454 participants with an average of 18,188 participants. (Hasan & Adisasmito, 2017).

The results of this study indicate that participants' access to health center is the most common reason for the distribution fairness. It has previously been known to make procedurally fair it is advisable to make risk-adjusted payments. The results of this study indicate that the access of PBI participants is also a risk of participant distribution. Thus, in order to avoid disparities in capitation funds between one health center and another, calculating the capitation norm using risk adjustment is something new that can be done. This risk adjustment can be based on age and gender and then combined with geographic risk adjustment.

CONCLUSION

External fairness in this study is mostly not fair. Both fair in terms of outcome, procedures and distribution. This unfairness is due to the inequality in the distribution of PBI for each health center. Where the distribution inequality has an impact on the capitation payment procedure between health centers and ultimately affects the disparity of income receipts between health centers.

REFERENCES

- Andoh-Adjei, F.-X., Spaan, E., Asante, F. A., Mensah, S. A., & Van der Velden, K. (2017). A narrative Synthesis of Illustrative Evidence on Effects of Capitation Payment for Primary Care: Lessons for Ghana and other low/middle-Income Countries. *Ghana Medical Journal*, 50(4), 207. <https://doi.org/10.4314/gmj.v50i4.3>
- Dessler, G. (1997). *Manajemen Sumber Daya Manusia* (T. Iskandarsyah (ed.)). Prentice-Hall Inc.
- Hasan, A. G., & Adisasmito, W. B. B. (2017). Analisis Kebijakan Pemanfaatan Dana Kapitasi JKN Pada FKTP Puskesmas di Kabupaten Bogor tahun 2016. *Jurnal Kebijakan Kesehatan Indonesia*, 6(3).
- Koss, S. K. (2008). *Solving the Compensation Puzzle*. The Society for Human Resource Management.
- Kurnia, A. N., & Nurwahyuni, A. (2015). Analisis Perhitungan Kapitasi pada Fasilitas

- Kesehatan Tingkat Pertama yang Bekerja Sama dengan BPJS Kesehatan KCU Kota Bogor Tahun 2015. *Jurnal Ekonomi Kesehatan Indonesia*, 2(1), 24–31.
- Langenbrunner, J. C., Cashin, C., & Dougherty, S. O. (2009). *Designing and Implementing Health Care Provider Payment Systems : How - To Manual*. The World Bank.
- Regulation of the Minister of Health the Republic Indonesia Number 69 in 2013, (2013).
- Regulation of the Minister of Health The Republic Indonesia Number 71 in 2013 concerning Health Services in the National Health Insurance, (2013).
- Pope, G. C., Kautter, J., Ellis, R. P., Ash, A. S., Ayanian, J. Z., Iezzoni, L. I., Ingber, M. J., Levy, J. M., & Robst, J. (2004). Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model. *Health Care Financing Review*, 25(4), 119–141. <https://doi.org/hcfr-25-4-119> [pii]
- Presidential Regulation of Republic Indonesia Number 12 in 2013 concerning Health Insurance, (2013). <https://doi.org/10.1017/CBO9781107415324.004>
- Smither, J. W. (1998). *Performance Appraisal State of The Art in Practice*. Jossey-Bass Publishers.
- Telykov, A. (2001). Guide to Prospective Capitation with Illustrations from Latin America. In *Health Sector Reform Initiative*. Abt Associates Inc. http://new.paho.org/hq/dmdocuments/2010/51-Guide_Prospective_Capitation_Illustrations_from_LA.pdf
- Timpe, A. D. (1992). *Seri Ilmu dan Seni Manajemen Bisnis Kinerja*. Pt Alex Media Komputindo.
- Yang, L., Sun, L., Wen, L., Zhang, H., Li, C., Hanson, K., & Fang, H. (2016). Financing strategies to improve essential public health equalization and its effects in China. *International Journal for Equity in Health*, 15(1), 1–12. <https://doi.org/10.1186/s12939-016-0482-x>
- Zahroh, A. H., Putri, R. A., Shima, L., Erdayani, E., Martaliza, R., Anggoro, T. P., & Wulansari, W. (2019). Risk Adjustment of Capitation Payment System: What Can Indonesia Adopt from other Countries? *Jurnal Ekonomi Kesehatan Indonesia*, 3(1), 118–124. <https://doi.org/10.7454/eki.v3i1.2408>

