Sapporo Medical Journal
Volume 57, Issue 08, August 2023

SelectingIndicators to Measure Primary Health Care Capacity and Performance Nationally in Indonesia

Ari Dwi Aryani[1], Adang Bachtiar[2], Cicilya Candi[2*]

[1]Faculty of Public Health Universitas Indonesia, Indonesia
[2]Health Policy and Administration Department Faculty of Public Health Universitas Indonesia, Indonesia

Abstract— Inequity in health services still occurs after the implementation of the National Health Insurance (JKN). Periodic monitoring of the performance of Primary Health Care (FKTP) is the key to reducing health service inequity as the main goal of JKN. This study aims to define indicators to measure performance and capacity that need to be updated. The research began with a systematic literature review (SLR) to identify indicators that can be used to measure the capacity and performance of FKTP. Measurement indicators obtained from SLR are then selected through Consensus Decision Making Group (CDMG). The indicators agreed on in the CDMG to articulate indicators that will use in measuring the capacity of primary health care in Indonesia are General practitioner (GP) ratio, the adequacy of health infastructure, and the amount of capitation received. Indicators that will use in measuring the performance of primary health care are first contact, cronic disease program routine inspection of diabetic patients and hypertensive patients, percentage of patients who come without being referred to the hospital, non-specialty referral ratio, percentage of patients referred back, percentage of screening: breast cancer, cervical cancer, heart disease, diabetes mellitus, and hypertension; and diabetes education. This study identified indicators to measure the capacity and performance of primary healthcare facilities that can be applied in Indonesia.

Keywords: Universal health coverage, capacity, performance, health service

Introduction

FKTP is the most accessible health service provider for JKN participants.(1) Performance monitoring is carried out periodically to ensure access to health services can reach the entire population and health services are received by individuals who need them(2) Thus, it is necessary to monitor the performance of FKTP.Monitor the performance of FKTP in a structured and continuous manner in Indonesia, since 2016 BPJS Kesehatan has implemented performance-based capitation payments (KBK). Research by Hidayat etal. (2017) found that the application of KBK influenced improving the quality of FKTP as indicated by a comparison between the quality index values achieved by the KBK Health Center compared to similar values in the Non-KBK Health Center group. Even though there has been an increase in the performance of JKN primary services nationally, there are still differences in performance achievements between regions, per type of FKTP and each FKTP.(3) Only FKTPs in Java and Sumatra were able to achieve the target, while FKTPs outside these areas were on average unable to achieve the indicators.(4) Therefore, it is necessary to evaluate the performance of FKTP by region.

In addition, the performance indicators set for the KBK include the Contact Rate, Non-Specialistic Referral Ratio, and Controlled Chronic Disease Management (Prolanis) Program Participant Ratio(3). However, of the three performance indicators of the KBK FKTP, only the non-specialist referral ratio

indicator has been achieved nationally. Contact Number is an indicator to determine the level of accessibility and utilization of primary services in FKTP by Participants. However, this indicator is assessed without considering geographical conditions and population density. Therefore, indicators are needed that consider geographical conditions, the ratio of FKTP compared to participants and health promotive and preventive efforts.Based on the background above, this research seeks to develop a model of FKTP performance indicators in the KBK scheme that can increase equity in health services, published in this journal could be in form of original article and invited review article.

Method

This study contained two stages. First : Systematic Review (SR), second : Consensus Decision Making Group (CDMG). The first stage aims to determine indicators to measure capacity and performance of primary health care. This search used three database: ProQuest, Scopus, and Science Direct and using The Preferred Reporting Items of Systematic reviewsMeta-Analyses (PRISMA)guidelines to adjusted the research. The first stage for the search applied with three indicators such as capacity andperformance. Each indicator used PCO (Population, Context, and Outcome).

Table 1. PCO Method Research of Capacity and Performance

Indicator	Population	Context	Outcome
Capacity	Primary Health Care (PHC)	Capacity PHC	PHC Capacity Indicators
Performance	Primary Health Care (PHC)	Performance PHC	PHC Performance Indicators

In the filter process, thestudy included full text, journal article type, dates of publication not older than ten years, the study with open access, and original research. Papers were selected based on the eligibility of articles to be reviewed, which included the title, abstract, and full text. After removing duplicate and insufficient articles, the complete reports obtained were those eligible for entry into further research.

The second stage with Consensus Decision Making Group (CDMG) refers to agreement on some decision by all members of a discussion group. The CDMG stage was to formulate indicators to measure capacit and the performance of FKTP. Members of the group consisted of selected members, namely the representative of the National Social Security Council of Indonesia, the Minister of Health Indonesia, the Cost Control and Quality Control Team BPJS, the Professional Organization, and the Healthcare Association. CDMG was conducted with the following steps:

Figure 1. Consensus Decision Making Group (CDMG) Steps

Basics steps to Consensus Decision Making Group (CDMG) Steps with six steps. For the first step was discussion with indicators from the first stage for the capacity and performance. Step two with identifying emerging proposals to gather input and ideas from all participants. Step three with identifying any unsatisfied concerns for the indicators. Step four with collaboratively modify the proposal to work through differences and reach a mutually satisfactory position. Step five asses the degree of support to collective intelligence. Final step, step six to finalize the decision or circle back to step one or three.

The facilitator for the CDMG helps with step by step until the formulates have been reached. The direct process of the meetings without involving for the decision-making. Make sure the facilitator makes all participants take roles to share their thoughts and share their individual expertise to reach a decision.

Results and Discussion

3.1 Searching and Screening Result

Identification paper for each indicator for the capacity and performanceindicators with 302.791 articles and 334.404 articles. Then deleted similar articles. After that the screening stage for fullpaper for each capacity and performance indicators with 450 articles and 2.584 articles. Deleted articles that were not eligible with 315 articles, 2.441 articles, and 4.305 articles. The study that relevant for the whole text for each indicator for the capacity and performanceindicators with 12 articles and 15 articles.

The indicators for Primary Health Care (PHC) capacity indicators with 12 articles. The indicators for PHCperformance indicators with 15 articles.

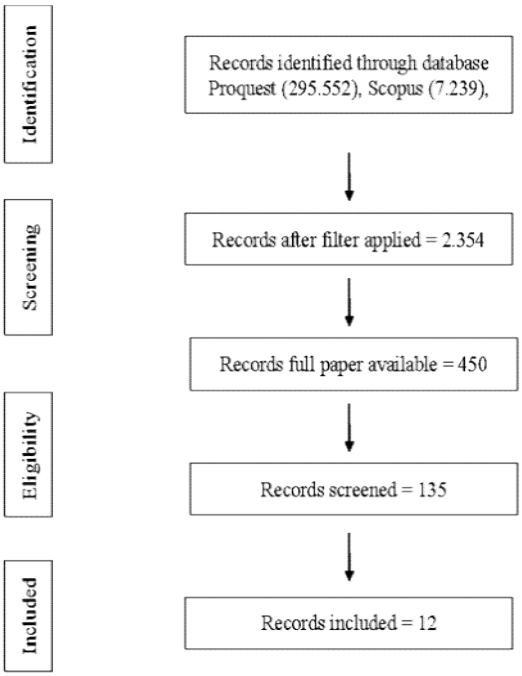

Figure 2. Systematic Review Flowchart of Capacity

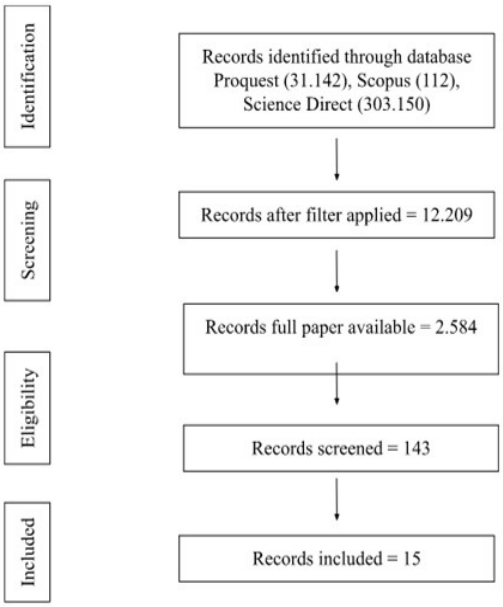

Figure 3. Systematic Review Flowchart of Performance

Table 2. Indicators Regarding Primary Health Care (PHC) from SLR

Variable	Indicators
Capacity	Management type, Facility types; Type of service provided; Districts; Service in years (operation); Daily service available; Infrastructure; Services; Drug availability; Human resources; IT System; and Workforce / Human Resources.
Performance	Proportion of patients with pain in diabetic neuropathy treated with traditional nonsteroidal antiphlogistics; Proportion of patients with pain in diabetic neuropathy treated with selective Cox-2 inhibitors; Proportion of patients with diabetes with a blood pressure measurement < 140/85 mmHg in the preceding 12 months; Proportion of patients with diabetes with HbA1c levels < 7.5% in the preceding 12 months; Proportion of patients with diabetes with total cholesterol < 5 mmol/l in the preceding 12 months; Proportions of patients with a total cardiovascular risk score over 20%; Mean based on the most recent systolic/diastolic blood pressure measurement; Mean based on the most recent total cholesterol measurement; Proportion of patients with two documented blood pressure measurements; Proportions of patients with a documented total cardiovascular risk score; Proportion of patients enrolled in health plans per region\Number of hospitalisations per 1000 persons; Proportion of patients enrolled in health plans per region; Proportion of patients with two documented blood pressure measurements; Mean based on the most recent total cholesterol measurement; Proportion of patients with diabetes with HbA1c levels < 7.5% in the preceding 12 month; Proportion of patients with diabetes with total cholesterol < 5 mmol/l in the preceding 12 months; Estimated smoking prevalence (%); Prevalence of obesity (%); COPD prevalence (%); Cancer prevalence (%); CHD prevalence (%); Number of active GPs on the number of active specialists; and Proportion of patients whose last total cholesterol measurement was ≤ 5 mmol/L.

The results of the SLR search were brought to the CDMG. The CDMG process involved 7 representatives from the Indonesian National Social Security Council (1 person), the Indonesian Ministry of Health (1 person), the JKN Cost Control and Quality Control Team (2 people), the Professional Organisation (1 person), and the Health Facility Association (1 person).

The CDMG process was based on the steps described in the method (figure 1). The CDMG results obtained indicators of FKTP capacity that will be used in measuring FKTP capacity in Indonesia are the ratio of general practitioners, the adequacy of health infastructure, and the amount of capitation received. Indicators of FKTP performance that will be used in measuring FKTP performance in Indonesia are first contact, cronic disease program routine inspection of diabetic patients and hypertensive patients, percentage of patients who come without being referred to the hospital,

non-specialty referral ratio, percentage of patients referred back, percentage of screening: breast cancer, cervical cancer, heart disease, diabetes mellitus, and hypertension; and diabetes education.

1.2. Discussion

1.2.1. FKTP Capacity Measurement

In order to provide outcomes that will increase health service equity, indicators of FKTP capacity and performance must be updated. The ratio of general practitioners was discovered to be one of the variables utilised to estimate FKPT capacity in this study. Previously, the number of general practitioners was utilised as an indication. According to the CDMG, the GP ratio would be better able to measure the capability of primary healthcare facilities. The availability of health workers greatly supports the service capacity of an FKTP, in addition to the availability of medicines, disposable medical supplies and infrastructure facilities. Based on BPJS Kesehatan regulation No. 2 of 2015, there are indicators to determine optimal coordination and cooperation at the FKTP level in a system such as referrals. Organized according to medical indications and competence was important.

GP Ratio. Adequate human resources were very important in providing optimal service to patients. Also, the availability of human resources will affect the type of service and duration of FKTP accessibility services to participants. And the adequacy of health facilities was assessed based on the sum of the FKTP credentialing or credentialing score was important with CDMG. Variables in health service facilities that must be available include the availability of health workers, financing the utilization of each health service, and the ease of getting health services. (5)

Infrastructure. Infrastructure selected as capacity indicator since it is critical to have adequate facilities and infrastructure when providing health services. IT availability is one of the metrics considered. The existence of an IT system that automates administrative services will reduce the workload of FKTPs for administration thereby increasing the capacity of health services. Providing quality, effective, and efficient services and patient safety oriented. The existence of an IT system (especially innovative use of IT in expanding the provision of services to participants) can improve access to services for participants. Data integration in IT systems is needed to increase access to health services that contribute to continuity of care as stated in the objectives of the Indonesian primary care system. (6)

The amount of capitation received. The capitation funds received by the Government's FKTPs (KBK) are used to pay for additional services for health workers and to support the operational budget, such as purchasing medicines and infrastructure. Salaries and other rights for government employees who work in government owned FKTPs are budgeted separately. (7) Meanwhile, for private FKTPs, the use of capitation funds is not regulated in laws and regulations. Private FKTPs manage their own capitation funds received every month.(8)

Ownership was very important in determining the budget orfinancing and can be used as a benchmark in assessing the performance of health facilities. But with the ownership can be less able to link between the type of ownership with service equity. Based on the type, the number of FKTPs collaborating with BPJS Health as of April 2022 was 23,391 FKTPs with details of 10,242 Health Centers (44%), Primary Clinics 7,077 (30%), Individual Practicing Doctors 4,857 (21%), Individual Dentists 1171 (5%) and Class D Pratama Hospital 44 (0.2%). The highest proportion of FKTPs are Community Health Centers with 147.5 million registered participants (79%) of the total JKN participants.(9)

Financing availability of system information for the amount of capitation received is based on

performance appraisal was important. There was a correlation with the effectiveness and quality of services and medical records. Hospitals make it possible to track results over time by seeing between expectations and available benefits. Evaluation medical records within a health care system to see the success of a program of healthcare to patients. (10)

In the Financing area there was a correlation with the size of the service benefits. Financing indicators, if assessed from the amount of capitation received based on performance appraisal, do not describe service capacity, but rather describe the suitability of capitation payments only. Quality services must be supported by adequate and fair financing. Health service financing will affect FKTP behavior in providing health services. Capitation is a set amount money received or paid out, it based on membership rather than on services delivered and usually is expressed in units of per member per month; may be varied by such factors as age and sex of the enrolled member(11).

1.2.2. FKTP Performance Measurement

First contact. First-contact services involve providing easily accessible services and utilizing these services when the need for services arises, so that the patient's first contact for services or service utilization. (12)In accordance with BPJS Health regulations No. 7 2019, the implementation of KBK payments was assessed based on the achievement with first contact number with a target of 150%. With low numbers for achievement in first contact it was a serious concern to find out the level of accessibility and utilization of primary services in FKTP. (13)

The performance evaluation includes KBK indicators that FKTPs must meet, such as the number of contacts, the ratio of non-specialist outpatient referrals, and the ratio of participants in a managed chronic disease programme. (14) First contact can assess care seeking behaviour and data management for the FKTP's facilities for every capacity and performance measurement.

Cronic disease program routine inspection of diabetic patients and hypertensive patients. Indonesia's government through BPJS Kesehatan has launched a chronic disease management program called Prolanis. This programme aims to improve outcomes for patients with chronic diseases such as diabetes and hypertension. Prolanis makes use of the health-care system and a proactive approach that is regularly integrated. Patients with diabetes or hypertension are encouraged to participate in this programme. The participation to compel patients to visit healthcare facilities in order to receive health care. (15) Prolanis for hypertensive patients with higher utilities value had an impact for physical and mental health state in the intervention group.(16)Especially for hypertension or high blood pressure and diabetes mellitus is a serious concern by the government because these two diseases can cause other complications which are more dangerous if not managed properly. The controlled ratio of Prolanis program participants is an indicator to determine optimization Prolanis management by FKTP in maintaining fasting blood sugar levels for type 2 diabetes mellitus patients or blood pressure for essential hypertension patients with a target of 5%. (17)

The achievement trend of health history screening continues to increase every year. It was recorded that in 2021, the number of participants who accessed the health history screening service was 2,205,979 people compared to the previous year which only recorded 195,675 people. (18)Percentage of screening: breast cancer, cervical cancer, heart disease, diabetes mellitus, and hypertension; and diabetes education by primary health care to focus the promotive and preventif based on data for every region. (19)Indicators for non-specialist referral ratio based on service quality in FKTP, such that the referral system is organised according to medical indications and competence is less than 2%. (17) In comparison to the targets stated, realisation in 2022 attained 60.01% (4,880 Community Health

Centres), or 100.02% of the 2022 target by 25 provinces. (20) In 2022 participants who use health services in FKTPs numbered 205,6 million and for participants were being referred to the hospital were 95,9 million.(9)From the composition of JKN-KIS participants which reached 224,481,164 participants (as of June 2020), 40% of the participants are also aged ≥40 years which is an age with a risk of chronic disease. Therefore, comprehensive promotive and preventive activities are needed as a form of prevention and control of chronic diseases so that they do not fall into catastrophic conditions. (18)

Percentage of patients who come without being referred to the hospital. The results of a study by the Center for Health Economics and Policy Studies (CHEPS) at the Faculty of Public Health, University of Indonesia (2017) with BPJS showed that during 2014-2017 there were 1.8 million cases with a diagnosis of referral back visiting hospitals and then 1.2 million cases were referred directly to type A hospitals from FKTP, and 714 thousand non-specialist cases. (21) With the KBK the health worker explains to patients that FKTPs now can provide without being referred. If the negotiating practice as patients' orientation of disease management is still hospital-based, with JKN inadequately acknowledge General Practitioners' experiences, lists of diseases set by JKN in primary care limits the GPs' practice, limited medicines available in primary care and limited numbers of GPs in Puskesmas will be high numbers of reffered. (22)Under JKN implementation the KBK will motivate the primary health care to continue to perform better, by being the first contact for participants who are their responsibility and dealing thoroughly with diseases according to their competence.

Percentage of patients who come without being referred to the hospital in non-specialty referral ratio.Referral services are health services provided by first-level health facilities to people with chronic diseases stable condition on recommendation/referral from advanced health facility and percentage of patients referred back with SISRUTE (referred integration system) by p-care. (23)Service coordination for the percentage patients who came without being referred to hospital, non specialty referral ratio and percentage of back patients referred were important. There was a correlation between the function of FKTP as gatekeepers. The arrival of patients and referrals influenced by various things, especially the emergence of moral hazard from the hospital side which often asks for repeat referrals from FKTP. This indicator should be optimally captured by RRNS (Outpatient Referral for Non-Specialistic Cases). So that participants do not need to be referred to the hospital and optimally manage chronic disease sufferers on a regular basis with FKTP.

Service coordination with optimizing the competence of medical personnel and health facilities according to the competence of general practitioners and fair financing methods. Referrals can be given according to medical indications. Two main things that must be considered in determining capitation are the accuracy of the prediction of utilization rates (use of health services) and the determination of unit costs. The capitation rate is highly influenced by the health service utilization rate and the type of health insurance package (benefit) offered as well as the unit cost of the service. (24)

Percentage of screening: Service comprehensiveness for the percentage Breast Cancer Screening, percentage Cervical Cancer Screening, percentage Heart Disease Screening, percentage DM Screening, percentage Hypertension Screening and Diabetes Education were important. For every cancer screening there was a correlation with prevention efforts as early as possible for suffering from cancer. One of the indicators in measuring UHC achievement according to WHO is in non-communicable diseases on cancer screening. The percentage of at-risk participants who were screened into FKTP performance to conducting preventive services with early detection of breast cancer cases.

When breast cancer is detected and treated early, the chances of survival are very high. The early

detection program development phase begins with the necessary management strategies for clinically detectable disease diagnosis based on awareness education and technical training, history and physical examination, and accurate tissue diagnosis.(25)Screening efforts aim at early identification of disease so that it can be treated as soon as possible and prevention of potentially catastrophic disease conditions.The results of the FKTP performance and capacity intervention cannot be intervened as equity, but through the provision of FKTP by the Regional Government. Urban and rural areas were very different in terms of the affordability of access to health services and the availability of medical personnel and limited infrastructure. The easiest access for the participant to use services will differ between urban and rural areas. Health equity has a close relationship with various similar concepts such as health disparities, health care disparities, health inequalities, health inequities. (26)

There was a correlation with the number of hospitalizations for a disease and its costs. The level of utilization of hospital services does not necessarily correlate with the performance of FKTPs as gatekeepers, but there was a moral hazard factor for participants and FKRTL and the ratio of FKRTL availability for the distribution of health services. This indicator can assess FKTP's equity and commitment to contacting its participants.

FKTP collaboration can be carried out if the results of credentialing fall into categories A and B with recommendation area. In certain conditions such as the unavailability of other FKTPs in an area, FKTPs with category C and D with unrecommendation area to credentialing results can still be collaborated with BPJS Kesehatan. All results of credentialing and recredentialing are entered into the Health Facilities Information System (HFIS) application owned by BPJS Kesehatan.(27)

Conclusion

Indicators to measure the capacity important for the availability of general practitioners, infrastructure, and financing availability of system information were important. Indicators for performance FKTP first contact, service continuity, service coordination and service comprehensiveness were important. Indicators from capacity and performance are needed to measure equity. With these indicators, the equity can be analyzed for evaluation with FKTP location, participant utilization for each region, utilization for each demographic and health outcome.

Competing Interest

The authors declare that there are no competing financial, professional, or personal interests that might have affected the research in this manuscript.

Availability of Data and Materials

As a source of data and information from ProQuest, Scopus, and Science Direct databases.

Authors' Contribution

ARA and AB contributed substantially to the concept and work design. ARA conducted data analysis and data interpretation. ARA drafting of the manuscript. CC and AB revised critically for the content and final approval of the version to be published.

Acknowledgment

The authors gratefully acknowledgeArifahAlfiyyah, Dewi Gemilang Sari and Nikmatul Hidayah for helping screening articles.

Financial Disclosure
This study receive a grant from University of Indonesia, Postgraduate PUTI.

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