Systematic Review

FACTORS RELATED TO THE ACHIEVEMENT OF SERVICE COMMITMENT-BASED CAPITATION INDICATORS AT COMMUNITY HEALTH CENTERS IN ACEH PROVINCE

ABSTRACT

The increasing trend of health care costs has prompted the government to seek financing alternatives that can streamline funds without reducing the quality of services. One such system is the implementation of the commitment-based capitation consequence where the puskesmas is paid based on the number of registered participants who are responsible for its effectiveness monitoring by looking at the tendency of contact numbers (≥1500/00), prolanis ratio (≥50%), and non-specialist case referral ratio (<0.5%), so it is expected that moral hazard from the supply side can be prevented or minimized. This study aims to determine the factors associated with the implementation of Capitation Based on Service Commitment

This research was conducted in Propinsi Aceh area with Puskesmas as analysis unit, with sequential model mixed method (quan → QUAL), qualitative data was taken by indeph interview method to key informant related to validate data which can not be validated by quantitative method.

The results of two year implementation significantly increased the average contact rate in 2020 by 192.6 0/00 (target ≥150 0/00), and the average prolanis ratio of 44.9% (≥50%), and lowering the average non-specialist case referral ratio to 0.3% (target <5%). From multivariate analysis, variables modeling related to achievement of service commitment indicator were capitation value, human resources (adequacy of doctor, nurse, midwife, pharmacy) are significant influence dominanly to achievement indicator of service commitment (p value <0.05).

mplementation of capitation compensation is positive enough to give an effect for all puskesmas efforts to achieve the indicator of service commitment, on the other side of the indication of moral hazard, so monitoring and evaluation is needed to create the quality service..

Keywords: implementation of capitation based on service commitment, communication contact, prolanis ratio, non-specialist case ratio

1. INTRODUCTION

The 1948 Constitution of the World Health Organization (WHO) states that "Health is a fundamental human right", which means that health is a very basic right for a human being. As a basic need, fulfilling health is not only the responsibility of everyone, but also the responsibility of the Government, because constitutionally, the Government is obliged to guarantee that all citizens in each region receive health services of the same quality and standard, according to their aspirations. the Indonesian people as referred to in Pancasila and the 1945 Constitution of the Republic of Indonesia were amended to include social security rights for all people (article 28H) and in 2002 with the fourth amendment to the 1945 Constitution the State was ordered to develop a National Social Security System (1945 Constitution, 2002).

To realize constitutional commitments, the government is responsible for implementing public health insurance through the National Health Insurance (JKN) since 1 January 2014. With the issuance of Law no. 24 of 2011 the implementation of JKN is managed by the Health Social Security Administration Agency (BPJS).

In an effort to be able to build quality services for National Health Insurance (JKN) participants, it is necessary to pay attention to aspects of service quality. The aspect of service quality is strongly influenced by the amount of payment, the behavior of the serving health workers, the motives for health services (profit seekers or not), and the adequacy of the supply of drugs and other consumables which affect the quality of services (JKN Roadmap, 2015)

The quality of health services is oriented towards aspects of patient safety, action effectiveness, compliance with patient needs, and cost efficiency. The quality control system for National Health Insurance services is carried out in a comprehensive manner covering compliance with medical quality standards (health services), non-medical quality (health facilities) and administrative quality (reporting). Apart from that, it is also necessary to ensure that the health service process runs according to the established standards and that there is monitoring of the Participant's health outcomes. The quality of health services provided must be measurable and standardized.

Various types of measurements, standards and efforts to improve service quality are available and continue to develop. One of them is the service commitment-based payment method, where this method is one of the most widely discussed strategic concepts, even various groups in America since 2003 have pushed for service commitment-based payments or pay for performance to become a top national priority and the Medicare insurance program.

In the implementation of the National Health Insurance, Health Social Security Administrative Body (BPJS Kesehatan) will be required to be able to monitor, evaluate and encourage the quality of service and safety of patients (Participants) provided by Health Facilities. It requires high support and commitment from all FKTPs to make quality primary services so that they become health facilities that are trusted and provide the best service. The concept of Primary Health Care (PHC) in strengthening primary health care facilities can encourage efficiency in health services. In order to obtain quality and affordable health services, it is necessary to be supported by health resources, complete facilities and infrastructure, scope of service and service commitment. Based on the above, to improve the quality of FKTP health services in the implementation of the National Health Insurance Program, capitation payments are implemented based on fulfilling service commitments.

One of the universal problems of health care programs in various countries is the sharp increase in health costs over time. Factors causing increased health costs include the epidemiological transition marked by changes in disease patterns that cause Indonesia to face a "Triple Burden", the use of sophisticated and expensive health technology and the provision of excessive health services (Gani, 1998; and Azwar, 2002). This uncontrolled increase in health costs causes inflation in the health sector in America 2-3 times greater than general inflation (Feldstein, 1998)

The doctor is of the opinion that this capitation payment has a negative impact on the income he receives. Their income reportedly fell by 30%. In the United States, 61% of Manage Care participants were disappointed with the shortened primary doctor's service time and the increased waiting time for these services (HIAA, 2000). Crowley, Zitner, and Smith (2001) stated that there is no single payment

method to health facilities (FFS, capitation, and salary system) that can satisfy all parties, because each payment method has its own strengths and weaknesses. This situation prompted MCO managers to develop other prospective payment methods, namely: package tariffs, budget systems and diagnostic related groups (DRG), FFS discounts, etc. (HIAA 2000, and Sulastomo 2001)

The implementation of JKN in primary and secondary services adheres to the principles of managed care which is based on cost control and quality control. The performance of health services in the JKN era can be seen in the Joint Regulation of the Secretary General of the Ministry of Health of the Republic of Indonesia and the Main Director of the Organizing Agency for Health Social Security No.HK.02.05/III/SK/089/2016 No.3 of 2016 and updated with the Joint Regulation of the Secretary General of the Ministry Health of the Republic of Indonesia and Main Director of Health Social Security Organizing Agency No.HK.01.08/III/980/2020 No.2 of 2020 concerning Technical Guidelines for Implementation of Capitation Payments Based on Fulfillment of Service Commitments in FKTP based on achievement indicators which include indicators (1) Contact Number ≥ 150 per mile, (2) Non-Specialistic Outpatient Referral Ratio < 5% and (3) Prolanis Participant Ratio Routinely Visiting FKTP ≥ 50%. If the FKTP can meet these indicators it is included in the safe zone.

By achieving the contact number, it is hoped that the efforts of the Puskesmas in maintaining the health of participants in their area will be more optimal because there has been an increase in health promotion efforts, preventive in an effort to maintain health, because visits are not only curative. And achieving a relatively small non-specialty outpatient referral ratio indicates that the services provided are more effective and efficient at a lower cost because PPK 1 has completed them as gatekeepers compared to if these services are carried out in hospitals, this is also a step to reduce the accumulation of patients in RS is like a problem that has been complained about a lot. Health services are expected to be structured and tiered, participants who need health services must first obtain health services at First Level Health Facilities (FKTP). If participants need advanced health services, a referral must be made by a first-level health facility, except in medical emergencies (Kemenkes RI, 2013).

Through the achievement of Prolanis indicators, it is hoped that health services for the elderly will be provided through a proactive approach that is carried out in an integrated manner involving participants in the context of health care for participants suffering from chronic diseases to achieve optimal quality of life with effective and efficient health care costs (Health Insurance Organizing Agency, 2014). The aim of this program in JKN is to encourage participants with chronic diseases to achieve optimal quality of life with an indicator that 75% of registered participants who visit the First Level Health Facilities have "good" results on specific examinations for Type 2 DM and Hypertension according to the relevant Clinical Guidelines so as to prevent disease complications (Health Insurance Organizing Agency, 2014).

JKN has been implemented since 2014, and service commitment-based capitation has been implemented since 2016. Until now it has entered its third year, but of the 340 Puskesmas in Aceh, not all Puskesmas have fulfilled the three established service commitment indicators, namely 234 (68.8%) of puskesmas and there has not been an analysis of the factors that influence the contact rate, the ratio of non-specialist case referrals, and the prolanis ratio, so that the effectiveness of the CBC implementation policy can be known, for this reason this research was conducted.

2. METHODS

This research was conducted in Propinsi Aceh area with Puskesmas as analysis unit, with sequential model mixed method (quan · QUAL), qualitative data was taken by indeph interview method to key informant related to validate data which can not be validated by quantitative method.

3. RESULT

General Description of Aceh Province Region In The Village To Conduct The Community Empowerment Process

Aceh Province is located between 01o 58' 37.2" - 06o 04' 33.6" North Latitude and 94o 57' 57.6" - 98o 17' 13.2" East Longitude with an average altitude of 125 meters above sea level . In 2012 Aceh Province was divided into 18 districts and 5 cities, consisting of 289 districts, 778 mukim and 6,493 gampongs or villages. The boundaries of the province of Aceh, to the north and east by the Malacca Strait, to the south by North Sumatra province and to the west by the Indonesian Ocean. The only land connection is with North Sumatra Province, so it has a fairly high dependency with North Sumatra Province.The area of Aceh Province is 5,677,081 ha, with forest as the largest land which reaches 2,290,874 ha, followed by smallholder plantations with an area of 800,553 ha. While industrial land has the smallest area of 3,928 ha.

As a region that is not far from the equator, the climate in. Aceh is almost entirely tropical. In coastal areas, the average temperature is 26.9 °C, the maximum temperature is 32.5 °C and the minimum is 22.9 °C. The relative humidity of this area ranges between 70 and 80 percent. Between March and August Aceh experiences a dry season phase, this condition is influenced by the air mass of the Australian continent. Meanwhile, the rainy season lasts from September to February, which is generated from the air masses of the Asian mainland and the Pacific Ocean. Aceh has rainfall that varies between 1,500-2,500 mm per year.

Aceh Province has a flat to mountainous topography. Areas with flat and sloping topography account for around 32 percent of the area, while hilly to mountainous areas account for around 68 percent of the area. Areas with mountainous topography are in the central part of Aceh which is a cluster of Bukit Barisan mountains and areas with hilly and sloping topography are located in the north and east of Aceh. Based on the hilly and sloping topography class there are in the north and east of Aceh. Based on regional topography class, Aceh Province which has a flat topography (0 - 2%) is spread along the west-south coast and north-east coast of 24.83% of the total area, sloping (2 - 15%) spread between the Seulawah mountains and the Krueng Aceh River , on the west-south coast and north-east coast of 11.29% of the total area; steep slope (15 - 40%) of 25.82 percent and very steep (> 40%) which is the ridge of the Seulawah mountains, Mount Lauser, and the shoulders of existing rivers of 38.06 percent of the total area.

Aceh Province has an average elevation of 125 m above sea level.

The percentage of area based on its altitude, namely: (1) Areas with an altitude of 0-25 m asl constitute 22.62 percent of the area (1,283,887.27 ha), (2) Areas with an altitude of 25-1,000 m asl amount to 54.22 percent of the area (3,077,445.87 ha), and (3) Areas with elevations above 1,000 m asl amounting to 23.16 percent of the area (1,314,526.86 ha).

The total population of Aceh at the end of 2009 was 4,363,477 people, with a total number of heads of families or households of 1,073,481 heads of families/households. Aceh's population growth rate for the last 5 years (2006-2009) was 1.66 percent. The city of Sabang has the lowest population growth rate compared to other districts/cities in Aceh, which is 0.10 percent, while the district of Aceh Jaya has the highest, which is 7.90 percent. The distribution of the population in the Aceh region is still uneven. The district/city that has the largest population is North Aceh District (532,535 people) and the smallest population is Sabang City (29,184 people).

Aceh has 119 islands, 35 mountains, 73 major rivers and 2 lakes. Land characteristics in Aceh Province in 2009 were mostly dominated by forests, with an area of 3,523,817 hectares or 61.42 percent. The second largest land use is large and small plantations reaching 691,102 hectares or 12.06 percent of the total area of Aceh. The area of paddy field farming is 311,872 hectares or 5.43 percent and dry season agricultural land reaches 137,672 hectares or 2.4 percent and the remaining mining, industrial, village, inland waterways, open land and other natural reserve lands are below 5.99 percent. 6. Regional Development Potential

Aceh Province has a variety of natural resource wealth including oil and gas, agriculture, industry, plantations, land and sea fisheries, general mining which have the potential to be developed in accordance with the Aceh Regional Spatial Plan. In general, the determination of Development Areas (WP) in Aceh is grouped based on geographical position, namely: (1) Banda Aceh and its surroundings, (2) East Coast, (3) Central Mountains, and (4) West Coast. The Development Area in question has several activity centers in the area which can be: National Activity Center (PKN), National Strategic Activity Center (PKSN), Regional Activity Center (PKW) and Local Activity Center (PKL). The determination of PKN and PKW is the authority of the government, and

has been stipulated in the National Spatial Plan (RTRWN). Meanwhile, street vendors are determined in the Provincial RTRW, in accordance with the provisions in Article 11 paragraph (3) of Government Regulation (PP) No.26/2008 concerning RTRWN. Determination of the development area based on the Aceh Province spatial plan.

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Description of Service Commitment-Based Capitation Implementation

Commitment-Based Capitation is carried out on the basis of the Joint Regulations

Secretary General of the Ministry of Health of the Republic of Indonesia and Main Director of the Health Social Security Organizing Agency No.HK.02.05/III/SK/089/2016 No.3 of 2016 and updated with the Joint Regulation of the Secretary General of the Indonesian Ministry of Health and Main Director of the Health Social Security Organizing Agency No. .HK.01.08/III/980/2020 No.2 of 2020 concerning Technical Instructions for Implementation of Capitation Payments Based on Fulfillment of Service Commitments at FKTP.

The implementation of Service Commitment-Based Capitation in Aceh Province began in June 2016. As for the implementation at the Community Health Centers, the consequence was that there was a cut if there was an indicator of service commitment that could not be found, while the implementation of CBC at other FKTPs including Clinics and Individual Practicing Doctors was also carried out, but there are no consequences and new consequences will be applied starting July 2018..

Quantitative Research Results

When viewed from the sub-district health center level, it can be seen that the least number of contacts is 56.90/00 to 339.20/00 with an average of 169.90/00 with a standard deviation of 75.90/00. And at the kelurahan health center level that the least number of contacts is 20.70/00 to 411.020/00 with an average of 196.30/00 with a standard deviation of 84.40/00. This shows that there is inequality in the achievement of contact numbers in the ACEH regional health centers.

When viewed from the sub-district health center level, it can be seen that the prolanis ratio is at least 0.0% to 100% with an average of 44.9% with a standard deviation of 40.9%. And at the sub-district health center level the prolanis ratio is at least 0.0% to 100% with an average of 59.1% with a standard deviation of 45.7%, while in the kelurahan that the prolanis ratio is at least 0.0% to 100% with an average of 42.8% with a standard deviation 41.8%. This shows that the achievement is quite even, even if on average it is still less than the expected target (> 50%), this shows that the village health center is also quite aggressive in conducting prolanis clubs so that it can boost the achievement of the prolanis ratio at the village health center.

The number of participants who were referred with a diagnosis included in the FKTP competency level according to the Clinical Practice Guidelines compared to the total number of participants referred by the FKTP multiplied by 100 (one hundred) from 2016 to 2020 shows that the ratio of non-specialist case referrals to puskesmas ranges from 0.0% to with 11.7%, with an average of 0.3%, a standard deviation of

1.03%,

Of the 340 Community Health Centers in ACEH, as of the end of December 2020, 230 (67.6%) Community Health Centers had succeeded in achieving the target of 3 safe indicators, and 5 (1.5%) Community Health Centers had not yet reached 3 indicators, and 105 (30.9%) Community Health Centers had reached 1 to 2. of the 3 targeted indicators.

Qualitative Research Results

The aspects of communication in this study that were asked to informants included transmission, clarity and consistency. Following are the results of data collection on the communication aspect in terms of CBC implementation described as follows:

In the transmission aspect, what is measured is how the process of delivering policies related to CBC, is conveyed in stages from policy makers to policy implementers and the community as the target beneficiary group as well as parties related to policy implementation based on the Joint Regulation of the Secretary General of the Indonesian Ministry of Health and the Main Director of the Social Security Administration Agency Health No.HK.01.08/III/980/2020 No.2 of 2020 concerning Technical Guidelines for Implementation of Capitation Payments Based on Fulfillment of Service Commitments at FKTP. Informants indicated that this KBK policy had been known and conveyed in stages from policy makers, in this case the BPJS, the Aceh Provincial Health Office, the Health Sub-Department, the Sub-District Health Center, and the Kelurahan Health Center in the Aceh Province region. In the aspect of clarity, what is measured is how the process of explaining the understanding of the policy is carried out appropriately, in accordance with the objectives of the policy and is carried out continuously, thereby minimizing misinterpretation or distortion of information from what policy makers want to policy implementers and targets. In the aspect of consistency, what is measured is whether there is a similarity in the information received from policy makers to policy implementers and target groups in policy implementation.

The disposition aspect in this study covers the attitudes of policy implementers and incentives for implementers who carry out policies within the framework of CBC implementation. In the aspect of the implementer's attitude, what is measured is the attitude or tendency of the executor's attitude at the Puskesmas level. Do the executors have an attitude of acceptance and make more effort to achieve the KBK indicators, are indifferent or reject the policy. In the aspect of incentives for policy implementers, what is assessed here is how the mechanism for utilizing capitation funds for the distribution of services, thereby strengthening efforts to achieve the 3 indicators of service commitment. Based on data collection through WM there are differences in the utilization of capitation for services. For starters, we found out what the capitation fund disbursement mechanism looks like to the sub-district health center.

The resource aspect in this study covers the availability of available resources, including human resources, funds and facilities in terms of implementing CBC. The human resources aspect in this study is based on the quantity and quality of human resources, because policy implementation will not be successful without the support of sufficient quantity and quality human resources. Quantity relates to the number of human resources whether it is sufficient to cover the entire target group, while the quality of human resources relates to the skills and competencies in the field. Facilities or facilities and infrastructure are one of the factors that influence policy implementation. The provision of proper facilities, such as buildings, land and office equipment will support the successful implementation of a policy. Aspects of facility resources in this study include health facilities. Health service informants indicated that health facilities including health centers, hospitals, clinics and several other health service facilities are one of the important elements to support the implementation of the KBK. In policy implementation, the budget is related to the adequacy of capital or investment in a program or policy to ensure the implementation of the policy, because without adequate budget support, the policy will not work effectively in achieving goals and objectives. Aspects of funding resources in this study include how the availability of funds needed to guarantee the achievement of service commitment indicators, and funds for the operation of the health center.

4. DISCUSSION

4.1 Discussion Systematics

In this discussion there is no separation of the discussion between the results of quantitative and qualitative research, the results of the two studies are combined to obtain a flow of discussion that supports each other.

4.2 Contact Number

A different concept was carried out by BPJS and the Ministry of Health through the implementation of Service Commitment-Based Capitation, where the number of visits was replaced by communication contacts which resulted in an assessment of the contact number indicator, where the contact numbers here were not limited to only the number of patients who came to the Health Center for examinations due to illness, but The contact number here is also intended as a communication contact which also accommodates health visits as a promotive and preventive effort, so that this achievement will remain a provider's effort in service cost efficiency.

In statistical calculations the number of contacts has a tendency to increase significantly/significantly during the period 2016 to 2020, namely an average of 68%, which indicates that the implementation of the CBC is sufficient to have an effect for the puskesmas to improve this indicator.

4.3 Prolanis Ratio

There are several things that underlie changes in the achievement of the prolanis indicator, this category is new. So that the puskesmas has just started to jointly manage the prolanis club, so that it strengthens promotive and preventive commitments, where in the implementation of prolanis, this club synergizes between health workers and prolanis patients, and between prolanis patients themselves. to further improve lifestyles, share healthy lifestyles, and together do light physical movements that make conditions fitter, and are expected to increase the quality of life of prolanis patients

4.4 Non Specialty Case Referral Ratio

It is also different from the concept of referral rates during the Askes period, where the referral rate in question is the referral rate of Askes patients to hospitals as in research (Nurbaiti, 2001), in such circumstances the number of referrals was quite high in Aceh Province reaching 27.25 % so it is indicated that the Puskesmas in Aceh have a tendency to refer Askes patients, which is reinforced by the doctor's statement regarding the weak motivation of doctors to control referrals to hospitals, the powerlessness of doctors to refuse patient requests to get services at hospitals.

4.5 Characteristics of the Health Center

The variable characteristics of the Puskesmas are well explained by the level of the puskesmas, the puskesmas category, and the accreditation status of the puskesmas. Based on modeling, the level of Community Health Centers is proven to have a relationship with the achievement indicators of commitment to health services in Aceh Province, and has a positive loading score (0.949), where sub-district health centers have a tendency to achieve better contact rates than village health centers with an average contact rate of 193.40/00 compared to the village health center 192.5 0/00, but this condition is possible in the field that the sub-district health center will experience more congested conditions, because the target audience for the sub-district health center is larger than that in the village. The modeling category of puskesmas has also been shown to have a relationship with the achievement indicators of commitment to service commitments to puskesmas in Aceh Province, and has a positive loading factor (0.864), where inpatient puskesmas (8.82%) have better achievement of the 3 indicators of service commitment compared to non-inpatient puskesmas. (91.18%). Based on modeling, the accreditation status of puskesmas has also been shown to have a relationship with achievement indicators of commitment to puskesmas services in Aceh Province, and has a positive loading factor (0.889), where puskesmas that are accredited (15.88%) have better achievement of the 3 indicators of service commitment compared to puskesmas that have not accredited (84.12%). Puskesmas that have been accredited are considered to have advantages that are not owned by puskesmas that have not been accredited in terms of service standards, facilities, and several studies of patient satisfaction at accredited puskesmas are better than puskesmas that have not been accredited (Ministry of Health, 2010).

4.6 Communication

According to Edward III in Rusli (2015: 100-104), there are three important aspects in communication (Rusli, 2015), namely:

Transmission is a major factor in communication, because before a public official implements a decision, he must realize that a decision has been made and an order for its implementation has been issued (Rusli, 2015), then good communication distribution will also produce a good implementation (Rusli, 2015). Agustino, 2008). The results of research on the transmission aspect, the order to implement the KBK has been issued through the Joint Regulation of the Secretary General of the Ministry of Health of the Republic of Indonesia and the Main Director of the Health Social Security Organizing Agency No.HK.01.08/III/980/2020 No.2 of 2020 concerning Technical Instructions for

Implementation of Capitation-Based Payments Fulfillment of Service Commitments at FKTP. The transmission aspect in the form of outreach about KBK is carried out quite optimally by BPJS, with exposure at the notification level at the provincial level, and more at the Sudinkes level, and directly to the sub-district Health Centers, while at the sub-district level health centers the transmission aspect is through email notifications and deepened by socialization from the Health Center Subdistrict. While socialization from central policy makers, namely the Ministry of Health is still lacking, so it seems as if BPJS has an interest in this matter, on the other hand this is intended to maintain the quality of service itself, the Ministry of Health is involved at the level of policy formulation and sounding related to policy formulation. From the research results it is known that, in the aspect of clarity which includes understanding regarding the provisions in the Joint Regulation of the Secretary General of the Ministry of Health of the Republic of Indonesia and the Main Director of the Health Social Security Organizing Agency No.HK.01.08/III/980/2020 No.2 of 2020 concerning Guidelines Technical Implementation of Capitation Payments Based on Fulfillment of Service Commitments to FKTP and related to the implementation of capitation fund management based on Aceh Provincial Governor Regulation No. 165 of 2012 concerning Patterns of Financial Management for Regional Public Service Agencies at the Health Service level, which was previously in the form of Jamkesda and now in the JKN era, the PIC has changed from the Yankes Sector to the Financing Planning Sector, so that it is still in the adjustment stage regarding the personal team that took over the change, so it is assessed not sufficiently exposed to this KBK policy. From the results of the study it is known that the KBK implementation policy is in line with the KPLDH policy, in which one of the focuses is efforts to increase healthy contacts which can increase KBK achievements in the healthy score indicator, in line with the KPLDH policy which has created a special team door to door to collect data on the health of community members Aceh Province, so that once reaching 2, 3 islands is exceeded, the KPLDH target is met, in other cases the contact number indicator is met. While this is acceptable, because the standard specifications for achieving healthy numbers have not been tightened with the requirements that must be met, it can still be accommodated so that it is considered consistent between policy makers and policy implementation between KPLDH achievements and the increase in contact numbers originating from healthy contacts.

Based on the results of the study, there were inconsistencies regarding the reporting flow of contact numbers through p care directly to BPJS, while KPLDH has its own application where reporting is accommodated per region that is entered per day, so there is no bridging in each that integrates the two, so even if entry is in p care, the KPLDH team must enter 2 times if they have to enter for healthy contact numbers. This is in line with Edward's theory, which states that inconsistencies can occur if the policies to be implemented are quite complex, the implementation of new programs and the many goals of various policies. It is hoped that in the future there will be bridging application integration between p care and KPLDH so that it can support the effectiveness of KBK implementation.

4.7 Disposition

Disposition is an individual tendency to behave, act, or behave towards a certain treatment (Ennis, 1996), whereas according to Edward in Widodo (2020: 104), disposition is the will, desire and tendency of policy implementers to implement policies seriously. really, so that what is the goal of the policy can be realized (Widodo, 2020). In policy implementation, it is not enough to have the skills of policy implementers, but also the willingness and commitment to implement the policy. In this study, the assessment of the disposition is seen from 2 (two) aspects, namely, the attitude of policy implementers and the provision of incentives to policy implementing staff

4.8 Resource

In implementing the policy, it must be supported by human, material and financial resources. Although the goals, objectives and content of the policy have been communicated clearly and consistently, if the implementer lacks the resources to implement it, the implementation will not run effectively and

efficiently.

4.9 Bureaucratic Structure

Policy implementation has not been effective due to the inefficiency of the bureaucratic structure. The bureaucratic structure includes aspects such as organizational structure, division of authority, the relationship between the relevant organizational units, and the organization's relationship with outside organizations and so on. Therefore, the bureaucratic structure includes fragmentation dimensions and SOPs which will facilitate and standardize the actions of policy implementers in carrying out their duties (Widodo, 2020).

5. CONCLUSION

From the research results, it was found several things related to the implementation of capitation-based commitment to puskesmas services in Aceh Province

Implementation of CBC for 2 years has been quite good and significantly increased the average contact rate in 2020 by 192.6 0/00 (target ≥150 0/00), and the average prolanis ratio was 44.9% (≥50%), and reduced the average non-specialist case referral ratio to 0.3% (target <5%)

From the multivariate analysis, the modeling variables related to the attainment of service commitment indicators are the characteristics of the puskesmas (level, category, status of puskesmas), capitation size, resources (adequacy of human resources for doctors, nurses, midwives, pharmacy staff), participants (number, participant risk profile). And from the modeling, it was found that disposition (capitation) and HR variables had a significant effect on the achievement of service commitment indicators (p value <0.05).

On the other hand, the application of capitation deduction compensation has a positive impact, and there is a risk of moral hazard indications in implementation in the field. On the positive side, it is enough to give a deterrent effect for the puskesmas to exert all efforts to achieve the service commitment indicator, and from the side it has the potential for moral hazard in implementation in the field. So that monitoring and evaluation is needed from various parties without being fragmented so that the ideals of KBK implementation to realize quality services can be carried out.

Regarding the achievement of contact numbers, there have been several very high spikes, with the same staff for 2 years in several puskesmas with large participation, which requires attention.

The gap between the decrease in RRNS and the increase in KNS in Aceh Province indicates a difference in the perception of diagnosis between staff at the Health Center and Hospital, the smaller the peer review diagnoses from 133 to 128 the lack of facilities, infrastructure, tools , efforts to strengthen human resources and facilitate completeness of resources so that peer review can reach 144 diagnoses that must be completed at the FKTP indicating that it still requires review

Efforts to achieve a prolanis ratio have the potential for moral hazard where participants who are registered are only those who visit regularly, but not all participants with chronic diseases so that with a small denominator it will be easy to achieve a prolanis ratio of 100%, a significant increase in the average prolanis ratio is not yet achieving the expected standard of achievement (> 50%) can be explained by the fact that there are still puskesmas that have not organized a prolanis club, so that there are still many who achieve a prolanis ratio of 0%.

The ratio of doctors: participants indicates the dominance of UKP services at the Puskesmas, where with a maximum ratio of doctors: participants it is obtained 1:79,060 with a standard visit of 15% of participants and doctors working hours of 5 hours per day and 25 working days, then the examination time per patient is 0.63 minutes.

As much as 80.15% of PBI (APBD) cannot be redistributed contrary to Law No. 40 of 2004 concerning SJSN regarding the principles of Equity and Portability, and Presidential Regulation No. 19 of 2016 which says that "...participants can request to be transferred to the first level health facility they want"

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