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Performance Based Capitation Settings in the National Health Insurance Program for Primary Healthcare Facilities

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Abstract: The National Health Insurance Program by the Health Social Security Administration Agency aims to provide access to quality, safe, and affordable health services. A capitation payment system is implemented for Primary Healthcare Facilities based on the number of registered participants, but this system faces obstacles in encouraging service quality improvement. To address this, Performance-Based Capitation was developed with key indicators such as contact numbers, non-specialist referral ratios, and controlled Prolanis participant ratios. This study uses normative juridical methods to analyze the regulations, implementation, and challenges of Performance-Based Capitation in National Health Insurance. The data was analyzed qualitatively through a study of laws and regulations, scientific literature, and related reports. The results of the study show that the implementation of Performance-Based Capitation is effective in increasing the utilization of Primary Healthcare Facilities, reducing the referral rate to an advanced level, and improving the management of chronic diseases. However, there are obstacles in the form of limited infrastructure, resource inequality, and lack of coordination between stakeholders. To increase the success of Performance-Based Capitation, it is necessary to strengthen regulations, increase the capacity of human resources, utilize information technology, and provide performance-based incentives.

Keyword: National Health Insurance, Performance-Based Capitation, Primary Healthcare Facilities.

INTRODUCTION

The National Health Insurance Program (Jaminan Kesehatan Nasional or JKN) organized by the Health Social Security Administration Agency (BPJS Kesehatan) is a mandate of Law Number 40 of 2004 concerning the National Social Security System. JKN is one of the government's strategic policies in realizing comprehensive, safe, quality and affordable health insurance for all Indonesian people. By becoming a JKN participant, individuals and their family members obtain health maintenance benefits and protection in meeting basic health needs (Putri, 2014). The health insurance benefits obtained by JKN participants are in the form of individual health services which include promotive, preventive, curative, and rehabilitative

services, including services for drugs, medical devices, and consumable medical materials. In addition, participants also get non-medical benefits in the form of accommodation for inpatient services (Rachmad Suhanda, 2015).

In the implementation of health services for JKN participants, BPJS Kesehatan collaborates with various health facilities, both Primary Healthcare Facilities (Fasilitas Kesehatan Tingkat Pertama or FKTP) and Advanced Referral Health Facilities. The first level of health services is non-specialist health services organized by Community Health Centers (Puskesmas), primary clinics, and independent practices of Doctors/Dentists while advanced health services are specialty/subspecialty services such as hospitals or main clinics (Suci Rahmadani, 2019). BPJS Kesehatan is obliged to make payments to health facilities for health services that have been provided to JKN participants.

In its implementation, payments by BPJS Kesehatan to health facilities are divided into 2 mechanisms. First, payments to FKTP are made on a capitation basis based on the number of participants registered in FKTP. Second, payments by BPJS Kesehatan to Advanced Referral Health Facilities are made based on the payment standards of Indonesian Case Based Groups (Ina-CBG) (Chatila Maharani, 2024).

Capitation payment is one of the payment systems that provides upfront funding to healthcare providers based on the number of participants enrolled, to provide a defined set of services for each participant within a certain period of time, regardless of the number of services provided (World Health Organisation, 2017). BPJS Kesehatan has implemented capitation payments for each FKTP since the beginning of the JKN program was launched. However, in its implementation, the payment of FKTP based on capitation still has shortcomings, such as the low quality of services in FKTP, the low utilization of FKTP by JKN participants, the tiered referral system that does not run optimally, the high number of referral cases to hospitals that are not in accordance with medical procedures and indications, and the non-optimal management of chronic diseases such as hypertension and diabetes mellitus (Ari Dwi Aryani, Adang Bachtiar, 2024). This is due to the lack of performance standards that encourage service quality, while every month FKTP gets a capitation that does not take into account its performance achievements.

Based on these problems, BPJS Kesehatan developed an innovative FKTP performance assessment mechanism that is connected to capitation payments called Performance-Based Capitation (Kapitasi Berbasis Kinerja or KBK) (HUMAS MENPANRB, 2022). Through KBK, the performance achievements of FKTP are measured every month and will affect the amount of capitation payments received. With the implementation of this mechanism, it is hoped that it can motivate FKTP to improve its performance, so that there is an increase in the use of services at FKTP and a reduction in the number of referrals to Advanced Referral Health Facilities. With this approach, FKTP is not only encouraged to improve efficiency but also to ensure that the services provided are of high quality (Fadila & Katmini, 2022). Performance-based capitation arrangements are considered important in ensuring that the JKN program can run in accordance with its original goal, which is to improve access and quality of public health services, but still carry out quality control and cost control (Grace E. C. Korompis, 2021).

KBK innovation began to be developed in 2014 until it was implemented in 2019 with the stipulation of BPJS Kesehatan Regulation Number 7 of 2019 concerning Guidelines for the Implementation of KBK Payments at FKTP. There are 3 performance indicators in KBK, namely the number of contacts, the ratio of non-specialist referrals and the ratio of controlled professional participants. With the KBK innovation, there was an increase in the utilization of FKTP services by JKN participants by 18.8% in 2019 compared to the previous year. Likewise, the referral ratio to advanced health facilities decreased by 27% from 2019 to 2020. The management of prolanis patients also increased by 56.85% in DM and hypertension patients (Djamhari, Eka A., 2020).

However, the implementation of performance-based capitation still faces various obstacles. One of the main challenges is the lack of adequate infrastructure to monitor and evaluate the performance of FKTP appropriately. In addition, the disparity in capacity and resources between FKTP in urban and rural areas is a significant obstacle in implementing performance-based systems equitably. In addition to technical challenges, legal arrangements related to KBK also require serious attention. Clear implementing rules are very important to ensure that this mechanism can run optimally (Fadila & Katmini, 2022).

The urgency of implementing KBK is also related to the effectiveness of the JKN budget. In recent years, JKN has always experienced a budget deficit due to an increase in health service claims, especially in FKRTL (Djamhari, Eka A., 2020). By ensuring that the FKTP functions optimally through the KBK mechanism, it is hoped that quality control and cost control, which are the principles of JKN health service implementation, can be carried out properly (Syukran, 2023).

This article aims to analyze performance-based capitation arrangements in JKN programs, by highlighting the regulatory aspects, implementation, and challenges faced. This analysis is expected to contribute to the development of policies that support the improvement of the quality of health services in FKTP while ensuring the sustainability of the JKN program as part of the national health system.

METHOD

This research uses the normative juridical method, which is a legal research approach that focuses on the study of applicable legal norms, both sourced from laws and regulations and relevant legal doctrines. This normative juridical approach is carried out to understand the legal arrangements related to Performance-Based Capitation (KBK) in the National Health Insurance Program (JKN), as well as to analyze its conformity with the principles of the national social security system and health services regulated in laws and regulations.

The main data source in this study is secondary data consisting of primary, secondary, and tertiary legal materials. Primary legal materials include various relevant laws and regulations, such as Law Number 40 of 2004 concerning the National Social Security System (SJSN), Presidential Regulation Number 59 of 2024 concerning the Third Amendment to Presidential Regulation Number 82 of 2018 concerning Health Insurance, Regulation of the Minister of Health Number 3 of 2023 concerning Health Service Tariff Standards in the Implementation of the Health Insurance Program, and BPJS Kesehatan Regulation Number 7 of 2019 concerning Guidelines for the Implementation of Performance-Based Capitation Payments. Secondary legal materials include books, scientific articles, and journals that address topics related to Performance-Based Capitation, health services, and the national social security system. Tertiary legal materials are used as support to enrich the analysis. The data analysis in this study is carried out qualitatively, by examining and interpreting the collected legal materials to answer the formulation of the problem. With this method, the research is expected to provide a comprehensive overview of performance-based capitation settings for FKTP in the JKN program, as well as recommendations for the development of a better system.

RESULTS AND DISCUSSION

Performance-Based Capitation Arrangements in the National Health Insurance Program

Capitation payment is one of the payment methods that is made in advance based on the number of people who are the responsibility of health facilities, regardless of the frequency or number of services provided. This concept aims to reduce the cost of health services by involving health facilities in bearing part of the financial risk (Hendrartini, 2008). In the context of the JKN program, capitation payments are known as capitation rates, which are monthly payments made in advance by BPJS Kesehatan to FKTP. The amount of this payment is based

on the number of registered participants regardless of the type or amount of health services provided.

BPJS Kesehatan developed the KBK method as a strategic step to improve the quality of health services at FKTP in the implementation of the JKN program. The KBK system is applied to all FKTPs, which includes various types of health facilities such as health centers, primary clinics, independent practice of doctors or dentists, and primary class D hospitals. FKTP plays an important role as a frontline in providing individual health services, including promotive, preventive, observational, diagnosis, treatment, treatment, and various other health services. With the KBK method, it is hoped that FKTP will not only focus on the quantity of services, but also on the quality of health services, so that it can provide optimal benefits for JKN participants (Rizki Fadila, Mega Putri Via, AAI Citra Dewiyani, 2023).

The legal basis for the implementation of performance-based capitation payments in the JKN program is Article 24 of Law No. 40 of 2024 concerning SJSN which states that BPJS develops a health service system, a service quality control system and a health service payment system to increase the efficiency and effectiveness of health insurance. Then it is explained in Presidential Regulation No. 82 of 2018 concerning Health Insurance, in Article 71 that BPJS Kesehatan makes payments to FKTP on a pre-effort or capitation basis based on the amount registered in the FKTP. Article 86 also stipulates that BPJS Kesehatan develops technical operationalization of the health service system, service quality control system and health service payment system to increase efficiency and effectiveness in the implementation of the health insurance program. Furthermore, the standard tariff for health services in the implementation of the JKN program is regulated in Permenkes No. 3 of 2023, especially Article 8 explaining the amount of tariffs based on the performance of the FKTP is determined on the level of participant visits to the FKTP, optimizing the role of basic health service providers and optimizing promotive and preventive services.

The implementation of KBK payments for FKTP refers to BPJS Kesehatan regulation No. 7 of 2019. KBK payment is an adjustment to the capitation rate based on the results of the assessment of the achievement of individual health service indicators that have been mutually agreed upon by BPJS Kesehatan and FKTP. The results of this assessment are in the form of FKTP performance results in order to improve service quality. Referring to this rule, there are 3 performance indicators in KBK payments, namely:

a. Contact number. The contact number is an indicator to determine the level of accessibility and utilization of primary services at FKTP by participants based on the number of JKN participants (per participant identity number) who receive health services at FKTP per month both inside the building and outside the building without taking into account the frequency of participant arrivals in one month. The calculation of the contact number is a comparison between the number of registered participants who have contact with the FKTP divided by the total number of registered participants in the FKTP multiplied by 1000.
b. Non-specialist outpatient referral ratio (RRNS). Non-specialist cases are diseases that are able to be diagnosed and managed independently and completely in accordance with the competency standards of doctors or dentists at FKTP. RRNS is an indicator to determine the quality of services at FKTP, so that the referral system is carried out according to medical indications and competencies. The RRNS calculation is a comparison between the number of referrals for non-specialist cases and the total number of referrals by FKTP multiplied by 100%. The number of RRNS is the number of referrals with diagnoses that are included in the type of disease that is the competence of doctors at FKTP, but is excluded for referrals of non-specialist cases with time, age, complication and comorbidity (TACC) criteria which are not included in the number of outpatient referrals for non-specialist cases.
c. The ratio of prolanis participants is controlled. The chronic disease management program (Program Pengelolaan Penyakit Kronis or Prolanis) is a health service with a proactive approach that is carried out in an integrated manner by involving participants, health

facilities and BPJS Kesehatan in the context of maintaining the health of participants with chronic diseases to achieve an optimal quality of life with effective and efficient health costs.

The ratio of controlled prolanis participants is an indicator to determine the optimization of Prolanis management by FKTP in maintaining fasting blood sugar levels for type 2 Diabetes Mellitus patients or blood pressure for essential hypertension patients. The calculation of the ratio of controlled prolanis participants is the achievement of the ratio of controlled DM prolanis participants plus the achievement of the ratio of controlled hypertension prolanis participants divided by 2.

Capitation payment adjustments are made every month based on the results of the previous month's FKTP performance targets. Capitation adjustments based on performance achievements are applied to FKTPs that have collaborated with BPJS Kesehatan for at least 1 (one) year, and/or have a minimum of 5,000 participants registered in FKTP. The calculation of KBK payment achievements is an indicator of contact number of 40%, an indicator of the ratio of outpatient referrals for non-specialist cases of 50% and an indicator of the ratio of controlled prolanis participants of 10%. The performance indicator target is the value of the calculation of the achievement of the KBK payment indicator with the provision that the contact number indicator target is at least one hundred and fifty per mile, the target indicator indicator of the outpatient referral ratio for non-specialist cases is at most 2%, and the target indicator indicator of the ratio of controlled prolanis participants is at least 5%. The table below explains the calculation of KBK payment achievements for FKTP.

Table 1. KBK Assessment

No	Performance Indicators	Weight	Target	Assessment Criteria		Achievement Values
				Rating	Description	
	a	b	c	d	and	f=bxd
1	Contact number	40%	≥150‰	4	≥150‰	1,6
				3	> 145 - <150‰	1,2
				2	> 140 - 145 ‰	0,8
				1	≤ 140 ‰	0,4
2	Non-specialist referral ratio	50%	≤2%	4	≤ 2 %	2
				3	> 2 - 2,5 %	1,5
				2	> 2,5 - 3 %	1
				1	> 3 %	0,5
3	Controlled ratio of prolanis participants	10%	≥5%	4	≥ 5 %	0,4
				3	4 % - < 5 %	0,3
				2	3 % - < 4 %	0,2
				1	< 3 %	0,1

Table 2. Capitation Payment Adjustment Based on KBK Achievement Value

Achievement value	% Capitation Payment	
	Puskesmas	Primary Clinic/ RS D Pratama
4	100 %	100 %
3- < 4	95 %	97 %
2- < 3	90 %	96 %
1- < 2	85 %	95 %

The Effectiveness of the Implementation of KBK in Improving the Quality of Health Services at FKTP

The implementation of KBK in FKTP has proven to be effective in improving the quality of health services. This system integrates the financing mechanism with the achievement of performance indicators, thus encouraging FKTP to be more proactive and responsible in providing services (Syukran, 2023). In its implementation, FKTP is required to ensure optimal service coverage, such as compliance in chronic disease management, increasing the number of patient visits, and providing more structured basic health services. In

addition, this system also encourages the rationalization of referrals to Advanced Referral Health Facilities, so that referrals are made only when absolutely necessary (Zahrina, 2023). This approach creates a more results-oriented orientation, where healthcare workers focus on improving service quality through more efficient and data-driven management. Thus, the implementation of KBK not only increases patient satisfaction but also supports the sustainability of the health system as a whole.

The effectiveness of KBK is also reflected in the increase in patient satisfaction with the services provided at FKTP. The implementation of a performance-based incentive system provides encouragement for health workers to work more responsively, quickly, and friendliness in serving patients (Nanda Elok Juwita, 2023). Thus, patients feel more appreciated and satisfied with the services received. In addition, periodic monitoring of performance indicators not only ensures that service quality is maintained according to the standards that have been set, but also serves as a reference for FKTP to continue to make improvements.

In the long term, the implementation of KBK contributes significantly to the efficiency of the use of capitation funds. With a results-oriented approach, FKTP is encouraged to manage resources more wisely, reduce the risk of waste, and maximize positive impacts on public health. In addition, more structured and effective services help prevent further complications or illnesses, thereby reducing the burden on healthcare facilities at an advanced level. The success of this KBK shows that the system not only provides benefits for FKTP in increasing efficiency and accountability, but also has a positive impact on the national health system. By improving the quality of services at the primary level, overall public health can be improved, creating a sustainability cycle that benefits all parties involved (Anggraini, M. R., Permatasari, P., Azahra, S., & Astuti, 2023). It can be concluded that several points of effectiveness arise from the implementation of KBK in health services at FKTP, namely (Anindita & Nadjib, 2024):

a. Increasing patient access to health services. With the implementation of KBK, FKTP is encouraged to expand the scope of health services. FKTP is more motivated to ensure that all registered patients can access health services easily. These performance-based incentives provide encouragement to FKTPs to provide better facilities, extend operational hours, or make direct visits to the community.
b. Decrease in referral numbers that do not meet standards. The KBK system requires FKTP to be more responsible in referring patients to FKRTL. This encourages FKTP to ensure that referrals are only made if absolutely necessary, in accordance with medical indications and competency standards that have been set. As a result, inappropriate referral numbers can be minimized, thereby increasing the efficiency of the referral system.
c. The increasing role of FKTP in promotive and preventive efforts. This capitation system provides additional incentives for FKTPs who actively carry out promotive and preventive activities, such as health education programs, immunizations, disease screening, and healthy lifestyle counseling. This step aims to prevent the occurrence of disease, or prevent the disease from developing to become more serious. This step can reduce the burden on advanced health services, while improving overall public health.
d. Increased patient satisfaction. With the KBK system, FKTP is encouraged to provide better, friendly, and responsive services to patient needs. Patient satisfaction increases because they feel they get greater attention, quality service, and fast and appropriate treatment. In addition, transparency in services and improved communication between health workers and patients are also important factors in increasing satisfaction levels.
e. Increased health cost efficiency. By reducing unnecessary referrals to FKRTL and prioritizing promotive and preventive efforts, the KBK system helps to reduce overall health costs. FKTP has become more focused on using existing resources effectively to provide the best service to patients. This not only reduces waste, but also allows for better budget allocation for other health programs.

Based on data from BPJS Kesehatan, nationally the achievement of KBK indicators shows an increasing trend in performance in 3 KBK indicators. The table below presents the achievement of the KBK indicator target nationally from 2020 to 2023.

Table 3. Achievement of KBK indicator targets (Kementerian Kesehatan, 2024)

No	Year	Contact Number	Target	Non-Specialist Referrals	Target	Controlled Prolanis Ratio	Target
1	2020	92,52	≥ 150 ‰	1,39	≤ 2 %	1,55	≥ 5 %
2	2021	98,21		1,27		2,17	
3	2022	121,32		1,15		3,17	
4	2023	125,55		1,36		4,42	

Obstacles in the Implementation of KBK in FKTP

The implementation of KBK in FKTP faces various significant challenges, thus affecting the effectiveness of its implementation. Based on data from BPJS Kesehatan, since the KBK payment system was implemented in 2019, only about 20-30% of health centers and clinics have managed to achieve the KBK indicator target in 2023 and are eligible to receive full capitation payments (100%). This shows that most FKTPs are still experiencing obstacles in adjusting to the new mechanism (Novat Pugo Sambodo, 2023).

One of the main obstacles is the lack of understanding and readiness of the FKTP, both in terms of health workers and management, towards the concept and technicalities of KBK implementation. Many FKTPs do not have adequate systems in place to accurately record, monitor, and report on performance, which ultimately makes it difficult for them to meet the set indicators. In addition, the lack of training provided to health workers related to the KBK mechanism often causes confusion in its implementation, making it difficult to achieve the main goal of KBK (Siti Halimatul Munawarah, Misnaniarti, 2020).

The limitations of infrastructure and technology are also a big obstacle, especially for FKTPs who are located in remote areas. Many healthcare facilities in the region do not have access to adequate health information systems to support real-time recording and reporting of performance data. This challenge is compounded by poor internet connectivity, which is a major obstacle to submitting reports online. As a result, some FKTPs have difficulty meeting reporting deadlines and are unable to undergo periodic performance evaluations (Rizki Fadila, 2021).

In addition to the technical aspect, the issue of incentives also plays an important role in hindering the success of KBK. Lack of clarity in the incentive distribution system often causes dissatisfaction among health workers, which leads to a decrease in work motivation. The high workload without being balanced with appropriate incentives adds to the psychological burden of health workers, so that the implementation of the program becomes less than optimal. Therefore, a more transparent and fair incentive system is needed to increase the morale of health workers.

External factors such as participant characteristics also affect the implementation of KBK. Participant mobility, vulnerability level, and trust in FKTP play an important role in determining the success of the program. In addition, the remote geographical location of healthcare facilities and the high cost of transportation are often obstacles, especially for participants living in remote areas. Participants' behavior, which is influenced by culture and social environment, is also a challenge, especially in adopting a healthy lifestyle that can support the success of KBK (Rian Adi Pamungkas, 2020).

From these various challenges, it can be concluded that the obstacles in the implementation of KBK in FKTP include legal, technical, and human resource capacity. Some specific obstacles that need attention are (Ari Dwi Aryani, 2022):

- Regulation: Inconsistency of rules or lack of harmonization between related regulations, resulting in difficulties in implementation.

- Human Resources: Lack of adequate training for health workers to meet the set performance indicators.
- Technology: Limitations in electronic recording to accurately monitor performance indicators, especially in FKTPs in remote areas.Infrastructure Readiness: Many FKTPs, especially in remote areas, do not yet have adequate information systems in place to support performance measurement.
- Geographical Inequality: FKTPs in areas with limited access to health facilities tend to have difficulty meeting certain performance indicators.
- Transparency: Problems in performance appraisals, where FKTPs feel evaluations are often not transparent.
- Coordination Between Stakeholders: Effective collaboration between BPJS Kesehatan, the Ministry of Health, and FKTP still needs to be improved.

Efforts That Can Be Made to Strengthen the Regulation and Implementation of KBK in FKTP

To strengthen the regulation and implementation of performance-based capitation in First Level Health Facilities (FKTP), several efforts that can be made include:

1. Strengthening Regulations and Policies
   a. Develop or update regulations governing performance-based capitation systems in a clear and comprehensive manner.
   b. Make policies that provide incentives to FKTPs who successfully meet performance indicators, as well as sanctions for those who do not meet standards.
   c. Develop technical guidelines that make it easier for FKTP to implement a performance-based capitation system.
2. Improvement of Information Systems and Technology
   a. Develop and update health information systems that are able to accommodate accurate and timely reporting of performance data.
   b. Implementation of technology that allows real-time monitoring and evaluation of FKTP performance.
   c. Training on the use of information systems for officers at FKTP so that they can report data correctly.
3. Capacity Building of Human Resources
   a. Conducting training and improving the competence of medical and non-medical personnel at FKTP regarding the performance-based capitation system.
   b. Providing education and training related to health service quality management and how to measure good performance.
4. Increased Supervision and Evaluation
   a. Strengthen supervision and evaluation of the implementation of performance-based capitation in FKTP through regular audits and continuous supervision.
   b. Establish clear and measurable performance indicators using standards mutually agreed upon between health insurance providers and FKTPs.
5. Preparation and Consolidation of Performance Indicators
   a. Establish performance indicators that are relevant to the needs of the community and that can be objectively measured, such as patient satisfaction levels, number of visits, and quality of service.
   b. Create performance standards that are transparent and accountable, and in accordance with the needs of public health services.
6. Provision of Incentives and Sanctions
   a. Develop a mechanism for providing incentives for FKTPs who have successfully achieved certain performance targets.

   b. Establish sanctions for FKTPs who cannot achieve the target or fail to meet the predetermined indicators.
7. Strengthening Collaboration between Stakeholders
   a. Improve communication and collaboration between BPJS Kesehatan, the Health Office, and FKTP to create an effective and efficient capitation system.
   b. Conduct regular meetings between FKTP and related parties to discuss developments and challenges in the implementation of performance-based capitation.
8. Provision of Adequate Facilities and Infrastructure
   a. Provide adequate facilities and infrastructure at FKTP to support optimal health services, such as complete medical equipment and comfortable rooms.
   b. Optimizing the use of technology in health services, such as the use of telemedicine, to improve efficiency and accessibility.
9. Transparency and Accountability
   a. Encourage FKTPs to open information about their performance to the public, in order to create transparency.
   b. Compile performance reports that are accessible to the public, provide feedback, and improve service quality.

With the combination of these efforts, the regulation and implementation of the performance-based capitation system in FKTP can run more effectively, transparently, and efficiently, which will ultimately improve the quality of health services at the first level.

CONCLUSION

The implementation of Performance-Based Capitation (KBK) in the National Health Insurance Program (JKN) is a strategic step to improve the quality of health services in Primary Healthcare Facilities (FKTP). Through KBK, capitation payments are associated with the achievement of performance indicators such as contact numbers, non-specialist referral ratios, and controlled Prolanis participant ratios. This system has succeeded in increasing the use of FKTP, reducing the number of inappropriate referrals, and optimizing the management of chronic diseases, thereby supporting the principles of quality control and cost control in JKN. However, the implementation of KBK faces significant challenges, including limited infrastructure, resource inequality between urban and rural areas, and lack of technical understanding at the FKTP level. To overcome these obstacles, it is necessary to strengthen regulations, develop health information systems, increase the capacity of human resources, and periodically monitor and evaluate the achievement of performance indicators. KBK has been proven to contribute positively to the efficiency and sustainability of JKN, although it still needs adjustments and improvements to be more effective and equitable. By strengthening collaboration between stakeholders, developing information technology, and implementing a fair and transparent incentive system, KBK can continue to support the improvement of access and quality of public health services in a sustainable manner.

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