
Managerial Strategies For Optimizing Performance-Based Capitation Indicators At The Jambi City Community Health Center In 2026

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Abstract

Performance Based Capitation (KBK) is a payment mechanism that links capitation payments to the achievement of three performance indicators of primary healthcare facilities: contact rate, non specialist referral ratio, and the ratio of controlled Prolanis participants. Three selected primary health centers in Jambi City showed different capitation payment consequences throughout 2025, ranging from 95 100% at Putri Ayu, 90 95% at Kebun Handil, and a constant 90% at Koni, despite receiving different amounts of capitation funds. This study aimed to analyze managerial strategies in optimizing KBK indicators at three primary health centers in Jambi City through the functions of planning, organizing, actuating, and controlling. A qualitative case study approach was used involving 26 informants from the three centers through in depth interviews, observation, and documentation, analyzed thematically with Nvivo and validated through source triangulation. The results show that organizing and controlling have run relatively consistently across the three centers, while planning and actuating still varied, mainly due to limited human resources, facilities, recording systems, and participant compliance. Differences in KBK achievement between health centers were not solely determined by the amount of capitation funds received, but by the ability of each center to integrate all four management functions.

Keywords: *Performance Based Capitation, Management Functions, Managerial Strategies, Community Health Centers, Primary Health Care*

INTRODUCTION

Universal Health Coverage (UHC) is one of the global priorities highlighted by the United Nations in the Sustainable Development Goals (SDGs), with a target for achievement by 2030 (Lestari & Kusumo, 2025). In line with this agenda, Indonesia has implemented the National Health Insurance (JKN) program since 2014 under the management of BPJS Kesehatan to ensure equal access to health services for all participants (Anindita et al., 2024). Community health centers (Puskesmas), as primary level health facilities, receive JKN funding through a capitation mechanism (Badan Penyelenggara Jaminan Sosial Kesehatan, 2019).

To improve the quality of care, the government has developed a Performance Based Capitation (KBK) scheme that links the amount of capitation payments to the achievement of three indicators: a Contact Rate (AK) of at least 150 per 1,000 participants, a Non Specialist Referral Ratio (RRNS) below 2%, and a Controlled Prolanis Participant Ratio (RPPT) of at least 5% (Badan Penyelenggara Jaminan Sosial Kesehatan, 2019). This scheme has been implemented in phases since 2016 and now covers all eligible primary level health facilities (Indonesian Ministry of Health, 2021). By comparison, Thailand allocates approximately 80% of its capitation funds to direct care services, while Indonesia allocates 60% to the same component, specifically in the city of Jambi, the share allocated to direct care services is set at 75%.

National data reveal a distinct challenge: of the 278.1 million registered JKN participants as of the fourth quarter of 2024, only 78.83% were active, while the utilization of primary outpatient care continued to rise to 512.52 million visits (Badan Penyelenggara Jaminan Sosial Kesehatan, 2019). This situation underscores the importance of strengthening the performance of community health centers (puskesmas) as gatekeepers of

primary health care, in line with the high JKN enrollment coverage in Jambi Province, which is projected to reach an average of 60.85% of the population by 2025.

Based on 2025 data from BPJS Kesehatan in Jambi City, there is a fairly wide variation in capitation funding amounts among community health centers (Puskesmas), ranging from Rp2,224,219,704 at the Putri Ayu Puskesmas the highest recipient to Rp639,574,038 at the Koni Puskesmas the lowest recipient out of a total of 20 Puskesmas in Jambi City, amounting to Rp25,316,135,096. These three Puskesmas with different funding levels Putri Ayu (high), Kebun Handil (medium), and Koni (low) were selected as research sites to determine whether the amount of capitation funding is directly proportional to their performance outcomes.

Tabel 1. Capitation Data for Three Selected Community Health Centers in Jambi City for 2025

Community Health Center	Funding Categories	Total Capitation Funds (Rp)
Putri Ayu	High	2.224.219.704
Kebun Handil	Medium	1.189.702.898
Koni	Low	639.574.038

Sumber: BPJS Health, Jambi City (2025)

Data on KBK performance throughout 2025 shows that the amount of capitation funding is not always directly proportional to the level of performance achievement. The Putri Ayu Community Health Center (Puskesmas), as the recipient of the highest capitation funding, actually experienced an increase in payment rates from 95% at the beginning of the year to 100% from April through December 2025, while the Kebun Handil Community Health Center, with moderate category capitation funding, experienced fluctuations between 90–95%, and the Koni Community Health Center, as the recipient of the lowest capitation funding, remained relatively stable at a 90% payment rate throughout the year. This pattern indicates that managerial factors play a significant role alongside the amount of funding received.

Similar conditions have been reported in various other regions across Indonesia. Fadila et al., 2023 in Blitar Regency found that although the average KBK achievement was relatively high, the Contact Rate and Prolanis Participant Control Ratio indicators remained unstable. Husdiningsih et al., 2026 in Konawe Regency reported a KBK achievement of 95.42%, yet the Contact Rate (AK) and Prolanis Participant Ratio (RPPT) indicators continued to fluctuate, while Risky et al., 2026 in Bombana Regency found that the RRNS had met the national target, but the AK and RPPT remained far below the standard. Factors influencing these outcomes have also been identified by various other studies: the availability and competence of human resources Fadila & Katmini, 2022, the knowledge, attitudes, motivation, and recognition of program staff (Syam et al., 2023), the availability of infrastructure, information systems, and policy support (Aryani, 2022), as well as low service utilization, suboptimal implementation of Prolanis, and weak monitoring and evaluation (Amirus et al., 2025, Izzatika et al., 2025, Susanti & Khairani, 2025).

In addition to being influenced by resources and policies, the success of KBK implementation is also heavily determined by managerial processes at health facilities. Rosita et al. (2024) indicate that although some indicators have met their targets, Prolanis participant engagement remains suboptimal, while Firdhaus et al. (2025) explain that KBK implementation proceeds through planning, execution, and monitoring evaluation phases involving various stakeholders. Rosida et al. (2024) found that resource constraints and limitations in support systems have resulted in suboptimal achievement of KBK indicators, thus necessitating the strengthening of managerial aspects. The approach deemed capable of

supporting this optimization is the application of the management functions of planning, organizing, actuating, and controlling (POAC): planning through target setting and resource allocation (Novyandina et al., 2025), situation analysis and program prioritization (Supartika et al., 2024), task distribution and delegation of authority in the organizing aspect, motivation and service innovation in the actuating aspect, and routine monitoring and evaluation including the accuracy of data entry in the PCare application in the controlling aspect. However, Astuti et al. (2023) found that the implementation of the PerformanceBased Capitation (KBK) system at the Talang Banjar Community Health Center in Jambi City still faces challenges in the form of limited human resources, suboptimal promotive and preventive activities, and a lack of understanding among staff regarding KBK indicators.

Based on these findings, research is needed at community health centers with different funding characteristics to gain insight into strategies for optimizing KBK indicators in health care practice. This study aims to analyze managerial strategies including the functions of planning, organizing, executing, and supervising in optimizing Performance Based Capitation indicators at three community health centers in Jambi City, namely the Putri Ayu, Kebun Handil, and Koni Community Health Centers.

RESEARCH METHODS

This study employed a qualitative approach using a case study design to conduct an in depth examination of managerial strategies for optimizing KBK indicators. The inclusion of three research sites with different capitation funding levels high, medium, and low allowed for a more comprehensive understanding of the application of management functions across varying contexts. The research design was naturalistic, meaning it examined phenomena in real world conditions without manipulating variables. The study was conducted at the Putri Ayu, Kebun Handil, and Koni Community Health Centers in Jambi City from April to December 2026.

The study subjects consisted of 26 informants from the three community health centers, comprising primary informants (community health center directors), key informants (BPJS program coordinators and Prolanis coordinators or contact persons), and supporting informants (treasurers, technical implementation unit staff, and service cluster coordinators), who were selected based on the relevance of their roles to the implementation of the KBK.

Tabel 2. Distribution of Research Informants Across Three Community Health Centers

Community Health Centers	Primary Informant	Key Informant	Supporting Informants	Total
Putri Ayu	1	2	6	9
Kebun Handil	1	3	5	9
Koni	1	2	5	8
Total	3	7	16	26

Sumber: primary research data, 2026

Primary data were collected through in depth interviews using an int erview guide developed based on the indicators of planning, organizing, actuating, and controlling, with the aid of audio recording devices. Secondary data were obtained from BPJS Kesehatan’s KBK achievement reports and community health center documents. Data collection was supplemented with documentation in the form of photographs and video recordings that included coordinates and the time of capture to support data validity.

The data were analyzed using thematic analysis with the assistance of the NVivo software, following the stages of raw data processing, data reading, coding into nodes and cases, visualization, and finally interpretation and drawing of conclusions. Data validity was assessed using four criteria: credibility through triangulation of sources among informants and between community health centers, as well as comparison of interview data with documentation, transferability through detailed descriptions of the characteristics of the location, informants, and the implementation of the KBK, dependability through systematic documentation of all research stages, from site selection to drawing conclusions, and confirmability through verification of findings against supporting field data (Mekarisce, 2020). This study also adhered to research ethics principles, including informed consent, voluntary participation, and the confidentiality of informants' identities, which were replaced with codes.

RESULTS AND DISCUSSION

Characteristics of Informants and Overview of KBK Outcomes

A total of 26 informants participated in the study, consisting of nine from the Putri Ayu Community Health Center, nine from the Kebun Handil Community Health Center, and eight from the Koni Community Health Center. The informants held various positions directly related to KBK management, ensuring that the information gathered came not only from the perspective of leadership but also from program implementers, BPJS coordinators, financial managers, and cluster officers. This diversity of informants enabled the study to illustrate the relationship between managerial decisions and the day to day delivery of services.

Secondary data shows fairly clear differences in performance among community health centers (Puskesmas). Putri Ayu demonstrated the most consistent improvement. From January through March 2025, the payment rate remained at 95%, then rose to 100% from April through December. During that period, AK and RRNS achieved levels that supported a total indicator score of 4, while RPPT was recorded at 0.4. Kebun Handil had a relatively stable AK at 1.6, but its RRNS and RPPT fluctuated over several months, causing the payment compliance rate to drop to 90% from May through August. Koni had an AK of 0.4, an RRNS of 2, and an RPPT of 0.1–0.2, resulting in a total achievement of 2.5–2.6 and a payment compliance rate of 90% throughout the year. These findings show that the main problems do not always occur across all indicators simultaneously but can be concentrated in specific indicators. Details of monthly performance are presented in Tables 3–5 to illustrate the patterns of change in indicators and payment consequences more clearly.

Table 3. Monthly Performance Based Capitation Achievement at Puskesmas Putri Ayu, 2025

Month	AK	RRNS	RPPT	Total	Payment consequence
Januari	0,8	2	0,4	3,2	95%
Februari	1,2	2	0,4	3,6	95%
Maret	1,6	1,5	0,4	3,5	95%
April	1,6	2	0,4	4	100%
Mei	1,6	2	0,4	4	100%
Juni	1,6	2	0,4	4	100%
Juli	1,6	2	0,4	4	100%
Agustus	1,6	2	0,4	4	100%
September	1,6	2	0,4	4	100%
Oktober	1,6	2	0,4	4	100%
November	1,6	2	0,4	4	100%
Desember	1,6	2	0,4	4	100%

Source: BPJS Health, Jambi City

Table 3 shows improvements in the performance of the Putri Ayu Community Health Center at the beginning of the year. The AK increased from 0,8 in January to 1,6 in March and remained at 1,6 through December. The RRNS increased from 1,5 in March to 2 starting in April, while the RPPT remained consistent at 0,4. The total performance score increased from 3,2 in January to 4 starting in April, followed by an increase in payment compliance from 95% to 100%. This indicates that simultaneous improvements in several indicators led to an increase in payment compliance.

Table 4. Monthly Performance Based Capitation Achievement at Puskesmas Kebun Handil, 2025

Month	AK	RRNS	RPPT	Total	Payment consequence
Januari	1,6	2	0,2	3,8	95%
Februari	1,6	2	0,1	3,7	95%
Maret	1,6	2	0,1	3,7	95%
April	1,6	2	0,1	3,7	95%
Mei	1,6	0,5	0,2	2,3	90%
Juni	1,6	0,5	0,1	2,2	90%
Juli	1,6	1	0,2	2,8	90%
Agustus	1,6	1	0,1	2,7	90%
September	1,6	1,5	0,2	3,3	95%
Oktober	1,6	2	0,2	3,8	95%
November	1,6	2	0,1	3,7	95%
Desember	1,6	2	0,1	3,7	95%

Source: BPJS Kesehatan Kota Jambi

Table 4 shows that the AK for the Kebun Handil Community Health Center remained relatively stable at 1,6 throughout the year, but the RRNS and RPPT fluctuated. From May through August, the RRNS ranged from 0,5 to 1, and the total achievement rate dropped to 2,2 – 2,8, resulting in a payment rate of 90%. After the RRNS increased to 1,5 in September and 2 from October through December, the payment rate returned to 95%. Thus, fluctuations in achievement rates were more evident in the RRNS and RPPT than in the AK.

Table 5. Monthly Performance Based Capitation Achievement at Puskesmas Koni, 2025

Month	AK	RRNS	RPPT	Total	Payment consequence
Januari	0,4	2	0,2	2,6	90%
Februari	0,4	2	0,2	2,6	90%
Maret	0,4	2	0,1	2,5	90%
April	0,4	2	0,1	2,5	90%
Mei	0,4	2	0,1	2,5	90%
Juni	0,4	2	0,1	2,5	90%
Juli	0,4	2	0,1	2,5	90%
Agustus	0,4	2	0,1	2,5	90%
September	0,4	2	0,2	2,6	90%
Oktober	0,4	2	0,2	2,6	90%
November	0,4	2	0,1	2,5	90%
Desember	0,4	2	0,1	2,5	90%

Source: BPJS Kesehatan Kota Jambi

Table 5 shows that the Koni Community Health Center has a consistent AK of 0.4 and an RRNS of 2 throughout the year, while the RPPT ranges from 0,1 to 0,2. The total achievement ranges from 2,5 to 2,6, so the payment rate remains at 90% from January through December. These conditions indicate that the low AK and suboptimal RPPT achievement are important factors that need to be addressed in the strategy for optimizing the KBK at the Koni Community Health Center.

Planning

The research findings indicate that planning functions have been implemented at all three community health centers (Puskesmas), but the level of planning detail varies. The

Kebun Handil Puskesmas has the most operational planning framework, with a target of 2,500 visits per month and an Activity Implementation Plan (RPK) that includes a schedule and the staff responsible for implementation. Monitoring is conducted daily so that staff can track progress before the end of the period.

At the Koni Community Health Center, planning is based on BPJS Kesehatan regulations and the results of indicator achievement evaluations. The planning is adaptive, as monitoring results are used to determine which indicators require more attention. Although all indicators remain targets, greater attention is given to the Contact Rate and Prolanis when the achievements for both fall short of expectations. Strategies employed include expanding service promotion and reactivating Prolanis activities.

Unlike the Handil and Koni clinics, the Putri Ayu Community Health Center does not yet have a specific KBK plan that sets measurable targets. Planning is focused more on maintaining enrollment and capitation through improvements in service quality. The head of the community health center emphasized that competition with private health facilities and the limited number of doctors are factors considered in efforts to retain enrollees. Consequently, the planning orientation at Putri Ayu focuses more on sustaining quality and enrollment than on specific targets for each indicator.

When compared to George R. Terry's planning principles which emphasize the establishment of clear objectives, targets, and steps for achievement the conditions at the three Community Health Centers demonstrate varying degrees of alignment. Kebun Handil most clearly translates targets into activities and monitoring, Koni uses evaluation results as the basis for adjusting its strategy, whereas Putri Ayu still has a gap between the Puskesmas's general planning and the specific planning for KBK indicators. These findings support Supartika et al. (2024), who state that planning must be supported by situational analysis and prioritization, as well as Fahmil et al. (2022), who note that unstructured planning can lead to suboptimal achievement of indicators.

Setting priorities should also be understood as prioritizing based on the need for improvement, this does not mean neglecting other indicators. At KONI, for example, AK and RPPT receive more attention because their scores are still low, but RRNS is still maintained. This approach is relevant to the characteristics of the KBK because all three indicators collectively influence payment outcomes. Fadila and Katmini (2022) also demonstrate that KBK performance is linked to human resources, facilities and infrastructure, service processes, and the implementation of Prolanis. This means that effective planning must be realistic in light of the organization's capacity and the characteristics of the participants.

Organizing

Organization at the three Community Health Centers (Puskesmas) has generally been carried out through the division of tasks based on core duties and functions, as well as the designation of responsible parties. At Putri Ayu, for example, staff responsible for patient contact are directed to support AK, Prolanis staff support RPPT, while doctors play a key role in managing referrals. The Head of the Community Health Center also assigns responsible parties to monitor progress and remind staff to ensure that KBK performance targets are maintained.

Organization involves more than just a single program. Research findings indicate the involvement of service staff, the BPJS point of contact (PIC), Prolanis staff, cluster staff, the administrative department, the PPTK or treasurer, and other stakeholders. Coordination takes place through mini workshops, meetings, roll calls, WhatsApp communications, and cross cluster coordination. This demonstrates that the KBK is positioned as an organizational responsibility, not merely the responsibility of the PIC.

Although a task structure is in place, the effectiveness of organizing is still limited by resource capacity. All three Puskesmas face constraints in terms of staffing levels, dual roles, and workload. At Koni, when staff members leave the facility for off site activities such as posyandu, the staff remaining at the Puskesmas must shoulder a heavier service burden. The head of the Koni Puskesmas also mentioned the need for staff in health promotion and environmental health.

These findings are consistent with those of Astuti et al. (2023) at the Talang Banjar Community Health Center in Jambi City, who identified limitations in human resources and infrastructure as barriers to achieving the Family Planning Performance Criteria (KBK). Fadila and Katmini (2022) also identified the availability of human resources as one of the factors associated with the achievement of these indicators. Thus, the organizational challenges at the three Community Health Centers are not primarily due to a lack of task allocation, but because the capacity of available staff is not always sufficient to carry out all tasks optimally.

Consequently, the designation of a Person in Charge (PIC) must be accompanied by a proportional distribution of the workload. A division of tasks that is purely administrative without adequate support in terms of time, manpower, and coordination risks causing record keeping tasks and promotive preventive activities to be overlooked. Therefore, strengthening organizational management in the context of the KBK should focus on a realistic division of tasks, cross program coordination, and aligning off site activities with the availability of staff on site.

Actuating

The actuating function is implemented through guidance, coordination, motivation, service, education, and mobilization of staff. However, the implementation varies depending on the indicator. For AK, the primary focus is on increasing the number of contacts while ensuring that these contacts are recorded and entered into the system. For RRNS, the focus is on ensuring that nonspecialized cases are managed at the primary health care center (FKTP) level according to capacity and referred when necessary. In the RPPT, implementation is directed toward providing services and monitoring participants with chronic diseases to ensure their health conditions remain under control.

At the Putri Ayu Community Health Center, efforts to increase AK involve all staff and service units. Efforts are made to record both healthy and sick contacts. Contacts that occur when parents accompany their children for immunizations are also viewed as opportunities for healthy contacts that need to be recorded. However, not all off site contacts are successfully entered into the system. Challenges include time constraints, participants not carrying identification or their National Identification Number (NIK), and the burden of data entry across multiple applications. The Community Health Center director also emphasized the need for repeated reminders, as some staff members have made contacts but have not yet consistently entered the data.

At the Kebun Handil Community Health Center, AK implementation is more targeted because there is a goal of 2,500 contacts per month and daily monitoring. Staff distinguish between visits by healthy and sick individuals, utilizing off site activities such as posyandu, posbindu, exercise sessions, and field activities as sources of healthy contacts when participant identities are available. During the period from March 2025 to March 2026, AK achievements were recorded as meeting the target for each observation period. These findings indicate that concrete targets accompanied by daily monitoring can help guide staff work behavior.

At the Koni Community Health Center, AK remains one of the indicators of concern. The head of the health center noted that the community has many health facility options, so promotion is needed to encourage participants to use the health center. In addition to

promotion, off site activities such as posyandu and posbindu are used to increase healthy contacts. Performance is monitored through the e claim system. This strategy demonstrates a combination of mobilizing staff and mobilizing the community.

Regarding the RRNS indicator, Putri Ayu implemented controls by instructing doctors to ensure patients receive care at primary health care facilities (FKTP) first before being referred, if indicated. Patient education was also provided. However, RRNS achievement is still influenced by patient requests for referrals and limitations in certain diagnostic facilities. Secondary data indicates that Putri Ayu's RRNS had not yet met the target by March 2025, with a value of 2.2, but was subsequently declared achieved from April 2025 through March 2026. These findings demonstrate that referral decisions are not solely based on administrative factors but are also influenced by service capacity and patient conditions.

In the RPPT, implementation is carried out through Prolanis activities, routine examinations, education, condition monitoring, medication management, reminders to participants, and communication via group chats or telephone. The study results show that achievement of this indicator cannot be fully controlled by healthcare workers because participants' conditions and adherence to treatment and Prolanis activities also determine the outcome. This becomes more complex in patients with hypertension or diabetes, as clinical conditions cannot always be controlled solely through interventions by healthcare workers.

From a managerial perspective, the implementation shows that guidance alone is not enough. Staff need system support, time, resources, participant information, and coordination so that guidance can be translated into action. This finding is consistent with Syam et al. (2023), who demonstrated a relationship between knowledge, attitudes, motivation, and recognition and the achievement of indicators. Astuti et al. (2023) also showed that limitations in human resources and facilities can affect the implementation of promotive preventive activities as well as data management.

Controlling

Controlling is the function most consistently implemented across all three community health centers. Monitoring and evaluation are conducted through mini workshops, cluster meetings, indicator assessments, and data monitoring. At Putri Ayu, monitoring is conducted monthly and involves health workers. At Kebun Handil and Koni, monitoring also involves the community health center directors, the BPJS point of contact (PIC), and the program coordinators. The results of these monitoring efforts are used to identify problems and determine follow up actions.

At Kebun Handil, follow up is carried out through reminders to staff, discussions in mini workshops, and the development of corrective measures. However, monitoring faces disruptions to the P Care system. The BPJS point of contact cited server disruptions as one of the obstacles. Additionally, the RPPT is influenced by patient conditions, so not all outcomes can be controlled by staff. External monitoring from BPJS takes the form of feedback on achievements, which is then conveyed to the designated contact person and the community health center director for discussion and follow up.

At Koni, monitoring and evaluation are conducted monthly through mini workshops involving all staff members. Indicators are monitored through appropriate systems: AK is tracked via e claims, referrals are monitored on a case by case basis, and Prolanis has its own designated person in charge. This approach demonstrates that control is exercised through a combination of organizational forums and data monitoring.

These findings are consistent with those of Firdhaus et al. (2025), who demonstrated that the successful implementation of the KBK is linked to leadership, ongoing monitoring, the involvement of health care workers, and routine evaluation. Rosida et al. (2024) also emphasize the importance of support systems and managerial strengthening. However, routine monitoring does not automatically lead to optimal outcomes if systemic issues,

human resource challenges, record keeping problems, and participant related factors remain unresolved.

Effective control, therefore, is not merely about knowing achievement figures, but about establishing a cycle of improvement: data is monitored, problems are identified, causes are discussed, corrective actions are determined, and the results are monitored again. At the three community health centers, elements of this cycle were evident, but the strength of follow up still depended on staff capacity and external conditions.

Barriers and Optimization Strategies

Research findings indicate that barriers to achieving the KBK stem from both internal and external factors. Internal factors include human resource limitations, overlapping duties, the burden of data entry across multiple applications, limited examination facilities, P Care system disruptions, and inconsistent contact information entry. External factors include participants choosing other health facilities, the unavailability of identification or NIK during field visits, patient requests for referrals, as well as the clinical conditions and adherence of Prolanis participants.

At Putri Ayu, data entry issues serve as a key example. Field visits actually take place, but they may not be recorded in the system because participants do not bring their NIK or staff do not have sufficient time to enter the data. The data entry burden is exacerbated by staff having to use multiple systems. The strategies implemented include involving all units, broadening understanding of health visits, and providing repeated reminders.

At Kebun Handil, the standout strategy was setting concrete AK targets and conducting daily monitoring. This approach allowed staff to identify shortfalls in achievement before the end of the month. For indicators influenced by participants, the approach involved education and monitoring, however, the community health center still faced limitations because participants’ health outcomes were not entirely within the staff’s control.

At Koni, the strategy focuses more on increasing the use of community health centers (Puskesmas) and off site activities for AK, as well as paying closer attention to indicators that remain low. Monthly monitoring is used to remind staff to make use of contacts from posyandu and posbindu. For Prolanis, mobilizing participants is a key component because while activities are already in place, participant participation needs to be continuously encouraged.

Table 6. Barriers and Managerial Strategies for Optimizing KBK

Aspects	Major obstacles	Strengthening strategies
Contact Rate	Contact information entry is inconsistent, National ID numbers/identification are not available during off site activities, heavy data entry workload in some applications, participants choose other facilities	Set contact targets, conduct daily/monthly monitoring, utilize posyandu, posbindu, and off site activities, ensure that every contact is recorded and entered into the system
Non Specialist Referral Ratio	Limited diagnostic resources, and patients continue to request referrals	Physician guidance, patient education, management of referrals based on medical indications, monitoring of referred cases
Prolanis Enrollment Ratio Under Control	Participants’ compliance and clinical condition cannot be fully controlled by staff	Strengthening Prolanis, routine checkups and monitoring, education, participant reminders, follow up with participants who do not attend regularly
Management/Human Resources	Limited staff, dual roles, and heavy workloads	Clear division of responsibilities and designated points of contact, proportional

		distribution of the workload, cross unit coordination
Information Systems	P Care/server outage and the use of multiple record keeping systems	Regular data monitoring, input reminders, follow up on system issues, use of monitoring results for improvement

Source: Research findings, 2026

Table 6 summarizes that barriers to achieving the KBK stem from both internal and external factors and vary by indicator. For AK, the main challenges relate to the consistency of contact records and the availability of participant identification during off site activities. For RRNS, limited diagnostic resources and referral requests pose barriers. In the RPPT, participants’ conditions and adherence also influence achievement. The strategies implemented are directed toward more specific targets, routine monitoring, strengthening education and services, improving record keeping, and follow up based on monitoring results.

When the four management functions are compared, it is evident that the strength of the “controlling” function in the three community health centers has not been fully balanced by an equally strong “planning” function. The most prominent optimization strategies identified in the study are:

- (1) Setting specific and realistic indicator targets,
- (2) Linking targets to task assignments,
- (3) Strengthening the implementation of promotive preventive care, Prolanis, and referral management,
- (4) Ensuring that every contact is recorded, and
- (5) Using monitoring results as the basis for follow up actions.

These strategies are not new, standalone programs, but rather a reinforcement of existing mechanisms.

Differences in performance among community health centers (Puskesmas) indicate that the amount of capitation funding is not the sole determining factor. Putri Ayu, with the highest capitation funding, has achieved 100% compliance since April, while Koni, with the lowest capitation funding, has maintained 90% compliance throughout the year. However, this relationship cannot be interpreted as a cause and effect relationship because this study is qualitative and was not designed to statistically test the influence of capitation funding. What can be demonstrated is that resource management and managerial processes are crucial contexts in translating funding capacity into service performance.

Overall, the research findings support the view of Supartika et al. (2024) that the POAC function can serve as an approach to improving KBK outcomes. However, its application must be contextual. Planning must identify which indicators are weak and what targets are realistic, organizing must ensure who is responsible for implementation, actuating must ensure that activities are actually carried out, and controlling must ensure that outcomes are monitored and issues are addressed. This integration forms the core of the managerial strategy identified in this study.

Table 7. Synthesis of managerial functions in KBK optimization

Function	Key Findings	Barriers	Direction of appreciation
Planning	All community health centers are engaged in planning, Handil Garden is the most measurable, Koni is adaptive, and Putri Ayu does not yet have specific KBK targets	Goals are not yet uniform, limitations in human resources and facilities	Specific, realistic, evaluation based goals

Organizing	The division of responsibilities and designated points of contact have been established and involve multiple departments	Limited human resources, dual roles, heavy workload	A more proportional distribution of tasks and workload
Actuating	Services, education, Prolanis, AK improvement, referral management	Inconsistent input, resources, participant choices, compliance	Strengthening guidance, education, record keeping, and monitoring
Controlling	Monitoring, evaluation, mini workshops, BPJS feedback, and routine follow up	Masukan yang tidak konsisten, sumber daya, pilihan peserta, kepatuhan	The data–problem–follow up–continuous monitoring cycle

Source: Research findings, 2026

Table 7 illustrates the interrelationship among the four management functions in optimizing the KBK. Planning sets targets and priorities, organizing ensures the allocation of tasks and accountability, actuating drives services and programs, and controlling ensures that achievements are monitored and followed up on. The research findings indicate that controlling is relatively consistent, but the strength of planning and organizing is not uniform across community health centers. Therefore, KBK optimization requires an integrated management cycle, rather than intervention in just one function.

CONCLUSION

Managerial strategies for optimizing performance based capitation indicators at the Putri Ayu, Kebun Handil, and Koni Community Health Centers in Jambi City have been implemented through the functions of planning, organizing, actuating, and controlling, however, the level of implementation has not been uniform. Planning is most evident at Kebun Handil through contact rate targets and daily monitoring, Koni uses evaluation results as the basis for strategy adjustments, whereas Putri Ayu remains more focused on maintaining enrollment and service quality without specific, measurable KBK targets. Organizing has been supported by the division of tasks and the designation of responsible parties, but it remains constrained by limited human resources, overlapping duties, and heavy workloads. Actuating is carried out through service delivery, education, Prolanis, increasing contact rates, and referral management, however, achievements are influenced by record keeping, facilities, choice of health facilities, conditions, and participant compliance. Controlling is the most consistent function, carried out through monitoring, evaluation, mini workshops, BPJS feedback, and follow up. Therefore, KBK optimization must be achieved through the integration of these four management functions with specific targets, a proportional division of tasks, the strengthening of promotive preventive activities and Prolanis, improvements in record keeping, and continuous monitoring and follow up.

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