

## Implementation of Jkn Capitation Funds at Suranadi Primary Health Center: an Edward III Policy Implementation Analysis

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### Abstract

*The implementation of capitation financing under Indonesia's National Health Insurance (Jaminan Kesehatan Nasional/JKN) is intended to strengthen comprehensive primary care, particularly promotive and preventive services. Nevertheless, the translation of capitation policy into daily organizational practice remains uneven across primary health centers. This study analyzes the implementation of JKN capitation funds at Suranadi Primary Health Center, West Lombok, using Edward III's framework of communication, resources, disposition, and bureaucratic structure. A qualitative case-study design was employed. Data were generated through in-depth semi-structured interviews, non-participant observation, and document review involving the head of the health center, the capitation treasurer, health professionals, and program managers. Data were reduced, coded, categorized, and interpreted thematically, while credibility was strengthened through source and method triangulation, member checking, and an audit trail. The findings demonstrate that implementation has not reached its intended level of effectiveness. Communication remained predominantly one-way, policy information was not evenly distributed, and regulatory changes were not consistently accompanied by operational clarification. Human resources were numerically adequate but unevenly distributed in competence and burden; supporting facilities and integrated information systems were limited; and capitation spending remained oriented toward curative services and service remuneration. Implementers generally accepted the policy, yet commitment was fragmented across administrative, clinical, and program priorities. Although formal structures and standard operating procedures were available, task overlap, weak cross-unit coordination, and centralized decision-making reduced organizational responsiveness. The study concludes that capitation implementation is shaped by the interaction of all four Edward III variables rather than by financial compliance alone. A more effective model requires two-way communication, competency-based workforce development, data-driven and balanced allocation, stronger SOP internalization, integrated digital reporting, and participatory governance.*

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## 1. INTRODUCTION

Indonesia's National Health Insurance program positions primary health centers as the operational foundation of universal health coverage. Through the capitation mechanism, primary health-care facilities receive prospective payments based on registered participants rather than on individual service claims. This arrangement is expected to

encourage cost control, continuity of care, and stronger attention to health promotion and disease prevention. In practice, however, the effectiveness of capitation depends on the capacity of local organizations to translate financing rules into coordinated service, budgeting, reporting, and accountability processes [1]–[4].

Suranadi Primary Health Center serves five villages in Narmada District, West Lombok, with approximately 27,820 residents and 8,685 households. The facility employs around 74 personnel from different professions and employment categories. Its service environment is characterized by a double burden of disease: infectious conditions remain common, while hypertension, diabetes mellitus, and other non-communicable diseases continue to increase. These conditions make balanced investment in curative, promotive, and preventive activities essential. Yet the organizational reality of a busy primary-care facility often pushes resources toward immediate clinical demand, leaving preventive programs with weaker operational support.

Prior studies on capitation management in Indonesia identify recurring problems, including an excessive concentration on service remuneration and curative care, limited managerial competence, fragmented information systems, uneven understanding of regulations, and weak accountability mechanisms [5]–[9]. Rachmawati, Syaodih, and Widjaja emphasized that capitation management must be assessed not merely as a financial procedure but as an integrated managerial process that links planning, utilization, supervision, and service outcomes [10]. Their work is particularly relevant to the present study because it highlights the managerial capacity required to ensure that capitation contributes to service improvement rather than functioning only as an administrative funding stream.

Health-service management research by Syaodih and colleagues also demonstrates that organizational coordination, claim governance, and managerial strategy influence the ability of health institutions to translate national financing arrangements into reliable operational outcomes [11]. In a related primary-care setting, Syaodih and co-authors found that clearly structured logistics procedures, coordinated roles, and timely information are essential for maintaining service continuity [12]. These findings support the view that capitation implementation should be examined through organizational behavior and implementation mechanisms, not only through budget realization figures.

Research involving Rinawati similarly underlines the importance of managerial integration, stakeholder engagement, and organizational readiness in health programs. Apsari, Andriani, and Rinawati showed that strategic implementation of chronic-disease management requires alignment between internal capacity, program coordination, and managerial priorities [13]. Salzabilla, Rohendi, and Rinawati further demonstrated that technology adoption in health organizations depends on perceived usefulness, ease of use, and organizational support [14]. Although these studies address different health-management issues, they reinforce the present study's argument that policy performance emerges from the interaction between communication, resources, implementer attitudes, and organizational arrangements.

The Edward III implementation model provides a suitable analytical framework for this problem. The model proposes that implementation effectiveness is shaped by four interdependent variables: communication, resources, disposition, and bureaucratic structure [15]. Communication concerns the transmission, clarity, and consistency of policy messages. Resources include personnel, competence, authority, budget, infrastructure, and information. Disposition refers to implementers' acceptance, commitment, motivation, and integrity. Bureaucratic structure concerns standard operating procedures, division of work, coordination, and decision-making. Weakness in one dimension may reduce the

effectiveness of the others; therefore, policy implementation should be understood as a system rather than a collection of isolated administrative tasks.

Most existing studies of JKN capitation focus on efficiency, financial compliance, or quantitative output indicators. Fewer studies explore how all four Edward III variables interact within the specific organizational context of a primary health center. This study addresses that gap by examining the implementation process at Suranadi Primary Health Center through a qualitative case-study approach. The objective is to analyze how communication, resources, implementer disposition, and bureaucratic structure shape the use of capitation funds and to formulate an implementation model that is operationally relevant for primary health-care management.

## 2. RESEARCH METHOD

### 3.1 Design and Setting

This study used a qualitative descriptive case-study design. The case-study strategy was selected because the implementation of capitation funds is embedded in a specific institutional setting and cannot be separated from local organizational arrangements, professional roles, workload, and external regulatory relationships [16], [17]. The study was conducted at Suranadi Primary Health Center, Narmada District, West Lombok, from February to March 2026.

The unit of analysis was the organizational process through which JKN capitation policy was communicated, resourced, interpreted, and coordinated. The study did not seek statistical generalization. Instead, it aimed to produce an analytically transferable explanation of implementation mechanisms that may inform comparable primary-care settings.

### 3.2 Participants and Data Sources

Participants were selected purposively because of their direct involvement in capitation governance. They represented the head of the primary health center, the capitation treasurer, physicians, nurses, midwives, and program managers. Recruitment continued until the information became repetitive and no substantively new theme emerged. Data were obtained from three sources: semi-structured interviews, non-participant observation, and institutional documents, including financial reports, planning records, SOPs, program documents, and relevant regulations.

**Table 1. Participant groups and information domains**

| Participant group             | Role in implementation                                | Primary information contributed                                                 |
|-------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------|
| Head of primary health center | Organizational accountability and strategic decisions | Policy communication, allocation priorities, coordination, and decision-making  |
| Capitation treasurer          | Financial administration and reporting                | Regulatory interpretation, budgeting, reporting, and accountability             |
| Health professionals          | Frontline service delivery                            | Operational understanding, workload, policy acceptance, and service priorities  |
| Program managers              | Planning and coordination of health programs          | Promotive-preventive activities, cross-program coordination, and resource needs |

### 3.3 Data Collection and Analysis

Interviews were guided by questions derived from Edward III's four variables. Communication questions explored policy channels, clarity, consistency, feedback, and training. Resource questions examined workforce distribution, competence, budget

utilization, infrastructure, and information systems. Disposition questions addressed acceptance, commitment, motivation, and perceived priorities. Bureaucratic-structure questions examined SOPs, division of work, coordination, and decision authority. Observations were used to assess interactions, work processes, facility support, and practical adherence to procedures. Documents were reviewed to compare formal arrangements with reported practice.

Analysis began concurrently with data collection. Interview records were transcribed and read repeatedly. Relevant segments were coded deductively under communication, resources, disposition, and bureaucratic structure, while inductive subcodes were added to capture context-specific issues such as one-way communication, workload imbalance, curative dominance, task overlap, and centralized decisions. Codes were grouped into categories and interpreted as themes. Credibility was supported by comparing participants and methods, confirming key interpretations with informants, and maintaining an audit trail of coding and analytic decisions [18], [19].

### 3. RESULTS AND DISCUSSION

#### 3.1 Results

Policy information was communicated through routine meetings, briefings, and WhatsApp groups. These channels ensured that information could be circulated quickly; however, participants described the process as predominantly one-way. The head of the health center stated that information was delivered through routine meetings and digital groups, but the process did not ensure comprehensive understanding. The treasurer similarly reported that information received from the district health office and BPJS Kesehatan was transmitted internally but did not reach all staff evenly.

Frontline personnel generally received summaries rather than technical explanations. Health professionals noted that the information was usually general and administrative, without sufficient examples of how capitation rules affected service planning. Program managers also reported that information was not integrated across programs. Consequently, different units developed different interpretations of the same policy requirement.

The quality of information was further weakened by formal and technical regulatory language. Participants indicated that financial terminology was difficult for staff without a financial-management background. They preferred operational guides, case examples, and simulation-based explanations. Frequent policy changes also created uncertainty. Changes were not always followed by a structured clarification mechanism, resulting in differences between interpretations at the central, district, and facility levels.

Socialization and training were available but were not routine or comprehensive. Training tended to focus on financial administrators, while health professionals and program managers were less frequently included. This created an asymmetry: those responsible for administrative compliance received more information than those expected to translate the policy into service activities. The communication problem therefore concerned not the absence of channels but the quality, reach, and dialogic character of communication.

The health center had a relatively adequate number of personnel, but competence and workload were unevenly distributed. The head of the facility observed that not all staff understood capitation policy, even though the overall number of workers was sufficient. Clinical competence was generally strong, yet knowledge of health financing, program integration, and accountability was limited. Program staff responsible for promotive and preventive services frequently held multiple assignments.

High patient volume intensified the imbalance. Frontline staff prioritized immediate clinical work, leaving less time for program planning, data review, and preventive activities. The treasurer carried a substantial administrative burden, and financial-management knowledge was concentrated in a small number of individuals. These conditions made implementation dependent on particular staff members rather than on distributed organizational capacity.

Facilities for basic services were available, but operational support for outreach, health promotion, and preventive programs was limited. Participants mentioned shortages in education media, transport, and field-support equipment. Information and financial reports existed, yet systems remained fragmented and were not fully digitized. Access to program and financial data was not evenly distributed, which limited the use of evidence in planning and monitoring.

The allocation pattern was also perceived as insufficiently balanced. A substantial proportion of capitation funds was directed to service remuneration and curative activities because of immediate patient demand and internal performance pressures. Program managers reported that preventive programs received less operational flexibility. Thus, the resource problem involved not only scarcity but also distribution, competence, information integration, and the strategic orientation of expenditure.

Implementers generally accepted the capitation policy and recognized it as a legitimate component of JKN. Administrative personnel demonstrated commitment to regulatory compliance, reporting, and financial accountability. Health professionals were committed to patient care, while program managers focused on achieving program indicators. These orientations were individually rational but not fully aligned with a shared organizational strategy.

Policy acceptance was therefore largely normative. Staff complied with regulations, but the policy was not consistently internalized as an instrument for rebalancing primary care toward prevention and population health. The motivation of implementers varied: some were driven by service quality, some by administrative responsibility, and others by the relationship between capitation and service incentives. Variation in motivation affected how priorities were interpreted.

Differences in professional background and policy exposure also produced divergent perceptions. Financial staff emphasized compliance, clinicians emphasized direct patient care, and program managers emphasized preventive targets. Without deliberate alignment, these perspectives generated fragmented commitment. The finding suggests that positive attitudes alone are insufficient; implementation requires a common interpretation of the policy's strategic purpose.

The formal organizational structure and division of tasks were available. Participants understood their basic roles, and SOPs existed for administrative and financial processes. Nevertheless, task overlap occurred during periods of high workload or when additional programs were introduced. Some staff performed duties beyond their principal roles, creating unequal burdens and uncertainty regarding responsibility.

SOP implementation varied according to individual understanding and operational conditions. Health professionals reported that procedures were sometimes adjusted to immediate service pressures. Program managers stated that cross-program coordination was not synchronized, even though formal procedures were in place. SOPs therefore functioned more as formal documents than as fully internalized routines.

Coordination across units was weak and information was sometimes delayed. Decision-making remained concentrated at the managerial level. Centralization helped preserve formal consistency but limited participation by frontline and program staff. As a

result, decisions were sometimes less responsive to field conditions, and implementers had limited ownership of allocation and program choices.

**Table 2. Summary of empirical findings based on Edward III variables**

| Variable               | Core findings                                                                                                     | Implementation consequence                                                              |
|------------------------|-------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Communication          | One-way transmission; uneven distribution; technical language; regulatory inconsistency; limited training         | Different interpretations and weak integration between administrative and service units |
| Resources              | Uneven competence and workload; limited outreach facilities; fragmented data systems; curative spending dominance | Reduced capacity for evidence-based planning and promotive-preventive services          |
| Disposition            | Policy acceptance but fragmented commitment; varied motivations and priorities                                    | Formal compliance without consistent strategic alignment                                |
| Bureaucratic structure | Task overlap; incomplete SOP internalization; weak coordination; centralized decisions                            | Slow adaptation, limited participation, and fragmented implementation                   |

### 3.1 Discussion

The findings confirm Edward III's argument that communication must be assessed through transmission, clarity, and consistency. Suranadi Primary Health Center had multiple communication channels, but transmission alone did not ensure implementation. Information was filtered as it moved from external agencies to facility managers and then to frontline staff. When messages reached service personnel only as general summaries, the policy remained administratively visible but operationally ambiguous.

The finding extends the literature by showing that communication quality in capitation implementation is closely related to professional language and role differentiation. Financial regulations are interpreted differently by managers, treasurers, clinicians, and program personnel. A communication strategy therefore requires role-specific translation rather than identical messages for all audiences. Rachmawati, Syaodih, and Widjaja's analysis of capitation management similarly implies that financial governance must be connected to operational understanding and service objectives [10].

Syaodih and colleagues' research on JKN claim governance also emphasizes that timely and coordinated information reduces administrative delays and improves organizational performance [11]. In the current case, the absence of a formal feedback mechanism meant that uncertainty persisted until problems appeared in implementation. Communication should therefore be designed as a cycle of dissemination, clarification, application, and feedback.

The resource findings demonstrate that numerical staffing adequacy does not equal implementation capacity. Staff numbers were relatively sufficient, but competencies related to policy interpretation, program budgeting, and data use were concentrated among a few individuals. This creates organizational vulnerability because implementation performance depends on specific personnel and may decline when workload increases or key staff are unavailable.

The dominance of curative expenditure reflects a rational response to immediate patient demand, but it also signals a misalignment between short-term operational pressure and the long-term incentives of capitation. Under capitation, preventive investment should

reduce future treatment demand. Yet preventive programs require dedicated staff time, outreach facilities, educational materials, and accessible data. Without these supports, the system naturally reverts to visible clinical activities.

The capitation-management study involving Syaodih supports the need for integrated planning and monitoring [10]. In addition, Rinawati's work on chronic-disease program strategy shows that sustainable health programs require alignment among internal capability, resource priorities, and organizational strategy [13]. The present findings add that integrated digital information is a practical resource because it connects epidemiological needs, financial allocation, service activity, and performance review.

The positive acceptance of capitation policy is an important foundation, but the results reveal a distinction between compliance and commitment. Administrative compliance was strong because regulations and reporting requirements were explicit. Strategic commitment was weaker because staff groups understood the policy through the lens of their own responsibilities. Clinicians prioritized patient care, financial staff prioritized accountability, and program managers prioritized target achievement.

This fragmentation does not indicate resistance in the conventional sense. Rather, it represents partial ownership. Each group supports one aspect of the policy but lacks a shared understanding of how capitation should transform the service model. Leadership should therefore frame capitation as a collective organizational strategy and connect individual roles to common outcomes. Training should include joint case discussions in which teams decide how to allocate resources based on population-health data.

Rinawati's research on health-program strategy illustrates that managerial alignment is needed to convert positive intentions into coordinated action [13]. Her work on technology acceptance also suggests that willingness to use organizational systems increases when benefits are visible and support is adequate [14]. Applied to capitation, staff commitment is likely to strengthen when they can see how preventive investments reduce workload, improve service continuity, and support fair performance outcomes.

The existence of formal structure and SOPs did not guarantee consistent implementation. This finding supports Edward III's emphasis on fragmentation: when responsibilities are distributed across units without effective coordination, policy execution becomes inconsistent. At Suranadi, SOPs were available but were not uniformly internalized, and work pressure encouraged informal adjustments.

Centralized decision-making can protect regulatory compliance, but excessive centralization limits responsiveness and learning. Frontline personnel possess information about patient demand, outreach barriers, and program feasibility. Excluding this knowledge from allocation decisions weakens policy adaptation. Participatory governance does not require abandoning authority; it requires structured forums in which managers, financial staff, clinicians, and program managers jointly review data and propose actions.

A more adaptive bureaucratic arrangement would combine clear accountability with distributed problem solving. SOPs should specify mandatory controls while allowing operational adaptation within documented boundaries. Cross-unit review meetings should examine capitation utilization, preventive indicators, service trends, and implementation barriers. This would transform the bureaucratic structure from a reporting mechanism into a learning system.

Based on the interaction of the four dimensions, this study proposes a contextual implementation model with five reinforcing components. First, policy communication should be translated into role-specific operational guidance and supported by a two-way clarification mechanism. Second, competency development should be interdisciplinary, involving financial, clinical, and program staff rather than focusing only on treasurers.

Third, resource allocation should be based on integrated epidemiological, service, and financial data and should explicitly protect promotive and preventive activities. Fourth, SOPs should be internalized through simulation, monitoring, and routine review. Fifth, decision-making should combine managerial accountability with structured participation by frontline and program implementers.

These components are sequential but also mutually reinforcing. Better communication improves competence and disposition. Stronger competence enables more effective data use. Participatory decisions increase ownership and improve SOP adherence. Integrated information makes coordination and accountability more transparent. Therefore, implementation improvement should not be pursued through a single intervention.

**Table 3. Recommended managerial actions**

| Priority           | Action                                                                                                   | Expected result                                                   |
|--------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| Communication      | Develop concise technical briefs, case simulations, and a recurring clarification forum                  | Shared interpretation and faster adjustment to regulatory change  |
| Capability         | Provide joint training for managers, treasurers, clinicians, and program staff                           | Distributed competence and reduced dependence on individual staff |
| Allocation         | Use disease burden, service utilization, and program indicators in budgeting; protect preventive funding | More balanced capitation utilization                              |
| Information system | Integrate financial, service, and program data in a digital dashboard                                    | Improved monitoring, transparency, and evidence-based decisions   |
| Governance         | Establish cross-unit capitation review meetings and participatory recommendations                        | Greater ownership, coordination, and responsiveness               |
| SOP management     | Conduct simulation, supervision, and annual revision of SOPs                                             | Consistent procedures with controlled operational adaptation      |

Theoretically, the study supports the continued relevance of Edward III's model in health-financing implementation. More importantly, it demonstrates that the four variables operate interactively. Communication problems reduce competence and generate divergent dispositions; resource constraints intensify curative orientation; fragmented dispositions weaken coordination; and centralized bureaucracy restricts feedback. The model is therefore most useful when treated as a relational system rather than as a checklist of independent variables.

The study also adds a contextual insight: workload and professional differentiation shape the effect of all four variables. In primary care, implementers work under

simultaneous clinical, administrative, and public-health demands. Policy implementation must therefore account for the time and cognitive capacity required to understand, coordinate, and document policy actions.

Practically, Suranadi Primary Health Center should institutionalize a capitation governance team with representation from management, finance, clinical services, and public-health programs. The team should review utilization and program outcomes quarterly, document policy clarifications, identify training needs, and recommend allocation adjustments. The district health office and BPJS Kesehatan should provide simplified technical guidance whenever regulations change and should facilitate cross-facility learning.

This research was conducted in one primary health center and therefore reflects a specific organizational and regional context. Most participants were internal actors; perspectives from the district health office, BPJS Kesehatan, local government, and service users were not explored in equivalent depth. Access to some sensitive financial documents was limited, and the qualitative design did not measure the magnitude of relationships among variables. Nevertheless, triangulation across interviews, observations, and documents enabled a detailed explanation of implementation mechanisms. Future research should compare several health centers, incorporate external stakeholders, and combine qualitative findings with financial, service, and population-health indicators.

#### 4. CONCLUSION

The implementation of JKN capitation funds at Suranadi Primary Health Center has not yet fully achieved the strategic intent of strengthening comprehensive primary care. Communication channels exist, but information remains one-way, uneven, and insufficiently operational. Human resources are numerically adequate but uneven in competence and workload, while facilities and data systems provide limited support for preventive programs. Implementers generally accept the policy, but commitment remains fragmented across administrative, clinical, and program priorities. Formal structures and SOPs are available, yet task overlap, weak coordination, and centralized decisions reduce responsiveness.

The principal implication is that capitation performance cannot be improved solely through stricter financial compliance. Effective implementation requires a coordinated organizational system that connects policy interpretation, workforce capability, balanced allocation, integrated data, shared commitment, and participatory governance. The proposed model offers a practical pathway for aligning the four Edward III variables and strengthening accountability, prevention, and service quality at the primary-care level..

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