Journal of Primary Care & Community Health
Volume 12: 1–8
© The Author(s) 2021
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/21501327211023707
journals.sagepub.com/home/jpc

Indonesian General Practitioners' Experience of Practicing in Primary Care under the Implementation of Universal Health Coverage Scheme (JKN)

Fitriana Murriya Ekawati[1] and Mora Claramita[2]

Abstract

Introduction: The Indonesian government has been implementing *Jaminan Kesehatan Nasional* (JKN) as the national universal coverage scheme to help Indonesian citizens affording medical care since 2014. However, after a few years of its implementation, a very limited study has been conducted to explore general practitioners' (GPs) views and experiences of practicing in primary care under JKN implementation. **Methods:** The study applied semi-structured interviews with GPs from January to February 2016, guided by a phenomenology approach in Yogyakarta province, Indonesia. The GPs were recruited using a maximum variation sample design. The interviews were recorded and transcribed, and the data were analyzed thematically. **Result:** A total of 19 GPs were interviewed. Three major themes emerged, namely: powerlessness, clinical resources, and administration. Transition to the JKN system has improved patient access to primary care without significant economic barrier, however, GP participants experienced a sense of powerless practice during JKN implementation. They also commented on limited clinical resources and claimed that JKN administration was complicated and burdened their practice. **Conclusion:** This study identifies various perspectives from GPs practicing in primary care under JKN implementation. The JKN improves access to primary care practice, but there are limited supports for GPs to practice optimally and maintain their relationships with patients. Extensive improvements are needed to upgrade the GP practice in primary care.

Keywords

experience, general practitioners, Indonesia, JKN, primary care, universal coverage

Dates received: 9 January 2021; revised: 16 May 2021; accepted: 17 May 2021.

Introduction

World Health Organization (WHO) has promoted universal health coverage in its member countries to provide affordable medical care access.[1] In line with this suggestion, the Indonesian government has introduced a national health insurance program known as *Jaminan Kesehatan Nasional* (JKN) in 2014. This national insurance is delivered under a single funding body, known as *Badan Penyelenggara Jaminan Sosial Kesehatan* (BPJS-K/The Social Security Administration Body for Health). The BPJS-K itself is a merger body of several former public insurance schemes in Indonesia, such as Askes (*Asuransi Kesehatan*, insurance for public servants), Jamkesmas (*Jaminan Kesehatan Masyarakat*, insurance for poor citizens), and Asabri (insurance for the military force).[2]

Several changes in the health service operation have been applied during the JKN implementation. The role of primary care practice as a gatekeeper in the health system is now highlighted. The JKN members need to register themselves in registered primary care clinics, such as Puskesmas (*Pusat Pelayanan Kesehatan* or Public primary care clinic)

[1]Department of Family and Community Medicine, Faculty of Medicine, Universitas Gadjah Mada, Indonesia
[2]Department of Medical Education, Faculty of Medicine, Universitas Gadjah Mada, Indonesia

Corresponding Author:
Fitriana Murriya Ekawati, Department of Family and Community Medicine, Faculty of Medicine, Universitas Gadjah Mada, Radioputro Lt 1 Sayap Barat, Jalan Farmako Sekip Utara, Yogyakarta 55281, Indonesia.
Email: fitriana.muriya@ugm.ac.id

Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (https://creativecommons.org/licenses/by-nc/4.0/) which permits non-commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (https://us.sagepub.com/en-us/nam/open-access-at-sage).

or private GP/family doctor practices to be able to get JKN benefits. Primary care is also now funded under capitation payment system, which provides a monthly payment to the clinic based on its number of registered patients. This system aims to encourage GPs to focus on promotive and preventive care rather than curative procedures.[3,4]

Under the JKN, both Puskesmas and private GP clinics are expected to handle 155 disease diagnoses that should be managed in primary care based on the level 4 competency according to Indonesian Medical Doctors Standards (*Kompetensi Dokter Indonesia* [SKDI]).[5-7] In addition, primary practices are now equipped with an online medical record in primary care (P-Care) to guide GPs manage and selectively refer their patients based on their standard of practice. When GPs refer their patients without conforming to the 155 disease guideline, P-Care will notify them with "red letters" and ask the GPs to justify their referrals. Otherwise, the patient treatment at the hospital will not be covered by the JKN.[4,8,9]

With the changes during JKN implementation above, very limited research has been conducted to evaluate or explore GPs' perspectives as the prime service provider in primary care. Current available studies have explored clinicians' perspectives, and mention that JKN's limited coverage and restrictive policy affect their ability to maintain their practice standards and inter-professional collaboration in primary care.[9] In addition, another study on exploring patient experiences in primary care emphasizes that patients tend to have less trust in primary care practice and they liked to access secondary care.[4] However, both of those studies inadequately in-depth explores the GPs' perspectives as the leading provider of JKN in primary care and their experience during this reform. Therefore, this study aims to provide a complementary investigation of the GPs' views and experiences in practicing with JKN in primary care, listen to their experience, and to figure out possible strategies for improving the quality of primary care practice during JKN implementation.

Methods

Design

This study is part of a larger study aiming to explore the GPs views and experience of a formal family medicine postgraduate study in primary care and JKN implementation in primary care.[10] This study used semi-structured interviews with a topic guide guided by phenomenology approach and maximum variation sample design.[11-14] The data collection took place in Yogyakarta province as a representative of urban and rural settings in Indonesia, which also has a high referral rate from primary care to hospitals.[4,15]

Recruitment

Participants recruited in this study were approached conveniently. This study was advertised at the authors' professional networks, such as GP mailing lists and WhatsApp groups[16] for primary care doctors affiliated with the Department of Family and Community Medicine Gadjah Mada University in Yogyakarta. Some of the prospective participants were also sent an email/message invitation for the study. GPs who were interested in participating in the study were followed up with telephone calls or messages, and were sent the study plain language statements (PLS) and consent forms. They were then grouped based on their practice location to represent five districts in Yogyakarta province, consisting of Sleman, Yogyakarta city, Bantul, Gunung Kidul, and Kulon Progo, until all of the districts were represented by a minimum of two recruited participants. Participation in this study was voluntary, GPs who refused to participate in the study were not asked for and were free not to provide their reason for refusal.

Data Collection

The data collection was conducted from January to February 2016. The interviews were conducted at the participants' practice or the first author's office in Yogyakarta. The interviews were conducted individually for each participant in Bahasa Indonesia language by the first author, a female GP in Indonesia, and has moderate experience of interviewing Indonesian health providers. The participants were aware and had been explained about the interviewer's roles as an Indonesian GP and a staff at a university. They had also been explained that their participation was for research purposes, which would not affect their relationship with the authors in the future.

At the beginning of each interview, characteristics of each participant were noted, and during the interview, they were asked two main questions: (i) their views and experiences of practicing under JKN insurance and (ii) their expectations for primary care practices under JKN. All interviews were audio-taped and transcribed individually, and the first author also noted significant verbal and nonverbal responses from the participants. All GP participants were rewarded with a pen/table clock souvenir as a token of their participation.

Strategies to ensure rigour and trustworthiness of the research and interviews[17,18] were conducted as follows. Prompts, such as "*can you tell me more about that*" and minimum engagements were performed following the participants' responses to increase the credibility of the interviews. The interview questions were also previously tested with five interview-validation participants and interview participants were provided with summary results of their responses for cross-checking process. Participants'

non-verbal responses were noted and the first author also wrote fieldwork notes during the data collection process for triangulation purposes. In addition, the authors' reflections on the themes were explained in the data analysis to increase the reflexivity of the data. Presentation of the quotes in the results section was added with context and narration of Indonesian primary care setting to increase the data transferability. The complete process of the data collection, analysis, and reporting process of the research are also explained in the following sections to maintain its dependability and confirmability.

Analysis

The data was analyzed thematically using interpretative phenomenological analysis approach[14,19] with these following steps. The first and the second author independently read all transcribed texts until they became familiar with the participants' views. The interview transcripts and the fieldwork notes were then uploaded in the NVivo 11-12 software[20] and coded for any meaningful quotes. The quotes were then grouped into themes and overarching themes separately by the authors who have a background in qualitative research and primary care practice to understand the participants' meaning and experience of practicing under the JKN implementation in primary care. The authors also discussed the meanings and themes and compared them with their reflections and experiences of researching and practicing in primary care. The discussions were conducted through four iterative fortnightly meetings until similar interpretations of the themes were achieved.

Result

A total of 19 GP participants were recruited and interviewed from 28 approaches. Their demographic characteristics were presented in Tables 1 and 2. Most of the GPs were female (n=13), aged 25 to 40 years (n=11), and practiced in rural areas (n=12). Each of the participants only had one interview and the interviews were ranged from 45 to 90 min. All interviews were audio-taped, but the transcripts were not returned to the participants. However, each participant was consulted with the interview summary at the end of each interview. Considering the participants' similar interview responses and the length of each interview, the authors concluded that the data had approached data saturation and decided to finish the data collection after interviewing the 19th participant.

Three major themes were identified from the data analysis: powerlessness, resources and administration, and are explained below.

Powerlessness

Powerlessness was the central theme identified in the study mentioned by almost all of the participants. The frustration and powerless primary care practice during JKN implementation were inseparable from the JKN strict regulations on referrals and trust issue GPs and patients currently have in Indonesian primary care. In our interviews, the ideal process of doctor-patient partnership and ultimate patient care in primary care had superficially been achieved, and GP practice was merely about pills, prescription, system, and referral procedures. At the beginning of most interviews, many GPs believed that JKN brought a different practice environment and many patients are now able to access primary care without having financial barriers. However, many told that JKN also increased the GPs' workload and significantly brought the trust issue to the surface. Some quotes to explain the powerlessness and trust issue are explain as follows.

First, the patients' orientation of disease management is still hospital-based and being treated by specialists. At most of the interviews, many GP participants (n=11) expressed that both JKN regulation and patients challenge their practice, particularly when patients came and asked for referral letters to hospitals. Under the JKN implementation, GPs are encouraged to reduce referrals to hospitals, and they are expected to manage their patient condition optimally in primary care. However, the GPs also told that many patients desired to be referred and managed by specialists regardless of their disease severity, resulting in they have to explain and negotiate the unnecessary referrals at the examination room. Many of the GPs then expected that JKN could help them to provide explanations of the health system changes and JKN coverages, which could be managed in primary care and which could not (Table 3).

Second, with the limited trust from the patients above, many GPs also reported having difficult practice due to

Table 1. Maximum Variation Sample Details.

Characteristic	Number
Gender	
Women	13
Men	6
Age range	
25-40	13
41-55	4
56-70	2
Practice location	
Yogyakarta city	3
Sleman	6
Bantul	3
Gunung Kidul	4
Kulon Progo	3
Practice type	
Public	9
Private	10
Practice experience	
Less than 5 years	4
5-10 years	7
10-15 years	3
>15 years	5

Table 2. Characteristic of Each Participant.

Name	Age ranges	Practice type	Practice experience
Doctor 1	25-40	Private	<5 years
Doctor 2	25-40	Public	5-10 years
Doctor 3	41-55	Private	>15 years
Doctor 4	25-40	Public	5-10 years
Doctor 5	25-40	Private	5-10 years
Doctor 6	25-40	Private	<5 years
Doctor 7	41-55	Private	>15 years
Doctor 8	56-70	Private	>15 years
Doctor 9	25-40	Public	5-10 years
Doctor 10	56-70	Public	>15 years
Doctor 11	41-55	Private	>15 years
Doctor 12	25-40	Public	10-15 years
Doctor 13	25-40	Public	10-15 years
Doctor 14	41-55	Private	10-15 years
Doctor 15	25-40	Private	<5 years
Doctor 16	25-40	Public	<5 years
Doctor 17	25-40	Private	5-10 years
Doctor 18	25-40	Public	5-10 years
Doctor 19	25-40	Public	5-10 years

regulations and lists of competencies set by the JKN. At this second point, the GPs felt that JKN superficially acknowledged their experiences and practice authority in primary care. Some GPs mentioned that they were capable of managing uncomplicated chronic diseases, but often JKN system would rule it out and encourage them to periodically refer patients to hospitals. The GPs were also required to register their chronic disease patients into JKN *Prolanis* or PRB (*Program Pengelolaan Penyakit Kronis* or *Program Rujuk Balik*, which both are chronic disease management) Program. This mechanism obliges GPs to refer most chronic disease patients to specialists at the first month of the program. After that, patients without any complications can be managed and received free prescriptions in primary care for another three months. At the end of the third month, GPs have to refer patients to the hospital again for monitoring, and this cycle repeats for the next four months. The GPs then added that if patients failed to get the approval of GP management from specialists, they would not get medicines from the affiliated pharmacies in primary care. Doctor 8 told us this story in which she had to refer many patients to see specialists just to fulfill Prolanis prescription requirements (Table 3).

Third, unfortunately, necessary referrals for diseases in the 155 JKN list of diseases are sometimes unavoidable; however, JKN prevented the referral process and GPs had limited power to confront the regulation. An example of this case was told by Doctor 7 of an earwax blockage case that the drainage procedures in GP practice were unsuccessful, and she had to refer patients to hospitals (Table 3). However, the JKN P-Care system would prevent the GPs from referring patients for ear wax removal should be managed in primary care, or their treatment in the hospital could not be claimed to JKN. She then expected that JKN could tolerate this kind of practice difficulty in primary care.

Clinical Resources

Another theme that emerged from the analysis is limited clinical resources in primary care, which prevent GPs from performing optimal patient management. The limited resource in primary care was also a challenge when they had to manage patients in Prolanis programs. After having their consultation in hospitals, patients in the Prolanis program will be deferred to primary care; however, specialists' prescribed medicines were often limited or unavailable in Puskesmas's pharmacy, resulting in the patients were referred back to the secondary care. In addition, some Puskesmas GPs also claimed an imbalanced ratio of GPs per patient in primary care. For example, two doctors in Puskesmas X had to serve more than 25 000 JKN members with more than 60 patients a day. This ratio was not ideal, given that the doctors have to practice in the Puskesmas and perform health promotions and attend structural meetings in the regional health offices (Table 3).

Administration

The increase of paperwork and claim administration was another prominent challenge shared by the GPs during JKN implementation. Many GPs mentioned that they had to deal with complicated claim, even, some further mentioned that

Table 3. Participants' quotes for each of the themes.

Theme	Sub-theme	Quotes
Powerlessness	Negotiating practice as patients' orientation of disease management is still hospital-based	*"JKN brings a valuable contribution to help patients access medical care. However, there is a kind of 'consumerism' amongst our patients. They all want to go to specialists. They thought that once they paid for the insurance, they could get everything from here. Then I need to explain again, which one is covered and is not covered by the JKN, which cases that we can appropriately refer to, which cases that we can manage in primary care. Even when I think the referrals are unnecessary, I need to explain again. However, I think I can give up my practice if I need to discuss everything with them during the encounter. I JKN has to help us by explaining its regulations to patients" (Doctor 10).*
	JKN inadequately acknowledge GPs' experiences	*"One day I had to refer many patients because they had to see specialists in Prolanis program. My referrals were so many, and it was nearly in the size of one-bus group. Can you imagine? Many of them also complained of the JKN long referral process, but I could not do anything more for their prescription. Then we discussed with JKN so that for very simple hypertension, we can manage patients ourselves in primary care" (Doctor 8).*
	Lists of diseases set by JKN in primary care limits the GPs' practice	*"Often, some diseases in the JKN list are very challenging to work on in our practice. I had a difficult case of ear wax removal. I have done many tricks, but still, I cannot get the wax out. When I decide to refer the patients to hospital as I could not handle it myself, P-Care wrote the diagnosis with 'red letters' stating that we cannot refer it. Oh No! No matter how hard we try to manage it" (Doctor 7).*
Clinical resources	Limited medicines available in primary care	*"The problem is we do not have any angiotensin receptor blocker pills in Puskesmas. We only have modest antihypertension medication such as furosemide, thiazide, and amlodipine. There was nothing we could do other than to refer back this patient to the hospital" (Doctor 11).*
	Limited numbers of GPs in Puskesmas	*"Ideally, we only provide service for 5,000 capitation members as we only have two GPs. However, our capitation member is 25 thousand. Every day we see 60-70 patients and often we ended up having only one doctor because another doctor had to go for a meeting. I felt overwhelmed when I do my practice alone as nowadays patients love to come to Puskesmas for any illnesses they have" (Doctor 19).*
Administration	Small capitation payment compared to patient cost	*"Sometimes, I calculate. . . to treat patients with trauma and lacerations on their skin, I would use my own needle, threads, local anaesthesia, pain killers, and antibiotics when I need to suture the wounds. Those (the prices) are too much for a patient (to purchase the needle and local anaesthesia), compared to just refer them to the hospital. I have to think of my take-home income too" (Doctor 3).*
	Complicated paperwork	*"The JKN administration requirement was difficult in the field. I had to fill in the (hard-copy) medical records, online medical records, having coordination with midwives, and I had to fill in four administrative papers, such as patient consent, laboratory, and invoice if I order my patient to have a laboratory exam. I need to ask for her consent and many things. The joy of practicing with well-paid income from JKN seemed only a wish" (Doctor 7).*

the cost of some procedures in primary care exceed the JKN individual capitation budget. However, this high cost made them doubt of the claim success to JKN, given that only a little can be claimed to the insurance. Therefore, some GPs thought it might be better to refer patients to secondary care rather than manage them in primary care and decrease their take-home income (Table 3).

The doctors also said that they had to fill in much JKN paperwork for any claim they made. The doctors then had to work on monthly reports before their capitation payment can be paid. For example, some GPs told that they had to complete the examination evidence form, patient consent, and medical record notes for one patient laboratory examination. Some doctors mentioned that this process forced them to concentrate more on the JKN bureaucracy than patient care.

Discussion

Summary of Findings

This study has identified essential views from the GPs regarding their experiences of practicing in primary care during JKN implementation. Our general findings demonstrated frustration, powerlessness and overwhelmed situations experienced by GPs when managing high patient demand and dealing with JKN regulation in primary care. Their situations are more painful when they also have to negotiate their practice competence, authority and challenging practice to satisfy JKN claims and referral procedures. Our findings also imply that the Indonesian primary care seems not yet ready to perform an ideal gate-keeping function and has significant trust issues with patients. Many patients still expect referrals even for mild illnesses that are manageable in primary care, while it seems that the roles of primary care are still underestimated in the health system.[9,21,22]

This hospital-oriented phenomenon is not surprising and can not be separated from prominent hierarchical culture in Indonesian health system. The system often puts specialists on the top of the hierarchical level, which can be seen from the hospital oriented-disease management and the GP training that is limited to medical doctor (MD) program without any further compulsory postgraduate training. However, to become specialists, MD graduates have to pursue another

three to four-years of specialist training. This gap of training then impacts on the GPs' confidence in managing patients, and in return resulted in the low trust from patients.[4,10] Meanwhile, GPs often perceived themselves in a higher hierarchical position than nurses, midwives, or even patients in primary care, which often make them expect patients to follow their advice with a limited mutual person-centered approach.[23-25] Therefore, when patients refuse the referral advice, the GPs then feel uncomfortable.

Furthermore, findings related to the resources and administration of JKN claims then burden the GP practice more. They have to not only deal with JKN regulation and challenging relationships with patients, but also dealing with limited clinical resources, complicated claim processes, and paperwork. If the practice is the GPs' action, unfortunately, they were only equipped with limited supplies and rewards.

Comparison with Existing Literature

Compared to other literature about primary care practice in Indonesia, findings in this study complement results of some studies related to GP practice under JKN implementation.[4,21,22] Findings in this study combined with results of our previous study on interviewing patients[4] complementary demonstrate a sense of adaptation and separation anxieties from both patients and GPs in primary care. Before the JKN implementation, the setting was previously regarded as a place to proceed many unnecessary referral letters to hospitals, and now, under the JKN, it has to perform more appropriate gatekeeping functions. Therefore, GP and patient groups need to adapt to their new roles and system as referral to hospitals could no longer be made without GPs' appropriate clinical judgment.

Our findings also similarly emphasise significant trust issues between GPs and patients, and the GPs' powerless practice during JKN implementation. Our findings confirm that primary care practice is also challenged by the current GP training, extensive JKN regulations, and limited facilities in primary care.[4,9,21,26,27] Therefore, with the increased work but limited training and practice supports, the GPs felt overwhelmed and unable to meet their patient demands. These feelings were worsened when the JKN also regulates a list of 155 diseases managed in primary care which creates an inflexible practice compared to managing patients without JKN.

How can the conditions be improved? At any health reform, primary care plays an essential role in the health system. If the setting could not perform appropriate gatekeeping functions in primary care, the aims of JKN to provide cost-effective medical access to patients would not be achieved. This impact already happens that JKN always reports deficits of funding each year to cover huge hospital medical expenses.[28,29] Therefore, the Indonesian medical paradigm needs to be shifted from hospital-oriented to primary care, and to prepare GPs with adequate practice skills in the setting. The establishment of formal postgraduate training for Indonesian GPs then becomes vital to enable primary care to create and improve its practice quality.[10,30]

The GPs should also be equipped with adequate clinical resources in primary care. The practice should be supplied adequate supports for appropriate patient management and to improve trust among the patients. Capitation payment from the JKN should be increased and simplified for its claims and be combined with pay-for-performance methods, allowing more innovative prevention services for non-visit patients.[31-33] The combination payment that is currently focused on chronic disease management (Prolanis and PRB) can also be expanded to cover other diseases or general health promotions.[8] The P-Care system and the list of diseases should be continuously improved to allow explanation of the GPs' clinical judgement, and primary care accreditation programs initiated by the Indonesian government can also be further applied to upgrade clinical resources rather than focusing on the administration aspects.[34,35]

Above all, the Indonesian government is already in an appropriate stage of ensuring affordable and convenient access for people to meet their basic health care needs in primary care. The JKN implementation is relatively recent, and strategies aiming to improve the GP practice would obviously require quite some time. The shifting paradigm also needs strong leadership from the government as the ultimate manager of the Indonesian health system. Therefore, JKN policies from the government should always be directed to support primary care practice.

Strengths and Limitations

This study is a small-size qualitative study using interviews to explore Indonesian GPs experiences during the early JKN implementation in Yogyakarta provinces. Many participants were also within the first author's professional networks in Yogyakarta that may limit the data generalisability to represent a broad spectrum of Indonesian conditions. However, the maximum variation sample used in the study has captured ranges of GPs views and experiences in the interviews, which increases the likelihood of the data saturation. Also, the interviews were conducted by the first author, who is a GP in Indonesia. Her background allowed genuine responses from the participants to share their practice stories in primary care and the phenomenological approach has enriched the interpretation of the findings. This study, together with our previous study of asking the patients' experiences,[4] is able to emphasize the main challenges of primary care practice and the urgent need for primary care practice improvements under JKN implementation.

Conclusion

This study reports views and experiences of Indonesian GPs of practicing in primary care under JKN implementation. Despite that JKN improves patients' access to health care, many GPs in Indonesia experience challenging practice, limited clinical resources, and extensive administration in primary care. Further research is needed, particularly on strategies to upgrade the GP practice and improving JKN funding scheme in primary care.

Acknowledgments

The first author would like to acknowledge the contribution of Dr. Nuretha and Dr. Aghna Gayatri for their assistance during data collection and willingness to read the first version of this manuscript. Also, Dr. Krishna Hort for his feedback during the manuscript development.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research: This research was funded under the Allison Sudrajat Prize from the Department of Foreign Affairs and Trade, Australia 2014 to 2016.

Ethics

Ethics approval for this study has been obtained from the Human Ethics Committee, Faculty of Medicine, Universitas Gadjah Mada number KE/FK/10/EC/2016. All participants gave their consent for the interviews, recordings, transcription, and academic publications using pseudonyms.

ORCID iD

Fitriana Murriya Ekawati https://orcid.org/0000-0002-3622-0510

Data Availability Statement

The raw materials of this study are not suitable for external sharing.

References

1. WHO. Questions and answers on universal health coverage 2012. 2014. Accessed February 25, 2014. http://www.who.int/contracting/documents/QandAUHC.pdf?ua=1
2. Ministry of Health Republic Indonesia. The Ministry of Health Regulation number 28 year 2014 about the implementation guideline of Indonesian universal health coverage. Jakarta. 2014. Acceseed October 28, 2015. http://dinkes.mataramkota.go.id/wp-content/uploads/2016/05/PMK-No.-28-Th-2014-ttg-Pedoman-Pelaksanaan-Program-JKN.pdf.
3. Trisnantoro L. Healthcare system reform and governance for sustainable development under Indonesia's health insurance (JKN) policy. In Holzhacker R, Agussalim D (eds.). *Sustainable Development Goals in Southeast Asia and ASEAN*. Brill; 2018; 143–159.
4. Ekawati FM, Claramita M, Hort K, Furler J, Licqurish S, Gunn J. Patients' experience of using primary care services in the context of Indonesian universal health coverage reforms. *Asia Pac Fam Med*. 2017;16:4.
5. Indonesian Medical Council. *Indonesian Doctors' Competency Standard*. KKI; 2012.
6. Febrianti E, Amran R, Haerani S. Basic study on the implementation of outpatient referral of BPJS health members in the first health facility at Makassar. *Int J Multicultural Multireligious Understanding*. 2019;6:694-704
7. Sari FN, Sanusi SR. Referral demand of patients in Pantai Cermin public health center Langkat. *Br Int Humanit Soc Sci J*. 2020;2:314-320.
8. Sekjen Kemenkes RI, BPJS, Utama D. Peraturan Bersama Sekretaris Jenderal Kementerian Kesehatan Dan Direktur Utama Badan Penyelenggara Jaminan Sosial Kesehatan Tentang Petunjuk Teknis Pelaksanaan Pembayaran Kapitasi Berbasis Komitmen Pelayanan Pada Fasilitas Kesehatan Tingkat Pertama. *Jakarta*. 2017. Accessed June 3, 2021. https://www.bpjs-kesehatan.go.id/bpjs/dmdocuments/bcff128bde925134919859642030ce9a.pdf.
9. Syah NA, Roberts C, Jones A, Trevena L, Kumar K. Perceptions of Indonesian general practitioners in maintaining standards of medical practice at a time of health reform. *Fam Pract*. 2015;32:584-590.
10. Ekawati FM, Claramita M, Istiono W, Kusnanto H, Sutomo AH. The Indonesian general practitioners' perspectives on formal postgraduate training in primary care. *Asia Pac Fam Med*. 2018;17:10
11. Etikan I, Musa SA, Alkassim RS. Comparison of convenience sampling and purposive sampling. *Am J Theor Appl Stat*. 2016;5:1-4
12. van Rijnsoever FJ. (I can't get no) saturation: a simulation and guidelines for sample sizes in qualitative research. *PloS One*. 2017;12:e0181689
13. Manen MV. Phenomenology in its original sense. *Qual Health Res*. 2017;27:810-825.
14. Neubauer BE, Witkop CT, Varpio L. How phenomenology can help us learn from the experiences of others. *Perspect Med Educ*. 2019;8:90-97.
15. Hendrartini J, Hanindriyo L. Evaluation of primary care dentist service in the implementation of Jaminan Kesehatan Nasional (JKN) in Central Java and Yogyakarta. *UGM Digit Press Health Sci*. 2018;1:19-30
16. Koum J, Acton B. WhatsApp. Accessed June 5, 2020. https://www.whatsapp.com/about/.
17. Korstjens I, Moser A. Series: practical guidance to qualitative research. Part 4: trustworthiness and publishing. *Eur J Gen Pract*. 2018;24:120-124.
18. Stahl NA, King JR. Expanding approaches for research: understanding and using trustworthiness in qualitative research. *J Dev Educ*. 2020;44:26-29.

19. Spiers J, Riley R. Analysing one dataset with two qualitative methods: the distress of general practitioners, a thematic and interpretative phenomenological analysis. *Qual Res Psychol*. 2019;16:276-290.
20. QSR International. Nvivo (Software) version 12.2.0 (3262). 2019. Accessed December 20, 2020. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/support-services/nvivo-downloads.
21. Syah NA. General practitioners' autonomy in the management of non-communicable diseases (NCDs) in the JKN era: is it feasible? *Rev Prim Care Pract Educ (Kajian Praktik dan Pendidikan Layanan Primer)*. 2019;2:89-91.
22. Mulyanto J, Wibowo Y, Kringos DS. Exploring general practitioners' perceptions about the primary care gatekeeper role in Indonesia. *BMC Fam Pract*. 2021;22:5.
23. Findyartini A, Kambey DR, Yusra RY, et al. Interprofessional collaborative practice in primary healthcare settings in Indonesia: a mixed-methods study. *J Interprof Educ Pract*. 2019;17:100279.
24. Claramita M, Riskiyana R, Susilo AP, Huriyati E, Wahyuningsih MSH, Norcini JJ. Interprofessional communication in a socio-hierarchical culture: development of the TRI-O guide. *J Multidiscip Healthc*. 2019;12:191-204.
25. Dewi WN, Evans D, Bradley H, Ullrich S. Person-centred care in the Indonesian health-care system. *Int J Nurs Pract*. 2014;20:616-622.
26. Maharani C, Afief DF, Weber D, Marx M, Loukanova S. Primary care physicians' satisfaction after health care reform: a cross-sectional study from two cities in Central Java, Indonesia. *BMC Health Serv Res*. 2019;19:290.
27. Nirmala PN, Indrayathi PA, et al. Perceived importance of health care facilities, staff capability, service time and selection of primary health care services by national health insurance participants. 2019. Accessed May 10, 2021. https://phpmajournal.org/index.php/phpma/article/view/212. doi: 10.15562/phpma.v7i2.212
28. Janah M, Rahayu AYS. Collaborative Governance Approaches in dealing with financial deficits in the JKN-KIS program in Indonesia. *Global J Bus Soc Sci Rev*. 2020;8:124-131.
29. Shreeshant Prabhakaran, Soewondo, Prastuti, et al., editors. Achieving financial sustainability for JKN. *4th inaHEA Annual Scientific Meeting & International Seminar on Health Economics*, Held in Surabaya, Indonesia 13–15 September, 2017.
30. Claramita M, Ekawati FM, Gayatri A, et al. Preparatory graduate professional training in general practice by using the 'experiential learning' framework. *Asia Pac Fam Med*. 2018;17:4.
31. Ellegård LM, Dietrichson J, Anell A. Can pay-for-performance to primary care providers stimulate appropriate use of antibiotics? *Health Econ*. 2018;27:e39-e54.
32. Basu S, Phillips RS, Song Z, Bitton A, Landon BE. High levels of capitation payments needed to shift primary care toward proactive team and nonvisit care. *Health Aff*. 2017;36:1599-1605.
33. L'Esperance V, Gravelle H, Schofield P, Santos R, Ashworth M. Relationship between general practice capitation funding and the quality of primary care in England: a cross-sectional, 3-year study. *BMJ Open*. 2019;9:e030624.
34. Setiadi AP, Wibowo Y, Herawati F, et al. Factors contributing to interprofessional collaboration in Indonesian health centres: a focus group study. *J Interprof Educ Pract*. 2017;8:69-74.
35. Werdhani RA. Medical problem in Asia pacific and ways to solve it: the roles of primary care/family physician (Indonesia Xperience). *J Family Med Prim Care*. 2019;8(5):1523-1527.