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FACTORS INFLUENCING PRIMARY HEALTH CARE INTEGRATION IMPLEMENTATION: A QUALITATIVE STUDY IN BELITUNG

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ABSTRAK

The integration of primary health care (PHC) in Indonesia has been transformed through Minister of Health Regulation No. 19 of 2024, emphasizing life-cycle-based comprehensive services. This policy aims to enhance accessibility and quality of services in Primary Health Care, Sub-Public Health Center, and Posyandu. However, implementation in archipelagic regions, such as Belitung Regency, faces challenges related to human resources, infrastructure, and bureaucratic coordination. This study aimed to explore the factors influencing the implementation of primary health care integration based on Permenkes No. 19/2024 at Badau Public Health Center, Belitung Regency, using Edward III's policy implementation framework. A qualitative descriptive approach was employed with seven key informants, including program managers, Primary Health Care heads, and implementers of the Integrated Primary Health Care (PHC) program. Data were collected through in-depth interviews and triangulated with document reviews. Thematic analysis was applied to identify factors affecting policy implementation. Findings indicate that policy implementation was influenced by four main factors: communication, resource availability, implementers' disposition, and bureaucratic structure. Effective communication and clarity of guidelines improved understanding and coordination among stakeholders. Adequate human resources and operational infrastructure supported service delivery, although disparities remained between urban and remote Primary Health Care. Positive disposition and commitment of implementers were critical for successful integration, while a well-defined bureaucratic structure facilitated task distribution and cluster management. The successful implementation of integrated primary health care in Badau Primary Health Care depends on comprehensive communication, sufficient resources, committed personnel, and structured bureaucracy. Addressing gaps in human resources and infrastructure is essential to ensure equitable and sustainable service delivery in archipelagic contexts.

Keywords: Integrated Primary Health Care, Permenkes 19/2024, Policy Implementation, Edward III, Qualitative Study

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INTRODUCTION

The integration of primary health care (PHC) represents a fundamental transformation in global health systems, emphasizing comprehensive, life-cycle-based services that enhance accessibility, equity, and quality while reducing fragmentation (WHO, 2024). Despite global efforts, approximately 50% of the world's population still lacks access to quality PHC, underscoring its urgency for Universal Health Coverage (UHC) (WHO, 2024). Strengthening PHC is recognized as a cost-effective strategy to improve population health and increase life expectancy, particularly in middle-income countries like Indonesia (Kruk et al., 2018; WHO, 2024).

In Indonesia, this transformation is institutionalized through Minister of Health Regulation No. 19 of 2024 (Permenkes 19/2024), shifting from vertical programs to life-cycle-based integrated services across Primary Health Care, Sub-Public Health Center, and Posyandu (Kementerian Kesehatan RI, 2024). However, operational challenges persist in archipelagic regions, where policy success depends heavily on inter-bureaucratic coordination, resource availability, and organizational capacity (Sastrawan & Rahmah, 2026).

In Belitung Regency, facilities supported by the Global Fund continue to face disparities, infrastructure bottlenecks, uneven staffing (Kementerian Kesehatan RI, 2024), logistical complexities in medical supply distribution, and limited access to digital health technologies (Prasetyo et al., 2024; Putri & Adnan, 2025; Rosita et al., 2025; Prima et al., 2025; Hartono & Wijaya, 2023).

Edward III's framework comprising communication, resources, disposition, and bureaucratic structure provides a systematic approach to analyze these critical determinants in island settings (Edward III, 1980). Given the limited empirical evidence following Permenkes 19/2024 in Indonesia's island regions, this study aims to explore the determinants influencing integrated PHC delivery at Badau Primary Health Care in Belitung Regency, providing evidence-based recommendations for sustainable and equitable health services.

METHODS

This qualitative descriptive case study, conducted from March to May 2026 at Badau Public Health Center and two comparison facilities in Belitung Regency, explored the determinants of Integrated PHC implementation under Permenkes 19/2024 (Gilson, 2021; Peters et al., 2022).

Seven key informants were purposively selected based on direct PHC integration involvement, key administrative/operational roles (1 manager, 3 PHC heads, 3 implementers), ≥1 year of service, and informed consent, following formal approvals from the Belitung District Health Office and PHC leadership. Triangulation informants—including the Head of the District Health Office and local health service recipients—were also purposively included to enhance validity.

Data were collected via 45–60 minute semi-structured, face-to-face, audio-recorded interviews structured around Edward III's policy implementation framework: communication, resources, disposition, and bureaucratic structure (Edward III, 1980). Manual thematic analysis was conducted on interview transcripts, supplemented by source triangulation with informant groups and document reviews (operational manuals, policy guidelines, internal reports). Institutional ethics and administrative approval were granted by Universitas Anak

Bangsa, with strict adherence to informed consent, anonymity, and voluntary participation.

Results and Discussion

Participant Characteristics

To provide an overview of the individuals involved in this study, the demographic and professional characteristics of the seven key informants and triangulation informants are detailed in Table 1 below.

Table 1Characteristics of Study Participants

No	Participant Code	Role / Position	Length of Service	Institution / Location
1	K1	Primary Health Care Head	> 5 years	Badau Public Health Center
2	K2	Primary Health Care Head	> 4 years	Comparison Primary Health Care 1
3	K3	Primary Health Care Head	> 6 years	Comparison Primary Health Care 2
4	K4	Program Manager / Coordinator	> 5 years	Badau Public Health Center
5	K5	PHC Program Implementer (Cluster 2)	> 3 years	Badau Public Health Center
6	K6	PHC Program Implementer (Cluster 3)	> 4 years	Badau Public Health Center
7	K7	PHC Program Implementer (Cluster 4)	> 3 years	Badau Public Health Center
8	T1	Head of District Health Office	> 10 years	Belitung District Health Office
9	P1 - P3	Community Members / Patients	-	Badau & Comparison Catchment Areas

Table 2 Main Themes and Subthemes from the Analysis

No	Variable	Subtheme	Key Findings
1	PHC Implementation	Cluster-based Implementation	PHC has been implemented through the cluster system but is still in the adaptation process.
2	PHC Implementation	Life-cycle Posyandu and Home Visits	Services have begun to cover the life cycle but are constrained by time, community health cadres, and public understanding.
1	Communication	Policy Socialization	Policy socialization has been conducted, but the depth of information is not yet uniform.
2	Communication	Clarity of Guidelines and Permenkes	Permenkes clarifies PHC direction, but technical aspects of reporting remain a challenge.
1	Resources	Human Resources and Double Job	Limitations in human resources and multiple job responsibilities are the dominant barriers.
2	Resources	Facilities, Medical Devices, BMHP, and Budget	Basic facilities are available, but medical devices, BMHP, and operational funds still need strengthening.
1	Disposition	Implementers' Commitment	Implementers accept PHC and are committed to executing the policy.

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2	Disposition	Workload	PHC is well-regarded but increases workload, applications, reporting, and screening tasks.
1	Bureaucratic Structure	SOP and Cluster Assignment	SOPs and task allocation exist, but overlapping responsibilities still occur.
2	Bureaucratic Structure	Reporting and Coordination	Reporting is not yet synchronized between the cluster-based and program-based systems.

1. Implementation of Integrated Primary Health Care Based on Minister of Health Regulation No. 19 of 2024
   a. Cluster-based Implementation

      The implementation of PHC in Belitung Regency, particularly at Badau Public Health Center, has commenced but is not yet fully optimal. The service system shifted from the previous individual health efforts and public health efforts based model to a cluster- and life-cycle-based approach. While preparatory activities, internal adjustments, and guideline studies were conducted in 2024, actual implementation began in 2025 after Badau Primary Health Care was designated as a pilot site for the Global Fund.

      Most informants reported that PHC was not immediately applied in 2024, as the old system was still in use. Real implementation began in 2025, including sorting patients according to Cluster 2 (maternal and child health) and Cluster 3 (adult and elderly services), accelerated by the Global Fund support:

      "In 2025 we really started… sorting patients according to Cluster 2 and Cluster 3, and at the same time we received the Global Fund grant." (K1, Primary Health Care Head)

      Triangulation informants from the Health Office confirmed that the pilot project enabled gradual cluster-based implementation with funding support and monitoring evaluation:

      "The Global Fund may have triggered this implementation, and subsequently, we could fund it independently from the region or BLUD." (T1, Head of District Health Office)

   b. Life-cycle Posyandu and Home Visits

      At the district level, PHC is expected to be implemented across Posyandu, Sub-Public Health Center, and Primary Health Care, covering the full life cycle from pregnant women, infants, toddlers, adolescents, adults, to the elderly. Field implementation, however, remains in transition, as Primary Health Care and Sub-Public Health Center continue adapting to cluster systems.

      At the Sub-Public Health Center level, patient services are organized by cluster, and community health cadres conduct biweekly meetings to discuss reports and home visit targets:

      "Patients are treated according to clusters. For example, Cluster 2 goes to me… every two weeks we meet to make reports and check what has not been achieved." (K5, Program Implementer)

Triangulation informants confirmed that services are perceived as accessible and friendly:

"The examination should be more thorough, not too brief. The laboratory should also be more complete, because going to Tanjung is quite far." (P1, Community Patient)

Home visits have expanded post-PHC to cover more target populations, rather than focusing only on toddlers who miss Posyandu visits:

"Previously, home visits were only for toddlers who didn't attend. Now, all after Posyandu are visited." (K6, Program Implementer)

2. Communication in PHC Implementation
   a. Policy Socialization

   Policy socialization included meetings, WhatsApp groups, Zoom sessions, local meetings, and training. Some informants reported clear communication, while others found technical guidance insufficient:

   "Initially, there was no special event… the information was only shared that there was an SK, but technical details were not thoroughly explained." (K4, Program Manager)

   Structured socialization was reported in other Primary Health Care:

   "*Policy socialization regarding PHC in Belitung has been well-structured… from top to bottom levels it has been ongoing." (K2, Program Manager)*

   Triangulation informants emphasized that Global Fund support helped guide cluster-based implementation:

   "Global Fund support facilitated the implementation… and later it could be funded independently." (T1, Head of District Health Office)

   Patients confirmed the importance of clear socialization for service experience:

   "The examination should be more thorough, not too brief. The laboratory should also be more complete, because going to Tanjung is quite far." (P2, Community Patient)

   b. Clarity of Guidelines and Regulations

   Despite socialization, early implementers experienced confusion due to lack of examples:

   "In the beginning, we were quite confused because there were no clear examples." (K3, Primary Health Care Head)

   Coordination occurred via WhatsApp, supervision, and meetings, but detailed technical guidance on reporting, cluster division, and application use remained necessary.

3. Resources in PHC Implementation
   a. Human Resources and Double Job

   Human resource availability was a major determinant in PHC implementation. Most informants highlighted limitations in staffing, particularly for specialized roles such as physiotherapists and family doctors. Basic service providers like doctors, midwives, and nurses were present, but staff often performed multiple responsibilities (double jobs), which disrupted service continuity during absences due to illness, leave, or training.

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"For basic services, such as midwifery, doctors, and nurses, staff are available. But for advanced services, like family doctors and physiotherapists, they are not present." (K1, Primary Health Care Head)

"Almost all staff at Badau Primary Health Care have double jobs… automatically, it is insufficient." (K4, Program Manager)

Triangulation informants confirmed that additional recruitment was necessary for IT, laboratory, and administrative staff to meet service demands:

"Currently, Primary Health Care staff require additional personnel, such as IT and laboratory staff… to fulfill service needs." (T1, Head of District Health Office)

Patients acknowledged limited resources but generally reported satisfactory and friendly service:

"The examination should be more thorough, not too brief. The laboratory should also be more complete, because going to Tanjung is quite far." (P3, Community Patient)

b. Facilities, Medical Devices, BMHP, and Budget

Facilities and infrastructure were critical for PHC. While basic facilities exist, gaps in medical devices, BMHP, and operational funds were reported. External funding from the Global Fund accelerated activities such as home visits, training, and administrative support, but could not fully cover infrastructure needs. Implementers emphasized that the availability of medical devices and BMHP directly affected screening quality:

"When BMHP or medical devices are missing or broken, services are automatically disrupted." (K5, Program Implementer)

4. Disposition in PHC Implementation

a. Implementers' Commitment

Implementers generally accepted and were committed to PHC. No strong resistance was observed, and staff followed guidance from Primary Health Care heads, engaging in training and adaptation:

"No resistance… we just learned and followed." (K2, Primary Health Care Head)

"All staff are motivated… we divide tasks and manage time despite handling other programs." (K6, Program Implementer)

Triangulation informants confirmed that commitment remained high despite resource limitations:

"Even with limited human resources, medical devices, and budgets, implementers strive to meet cluster needs and conduct home visits using Global Fund support." (T1, Head of District Health Office)

b. Workload

PHC increased workload due to additional screening, home visits, reporting, and application use. Some implementers reported that these added tasks affected efficiency but were manageable:

"Additional workload is real… forms to fill are more numerous." (K7, Program Implementer)

Patients noted that despite additional procedures, service remained adequate and friendly:

"Services are good, friendly, and not delayed." (P1, Community Patient)

5. Bureaucratic Structure in PHC Implementation
   a. SOP and Cluster Assignment

   Standard operating procedures (SOPs) and cluster task allocations were established, but overlapping responsibilities and double reporting still occurred. Informants explained that each cluster had its own SOP, complemented by a master SOP for the Primary Health Care:

   "I asked each cluster to make their SOP… then I made a master SOP." (K1, Primary Health Care Head)

   At Sub-Public Health Center Tanjung Tinggi, cluster responsibilities were clearer, helping staff understand their roles:

   "Each nurse is assigned to Cluster 3… the structure is now more organized." (K5, Program Implementer)

   However, overlapping duties remained, particularly for Cluster 1, which had high responsibility but limited time and staff:

   "Some staff still perform multiple tasks simultaneously." (K4, Program Manager)

   Triangulation confirmed that while SOPs are officially in place, field implementation requires routine supervision:

   "SOPs are clear, but field implementation still adapts to conditions at each Primary Health Care. Some still report per program, requiring regular supervision." (T1, Head of District Health Office)

   b. Reporting and Coordination

   Reporting is conducted according to cluster structure at Primary Health Care, but Health Office requirements remain program-based, leading to partial misalignment. Monitoring and evaluation are routinely performed but need further reinforcement:

   "Primary Health Care reports follow PHC clusters, but Health Office still wants program-based reports… adjustment is ongoing." (K1, Primary Health Care Head)

6. Impact of PHC on Health Services

   PHC positively affected primary health care services, improving screening, early detection, home visits, and service coverage. Screening identified hypertension and diabetes earlier, allowing timely intervention:

   "Screening success is the main benefit; hypertension and diabetes are detected early, enabling prompt therapy." (K2, Primary Health Care Head)

   Service accessibility improved, particularly for communities distant from Primary Health Care:

   "Communities are now better covered, especially those far from the Primary Health Care." (K3, Primary Health Care Head)

   Home visits increased Sub-Public Health Center service activity beyond just sick patients:

   "Services at Sub-Public Health Center have improved due to healthy home visits, not just waiting for sick patients." (K5, Program Implementer)

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Patients reported satisfaction but suggested more complete laboratory facilities:

"Examination should be more thorough… the lab should also be more complete." (P2, Community Patient)

The present study evaluates Integrated Primary Health Care (PHC) implementation under Permenkes No. 19 of 2024 at Badau Public Health Center, highlighting its transition into a life-cycle and cluster-based model following its 2025 Global Fund pilot designation. This phased approach enabled structured patient sorting (Clusters 2 and 3) and home visits, though operationalization remains uneven due to gaps in technical understanding, coordination, and resources, mirroring findings across other regions (Zakia, 2024; Dhynianti et al., 2025). Communication served as a central determinant; while structured socialization aided cluster understanding, inconsistencies in technical interpretation created service variations. Aligning with Edward III's framework, consistent and detailed communication channels are vital to prevent divergent interpretations (Edwards III, 1980; Smith et al., 2022; Rahmawati & Pratama, 2023).

Resources encompassing human resources, infrastructure, equipment, and operational funds were identified as critical determinants of implementation success. Although core personnel (doctors, midwives, and nurses) were available, the lack of specialized staff (physiotherapists and family doctors) forced employees to manage multiple responsibilities. This reflects broader global and regional health workforce challenges, including shortages, uneven distribution, and multiple job holding (World Health Organization, 2025; Edwards III, 1980; Nindrea et al., 2023; Endalamaw et al., 2024; Matovu et al., 2023).

Implementers demonstrated positive disposition and commitment toward adopting new workflows, conducting home visits, and managing additional reporting requirements; however, the increased workload poses long-term sustainability risks for staff and community health cadres (Endalamaw et al., 2024; Matovu et al., 2023; Bosu et al., 2022). Regarding bureaucratic structure, while SOPs and cluster-based task allocations exist, overlapping responsibilities and dual reporting systems—where local operations follow clusters while Health Office reporting still adheres to program-based formats created operational inefficiencies, supporting Edward III's framework regarding fragmented structures (Edwards III, 1980).

Despite these challenges, PHC implementation yielded positive outcomes, including early detection of non-communicable diseases (hypertension and diabetes), expanded home visit coverage across all life stages, and high patient satisfaction, mirroring trends in remote health center catchments (Wandira et al., 2024). Furthermore, external support from the Global Fund accelerated adoption and initial implementation through technical assistance, funding, and training, highlighting the pivotal role of donor support in archipelagic regions (Nugraha & Santoso, 2025; Leeman et al., 2023). However, long-term sustainability depends on local health systems' absorptive capacity and continued investment (WHO & UNICEF, 2020). Overall, successful PHC integration requires a multi-dimensional approach combining clear communication, adequate resources, committed

implementers, and refined bureaucratic processes to bridge national policy with local execution (Greenhalgh et al., 2023).

CONCLUSION AND RECOMMENDATIONS

The implementation of Integrated Primary Health Care (PHC) at Badau Public Health Center has successfully initiated cluster- and life-cycle-based services, extending through Sub-Public Health Center and Posyandu networks. However, as implementation remains in an adaptive phase, operational effectiveness is constrained by technical ambiguity, resource limitations, communication inconsistencies, and heavy administrative workloads, despite positive staff commitment and existing bureaucratic frameworks. To optimize delivery, the Health Office should strengthen technical supervision, inter-level coordination, and reporting system harmonization. Simultaneously, Primary Health Care leadership must refine internal management, SOPs, cluster task allocation, and staff capacity building. Future research should assess broader geographic coverage, long-term sustainability, financial efficiency, and digital readiness, thereby enriching policy implementation theory and public health management in archipelagic contexts..

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