Journal of Health and Nutrition Research
Vol. 5, No. 2, 2026, pg. 908-919, https://doi.org/10.56303/jhnresearch.v5i2.845
Journal homepage: https://journalmpci.com/index.php/jhnr/index

e-ISSN: **2829-9760**

Evaluation of Integrated Primary Care (ILP) Implementation: A Qualitative Assessment of Input and Process Dimensions in Banjarbaru City Health Centers

Anggun Wulandari [1], Neka Erlyani [2], Fauzie Rahman[1], Nur Laily[1], Andini Octaviana Putri[1], Lia Anggraini[1], Siti Maimunah[1], Sri Wulandari[1], Nuralpisah[1], Fitrya Hayati Alkamaliah[1], Ahmad Navijay[1], Muhammad Arifin[1]

[1] Public Health Study Program, Lambung Mangkurat University, Indonesia
[2] Psychology Study Program, Lambung Mangkurat University, Indonesia

Corresponding Author Email: anggun.wulandari@ulm.ac.id

Copyright: ©2026 The author(s). This article is published by Media Publikasi Cendekia Indonesia.

ORIGINAL ARTICLES

Submitted: 14 September 2025

Accepted: 23 April 2026

Published: 01 August 2026

Keywords:
Adaptive Strategies, Integrated Primary Care, Health System Evaluation, Health Policy Implementation, Primary Health Center

OPEN ACCESS

This work is licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License

ABSTRACT

Primary health care is the foundation of the health system with a focus on promotion and prevention. To strengthen this, the Indonesian Ministry of Health launched Integration Primary Care (ILP) policy in 2023, although its initial implementation faced various obstacles. This study aims to assess the input (human resources, infrastructure, and funding) and process (planning, organizing, implementing, and evaluating policies) dimensions of ILP implementation in Banjarbaru City Health Centers. The study used a descriptive qualitative approach with 20 informants consisting of health center heads and program managers in 10 health centers through purposive sampling. Data were collected through focus group discussions. Validity was tested using source and technique triangulation. This study uses an evaluative approach based on Azwar's (1996) health systems theory, which allows for a comprehensive analysis of the input and process components in ILP implementation. The results showed that ILP was still constrained by limited human resources, especially the limited core implementing staff and ILP supporting infrastructure does not fully meet standards. However, adaptive strategies such as cluster role sharing, cross-sector collaboration, and community involvement supported the policy's sustainability. In terms of process, planning, organization, implementation, and evaluation were carried out, but were still influenced by old mechanisms and minimal budgetary and organizational support. This study provides an understanding of ILP implementation in Primary Health Centers by highlighting systemic barriers and local strategies. This study concludes that there is a need for preparedness for the procurement and distribution of strategic medical devices, particularly screening tools and basic services, as well as strengthening the guidance, monitoring, and evaluation of ILP implementation periodically through technical assistance.

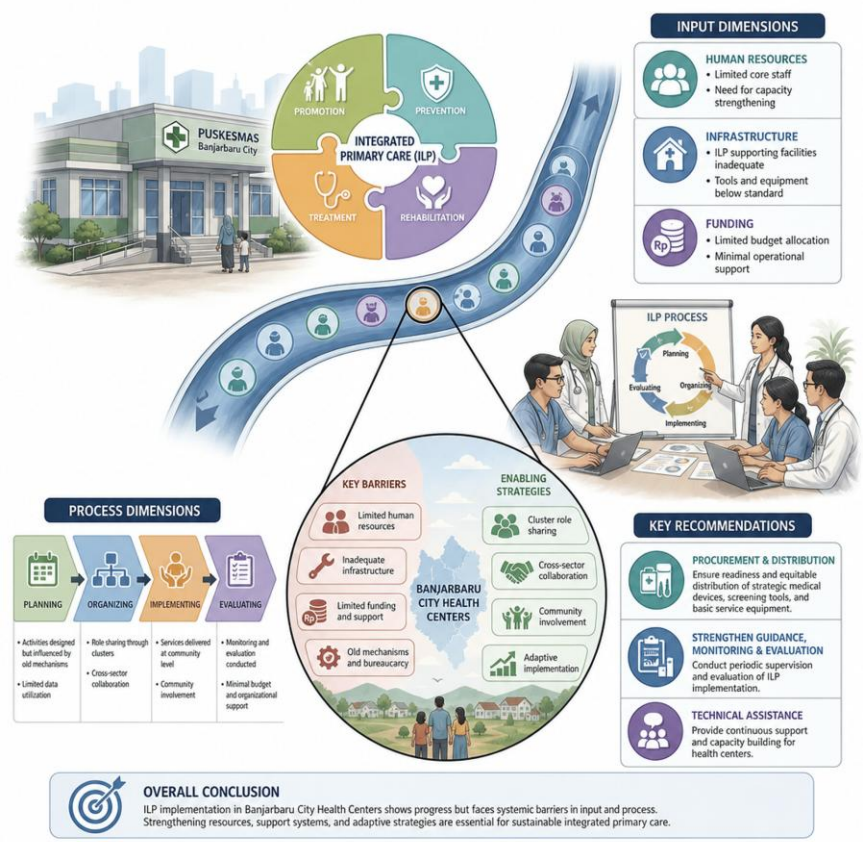
Key Messages:

- The early implementation of Integrated Primary Care (ILP) in Banjarbaru City demonstrates that while local adaptive strategies can temporarily mitigate systemic resource and infrastructural constraints, sustained policy optimization necessitates targeted improvements in essential medical equipment allocation and continuous technical assistance.

Access this article online

Quick Response Code

GRAPHICAL ABSTRACT



INTRODUCTION

Strengthening primary healthcare is a national priority in Indonesia. The Ministry of Health has made Integration Primary Care (ILP) one of the main pillars for delivering services that are comprehensive and family-oriented. Primary care is the base of the national health system and works from the community upward (1). The 1978 Alma-Ata Conference first defined it as essential care that a country can sustain socially and economically. In Indonesia the emphasis falls on promotive and preventive work (2,3). Law No. 17 of 2023 now regulates this and requires services to be integrated across individual and community levels (4).

Primary Health Centers deliver most of this care, and Indonesia has 10,180 of them (5,6). The Ministry of Health launched the ILP policy in 2023 to widen access and raise service quality, following the first pillar of health system transformation (6–8). Integration has not been easy. Community-based health efforts (UKBM) remain poorly coordinated, and 18,193 villages and urban wards still have no basic health facility (9,10). In Banjarbaru, only 40% of Primary Health Centers have implemented ILP, mainly because facilities and infrastructure fall short.

We evaluated the program using the systems approach of Azrul Azwar (1996), which reads a program through five dimensions: input, process, output, target, and impact (11–13). This study covers input and process only. ILP is still new, so its output cannot yet be measured. Looking at these two dimensions shows whether implementation matches what the policy intended, and where it can be improved (14,15). It also catches bottlenecks early, while there is still time to adjust policy before outputs and impacts arrive. The aim here is to assess input (human resources, infrastructure, funding) and process (planning, organizing, implementing, evaluating) in ILP implementation at Banjarbaru City Health Centers.

METHODS

This study employed a descriptive approach with a qualitative research design to provide an in-depth description and analysis of input and process indicators in the Integration Primary Care (ILP) policy

https://doi.org/10.56303/jhnresearch.v5i2.845

in Primary Health Centers within the Banjarbaru City working area. The research on ILP was conducted in Banjarbaru City because this region has a strategic role in the health service system in South Kalimantan, the high dynamics of logistics needs, and adequate system and data readiness. This series of research activities was carried out in May-November 2025. While data collection was carried out in July-August 2025. The research subjects were selected using a purposive sampling method. This study involved all 10 public health centers in Banjarbaru City, with 20 informants consisting of heads primary health center and representatives of ILP management. There were two FGD sessions, each consisting of 10 participants, each representing a primary health center within the Banjarbaru City, South Kalimantan Province. FGD questions were structured based on specific indicators of "input" (human resources, funding, facilities) and "process" (planning, organizing, implementation, evaluation).

Data were collected through focus group discussions (FGDs), supported by tools such as voice recorders, writing instruments, and cameras for documentation. Triangulation was applied to test data validity using multiple sources and techniques. Source triangulation compared data across different informants, while technique triangulation compared interview results with written documents written documents such as regulations on the implementation of ILP, namely the Decree of the Minister of Health of the Republic of Indonesia Number 2015 of 2023 and the Regulation of the Minister of Health Number 19 of 2024, as well as regulations on community health centers, namely the Regulation of the Minister of Health No. 19 of 2024. Data analysis was conducted through the stages of data reduction, data presentation, conclusion drawing, and verification. Coding was done manually. Based on Azwar's theory, the input construct explores human resources, funding, and facilities. Meanwhile, the process construct explores planning, organizing, implementation, and evaluation.

CODE OF HEALTH ETHICS

This study received ethical clearance No. 084/KEPK-FKIK ULM/EC/VI/2025 from the Health Research Ethics Committee, Faculty of Medicine and Health Sciences, Lambung Mangkurat University.

RESULTS

Analysis of Integration Primary Care (ILP) Implementation Based on Input Indicators Human Resources Aspect

Staffing is the biggest obstacle to ILP implementation. Health centers lack core personnel, especially doctors and nurses, and cannot fill the newly mandated posts for clinical psychologists and physiotherapists. At Sungai Besar Primary Health Center, thin staffing means health workers carry double duty, handling clinical services and outreach at the same time. The Head of the Primary Health Center put it this way:

"Overall, we have 66 health workers, but only three doctors, including myself. There are also only three nurses."

This shortage contrasts with Banjarbaru Selatan Primary Health Center, which, with 80 personnel, is able to distribute tasks more proportionally across clusters according to staff competencies.

Staff placement generally follows professional background and cluster needs, but informants said no strict competency criteria exist. The 2024 regulation added pressure by requiring professional posts that many centers still cannot fill. Capacity building runs through periodic training organized by the City and Provincial Health Offices, though only selected staff attend, so centers depend on internal knowledge-sharing afterward. Coordination happens through monthly mini-workshops (Lokmin), cross-sectoral meetings, and cluster discussions, with informal messaging filling the gaps. Everyone recognizes the regulatory basis for ILP; staffing capacity to meet it varies widely.

Funding Aspect

ILP has no funding stream of its own. It draws on national operational assistance (BOK/APBN), regional budgets (APBD), institutional funds (BLUD/BOD), and sometimes Corporate Social Responsibility (CSR). Managers have to work across these sources, and the result is uneven between

https://doi.org/10.56303/jhnresearch.v5i2.845

health centers. APBD contains no separate budget line for ILP. Only BOK names ILP activities directly, and the share for management functions is small. One informant explained:

"There is no specific percentage. Only BOK directly states there is funding for ILP… and the proportion for management is the smallest."

Training budgets are especially tight, so some centers partner with educational institutions or seek CSR support. Whether CSR is available depends on where the center sits, which widens the gap between facilities.

Disbursement is another recurring problem. The system has moved toward cashless transfers, but funds often arrive after activities are finished, leaving staff to cover costs in the meantime. APBD covers basic operating costs such as electricity and water, while ILP activities have to compete with other programs because nothing is earmarked for them

Table 1. Summary of Input Indicators in ILP Implementation Based on Human Resources

Sub-Component	Standard / Regulatory Requirement	Actual Condition	Identified Gaps / Challenges
Competency and Placement	Personnel placement based on professional qualifications and cluster-based service competencies.	Placement adjusted to available personnel; no specific formal criteria. Cross-cluster role arrangements implemented (nutrition, laboratory, etc.).	Competency gaps in certain service clusters. Role overlap due to limited staff availability.
Capacity Building / Training	Training adjusted to Ministry of Health requirements and professional standards.	Regular trainings provided by City and Provincial Health Offices, but limited coverage	No dedicated budget for independent training. Dependence on external organizers and available funding.
Coordination Mechanism	Cluster-based coordination in ILP through structured management forums.	Coordination through monthly Lokmin meetings, cross-sectoral meetings, cluster meetings, and WhatsApp groups.	Coordination requires additional time and workload; adaptation to new cluster-based structure.
Regulatory Basis	ILP guided by Ministerial Decree No. HK.01.07/MENKES/2015/2023 and strengthened by Minister of Health Regulation No. 19 of 2024 concerning Primary Health Centers.	Regulatory framework available and acknowledged by implementers.	Implementation readiness not fully aligned with regulatory demands (especially HR fulfillment).

Table 2. Summary of Input Indicators in ILP Implementation Based on Funding

Sub-Component	Standard / Policy Orientation	Actual Condition	Identified Gaps / Challenges
Funding Structure	ILP integrated within overall PHC financing; may utilize BOK (APBN), APBD, and other legitimate sources.	No dedicated ILP budget line. Funding derived from BOK (APBN), APBD, BLUD/BOD, and CSR.	Uneven funding distribution across PHCs. Potential disparities in ILP implementation quality.
CSR and External Support	Permitted as supplementary funding.	There is PHCs receive CSR, others do not.	Geographic-based disparities in support.
Budget Adequacy	Funding should support cluster-based service needs.	Budget depends on central approval and proposal realization.	Proposal-based system limits flexibility; centers must adapt to approved ceiling.
Disbursement Mechanism	Efficient and accountable financial system.	Initial adaptation difficulties; currently cashless transfer system. Disbursement often post-activity (reimbursement system).	Temporary financial burden on staff. Delays affect activity implementation flexibility.

https://doi.org/10.56303/jhnresearch.v5i2.845

Facilities and Infrastructure Aspect

Facilities and infrastructure do not fully meet ILP standards, particularly for screening and for specific clusters. The Ministry of Health provides a digital application (SOPHI) for reporting equipment stock and submitting procurement requests, but what actually arrives depends on budget ceilings and local government priorities. Several essential devices are in short supply: ultrasound (USG), electrocardiography (ECG), and equipment for physiotherapy and clinical psychology. The shortages push more patients to hospital referral and leave screening coverage below target. District-level budget efficiency measures tighten procurement and maintenance further, and infrastructure needs compete with other programs because ILP has no dedicated funding.

An ILP Manager described the problem in concrete terms:

"For service delivery, laptops and computers are limited, and we even have to use our own personal devices…"

The gap between what the regulation expects and what a center can actually do shows up here. Procurement is also technically awkward: proposals must fit budget ceilings and administrative catalog requirements, not every request can be accommodated, and staff have to rank needs by urgency. A formal system for planning and submitting facility requests does exist. Funding, procurement rules, and equipment supply still limit how complete ILP services can be.

Table 3. Summary of Input Indicators in ILP Implementation Based on Facilities and Infrastructure

Sub-Component	Standard / Regulatory Requirement	Actual Condition	Identified Gaps / Challenges
Clinical Equipment per Cluster	Equipment must meet Ministry of Health technical standards per service cluster (e.g., USG for MCH cluster).	Several essential tools unavailable or limited (USG, ECG, physiotherapy tools, clinical psychology tools).	Increased patient referrals to hospitals. Screening coverage targets not achieved.
Screening Equipment	Adequate screening tools to support preventive services.	Limited blood sugar screening equipment; some devices easily damaged (e.g., sphygmomanometers).	Screening activities constrained; reduced service effectiveness.
Procurement System	Digital submission through SOPHI application; aligned with national standards.	System available but realization depends on budget ceiling and health office priorities.	Not all proposals accommodated; long procurement process.
Administrative Support Tools	Sufficient computers/laptops for service documentation.	Limited laptops and computers; staff sometimes use personal devices.	Administrative burden; risk to service documentation quality.
Budget Efficiency Impact	Infrastructure support expected to sustain ILP implementation.	Budget efficiency policies affect medicines, maintenance, and equipment procurement.	Infrastructure must compete with other programs due to absence of dedicated ILP budget.

Analysis of Integration Primary Care (ILP) Implementation Based on Process Indicators
Planning Aspect

Planning Aspect

The move from a sector-based to a cluster-based approach is the main structural change in ILP planning. The planning cycle still follows the local government's annual and monthly framework, but activities are now grouped and tracked by service cluster and ILP performance indicators, with monitoring and evaluation carried out quarterly per cluster. Beyond that adjustment, procedures look much as they did before and still hinge on the district's financial cycle. Budget rigidity came up repeatedly. As one informant explained:

"The main challenge lies in the budget, which lacks flexibility… we still have to follow the financial system flow of the city government." (ILP Manager)

Resource planning covers staff, infrastructure, and budget, with infrastructure gaps submitted through official Ministry channels. Field conditions and ceiling limits usually force local adjustments. Coordination between internal units and the Health Office is cooperative but slow, especially when

https://doi.org/10.56303/jhnresearch.v5i2.845

priorities have to be lined up across programs. ILP planning is therefore structural reform inside existing administrative limits rather than a rebuilt procedure.

Table 4. Summary of Process Indicators in ILP Implementation Based on Planning Aspect

Sub-Component	Old Mechanism (Program/Sector-Based)	ILP Mechanism (Cluster-Based)	Identified Challenges
Planning Structure	Plans prepared based on service programs (MCH, NCD, etc.).	Plans prepared based on ILP service clusters.	Structural adaptation required; planning pattern largely remains similar to previous system.
Budget Planning System	Followed the annual local government financial planning cycle.	Still follows the district financial system, but aligned with ILP indicators and cluster needs.	Limited budget flexibility; dependent on ceiling approval and revisions by the Health Office.
Monitoring and Review of Plans	Program-based monitoring conducted periodically.	Monitoring and evaluation conducted per cluster using ILP performance indicators.	Planned activities are not always realized due to budget constraints.
Timeline Framework	Annual planning broken down into monthly activities.	Annual ILP framework with monthly breakdown and quarterly evaluation per cluster.	Must comply with the regular local government planning cycle.
Resource Planning	Human resources, infrastructure, and budget planned per program.	HR, infrastructure, and budget planned according to cluster needs; shortages proposed through Ministry application.	Dependence on budget approval and field conditions.
Collaborative Planning	Involved head of PHC and program managers.	More collaborative: head of PHC, cluster coordinators, planning team, and sometimes the Health Office.	Cross-program coordination requires time to reach agreement.

Organizational Aspect

ILP organization distributes tasks by cluster according to staff competencies. The existing management structure stays, with cluster coordinators and persons-in-charge (PICs) added for reporting and supervision. Cross-program and cross-sector collaboration sits at the center of the arrangement and brings in village leaders and community cadres alongside health workers. Formal coordination runs through mini-workshops, quality meetings, and management review meetings; informal coordination runs mostly on digital platforms. The mechanisms work, but workload and thin staffing still bite, and training reaches staff unevenly, so centers rely on internal knowledge-sharing. One informant summarized:

"The biggest challenge is time and human resources. Sometimes the staff is limited, but the activities are numerous." (ILP Manager)

Organizational adaptation under ILP therefore rests on internal collaboration and shared responsibility across programs.

Table 5. Summary of Process Indicators in ILP Implementation Based on Organizational Aspect

Sub-Component	Old Mechanism	ILP Mechanism	Identified Challenges
Task Distribution	Responsibilities assigned per program unit.	Responsibilities assigned per service cluster and staff competencies; sub-coordinators and PICs designated.	Increased workload; limited human resources.
Cross-Program and Cross-Sector Involvement	Limited to related programs.	Involves almost all internal units (doctors, midwives, nurses, health promotion, nutrition) and external sectors (village leaders, sub-district officials, cadres).	Increased coordination complexity.

https://doi.org/10.56303/jhnresearch.v5i2.845

Sub-Component	Old Mechanism	ILP Mechanism	Identified Challenges
Organizational Structure	Standard PHC management structure.	Existing structure maintained with additional cluster roles and reporting PICs.	Adaptation of new roles within existing structure.
Training and Capacity Building	Program-based training.	ILP-related training provided but limited and not evenly distributed.	Not all staff directly trained; reliance on knowledge-sharing.
Operational Coordination	Conducted through routine meetings.	Combination of formal forums (mini-workshops, quality meetings, management reviews) and informal digital communication (WhatsApp, Google Forms).	Coordination delays due to staff workload.
Community Involvement	Community involved in selected activities.	Systematic involvement of cadres, NGOs, neighborhood leaders, and community forums (MMD).	Requires intensive communication and sustained engagement.

Implementation Aspects

ILP has changed how work flows, most of all in the move from a polyclinic model to a cluster system with mandatory screening before consultation. Services became more complete and also longer. Early on, the main difficulty was readiness: specific equipment and trained staff were missing. Centers worked around infrastructure and staffing gaps by coordinating with other health centers and drawing more on community cadres.

The Head of the Primary Health Center described one operational constraint:

"Staff are still complaining about having to use their own mobile phones or tablets. Meanwhile, the Primary Health Center cannot afford to purchase them due to the large number required."

The gap between expanded service expectations and available resources is visible here.

Scheduling has to stay flexible because of weather, community events, and late budget disbursement. Monitoring uses both digital dashboards and manual forms, though coverage is patchy where connectivity or administration gets in the way. Informants still reported better coverage of essential services such as ANC and immunization. They also reported a heavier workload, particularly for nurses, who absorbed the extra screening and paperwork.

Table 6. Summary of Process Indicators in ILP Implementation Based on Implementation Aspects

Sub-Component	Old Mechanism	ILP Mechanism	Identified Challenges
Service Delivery System	Polyclinic-based; patients directly consulted doctors.	Cluster-based; patients undergo screening before consultation.	Longer waiting times; initial community complaints.
Health Worker Workflow	Focused on respective clinics.	Adaptation to cluster system with comprehensive screening tasks.	Increased workload, particularly for nurses.
Implementation Flexibility	Relatively fixed schedule.	Flexible scheduling adjusted to local conditions (weather, harvest season, village events).	Must balance flexibility with achievement of performance targets.
Infrastructure Readiness	Adjusted to polyclinic needs.	Requires additional equipment (ECG, screening tools, digital devices).	Limited facilities; staff sometimes use personal devices.
Use of Technology	Primarily manual reporting.	Use of monitoring dashboard applications and digital reporting forms.	Limited connectivity in remote areas; incomplete coverage.
Community Engagement	Limited to promotive/preventive activities.	Community involved in needs assessment (MMD), screening activities, and feedback processes.	Initial resistance due to new service flow.
Continuous Improvement	Periodic internal evaluation.	Weekly/monthly internal evaluations leading to system adjustments (queue system, visual education media).	Increased coordination and socialization burden at PHC level.

https://doi.org/10.56303/jhnresearch.v5i2.845

Evaluation Aspect

Evaluation runs through internal and cross-sectoral forums. Monthly mini-workshops are the main internal mechanism, backed by quality meetings and biannual management review meetings. Cross-sectoral evaluation happens quarterly with district-level coordination. Indicators are still mostly standard service metrics such as ANC coverage, immunization, and child weighing, with behavioral and participation indicators being added gradually. Incomplete data and late reporting remain the persistent problems, especially in remote areas and during staff rotations.

Reporting formats change often, which adds administrative work. One informant noted:

"The reporting format sometimes changes, so the staff have to adapt again." (ILP Manager)

Staff cope by helping each other and using simplified digital tools instead of manual reporting. Evaluation under ILP is more structured and more regular than under the previous system. Administrative workload, data quality, and reporting delays still hold performance monitoring back.

Table 7. Summary of Process Indicators in ILP Implementation Based on Evaluation Aspect

Sub-Component	Old Mechanism	ILP Mechanism	Identified Challenges
Internal Evaluation Forums	Routine program meetings.	Mandatory monthly mini-workshops, quality meetings, and biannual management review meetings.	Dependent on budget availability for meeting implementation.
Cross-Sector Evaluation	Not always structured.	Quarterly cross-sector mini-workshops chaired by sub-district head.	Requires cross-sector coordination and logistical support.
Evaluation Indicators	Standard service indicators (ANC, immunization, etc.).	Maintains standard indicators and incorporates behavioral and participation indicators.	Some indicators not optimally measured due to incomplete data.
Reporting System	Manual routine reports.	Combination of manual forms and digital dashboards.	Delays in data submission from remote areas; frequent format changes increase administrative burden.
Corrective Actions	Follow-up through internal discussions.	Adaptive strategies, peer support, gradual shift to simplified applications.	Increased administrative workload for staff.

Patient Perspective and Satisfaction

ILP has cut two ways in service delivery. Coverage of preventive services has risen, including antenatal care (ANC) visits, immunization, and health screening. At the same time, the cluster-based flow has made patients wait longer and has drawn more complaints.

The main change is mandatory screening before clinical consultation. Under the old polyclinic system patients went straight to a doctor; under ILP they first go through blood pressure measurement, anthropometric assessment, and risk factor screening. The aim is earlier detection and better service quality, and the cost is a longer visit. Ratings on public platforms have fallen and complaints about waiting times have grown.

Dissatisfaction comes mostly from the extra steps and from limited public understanding of why the preventive screening is there. Resistance has eased over time, and participation in preventive services has improved. Whether ILP succeeds therefore depends on system readiness and resources, and equally on how well managers handle patient experience and community expectations.

DISCUSSION

Analysis of the Implementation of Integrated Primary Care (ILP) Based on Input Indicators

Human Resources Aspect

Too few doctors and nurses, most visibly at Sungai Besar Community Health Center (Puskesmas), leaves health workers carrying clinical services, outpatient activities, and surveillance duties at once. The problem is not only how many staff there are. Roles are unevenly divided, and ILP tasks were added on top of existing ones without adjusting job descriptions or workload.

Over time this double load risks burnout, weakens focus and coordination, and can erode both

https://doi.org/10.56303/jhnresearch.v5i2.845

quality and continuity of care. South Banjarbaru Community Health Center points the other way: allocating roles by cluster and competency makes ILP implementation more orderly. How work is organized and divided therefore matters as much as headcount. Jannah, Susanto, and Hidayat (2023) reached a similar conclusion, finding that adequate staffing shapes how smoothly clusters coordinate under ILP (16).

Requiring specific professionals such as clinical psychologists and physiotherapists, as the latest regulations do, widens the distance between policy standards and what community health centers can actually staff. Existing personnel absorb the difference, which argues for structural workforce planning rather than ad hoc fixes at the implementation level. Mait TO, Rosyidah, and Sulistyawati (2025) reported the same shortage of qualified promotive and preventive staff across many community health centers (17). Routine training does raise competency, but it has not been folded into the ILP framework. Coordination adapts well enough through Lokmin meetings and informal WhatsApp forums, which keeps communication flexible and service integration workable. Optimizing ILP therefore means getting four things right together: staff numbers, competency-based roles, compliance with professional regulations, and a capacity building program that does not stop.

Funding Aspect

The results show ILP treated as an approach rather than a program with its own budget. Integrating across funding sources is possible this way, but it limits implementation in practice. Without a clear budget, ILP activities compete with other priorities, which delays implementation, restricts training, and weakens monitoring and evaluation. CSR funding turned out uneven and tied to regional characteristics. Our findings match earlier work in showing that CSR cannot sustain ILP. In Banjarbaru, ILP needs routine operational money for coordination, capacity building, and facility maintenance, and voluntary or project-based funding does not cover that reliably. Late disbursement pushes health workers to front operational costs themselves, which adds still more administrative work.

Fuady et al. (2024) found the same dependence on BOK, with CSR and other private funds arriving only ad hoc and unstructured (18). Bureaucratic delay in disbursement also slows implementation, which matches Fatonah (2024), who found that central and regional financial regulations frequently hold up preventive programs (19). Sustaining ILP therefore depends on transparent financial governance, efficiency measures, and stronger multisectoral collaboration. A dedicated ILP budget line in the Regional Budget (APBD), covering routine operational costs and facility maintenance that CSR cannot guarantee, would help community health centers considerably.

Facilities Aspect

Facilities and infrastructure shape whether ILP works, and they are unevenly distributed. Missing basic medical equipment such as ultrasound (USG) and electrocardiogram (ECG), together with gaps in physiotherapy and clinical psychology support, sends more patients to hospital. That works against the idea of primary care as the foundation of the health system and shifts cost upward to secondary care. Service quality at this level still depends on having equipment that meets standards. Mait TO (2025) reported comparable limits at many Primary Health Centers in Indonesia, especially around digital reporting and family-based care (17).

The Ministry of Health does provide SOPHI, an application-based system for submitting facility requests, but realization lags. Bureaucratic process, budget limits, and dependence on the District Health Office mean urgent needs often wait. Indriyati (2023) reported the same pattern, identifying procurement delays and thin capital expenditure budgets as major obstacles to cluster-based health services (20). ILP therefore needs procurement that responds faster, planning built on actual needs, and cross-sectoral coordination, so that Primary Health Centers meet national facility standards.

Analysis of Integration Primary Care (ILP) Implementation Based on Process Indicators Planning Aspect

ILP planning in Banjarbaru still follows the earlier pattern, adjusted to a cluster-based structure.

https://doi.org/10.56303/jhnresearch.v5i2.845

That keeps administration simple and limits flexibility, particularly in budgeting, which stays tied to the local government planning cycle. Not every planned activity can be carried out on schedule. The transformation here reads as adaptation to national policy layered onto existing practice. The main obstacles are budget limits and top-down financial rules, which open a gap between what centers need on the ground and what they are allocated. Endrawati R dkk (2025) found the same thing, with regional budget flexibility determining whether primary health programs succeed (21,22).

Organizing Aspect

Organizationally, ILP leans on cross-program and cross-sector coordination. Formal forums such as mini-workshops and management meetings exist, yet day-to-day coordination runs through online groups and personal contact. That informality is efficient in the short term and fragile in the longer one, since it concentrates coordination effort and breaks down when staff rotate. Competency-based task division, sub-coordinators and PICs, and a structured evaluation forum all indicate readiness to implement the policy. Limited training, coordination that sometimes stalls, and thin staffing are the counterweights.

Hanafiah (2024) reported much the same, arguing that clear roles, training, and steady cross-program coordination determine whether primary care organization works (23). Community involvement through cadres, neighborhood associations (RT/RW), and NGOs strengthens implementation, which matches Astuti F, dkk (2025) on the role of cadres and community leaders in community-based health activities (22,23). Organizing ILP is thus a question of formal structure and, just as much, of how communication, coordination, and community participation adapt in practice. Multisectoral integration and flexible digital communication have held comprehensive primary care together where they are used.

Implementation Aspect

Implementation faces difficulties on several fronts at once: workforce readiness, infrastructure, and the need to stay flexible. Thin staffing, inadequate equipment, and resistance to the shift from polyclinic to cluster system all point to the same requirement, that transforming primary care needs technical support, continuous training, and adequate facilities (24). Community involvement lends the program legitimacy, visible in participation in Village and Sub-District Community Deliberations and in how people responded to screening. Sari et al. (2024) similarly identified community participation as decisive for ILP (25).

Wider coverage of services for pregnant women, routine immunization, and greater community awareness of regular checkups show what ILP can achieve when systemic support holds. Complaints about long waits and the growing workload for health workers show where service delivery needs attention before satisfaction slips further. ILP set out to improve service quality; so far it has also lengthened waiting times and lowered Google Maps ratings. During a transition, waiting time affects public trust. Change management is therefore needed for staff and for community expectations alike. Success depends on balancing internal readiness (staff, facilities, workflow) against external support (cross-sector and community). Without both, ILP is hard to sustain, however sound the concept is for improving primary healthcare quality (25).

Evaluation Aspect

Evaluation at community health centers operates in layers, from mini-workshops and quality meetings up to cross-sectoral meetings. It remains mostly internal, with limited outside participation. Widening the role of cross-sectoral agencies and health offices would let evaluation address technical field problems rather than administrative ones alone, as Zulkarnaen et al. (2023) argued (25). The indicators used are mostly quantitative: ANC, infant weighing, immunization. Adding behavioral indicators such as attendance and change in community knowledge is a step forward, though weak digital recording and reporting reveals the distance between central policy and technical readiness in the field (25).

Delayed data, staff rotation, and changing report formats all point to the need for an evaluation system that stays consistent and is easy to use, supported by simple digital tools. Staff have already started adapting, working together and using basic applications. For evaluation to be effective over time,

https://doi.org/10.56303/jhnresearch.v5i2.845

instruments need standardizing and staff need training to keep up with a reporting system that keeps shifting. ILP evaluations do run on schedule; whether they are useful depends on better reporting systems, consistent instruments, and more external involvement. Otherwise evaluation becomes a formality rather than a way to reflect on and improve service quality.

CONCLUSION

Integrated Primary Services (ILP) is running in Banjarbaru community health centers (Puskesmas) in line with national policy and guidelines, organized around service clusters. On the input side, staffing is the main constraint: core personnel such as doctors and nurses are too few, and the posts required by the latest regulations, clinical psychologists and physiotherapists among them, remain unfilled. ILP funding comes from the Regional Budget (APBD), the Regional Development Planning Agency (APBD), and Corporate Social Responsibility (CSR), and it is not distributed evenly between centers. Financial capacity therefore differs from one center to the next, particularly for cadre training and supporting facilities. Medical equipment and supporting infrastructure also fall short of standard, especially for screening services and certain clusters. On the process side, planning has moved from a sectoral to a cluster-based approach, with more structured monitoring and evaluation. Cross-program and cross-sector coordination works through formal forums and informal online communication. Despite the constraints, coverage of several essential services in Banjarbaru has risen, including prenatal visits and immunization. The gains came with a heavier workload and longer service times, most of all at the screening stage.

DECLARATION OF THE USE OF AI

The authors declare that no artificial intelligence (AI), AI-assisted technologies, or large language models (LLMs) were used in the conception of the study, data analysis, or the drafting, writing, and editing of this manuscript. The only exception is the graphical abstract, which was created using the design platform Illustrae (https://illustrae.co/). The authors take full responsibility for the content and accuracy of the graphical abstract and the entire manuscript

FUNDING

This research was funded by the Directorate of Research and Community Service, Ministry of Higher Education, Science, and Technology, in 2025.

ACKNOWLEDGMENTS

The authors would like to thank the Directorate of Research and Community Service, Ministry of Higher Education, Science, and Technology, the Investment and One-Stop Integrated Services Agency (DPMPTSP), the Banjarbaru City Health Office, all heads of community health centers in the Banjarbaru City area, and program managers for their valuable support and information, enabling this research to be successfully implemented.

CONFLICTS OF INTEREST

The authors declare no conflict of interest

REFERENCES

1. WHO. Primary Health Care. World Health Organization. 2024.
2. Prade M, et al. Proposal For A Shared Definition of Primary Healthcare By Health Professionals: A National Cross-Sectional Survey. PLOS ONE. 2023; 18(3): 1–13.
3. Kementerian Kesehatan RI. Transformasi Layanan Primer. Kementerian Kesehatan Republik Indonesia. 2023.
4. JDIH BPK. Undang-Undang (UU) Nomor 17 Tahun 2023. Database peraturan. 2023.
5. Noor ZA, Sekarningrum TD, Sulistyaningsih T. Disparitas Perkotaan- Pedesaan: Pemerataan Dalam Akses Layanan Kesehatan Primer Untuk Lansia Selama Pandemi Covid-19. JPPI (Jurnal Penelitian

https://doi.org/10.56303/jhnresearch.v5i2.845

Pendidikan Indonesia). 2021; 7(4):576–85.
6. Kementerian Kesehatan RI. Kemenkes Luncurkan Program Integrasi Layanan Primer Kabupaten Kendal Sehat Negeriku. Kementerian Kesehatan Republik Indonesia. 2024.
7. Kementerian Kesehatan RI. Pedoman Indikator Program Kesehatan Masyarakat Dalam RPJM dan Renstra Kementerian Kesehatan Tahun 2020-2024. Jakarta: Kementerian Kesehatan RI. 2020.
8. Kementerian Kesehatan RI. Kemenkes Luncurkan Integrasi Layanan Primer Untuk Perkuat Pemenuhan dan Kompetensi SDM Kesehatan di Fasyankes, Kemenkes Luncurkan Integrasi Layanan Primer Untuk Perkuat Kompetensi Pemenuhan dan SDM Kesehatan di Fasyankes. Kementerian Kesehatan Republik Indonesia. 2023.
9. Kementerian Kesehatan RI. Keputusan Menteri Kesehatan Republik Indonesia Nomor HK.01.07/Menkes/2015/2023 tentang Petunjuk Teknis Integrasi Pelayanan Kesehatan Primer. Jakarta. 2023.
10. Dhynianti L, Darmawan ES. Kerjasama Pemerintah Swasta dalam Pemenuhan Pelayanan Kesehatan Primer di Jakarta. Jurnal Cahaya Mandalika. 2024; 5(1):486–501.
11. Azwar A. Pengantar Administrasi Kesehatan. Jakarta: Binarupa Aksara. 1996.
12. Ras A, Genda A, Sumilih DA, Rahim H, Nurlela A, Ramadhan S. Tantangan dan Peran Pemerintah Dalam Meningkatkan Pelayanan Kesehatan di kabupaten takalar. Journal Publicuho. 2024; 7(3):1574
13. Silalahi VHC, Purba BKF, Sihombing RA. Membangun Kesejahteraan Masyarakat Indonesia Sehat: Strategi Komprehensif Dalam Pencegahan Penyakit, Reformasi Sistem Kesehatan, dan Peningkatan Kesadaran Isu Kesehatan Mental. Jurnal Cakrawala Akademika. 2024; 1(3);143–62.
14. Arifin S, Rahman F, Pujianti N, Laily N, Wulandari A. Ilmu dan Seni Administrasi Kebijakan Kesehatan. Yogyakarta: CV Mine. 2020.
15. Laily N, Arifin S, Rahman F, Pujianti N, Wulandari A. Perencanaan dan Evaluasi Program Kesehatan Masyarakat. Yogyakarta: CV Mine. 2021.
16. Jannah M, Susanto T, Hidayat T. Analisis kesiapan puskesmas dalam implementasi integrasi layanan primer (ILP). Jurnal Pendidikan Indonesia. 2023; 4(2):133–40.
17. Mait TO, Rosyidah, Sulistywati. Evaluasi Kesiapan Promkes dalam Implementasi Program Integrasi Layanan Primer (ILP) di Puskesmas. Jurnal Penelitian Inovatif (JUPIN). 2025; 5(1):133–40.
18. Fuady A, Anindhita M, Haniifah M, Ahsan A, Sugiharto A, Haya MAN, Pakasi T, Kusuma D, Solikha DA, Ali PB, Widyahening IS. Bridging the gap: financing health promotion and disease prevention in Indonesia. Health Res Policy Syst. 2024; 22(1):146.
19. Fatonah, Supriono. Pengujian Substantif Pengeluaran Kas pada Puskesmas Kemiri Kabupaten Purworejo. Jurnal Tajam. 2024; 7(2):83–92.
20. Indriyati L, Wahyudin A, Sulistyowati E. Evaluasi Program Pilot Project Transformasi Layanan Primer Di Puskesmas Telaga Bauntung Kabupaten Banjar Tahun 2022. Jurnal Kebijakan Pembangunan. 2023; 18(1):65–80.
21. Endrawati R, Zahro SL, Laili ZR, Bernince. Sosialisasi Penerapan ILP di Posyandu UPT Puskesmas Pesantren II Kota Kediri. Jurnal Pengabdian kepada Masyarakat. 2025; 3(2):217–30.
22. Astuti F, Mekarisce AA, Solida A, dkk. Analisis Implementasi Program Posbindu PTM di Wilayah Kerja Puskesmas Putri Ayu Kota Jambi Tahun 2024. Jurnal Kesehatan Masyarakat. 2025; 18(1):1–10.
23. Hanafiah S, Kurniawan A, Mulyani D. Evaluasi Kesiapan Promkes dalam Implementasi Program Integrasi Layanan Primer (ILP) di Puskesmas. Jurnal Penelitian Inovatif. 2024; 10(1):23–32.
24. Sari N, Latip, Suryani L, Wahyuni L. Partisipasi Masyarakat Lansia dalam Program Posyandu ILP Kelurahan Laksamana Kecamatan Dumai Kota. Jurnal Administrasi Publik dan Pemerintahan STISIP Imam Bonjol (SIMBOL). 2024; 3(2):112–8.
25. Zulkarnaen R, Sarjan M, Andri A, Ramadhanti R. Evaluasi Kinerja Pelayanan pada Unit Pelaksana Teknis Daerah Kesehatan Pusat Masyarakat Teluk Kuantan. Jurnal Komunikasi dan Administrasi Publik. 2023; 10(2):725–32.

https://doi.org/10.56303/jhnresearch.v5i2.845