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READINESS FOR THE IMPLEMENTATION OF INTEGRATED PRIMARY CARE (ILP) FROM THE LEADERSHIP PERSPECTIVE AT TLOGOSADANG COMMUNITY HEALTH CENTER

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INTRODUCTION

Primary healthcare represents the foundational cornerstone of resilient, equitable, and sustainable national health systems worldwide. In accordance with the World Health Organization (WHO) Operational Framework for Primary Health Care, effective primary care delivery requires integrated, people-centered health services, multisectoral policies, and empowered community networks that span the entire life course (World Health Organization, 2018, 2020). In Indonesia, the Ministry of Health has embarked upon an unprecedented health system transformation, placing primary care reform as the foremost priority pillar. A centerpiece of this transformation is the national enactment of Integrated Primary Care (Integrasi Layanan Primer [ILP]), institutionalized through Minister of Health Regulation (Permenkes) Number 19 of 2024 concerning the Management of Community Health Centers (Community Health Center). This statutory mandate replaces traditional fragmented health programs with life-cycle-based service clusters, extending integrated delivery from subdistrict Community Health Center down to village health posts (Posyandu Prima) and household outreach (Kementerian Kesehatan Republik Indonesia, 2023; Rahma Muthia Zakia, 2025).

Despite its visionary policy architecture, translating national ILP mandates into daily operational reality imposes immense structural, cultural, and administrative demands upon frontline healthcare organizations. Community Health Center are confronted with sweeping modifications in managerial governance, reporting mechanisms, and inter-professional workflows. At the local operational level, such as Tlogosadang Community Health Center in Paciran District, Lamongan Regency, early field implementation has encountered considerable friction. Preliminary diagnostic surveys conducted among six healthcare personnel revealed that 100% of respondents experienced significant increases in administrative and clinical workloads following ILP introduction. Furthermore, severe task-shifting and dual functional burdens (such as midwives and nurses serving concurrently as clinical providers and electronic medical record enumerators), chronic deficits in desktop computer terminals, and erratic rural internet bandwidth have constrained effective service delivery. These operational barriers demonstrate that structural policy pronouncements alone cannot guarantee seamless reform without adequate internal organizational readiness.

Within organizational science and public health management, leadership readiness serves as the principal engine of successful policy adoption. Leaders are tasked with articulating a compelling strategic vision, mobilizing finite human and fiscal resources, aligning operational routines, and fostering psychological safety among frontline staff navigating radical workplace reorganization (Azmy, 2021; Byeon et al., 2022). Prior empirical studies corroborate the pervasive operational barriers facing Community Health Center reforms. Suwono (2025) identified deficient information technology competencies, superficial policy socialization, and infrastructural connectivity gaps as major impediments to ILP rollout in East Java. Similarly, Diantika & Debrina (2021) demonstrated that leadership supervisory functions directly dictate

employee performance, while Meri et al. (2022) revealed that incomplete managerial cycles (planning, organizing, executing, and controlling) critically undermine healthcare delivery efficacy. Furthermore, Ardiansyah (2024) underscored that visionary public leadership is paramount to prevent policy stagnation during municipal bureaucratic transitions.

Notwithstanding this expanding literature, most published inquiries remain limited to broad programmatic evaluations, quantitative employee satisfaction surveys, or isolated telemedicine feasibility assessments. Rigorous empirical studies examining organizational readiness for ILP using validated behavioral change theories, particularly during the early implementation of Minister of Health Regulation No. 19 of 2024, remain limited. To systematically address this theoretical and empirical void, Bryan J. Weiner's Theory of Organizational Readiness for Change provides an exceptionally robust analytical framework (Weiner, 2009). Weiner conceptualizes organizational readiness as a shared psychological state comprising two distinct but interrelated dimensions: change commitment (the shared resolve of organizational members to pursue the courses of action involved in change implementation) and change efficacy (the shared belief in their collective capabilities to execute that change, contingent upon task demands, resource availability, and situational factors) (Rismansyah et al., 2021; Weiner, 2009).

Therefore, this study aimed to analyze the organizational readiness for Integrated Primary Care (ILP) implementation from a leadership perspective at Tlogosadang Community Health Center, Lamongan Regency, utilizing Weiner's Organizational Readiness for Change framework across change commitment and change efficacy dimensions. The resulting insights provide actionable operational strategies for primary care directors, district health authorities, and healthcare policy planners navigating national healthcare transformation.

METHODS

2.1 Research Design

This study employed a descriptive qualitative case study design. A qualitative case study approach was selected to capture an in-depth, contextualized understanding of leadership behaviors, organizational adaptation processes, and managerial barriers during the initial rollout of Integrated Primary Care (ILP) within a bounded primary healthcare environment (Kusumastuti & Khoiron, 2019; Saryono, 2010). The analytical paradigm was theoretically grounded in Bryan J. Weiner's Organizational Readiness for Change model, evaluating two core dimensions: change commitment and change efficacy (Weiner, 2009).

2.2 Research Population and Sample

The study informants were selected using a non-probability purposive sampling technique based on explicit operational criteria: (1) active leadership and managerial positions at Community Health Center Tlogosadang; (2) direct responsibility in the formulation of annual Community Health Center planning (RUK/RPK) and cluster management; and (3) willingness to participate in in-depth interviews. A total of six key informants participated: the Head of Community Health Center (Community Health Center Director), the Community Health Center Administrative Coordinator, Coordinator of Cluster 1 (Management and Administration), Coordinator of Cluster 2 (Maternal and Child Health / Life-Course Services), Coordinator of Cluster 3 (Adult and Elderly Health), and

Coordinator of Cluster 4 (Infectious Disease Control and Environmental Health).

2.3 Research Setting and Time

The research was conducted at Tlogosadang Community Health Center (Community Health Center Tlogosadang), located in Tlogosadang Village, Paciran District, Lamongan Regency, East Java Province, Indonesia. Fieldwork, qualitative interviews, direct observational site visits, and institutional document reviews were executed across a four-month period spanning November 2025 to February 2026.

2.4 Research Procedures

The research was conducted through three sequential phases: preparatory, fieldwork implementation, and data synthesis. In the preparatory phase, research licensing was obtained, followed by preliminary observational surveys with staff. During fieldwork, in-depth semi-structured interviews were conducted face-to-face in private offices using audio-recording devices. Interviews were accompanied by direct passive observations of service workflows across polyclinic clusters and systematic documentary reviews of institutional records (e.g., Community Health Center Annual Operational Plans [RUK/RPK], Minilokakarya monthly meeting minutes, staffing logs, and cluster service registries).

2.5 Data Collection Techniques

Data collection integrated three complementary qualitative techniques: (1) in-depth semi-structured interviews exploring perceived policy value, managerial commitment, resource appraisal, and technical constraints; (2) participatory field observations documenting physical facility layouts, computer terminal availability, patient queues, and inter-cluster handovers; and (3) documentary analysis examining official circulars, standard operating procedures (SOPs), and electronic reporting databases (Primary Care / ASIK applications).

2.6 Research Instruments

The primary research instrument was the investigator, supported by a semi-structured interview guide formulated based on Weiner's Organizational Readiness for Change indicators and WHO Primary Health Care Operational Framework guidelines (Weiner, 2009; World Health Organization, 2020). The interview guide explored two principal domains: change commitment (policy alignment, strategic leadership direction, managerial resource mobilization, monitoring and evaluation) and change efficacy (human resource capability, digital health information systems, logistics and pharmaceutical supply, and medical infrastructure).

2.7 Data Analysis

Qualitative data analysis was performed using the Miles, Huberman, and Saldana interactive model comprising three concurrent flows: data condensation (transcription, coding, and categorizing into thematic nodes), data display (narrative matrices and structured thematic tables), and conclusion drawing/verification (Miles et al., 2014; Sjahruddin et al., 2024). Data trustworthiness and qualitative rigor were established via source triangulation (comparing accounts from the Community Health Center Director, Administrative Coordinator, and Cluster Heads) and method triangulation (cross-verifying interview narratives against observational field notes and physical planning documents). Member checking was conducted with key informants to confirm transcript accuracy.

2.8 Scope and Limitations of the Research Used

The study's scope was delimited to administrative and clinical leadership at a single coastal community health center in Lamongan Regency during the transitional rollout of Permenkes No. 19 of 2024. Methodological limitations include the small purposive sample size (n = 6), potential self-reporting and social desirability biases during administrative interviews, and the absence of perspectives from village-level health cadres (Posyandu Prima) or visiting patients. The study was conducted with the patient's informed consent and the ethical approval status and confirm that appropriate written consent for publication was obtained.

RESULTS AND DISCUSSION

3.1. Result

Qualitative findings regarding leadership readiness for Integrated Primary Care (ILP) implementation at Community Health Center Tlogosadang were systematically organized across the two primary dimensions of Weiner's Organizational Readiness for Change framework: (1) Change Commitment and (2) Change Efficacy (Weiner, 2009). Table 1 summarizes the qualitative thematic matrix, empirical field findings, and corresponding operational status.

Table 1. Qualitative Thematic Matrix of Leadership Readiness for ILP Implementation at Community Health Center Tlogosadang

Readiness Dimension	Core Analytical Sub-Theme	Empirical Findings & Field Observations	Readiness Status
Change Commitment (Weiner, 2009)	1. Strategic Planning & Resource Alignment	Head of Community Health Center formally integrated ILP into annual planning (RUK/RPK) and budget lines; restructured organizational staffing into life-course clusters.	Established / Good
	2. Managerial Organizing & Task Delegation	Cluster coordinators appointed; initial workflow mechanisms established; however, staff suffer from severe task-shifting and dual functional roles.	Partially Optimal
	3. Monitoring, Evaluation & Quality Assurance	Monthly Minilokakarya meetings utilized for supervision; but evaluation remains reliant on obsolete Penilaian Kinerja Community Health Center (PKP) indicators.	Constrained
Change Efficacy (Weiner, 2009)	1. Human Resource Technical Capability	Clinical competencies in preventive-curative care are strong; but severe deficits exist in administrative data entry, target tracking, and life-course screening.	Moderate / Unprepared
	2. Digital Health Information Systems		

Staff utilize ASIK and Primary Care applications; severely hindered by complex interfaces, lack of interoperability, and unstable rural internet.
Sub-optimal / Deficient

3. Medical Logistics & Infrastructure
Basic medicines and essential supplies available; but physical room layouts lack cluster co-location, with severe shortages of computer terminals.
Resource-Constrained
Source: Qualitative synthesis from in-depth interviews, observations, and institutional documents at Community Health Center Tlogosadang, 2026.

As detailed in Table 1, the organizational readiness for ILP implementation demonstrates a pronounced dichotomy between leadership intention and frontline operational capability.
The findings indicate that the Head of Community Health Center and cluster coordinators have cultivated strong shared commitment toward adopting ILP. Strategic commitment was demonstrated by embedding ILP requirements into institutional operational plans (Rencana Usulan Kegiatan [RUK] and Rencana Pelaksanaan Kegiatan [RPK]), designating formal cluster leadership decrees, and aligning fiscal expenditures with integrated screening activities. However, execution consistency was compromised by legacy bureaucratic inertia: formal monitoring continues to evaluate performance against obsolete Community Health Center Performance Assessment (PKP) metrics rather than updated Permenkes No. 19 of 2024 indicators. Furthermore, cross-cluster coordination remains sporadic and siloed, with coordinators struggling to maintain inter-cluster patient referrals due to severe personnel shortages and concurrent clinical duties.
Change efficacy was appraised as moderate but distinctly sub-optimal. While clinical personnel exhibited robust self-efficacy regarding standard diagnostic and therapeutic protocols, their collective confidence plummeted when executing ILP-mandated administrative duties, comprehensive life-course health screenings, and real-time electronic reporting. Information system barriers emerged as the single greatest deterrent to change efficacy: healthcare workers were forced to navigate multiple non-interoperable software portals (ASIK, SIMPUS, and P-Care) on personal mobile devices due to the lack of dedicated desktop computers, frequently aggravated by erratic rural internet connectivity. In terms of physical infrastructure, the existing spatial layout of Community Health Center Tlogosadang reflects traditional disease-oriented clinics rather than integrated life-course clusters, impeding patient flow and coordinated team consultations.

3.2 Discussion

The study found that although leadership at Community Health Center Tlogosadang demonstrates strong commitment to implementing ILP under Permenkes No. 19 of 2024, organizational change efficacy remains limited. Dual clinical-administrative workloads, outdated performance appraisal instruments, fragmented digital systems, and inadequate infrastructure hinder effective implementation. Thus, the organization demonstrates aspirational readiness, characterized by a strong willingness to change but insufficient operational capacity.

Weiner's Theory of Organizational Readiness for Change (2009) explains the gap between strong change commitment and limited change efficacy. Although leaders recognize the importance of ILP, their ability to implement it is constrained by excessive workloads, insufficient resources, and complex administrative requirements. Furthermore, the continued use of outdated PKP performance indicators creates institutional misalignment between new ILP policies and existing bureaucratic practices (Byeon et al., 2022; Weiner, 2009).

3.3 Implications

The findings have direct policy and managerial implications: (1) District Health Offices must urgently harmonize Community Health Center Performance Evaluation (PKP) guidelines with ILP indicators to eliminate bureaucratic contradictions; (2) Municipal governments must allocate capital grants to upgrade rural Community Health Center digital infrastructure, ensuring high-speed internet and dedicated cluster computer terminals; and (3) Community Health Center leadership must institute supportive leadership practices, shielding clinical personnel from excessive clerical data entry through the recruitment of dedicated health informatics operators.

3.4 Research contribution

This study offers a novel theoretical application of Weiner's Organizational Readiness for Change model within the context of Indonesian primary care transformation, providing empirical baseline qualitative data for health service researchers and policymakers.

3.5 Limitations

Several methodological limitations must be acknowledged: (1) The qualitative case study design was conducted at a single health center, limiting generalizability to urban or differently resourced facilities; and (2) The informant sample was small (n = 6) and restricted to internal leadership.

3.6 Suggestions

Future research should implement mixed-methods, multi-center longitudinal designs tracking organizational readiness scores before and after targeted leadership training, incorporate perspectives from community health cadres and patients, and conduct policy implementation fidelity audits across diverse socio-geographic regions of Indonesia.

CONCLUSION

Organizational readiness for the implementation of Integrated Primary Care (ILP) from the leadership perspective at Tlogosadang Community Health Center has been established in terms of change commitment but remains unoptimized in change efficacy. Leadership demonstrates strong dedication by embedding ILP into annual planning, budget allocation, and cluster organization. However, operational execution is constrained by dual workloads, persistent reliance on obsolete performance indicators, digital platform fragmentation, and physical infrastructure limitations. Strengthening managerial execution, harmonizing evaluation metrics, and equipping clusters with dedicated digital infrastructure are vital to achieving sustainable ILP success.

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DDS: Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Writingoriginal draft. NVR, EMS, MGS: Supervision, Validation, Methodology, Writingreview and editing, Project administration.

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