



INTEGRATED PRIMARY CARE IN INDONESIA'S PRIVATE FACILITIES: A SCOPING REVIEW

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ABSTRACT

Indonesia's Integrasi Layanan Primer (ILP) reform reorganizes primary care around the life course, prevention, and coordinated service networks. Implementation has concentrated on Puskesmas and their public networks, while private first-level health facilities remain major access points within the National Health Insurance system. Objective to synthesize evidence on ILP implementation and identify components that can be realistically adapted for private primary care facilities in Indonesia. This scoping review followed JBI guidance and PRISMA-ScR reporting. PubMed, ScienceDirect, and Google Scholar were searched using keyword combinations including integrated primary care, Integrasi Layanan Primer, Puskesmas, private primary care, FKTP, and BPJS for empirical studies published in 2021-2026. Journal indexing was cross-checked through SINTA for Indonesian sources. Of 87 records initially identified, fifteen studies met the eligibility criteria and were synthesized using inductive thematic narrative analysis. Five themes emerged: institutional readiness, digital information systems, financing and referral governance, private-sector roles and constraints, and international lessons on integrated care. Readiness was uneven, with recurrent gaps in workforce capacity, infrastructure, data interoperability, and financing. The evidence supports four enabling conditions for private-sector participation: fit-for-purpose clinical pathways, interoperable data exchange, aligned incentives, and facility-level clinical leadership. A networked model, with Puskesmas coordinating territorial public-health functions and private facilities acting as connected clinical nodes, appears more feasible than direct replication of the Puskesmas cluster model. Expanding ILP to private facilities is feasible but should be phased and governed as a partnership rather than treated as a simple policy extension. Clear accountability, referral feedback, financing, data standards, workforce support, and patient-centered continuity are necessary to prevent integration from becoming additional administrative burden without meaningful improvement in care.

Keywords: health governance; integrated primary care; interoperability; private primary care; puskesmas

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INTRODUCTION

Primary health care (PHC) is the part of a health system that most directly shapes whether people receive timely, continuous, and equitable care. The World Health Organization frames PHC as a whole-of-society approach that combines health promotion, disease prevention, treatment, rehabilitation, and palliative care across the life course (World Health Organization, 2025). Indonesia has translated this orientation into Integrasi Layanan Primer (ILP), or Integrated Primary Care, a reform that reorganizes primary care around life-course clusters, stronger community outreach, and connected service networks. The policy is reinforced by the 2023 technical guideline for integrated primary health services and by Regulation of the Minister of Health No. 19 of 2024, which places integrated care within Puskesmas, their networks, and affiliated primary care providers (Ministry of Health of the Republic of Indonesia, 2023, 2024).

The policy direction is clear, but implementation capacity is not uniform. A mixed-methods assessment of 44 Puskesmas in Jakarta classified only 47.4% as ready for ILP, with human resources and infrastructure among the weakest inputs (Dhynianti et al., 2025). National evidence on health information systems also shows a heavy digital workload: Puskesmas may operate many overlapping applications, with duplicated data entry, unstable connectivity, and limited analytic functionality (Aisyah et al., 2025). These are not minor technical inconveniences. ILP depends on

continuity across life stages, service clusters, community networks, and referral levels. When data cannot move with the patient, integration can exist on an organizational chart while care remains fragmented in practice.

Private first-level health facilities, or Fasilitas Kesehatan Tingkat Pertama (FKTP), make this implementation problem more important. The National Social Security Council reported 23,443 FKTPs partnered with the National Health Insurance program as of October 31, 2025, illustrating the scale of the service network beyond government-owned facilities (National Social Security Council, 2025). Private clinics and independent practices are therefore not peripheral actors. For many patients, they are the routine entry point to care. Earlier Indonesian research has already shown that private primary care providers can contribute to screening, health promotion, referral, and reporting, but their participation is constrained by weak incentives, fragmented information systems, limited logistics, and unclear collaborative arrangements (Arini et al., 2022, 2024).

The policy temptation is to treat private participation as a matter of extending the existing Puskesmas model. That assumption is weak. Puskesmas are territorial public institutions with population-health duties, bureaucratic staffing structures, and responsibility for community surveillance. Private clinics are usually smaller, not territorially mandated, and more sensitive to workflow costs, reimbursement, and managerial capacity. Recent evidence from low- and middle-income countries similarly shows that public-private primary care partnerships depend on explicit roles, resource allocation, accountability, monitoring, and meaningful participation rather than on formal affiliation alone (Dove et al., 2025). Primary care networks can strengthen access and coordination, but their effects depend heavily on network design and implementation context (Gadeka et al., 2026).

A synthesis focused on adaptation is therefore needed. Existing Indonesian studies mainly describe readiness, early implementation, digitalization, financing, or specific collaborations. Few directly ask how lessons from Puskesmas-based ILP should be translated into a workable model for private FKTPs. This scoping review addresses that gap by answering two questions: (1) how has ILP implementation in Indonesian Puskesmas and related primary care settings been reported, including achievements, barriers, and enabling factors; and (2) which implementation components can be adapted for private FKTPs without simply reproducing the organizational design of Puskesmas? The review aims to produce a practical, evidence-informed model that remains attentive to system capacity, provider incentives, and the patient's experience of continuity.

METHOD

This study used a scoping review design because the evidence base is heterogeneous, implementation-oriented, and still emerging. The review followed the JBI approach to scoping reviews and was reported in line with PRISMA-ScR (Peters et al., 2024; Tricco et al., 2018). The Population-Concept-Context framework guided eligibility. The population included Indonesian primary care facilities, particularly Puskesmas, Posyandu, private clinics, and relevant health workers. The concept was ILP implementation, including readiness, outcomes, barriers, enabling conditions, information systems, financing, referral, and private-sector participation. The context was Indonesian primary care, with a small number of international integrated-care studies retained as comparative implementation evidence.

Searches covered publications from 2021 through 2026 and were conducted in PubMed, ScienceDirect, and Google Scholar. For Indonesian journals, index eligibility was checked through SINTA, while international journal quality was prioritized through reputable indexed sources. Search terms combined controlled and free-text concepts such as integrated primary health care, integrated primary care, Integrasi Layanan Primer, Puskesmas, community health center, Posyandu, private primary care, private clinic, FKTP, BPJS, and referral. Boolean operators were used to combine the concepts in English and Indonesian.

Eligible records were empirical journal articles published in English or Indonesian between 2021 and 2026, available in full text, and substantively related to primary care integration, ILP, or private FKTP participation. Quantitative, qualitative, and mixed-methods studies were eligible. Editorials, commentaries, theses, conference proceedings, community-service reports without research data, and papers unrelated to primary care integration were excluded. Secondary reviews and policy documents were not charted as included empirical studies, but recent sources were used to interpret the findings and strengthen the policy discussion.

Study selection followed the PRISMA-ScR sequence. Eighty-seven records were identified. Eighteen duplicates were removed manually using DOI, title, and author information, leaving 69 records for screening and eligibility assessment. Fifty-four records did not meet the inclusion criteria, and 15 studies were included in the final synthesis. Data were charted by author, year, country, design, setting, implementation focus, and key findings. An inductive thematic-narrative synthesis grouped recurrent findings into five themes: institutional readiness; health information systems and digitalization; financing and referral governance; the role and constraints of private FKTPs; and international lessons for integrated primary care. Because the purpose was evidence mapping rather than pooled effectiveness estimation, no meta-analysis was conducted.

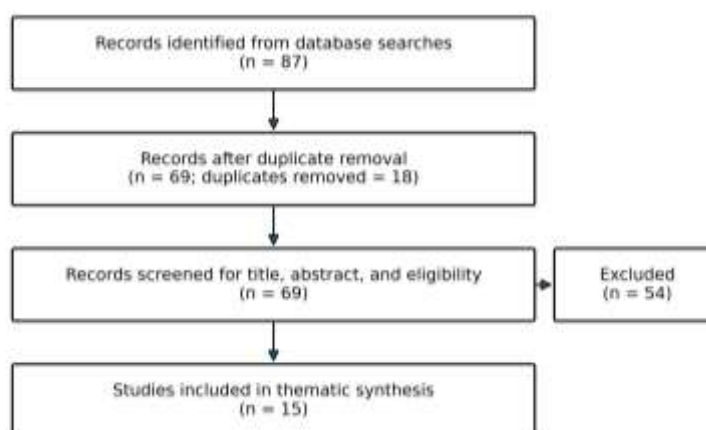


Figure 1. Study selection flow for the scoping review.

RESULT

Fifteen studies were included: 12 from Indonesia, two from the United States, and one from Australia. Six Indonesian studies directly examined ILP or life-course primary care implementation in Puskesmas or Posyandu; the remaining Indonesian studies addressed digital systems, private primary care, performance-based financing, or referral governance. The international studies provided comparative evidence on integrated behavioral health and community-primary care integration. Across the evidence base, policy support was generally stronger than operational readiness. Workforce capacity, infrastructure, data interoperability, financing, and sustained community participation repeatedly shaped implementation.

Table 1.

Characteristics and key findings of included studies

Study/design	Setting/focus	Key finding
Rachmaningsih & Sari (2025), qualitative, Indonesia	Puskesmas Pamulang; cluster readiness, networks, digitalization	Low readiness for cluster-based services and digitalization; network resources were insufficient.
Dhynianti et al. (2025), mixed methods, Indonesia	44 Puskesmas in Jakarta; institutional readiness	Only 47.4% were categorized as ready; workforce and infrastructure were major weaknesses.
Aisyah et al. (2025), cross-sectional, Indonesia	Puskesmas; national and local health information systems	Multiple overlapping systems, redundant data entry, outages, and weak analytic functions increased burden.
Eda et al. (2025), qualitative case study, Indonesia	Puskesmas Wae Nakeng; ILP implementation using CFIR	Strong regulation, cross-sector collaboration, and adaptive staff supported implementation; budget, data storage, and community participation

Study/design	Setting/focus	Key finding
Hartana et al. (2026), mixed methods, Indonesia	Puskesmas Ciwandan; ILP and service access	remained barriers. Most respondents perceived implementation positively, but staffing, infrastructure, and policy adaptation remained constraints.
Siswati et al. (2025), mixed methods, Indonesia	ILP Posyandu in Yogyakarta; cadre readiness	Cadres were relatively ready but still needed logistics, financing, training, and community participation.
Putri et al. (2025), cross-sectional, Indonesia	ILP Posyandu; knowledge and five-table skills	Knowledge was strongly correlated with implementation skill ($r = 0.704$; $p < .001$).
Arini et al. (2022), qualitative, Indonesia	Private clinics and general practitioners; TB-diabetes collaborative care	Private providers could support promotion, bidirectional screening, referral, and reporting, but needed capacity and logistical support.
Arini et al. (2024), qualitative, Indonesia	Private primary clinics; TB-diabetes co-screening	Paper-based reporting and non-interoperable information systems obstructed integrated screening.
Wijaya (2025), mixed methods, Indonesia	120 private primary care clinics in Bali; EMR adoption	Transformational leadership was strongly associated with electronic medical record adoption.
Sitorus (2025), qualitative, Indonesia	FKTP; performance-based capitation for diabetes and hypertension	Stakeholders supported chronic-disease indicators and sustainable incentives to strengthen care performance.
Ridwan & Ramadhan (2025), quantitative survey, Indonesia	FKTP; referral governance and access	Facility location and access influenced referral patterns; collaboration with private family physicians was recommended for underserved areas.
Staab et al. (2022), mixed methods, United States	Community health centers; primary care-behavioral health integration	Recruitment, retention, and reimbursement were recurrent barriers to integration.
Filippi et al. (2024), mixed methods, United States	Family medicine training; integrated behavioral health	Communication and collaboration were feasible, but sustainability required space, staffing, and financial support.
Carrigan et al. (2023), qualitative, Australia	Patients and providers; community-hospital-primary care model	Integration improved perceived access and efficiency, while communication gaps, staffing, waiting time, and safety remained concerns.

Institutional readiness is uneven and cannot be inferred from positive perceptions

Six studies examined readiness or early ILP implementation in Puskesmas and Posyandu. The most important pattern was the gap between policy adoption and implementation capacity. Dhynianti et al. (2025) found that fewer than half of sampled Puskesmas were ready when institutional inputs and processes were assessed systematically. Rachmaningsih and Sari (2025) similarly reported weak readiness for cluster-based service organization, digitalization, and network resources. By contrast, Hartana et al. (2026) reported highly positive frontline perceptions of ILP implementation while still identifying staffing and infrastructure shortages. These findings should not be treated as contradictory. They indicate that perceived progress and objective readiness measure different things. Staff may experience clearer service flow or improved access while the organization still lacks the resources needed for stable, scalable implementation. At community level, readiness depended on practical support rather than attitude alone. Posyandu cadres were generally willing to implement integrated services but still required logistics, funding, training, and community participation (Siswati et al., 2025). Knowledge was strongly associated with skill in the five-table service system (Putri et al., 2025), suggesting that training can translate into operational competence. Eda et al. (2025) further showed that leadership, cross-sector collaboration, and supportive regulation can compensate for some local constraints, although they do not remove budget and data-management problems.

Digital interoperability is a care-continuity issue, not only an IT issue

Three studies placed information systems at the center of integration. Aisyah et al. (2025) documented a fragmented digital environment in Puskesmas, including redundant data entry and

unreliable systems. Arini et al. (2024) found that paper-based reporting and non-interoperable systems limited TB-diabetes co-screening in private clinics. In Bali, Wijaya (2025) showed that leadership influenced electronic medical record adoption in private primary care. Together, these studies suggest that interoperability problems are shared across public and private providers. They also show why simply requiring more reporting is a poor implementation strategy. When every new program creates another interface, form, or duplicate entry, integration may increase administrative fragmentation rather than reduce it.

Financing and referral rules determine whether integration becomes routine practice

The evidence on financing and referral governance shows that implementation cannot depend on professional goodwill alone. Arini et al. (2022) described the potential of private providers in health promotion, bidirectional screening, referral, and reporting, but also identified insufficient logistical and incentive support. Sitorus (2025) found stakeholder support for performance-based capitation tied to chronic-disease indicators, provided that targets and payments are realistic and sustainable. Ridwan and Ramadhan (2025) showed that geographic access affects referral behavior and recommended structured collaboration with private physicians in underserved areas. These findings shift the policy question from whether private FKTPs should participate to how participation should be financed, monitored, and connected to referral feedback.

Private FKTPs require an adapted implementation package

Four Indonesian studies directly illuminate private-sector participation (Arini et al., 2022, 2024; Ridwan & Ramadhan, 2025; Wijaya, 2025). The evidence supports four enabling systems. First, private facilities need clinical pathways and standard operating procedures that translate life-course goals into feasible activities at clinic level. Second, data exchange must connect private electronic records, Puskesmas coordination functions, BPJS reporting, and national interoperability standards. Third, financing must recognize the additional workload of screening, prevention, reporting, and referral coordination. Fourth, clinical leadership matters because smaller private facilities often depend on a limited number of decision-makers for workflow and technology adoption. These conditions imply adaptation, not direct replication of the Puskesmas cluster structure.

International evidence reinforces the importance of workforce, financing, and communication

The three comparator studies showed structural similarities across health systems. In United States community health centers, integrated behavioral health was constrained by recruitment, retention, and reimbursement (Staab et al., 2022). Practice-based implementation research likewise found that communication could improve while long-term sustainability still depended on space, staff, and financial support (Filippi et al., 2024). Australian patients and providers valued accessible and efficient integrated care but raised concerns about waiting times, communication gaps, safety, and staff shortages (Carrigan et al., 2023). The recurring lesson is simple: coordination cannot be sustained through protocol alone. It needs people, time, information, and financing.

DISCUSSION

This review suggests that Indonesia has a credible policy foundation for integrated primary care but a substantial implementation gap. The most consistent barriers are not a lack of policy intent. They are capacity mismatches between what ILP expects facilities to do and what facilities can reliably support. Workforce shortages, infrastructure limitations, fragmented data systems, unclear referral coordination, and insufficient incentives recur across settings. This matters because an integration reform can fail in two ways. It can fail visibly, when services are not delivered, or it can fail quietly, when facilities comply administratively while patients still experience repeated histories, duplicated screening, weak referral feedback, and disconnected follow-up. For private FKTPs, the most defensible model is a networked ILP arrangement. Puskesmas would retain the territorial functions that private clinics are not designed to perform, including population-health coordination, community surveillance, and area-based network management. Private clinics and independent practices would function as connected clinical nodes with clearly defined service packages, referral

obligations, reporting standards, and feedback mechanisms. This is consistent with newer evidence on PHC networks in low- and middle-income countries, which indicates that networks may strengthen access and coordination but that benefits depend on how relationships, accountability, and operational links are designed (Gadeka et al., 2026).

Governance is the part that cannot be left vague. A recent systematic review of public-private PHC partnerships found that effective governance depends on partnership design, stakeholder participation, transparent resource allocation, monitoring, and explicit roles and responsibilities (Dove et al., 2025). Applied to ILP, a memorandum or formal network agreement should specify who conducts which screening activities, who supplies commodities, who pays for added work, what data must be exchanged, how referral feedback is returned, how performance is reviewed, and what happens when capacity thresholds are not met. Without this level of clarity, a network risks becoming a one-way transfer of public responsibilities to private providers. Digital integration also requires a harder look at workload and data governance. Indonesia's SATUSEHAT interoperability agenda offers an important technical foundation, but recent analysis has identified practical pain points involving server reliability, FHIR profile selection, and mapping electronic medical record data into standardized formats (Heryawan et al., 2025). For private clinics, interoperability should therefore be judged by whether it reduces duplicate work and improves continuity, not merely by whether data can technically be transmitted. A technically connected system that still requires parallel manual reporting is not operationally integrated.

Financing should follow the same principle. Performance-based incentives can support preventive and chronic-disease services, but narrow metrics can also produce gaming or superficial compliance if targets are disconnected from patient need. A stronger design would combine a limited set of measurable process indicators with continuity and outcome measures, while avoiding an excessive reporting burden. Recent meta-analytic evidence shows that integrated care involving primary care can improve access and continuity, although benefits do not automatically translate into all downstream outcomes (Zhang et al., 2025). That finding is a useful warning against overselling ILP. Integration is an enabling architecture, not a guarantee of better health outcomes by itself. Equity is another risk. Private facilities tend to follow patient demand and financial viability rather than territorial need. If ILP incentives mainly reward clinics that already have better staffing, internet connectivity, and information systems, network expansion could unintentionally widen the gap between well-served urban populations and underserved areas. Referral collaboration with private physicians may help address geographic barriers (Ridwan & Ramadhan, 2025), but only if contracting and incentives deliberately include underserved populations. A phased rollout should therefore start with readiness mapping, minimum technical standards, and explicit equity criteria rather than a uniform national requirement.

A practical sequence emerges from the evidence. First, map private FKTP readiness across workforce, service capacity, electronic records, connectivity, JKN enrollment, and referral capability. Second, define a minimum ILP package for private facilities using clinical pathways rather than the full Puskesmas cluster architecture. Third, establish interoperable data and closed-loop referral feedback before expanding reporting requirements. Fourth, test payment mechanisms that compensate preventive and coordination work. Fifth, evaluate not only coverage and screening counts, but also continuity, patient experience, provider workload, and avoidable referral delays. This sequence treats implementation as a learning process rather than a compliance exercise. The review has limitations. Only 15 empirical studies were included, and most Indonesian evidence reflects early implementation, readiness assessments, single-site studies, or specific subcomponents such as digitalization and financing. Direct comparative studies between Puskesmas and private FKTPs remain scarce. The international comparator studies come from health systems with different financing and organizational structures, so transfer should be conceptual rather than literal. Finally, the scoping design maps evidence and implementation patterns but does not establish the

effectiveness or cost-effectiveness of private-sector ILP participation. These gaps make pilot evaluation essential before large-scale adoption.

CONCLUSION

Indonesia's ILP reform has a strong policy rationale, but the evidence shows that implementation quality depends on organizational readiness, interoperable information systems, sustainable financing, referral governance, leadership, and workforce capacity. Private FKTP participation is both necessary and plausible because private facilities already serve as routine entry points to care. However, treating private clinics as smaller Puskesmas would be a design error. The more realistic approach is a networked model in which Puskesmas coordinate territorial public-health functions while private facilities deliver defined clinical services through shared pathways, data standards, incentives, and closed-loop referrals. Implementation should be phased, equity-sensitive, and evaluated from the perspective of both providers and patients. The immediate priority is not expanding the label of ILP, but proving that integration produces less fragmentation, more continuity, and a manageable workload at the point of care.

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