Qualitative Research

Perceptions of Indonesian general practitioners in maintaining standards of medical practice at a time of health reform

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Abstract

Background. There is little research on how GPs experience the demands of maintaining standards of medical practice in developing countries and what strategies might improve their capability to provide high-quality primary health care (PHC).

Objective. This study aims to explore the underlying factors, which shape GPs’ experience within the Indonesian PHC system and impact on their experience of professional practice.

Methods. A grounded theory approach was applied using semi-structured interviews of 25 purposively selected GPs in West Sumatra, Indonesia. The interviews were analysed inductively through an iterative process of the interplay between empirical data, emerging analysis and theory development.

Results. Three major health care systems attribute shaped GPs’ experiences of professional practice, including (i) a restricted concept of the PHC system, (ii) lack of regulation of private primary care practice conducted by GPs, midwives, nurses and specialists and (iii) low coverage and inappropriate policy of the health insurance system.

Conclusion. The findings indicate that a major revision of current health care system is required with a focus on promoting the concept of PHC services to the population, redefining the role of the GP to deliver recognised best practice within available resources, changing the way GPs are remunerated by the public health system and the health insurance industry, policing of the regulations related to the scope of practice of other health care professionals, particularly midwives and nurses, and regulation of prescribing. GPs can be the champions of the PHC service that Indonesia needs, but it requires sustained systematic change.

Key words. Developing countries, general practitioners, health care reform, primary health care, professional practice.

Introduction

GPs have important roles in providing primary health care (PHC) services for the community and a role in developing an effective and efficient PHC system (1). GPs’ roles are arguably more challenging in developing countries. This is due to the complexity of the health problems faced and the so-called ‘double burden of disease’ meaning a high prevalence of infectious and degenerative diseases at the same time.

The Indonesian PHC strategy is realised in a network of public health facilities across the country, with Puskesmas (community...
health centre) at the subdistrict level and a hospital at the district level. To increase accessibility to health care services, a range of auxiliary centres such as Pustu (subhealth centre), Polindes (village maternity post) and Poskesdes (Village Health Post) support each Puskesmas. The physician-population ratio in Indonesia is much lower compared to the world median: 2.9 and 16 per 10,000, respectively (2). Doctors are distributed unevenly across the country. There is one doctor for every 2,763 population in urban areas, whereas in rural area, one doctor serves 16,793 people (3). GPs make up ~80% of the total number of physicians (4). Due to the scarcity of GPs, particularly in rural and regional areas, the Indonesian Government has authorised midwives and nurses to provide primary care within the Puskesmas and their auxiliary centres (5,6). Most health care personnel in Indonesia, including specialists, GPs, midwives and nurses, undertake dual practice by working in both the public and private sectors mainly to supplement the low salary paid to public servants. Even though it is predicted that the role of these private ambulatory care facilities will increase in the future, they are currently rarely referred to when discussing health care facilities in Indonesia (6).

The Indonesian Government is developing its health care financing system to achieve universal coverage, managed by a non-profit organisation called Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS-Kesehatan). In this system, GPs are paid by a capitation system and are required to dispense medicines. Specialists, on the other hand, and in-patient services are paid for by a fee for service and a case-mix/diagnosis related group scheme—Indonesian Case Base Groups (INACBGs) (7). As insurance cover from the BPJS-Kesehatan has increased, the number of GPs providing private services has increased rapidly. The capitation fee remunerated for private practice GPs is higher than the capitation fee paid for Puskesmas.

By 2019, the entire population of Indonesia should be covered by BPJS-Kesehatan for their basic health care needs in ambulatory and in-patient services. For patients deemed to be above the poverty line, the premium for BPJS-Kesehatan is paid for by themselves or their employers. For those living under the poverty line, the Government pays for health insurance contributions through the BPJS-beneficiary contribution program—Penerima Bantuan Iuran (PBI) (8). They must visit a Puskesmas for their primary care needs. However, for secondary or tertiary services, PBI recipients have similar rights to non-PBI patients, in that they can access any BPJS-Kesehatan’s health care provider partners, both public and private. The PBI program is a continuity of existing free health insurance schemes for the poor: Jamkesmas and Jamkesda (7). The PBI premium rate is lower than the non-PBI.

In 2013, 72% of the Indonesian population were covered by various health insurance schemes. Their membership is gradually being transferred into the basic cover of BPJS-Kesehatan from 2014 (7). Thus, based on the 2013 data, ~28% or 75 million people are not covered (7). The uninsured population is mostly made up of the working classes, who are particularly vulnerable to falling into poverty when they get sick since they have to pay for their health care services out of their own pocket (9). In addition to the basic cover of BPJS-Kesehatan, Indonesians can purchase private insurance. In 2013, only 1.2% of the population were able to purchase extra cover from private insurance (7).

Furthermore, new rules and regulations are being developed and issued to improve various aspects of PHC such as new standards of competence—Standar Kompetensi Dokter Indonesia (SKDI) and a new re-registration system for doctors (10). Since 2006, medical schools have been required by the Indonesian Medical Council—Konsil Kedokteran Indonesia (KKI) to develop curricula, which aim to prepare students to achieve competences stated within the SKDI (11–13). As shown in Table 1, the new standards oblige the implementation of competence-based curriculum, internship program and re-registration system for doctors. Prior to this reform, the GP-training curriculum was discipline based, and internship and re-registration system were absent. So far, vocational training for GPs in Indonesia is unavailable.

It is anticipated that GPs will be a key stakeholder in all of the new Government-led PHC initiatives. Whilst the improvement of GPs’ clinical performance is an important objective of the health policy changes, it is still not certain how practicing GPs perceive and maintain standards of practice in primary care, and whether they will be ready to respond as the reforms are implemented. Additionally, maintaining a complex role is not without its personal challenges. The literature widely discusses the increase of health problems among GPs, and the decrease in their job satisfaction, in many developed countries (14–17). However, there are few theoretically informed studies exploring the underlying factors, which describe how GPs navigate their way within the landscape of a PHC system in developing countries. This study aims to explore the underlying factors that shape GPs’ experience within the Indonesian PHC system and impact on their experience of professional practice.

Methods

Research setting and participants

Participants of this study were GPs practicing in West Sumatra. Ethical approval was obtained from the University of Sydney, where the first author undertook her doctorate. Support for the research was given by the Indonesian Medical Association—West Sumatra branch, who also provided a list of all GPs. The local ethics review board (Faculty of Medicine Andalas University) provided endorsement of the study. Potential participants were contacted via telephone and a total of 25 GPs gave informed consent.

Research design and analysis

In this qualitative study, using grounded theory (18), semi-structured interviews facilitated the collection of sensitive information from the participants about their experiences of medical practice. Participants were asked how they conceptualized good practice in PHC, how they developed and maintained good practice and how they evaluated the extent to which their practice reflects good practice. The interviews were conducted in Bahasa Indonesia by the first author (NAS) and ranged from 30 to 90 minutes. They were audiotaped with participant consent, transcribed and de-identified. The transcripts were imported into NVivo Version 9 (QSR International Pty Ltd, Doncaster, Victoria, Australia) for efficient data management and coding.

In line with grounded theory, data collection and analysis, and theoretical framework development were conducted simultaneously (18,19). The first author coded the first two interview transcripts and grouped these codes into categories using a constant comparative method. The emergent analysis also guided the purposeful selection of other GP’s for inclusion in the study. The open coding process stopped when data was saturated (19). Transcripts were then selectively coded to ensure categories were adequately supported by data. Categories were then analysed further to construct a theoretical framework (20).

The first author continuously discussed the data collection and interpretation with the other authors. Five selected interview transcripts were translated into English to enable discussions among authors regarding data analysis and theoretical framework.
development. The translation was conducted by the first author in discussion with the second and fifth author regarding the appropriateness of the English translation. Emergent ideas and questions during data collection and analysis were recorded through memo-writing and diagramming activities. The first author asked participants in person and via phone if they agreed with the analysis and emergent findings to validate the researchers’ interpretation of data.

Results

Participant characteristics
At the time of this study, most of the 25 participants were working as Government employees at Puskesmas, public hospitals, the Department of Health and universities. The majority of participants had more than one job (this is referred to as dual practice). In addition to working in the public health system and as public servants, most also worked either as private solo practitioners, or employed by private hospitals, or the health care clinics of private businesses and industrial companies. This is consistent with reported figures, which indicate that 81% of doctors (GPs and specialist) in West Sumatra were engaged in dual practice (21). Table 2 shows the variation in participant characteristics in terms of their gender, age, practice type, practice location, other activities and services offered to members of insurance companies.

Our data illustrates three main underlying factors that shaped GPs’ experience of professional practice within the Indonesian PHC system. These were a restricted concept of the PHC system, lack of regulation of private primary care practice conducted by GPs, midwives, nurses and specialists and the low coverage and inappropriate policy of the public health insurance system.

A restricted concept of the PHC system
Participants felt that the Government had a restricted concept of a PHC system, which considered the Puskesmas as the only focus of its PHC strategies. Further, the Government did not recognise the specialist nature of the primary care and public health activities within Puskesmas and their auxiliary network. Many GPs working at Puskesmas had double duties: both as the manager of Puskesmas’ public health initiatives—Usaha Kesehatan Masyarakat (UKM) and as primary care clinicians who served patients in the Puskesmas clinic—Usaha Kesehatan Perorangan (UKP) (22). This resulted in GPs having to delegate their clinical work at the Puskesmas to their staff (midwives and nurses). This raised concerns about GP workload and the quality of the services provided where nursing staff were acting outside their scope of practice.

I am in Puskesmas, the only GP there. I am also burdened with managerial task, meetings, etc. It is impossible for me to handle it all by myself, so I have to share my responsibilities to examine patients and write prescriptions with midwives and nurses. (Interviewee 12)

The Puskesmas GPs also reported that their workload had increased significantly, for example one GP (interviewee 8) served 70–100 patients per day after the introduction of the Jamkesmas and Jamkesda (health insurance paid by the Government for the poor). The policymakers of these health insurance schemes were expected to attend the Puskesmas for their primary care services. As a result, the number of patients served by Puskesmas had increased, whilst the number of GPs working in Puskesmas remained static. Under these conditions, sharing PHC responsibilities and roles between GPs and midwives/nurses became increasingly inevitable.

It is not wrong to send them (midwives and nurses) to the villages, but they should only work on maternity and child care. Unfortunately, they are also targeted to serve primary care services independently. The Government should have made a clear boundary at the start. (Interviewee 12)

Participants recognised the compounding issues of staff working beyond their scope of practice in Government initiatives, which continuously expanded the Puskesmas auxiliary network, which were only staffed by midwives and nurses. The majority of participants believed that the PHC

Table 1. Indonesian Medical Education System before 2006, between 2006 and 2012 and after 2012

<table>
<thead>
<tr>
<th>Phases of medical education</th>
<th>Medical education before 2006 (KIPDF I and II)</th>
<th>Medical education between 2006 and 2012 (KIPDI III)</th>
<th>Medical education after 2012 (revision of KIPDI III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>Bachelor of Medicine—preclinical years</td>
<td>8 semesters discipline-based curriculum, teacher centred</td>
<td>7 semesters integrated/competence-based curriculum, SPICES approach†</td>
</tr>
<tr>
<td></td>
<td>Bachelor of Surgery—clinical/clerkship</td>
<td>4 semesters in hospital (clinical rotations) and small part in Puskesmas</td>
<td>3 semesters in hospital (clinical rotations) and small part in Puskesmas</td>
</tr>
<tr>
<td>Post-graduate</td>
<td>To be GPs practice in primary care</td>
<td>None</td>
<td>One-year internship†</td>
</tr>
<tr>
<td></td>
<td>To be specialist</td>
<td>Specialist training</td>
<td>• 8 months in hospital</td>
</tr>
<tr>
<td></td>
<td>CPD§</td>
<td>Not highly recommended</td>
<td>• 4 months in Puskesmas</td>
</tr>
<tr>
<td></td>
<td>Both GPs and specialists</td>
<td>Required for registration and re-registration†</td>
<td>• One-year internship, idem with GP</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Specialist training</td>
</tr>
</tbody>
</table>

†The decision of KKI No. 20/KKI/KEP/IX/2006.
‡SPICES, student-centred, problem-based, integrated, community-based, elective/early clinical exposure, systematic.
§The Health Ministry Regulation No. 299 year 2010.
¶The decision of KKI No. 42/KKI/KEP/XII/2007.
∥Kurikulum Inti Pendidikan Dokter Indonesia.
Continuing professional development.
Table 2. Participant characteristics: GPs practicing medicine in West Sumatra in 2010

<table>
<thead>
<tr>
<th>Number</th>
<th>Participant characteristics</th>
<th>Numbers</th>
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<tbody>
<tr>
<td>1.</td>
<td>Gender</td>
<td></td>
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<tr>
<td></td>
<td>Male</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>14</td>
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<tr>
<td>2.</td>
<td>Age</td>
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<tr>
<td></td>
<td>25–35 years</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>36–50 years</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>&gt;50 years</td>
<td>9</td>
</tr>
<tr>
<td>3.</td>
<td>Practice types: most of participants dual practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Solo</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Puskesmas</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Private health clinic</td>
<td>7</td>
</tr>
<tr>
<td>4.</td>
<td>Practice location</td>
<td></td>
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<tr>
<td></td>
<td>Urban</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Suburban</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>Other activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Retired</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Lecturer</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Puskesmas</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Health department</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Company doctor</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>State health insurance</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Private health insurance</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>11</td>
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</table>

The system should be modelled around primary and community services led by the GP and supported by appropriate staff. Increasing the number of Puskesmas auxiliary centres that were staffed only by midwives and nurses was not regarded as an appropriate solution for delivering effective PHC. Conversely, participants argued that these Government initiatives potentially blurred professional boundaries among GPs, midwives and nurses, and made it difficult to work collaboratively.

In summary, the restricted concept of PHC system had contributed to GPs believing they were unfairly overworked and unable to provide good quality care in a comprehensive way. This restricted concept had significantly contributed to the blurred boundaries of authority between midwives and GPs, which had led to competition between the personnel of these two health care professions.

The lack of regulation of private primary care practices

As a consequence of placing Puskesmas as the single player of its PHC agenda, the Government overlooked the roles of private ambulatory care facilities and have not enforced sufficient control over them. Participants reported that due to the lack of monitoring of private primary care practices, their specialist colleagues had encroached into the primary care domain. Participants believed that Puskesmas and private practice GPs were not in the interest of patients for their health care needs, even though those patients were in the domain of primary care. They also reported feeling excluded from the patient care pathway in that patients often circumvented the GP and specialists regularly failed to request a referral letter, and rarely sent patients back to the referring GP, if the patient was uninsured.

In the case of patients without health cover, they (mostly the well-off) by-pass us by visiting the specialists directly. They come without a GP's referral letter, are the specialist refusing them? Never! They never refuse them. If they see us, they need to be referred, then we refer them, but because they are not under health cover agreement, they never come back to us. They continue to have care there with the specialists. (Interviewee 1)

Furthermore, based on their patients’ stories, participants suspected that midwives and nurses also provided PHC services which were beyond the scope of their professional legal competencies, in private practice settings outside the auspices of Puskesmas and their auxiliary centres.

Trusted midwives have lots of patients. Even in my place, there is an anaesthesia nurse treating patients in his surgery and he has much more patients than me and other neighbouring GPs. (Interviewee 19)

Participants were concerned that some GPs were similarly managing cases outside their scope of practice and were not referring their patients to specialists for further management. Suspected reasons were the patient’s insistence on being managed by GPs due to their financial difficulties, and the GPs’ personal interests such as for financial gain.

Unfortunately, there are some GPs who grab everything, do whole of patient care. They tackle everything on their own even though the patients actually should be referred. (Interviewee 15)

Other examples of poor practice, reported by participants included some GPs using expensive new generation medicines in order to gain patients’ confidence and increase patient volume.

Thus, our data indicated that the lack of Government control on private primary care practices had significantly contributed to escalating conflict and competition between primary care professions and the secondary care specialists due to the unclear scope of practice between them.

The low coverage and inappropriate policy of health insurance system

Participants believed that a lack of universal health insurance coverage deterred sick patients, many of whom were uninsured, from seeking GP’s medical services.

"Their financial capability is very limited and they have no special funding for health, so that they ignore their cough till the disease got worse.” (Interviewee 2)

Participants reported that as a result of the financial burdens associated with accessing PHC from the GP, patients tended to ‘... self-medicate instead’ (Interviewee 4) by buying over-the-counter...
medicines, obtain prescription medicine from pharmacies and drug stores without a physician's prescription, use alternative and traditional medicine and access the services of midwives/nurses, which were cheaper than GPs. Another consequence of unsuccessful self-treatment was that patients would seek specialists’ services because they thought that GPs would not be able to handle the advanced state of their diseases. Invariably, such patients were challenging to manage due to the urgency and advanced nature of their illnesses resulting from the delay in seeking medical help, and limited financial capability.

Participants indicated that the BPJS-Kesehatan supported GPs’ self-dispensing practices by explicitly requiring GPs to provide medicines for their policyholders. Participants discussed the difficulties they had in managing their supply of medicines to meet the needs of their patients, while the medicine expense was included in their capitation scheme. The impact of the capitation system was that GPs were paid the same amount for a certain period of time for each policy holder assigned to them, regardless of whether the policy holders sought GPs’ services or not. This reverse incentive often made GPs appeared to feel indifferent in sorting out the problems of patients who were members of the health insurance companies. They opened their ‘gate’ wider and made inaccurate referrals and let more patients accessing secondary care services from the specialists. In addition, participants specifically reported that the policies of health insurance companies interfered with their professional autonomy and capacity to provide clinical services. For example, some health insurance companies’ policies limited GPs’ access to clinical examination procedures, and required GPs to refer any patients who needed laboratory tests to their partner hospitals, even for relatively straightforward medical problems that could be managed in primary care.

They impose some limitations for GPs, for example GPs could not utilize certain diagnostic procedures. Finally, GPs find it difficult to develop themselves and have less opportunities to manage different types of patients. (Interviewee 7)

As a result of these limitations, participants perceived that they were no longer able to carry out their professional responsibilities and act in accordance with their self-chosen and informed management plan. Instead they felt their clinical decision making and patient management approaches were controlled and constrained by health insurance companies.

**Discussion**

This study showed three attributes of the Indonesian PHC system, which shaped GPs’ experience within the Indonesian PHC system. These included a restricted concept of the PHC system, lack of regulation of private primary care practice and low coverage and inappropriate policies of the public health insurance system. These attributes have contributed to GPs’ job dissatisfaction due to high workload and low levels of professional autonomy. Secondly, these issues have contributed to blurring of professional boundaries and damaging of inter-professional and collaborative relationships between GPs and other PHC professionals. Thirdly, these issues have confused the community and damaged the public image of the PHC system and the critical role of the GP.

Despite the positioning of Puskesmas and their auxiliary centres as the main feature of the Indonesian PHC system, they were not staffed by sufficient number of GPs as the gate keepers of the health care system. One reason might be the difficulties in attracting GPs to practice in rural and remote areas, and the low salary paid to public servants (3,23). Consequently, the workload of Puskesmas GPs was very high. The impact of the heavy workload on GPs’ job satisfaction, work style and quality of work is widely discussed in the literature. A heavy workload and lack of time decreased GP’s satisfaction with their job (24). Consultation time and intervals also impacted GP’s work style and quality (25). These findings resonate with how participants in our study approached their clinical tasks. They had to speed up in examining their patients and unavoidably asking nurses and midwives to practice outside their scope of practice.

Moreover, participants discussed the health insurance coverage and policies as other sources of dissatisfaction on their job due to their inability to properly carry out their professional responsibilities. The absence of health insurance cover had prevented ~75 million Indonesians (7), particularly who had poor financial circumstances, to seek health care professional services due to their financial inability to pay for the services (26). The literature has documented that financial constraints decrease access of people without health insurance protection to health care services globally (27-31). Thus, these people would self-medicate, seek help from alternative and traditional medicine, as well as from midwives/nurses, or buy over-the-counter medicine, and even prescription medicines from unprofessional pharmacies and drug stores that illegally sell medicines without a doctor’s prescription. These community self-medication habits negatively impacted GP’s professional practice through increasing the difficulties of cases to be managed by GPs due to delayed treatment and drug resistance, and lowering the community trust and adherence of GP’s treatment. One reason that participants gave for GPs not referring patients for further management was the patient’s insistence on being managed by GPs due to their financial difficulties.

However, increasing health insurance coverage did not necessarily improve GPs’ working satisfaction. The insurance policies limited GPs’ professional authority in accessing certain medicines and clinical examination procedures even though based on the standard of medical competence (32,33), these medicines and procedures were included in primary care scope of practice. These limitations decreased GPs’ flexibility and involvement in managing patients because they had to send their patients to secondary care facilities appointed by the health care insurance companies, if their patients needed certain medicines and procedures that the GPs could not use. Thus, GPs believed that the health insurance policies had controlled and constrained their autonomy. In addition, participants also believed that self-dispensing had lowered the community’s trust and satisfaction with their services. GPs had to limit their spending on medicine in order to increase their practice revenue because medicine expenses were included in their capitation payment. On the other hand, it was easy for the community to get newer generation medicines than those provided by GPs from pharmacies without a prescription. Internationally, health insurance policies have often been shown to impede physicians’ professional decision-making processes, in turn hampering their abilities to provide high-quality patient care (34). In contrast, increasing professional freedom in line with the professional norms can help physicians to manage their time and ensure their patients get high-quality care (35,36).

Furthermore, as a consequence of designating Puskesmas as the single focus of the Government PHC initiative, the private PHC sector was not considered as part of Indonesian PHC system, hence was not controlled appropriately. As a result, GPs were not the only PHC providers for ~75 million Indonesian population (uninsured) (7). It was common for midwives and nurses to provide primary care services in their private practices outside the auspices of Puskesmas and their auxiliary centres. Meanwhile, the specialists breached their
professional boundaries by failing to request a referral letter and rarely sending patients back to GPs for subsequent management. Similarly, GPs often practiced medicine out of their scope of practice. This lack of boundaries around professional responsibility and authority had negatively impacted the inter-professional interaction between these three professions in a way that could potentially jeopardise patient safety.

Participants reported the unclear scope of practice in primary care had contributed to increased competition between private practice of GPs and midwives/nurses. In the UK, Australia and the USA, teamwork and collaboration in primary care is desirable and considered good practice. Midwives focus on a clearly defined scope of practice to do with pregnancy and childbirth, whilst nurses manage minor cases, or protocol-driven chronic disease management supervised by the GP but only the complicated ones see GPs. This practice can reduce the workload of GPs (37–39). A contrasting practice existed in Indonesia. The unclear scope of practice and lack of clear boundaries regarding professional authority between the PHC professions functioned as a barrier to collaborative working among these professions in Indonesia and even led to competition.

The intersection and impact of these various attributes of the PHC system had challenged the community’s understanding about the professional roles of and the relationship between GP and other providers, such that the community could no longer identify the specific role of each profession. Rather they viewed that all health care professions had a similar role of diagnosing and managing people who had illnesses. Furthermore, these issues had lowered the community’s trust and satisfaction regarding the health care services provided by GPs, serving to undermine the GP role as a gatekeeper within the health care referral system. There is some grey literature documenting the community’s image of primary care doctor or GP. The authors believed that the community’s image of a GP is typically not as good as their image of a specialist physician (40). Patients and society tended to perceive GPs as lower in status, and hence competence, than specialist physicians (40,41), leading to a situation in which specialists were able to take over all the GPs’ work.

Based on our findings we make several recommendations for establishing a strong PHC system both in public and private PHC facilities. The role of Puskesmas needs to be refined by considering the specialist nature of the primary care and public health activities they deliver. The concept of PHC system should be broadened to encompass Puskesmas and private PHC services. The role of GPs should be redefined for an effective and efficient PHC system by recognizing GP as a generalist specialty. Relevant law and ordinance should be applied in order to ensure health care professionals work within their scope of practice. The state government needs to conduct a review at the policy level, to ensure that the existing professional regulatory framework is enforceable, and that deregistration is perceived as a real possibility for unprofessional behaviours. A number of countries, for example Australia (https://www.ahpra.gov.au/) and the UK, have implemented national professional accreditation bodies that span all of the health care professions. Thus, GPs and midwives/nurses could work collaboratively in providing PHC services for the community, through an effective PHC teamwork.

A review of the state and local Government health care budget needs to plan for increasing Government spending in health insurance. Thus, the Government could increase the health insurance coverage especially for working class society and increase the amount of insurance premium or contributions paid for each PBI recipient. Universal coverage would enable government to have more control over all health care professionals and promote the gate keeping function of GPs, contributing to an effective and efficient health care service. However, the state Government should require health insurance providers (BPJS-Kesehatan) to review their policies on GPs’ remuneration system and practice regulation. The PBJS-Kesehatan should minimise its limitations on GPs’ professional autonomy, within a revised scope of practice. Health insurance policies should be in line with professional norms so that GPs and specialists could ensure their patients get high-quality care (35,36). Finally, the Government has to increase law enforcement in the medicine distribution system by improving practice supervision both for health care personnel and for pharmacies and drugstores.

**Limitations of this study**

Although these qualitative findings are not considered generalisable to other settings, we suggest there are fundamental similarities in professional experience of GPs throughout Indonesia. We anticipate that the findings and proposed recommendations will be of value to GPs and all those stakeholders who have an interest in the outcomes of primary care services in Indonesia and other developing countries.

**Conclusion**

The findings indicated that there needs to be systematic change where GPs can consider themselves as being useful, and effective providers of primary care. Major revision of the current health care system is required with a focus on promoting the concept of PHC services to the population, redefining the role of the GP to deliver recognised best practice commensurate with available resources, changing the way they are remunerated by the public health system and the health insurance industry, policing of regulations related to the scope of practice of other health care professionals, particularly midwives and nurses, and regulation of prescribing. GPs can be the champions of the PHC service that Indonesia needs for its population’s health needs, but it requires sustained systematic change.

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