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Factors contributing to interprofessional collaboration in Indonesian health centres: A focus group study

Adji Prayitno Setiadi [a], Yosi Wibowo [a, *], Fauna Herawati [a], Sylvi Irawati [a], Eko Setiawan [a], Bobby Presley [a], M. Arif Zaidi [b], Bruce Sunderland [c]

[a] Centre for Medicines Information and Pharmaceutical Care (CMIPC), Faculty of Pharmacy, Universitas Surabaya, 5th Floor, Building FF, Jl. Raya Kalirungkut, Surabaya 60293, Jawa Timur, Indonesia
[b] East Java Provincial Health Office, Ministry of Health Republic of Indonesia, Jl. Jend. A. Yani No. 188, Surabaya 60231, Jawa Timur, Indonesia
[c] School of Pharmacy, Faculty of Health Sciences, Curtin University, Kent Street, Bentley, Perth, Western Australia 6102, Australia

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ABSTRACT

Background: The burgeoning health burden in Indonesia requires strengthening primary care services through interprofessional collaboration.
Purpose: to explore factors contributing to interprofessional collaboration within health centres Indonesia.
Methods: Eight focus group discussions involving a range of health professionals from health centres were conducted in four districts in East Java, Indonesia. Thematic analysis was used to generate findings.
Results: Collaborative practices in Indonesian health centres are directly affected by health professional interactions (personnel level) – hierarchy and lack of role understanding have been reported as barriers to the interactions. These factors are in turn affected by health centre's environment (organisational level) and the Government legislation/policy (health system). The health centre's environment included organisation's culture, team management, physical space, as well as communication and coordination mechanisms.
Conclusions: Factors contributing to collaborative practices in this setting were complex and intertwined. Structuring collective actions or strategies would be required to address the identified collaborative issues.

1. Introduction

Indonesia is the world's largest island nation with a population of more than 200 million.[1,2] Whilst infectious diseases still remain prevalent, Indonesia faces an increasing burden of chronic diseases, such as cancers, cardiovascular and chronic respiratory diseases.[3] In 2014, the country launched a national health insurance programme (*Jaminan Kesehatan Nasional – JKN*) aiming to improve accessibility and quality health care for all Indonesians.[4] In order to support the programme, the Ministry of Health's priority policy for 2015–2019 includes strengthening primary care services in which health care providers are encouraged to collaborate to improve quality use of medicines and patient safety.[5]

Collaborative practice in health care occurs when multiple health workers from different professional backgrounds provide comprehensive coordinated services to patients, their families, carers and communities to achieve the highest quality of care across settings.[6] Effective collaborative practice and optimised health-services, strengthens health systems and improves health outcomes.[7–12] Research worldwide has shown that collaborative practice can improve access to and coordination of health services, appropriate use of specialist clinical resources, improved health outcomes for people with chronic diseases, patient care and improved safety.[13–15] Collaborative practice can also decrease disease complications, length of hospital stay, conflict among caregivers, staff turnover, hospital admissions, clinical error rates, and mortality rates.[9–11,13,16–19] In primary care settings, patients have reported higher levels of satisfaction, better acceptance of care and improved health outcomes following treatment by a collaborative

* Corresponding author.
E-mail addresses: adji_ps@hotmail.com (A.P. Setiadi), yosi_wibowo@staff.ubaya.ac.id (Y. Wibowo), fauna@staff.ubaya.ac.id (F. Herawati), sylvi.irawati.2010@gmail.com (S. Irawati), ekosetiawan.apt@gmail.com (E. Setiawan), bobbypresley@gmail.com (B. Presley), m.arif.zaidi@gmail.com (M.A. Zaidi), B.Sunderland@curtin.edu.au (B. Sunderland).

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team.[16]

Several factors may contribute to the successful implementation of interprofessional collaborative practice, such as institutional support (e.g. governance, structured protocols, availability of space and time), working culture support (i.e. communication strategies), professional support (e.g. common interest, willingness, trust), policy support, interprofessional training and long-term funding.[6,20–24] Specific factors may differ between countries as no two health systems in the world are exactly the same. Thus, countries seeking to move towards more collaborative types of practice should begin with assessing what is readily and currently available, and building on what they have. A questionnaire survey of Indonesian health professionals has reported positive attitudes towards collaboration,[25] a better understanding of the local context is required for translation into actual practice. In Indonesia, primary care services are mainly provided within *Pusat Kesehatan Masyarakat* (*Puskesmas)* or health centres with a referral system to the secondary and tertiary facilities, thus health centres are front-line in the implementation of JKN. This study aims to explore factors contributing to interprofessional collaboration within health centres in Indonesia.

2. Methods

2.1. Research design

A qualitative study used focus groups of health professionals employed in Indonesian health centres. This qualitative method was chosen as it enabled exploratory work to be carried out in order to assess the views of study participants.[26] Approval for the study was obtained from the Human Research Ethics Committee of Universitas Islam Indonesia (No. 40/Ka.Kom.Et/70/KE/V/2016).

2.2. Research setting

The study was conducted in East Java, a province of Indonesia located at the eastern end of Java island, with an area of 47,963 km^2.[27] According to the 2010 Population Census estimates, there were approximately 37 million people residing in the East Java, making it Indonesia's second-most-populous province.[1] Although, the health status of the population in Java-Bali regions are generally more advanced than the Eastern parts; East Java's morbidity and mortality rates related to chronic diseases, such as diabetes and cardiovascular diseases, were among the highest in Indonesia.[3] East Java is divided into 29 districts (*kabupaten*) and 9 cities (*kota*)[27]; a health centre is a technical unit of a District/City Health Office to provide primary health care in a sub-district level (*kecamatan*). In 2014, there were 960 health centres in East Java, giving a ratio of 1 health centre per 40,219 of the population. Almost 60% of these health centres included inpatient care to provide first aid for emergency cases, while the remainder only have outpatient facilities.[28] Regulations state that a health centre should be at least staffed by a physician, a dentist, a nurse, a midwife, a public health staff, an environmental health staff, medical laboratory technologist, a nutritionist, and pharmacy staff.[29] Shortages of health staff in health centres has been reported.[28]

2.3. Sample and recruitment

Participants in focus groups were health professionals, including physicians, pharmacists and/or pharmacy technicians, nurses and/or midwifes, who were currently working in the health centres. Focus groups were conducted in four districts in East Java, namely Trenggalek (a southern district), Madiun (a western district), Tuban (a northern district), and Mojokerto (a central city). These different areas in East Java were chosen to ensure a wide representation of primary care providers across East Java. Participants were purposefully selected by the Chief of the District/City Health Office. Two focus groups were organised in each district/city and conducted in the District/City Health Office; each focus group consisted of a mixture of health professionals practising in different health centres in the related district/city.

2.4. Data collection

Participants received an information letter and invitation to attend the focus group. Before the focus group, the nature of the study was explained and informed consent was obtained. Each focus group was facilitated by one moderator and one note-taker. The design of focus group questions was aided by a literature review,[6] followed by a meeting of researchers as well as facilitators (AP, BOB, MM, YW, SI, FA) to finalise the process. The summary of focus group questions can be seen in Table 1.

The participants in two of the focus groups did not consent to have their discussions audiotaped. Hence, extensive notes were taken by a note-taker during the sessions. Both facilitators (moderator and note-taker) expanded these notes during the debriefing session after the focus group, and generated a set of debriefing notes. All focus groups were conducted in Bahasa Indonesia in 2016. Each focus group lasted about 90 min; a summary was provided to the participants at the end of the discussion as a means of member-checking, ensuring credibility of the data.[30]

2.5. Data analysis

Audio-recorded data from the focus group meetings were transcribed into Microsoft Word. Transcribed data was thematically analysed[31] by one of the researchers (YW), who discussed and confirmed extracted themes with one of the researchers for consistency (AP). The analysis firstly involved a process of familiarisation with the data by listening to the audio-recordings and reading the transcripts several times. Following this, significant comments relating to factors contributing to collaborative practice were identified and coded. The codes were then clustered and organised at a broader conceptual level (i.e. themes). The data were analysed manually by cutting and pasting between documents. Data analysis was conducted in Bahasa Indonesia and the illustrative verbatim quotes and theme labels were translated into English by YW.

3. Results

Of 72 health professionals approached, 69 agreed to participate in 8 focus group meetings (Table 2). Data saturation occured after the sixth meeting, from which no new information on factors was gained during data analysis. However, as a further two meetings had already been organised, all meetings were performed. All data were used in the analysis.

There were three themes that emerged from focus group discussions regarding factors contributing to interprofessional collaboration in Indonesian health centres. These themes pertained to: i) personnel level: interprofessional interactions; ii) organisational level: health centre's environment; and iii) system level. The identified themes were complex and intertwined and, as such, the Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) framework[32] and ecological model[33,34] were combined to explain the interconnections (Fig. 1). The IECPCP framework highlighted the micro (interactional), meso (organisational) and macro (systemic) factors that affect collaborative