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From Cooperatives to Health Providers: Implementation Challenges of Indonesia's Red-and-White Village Cooperative Clinics

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Abstract

The Red-and-White Village Cooperative (Koperasi Desa Merah Putih, KDMP) is an Indonesian government initiative that mandates village cooperatives to provide primary health services alongside economic activities. More than one year after its launch, however, KDMP clinics have not operated independently, and the reasons remain poorly understood. This study aimed to explore the implementation challenges that prevent KDMP from functioning as a health service provider. A qualitative implementation research design guided by the Consolidated Framework for Implementation Research (CFIR) was used. In-depth interviews were conducted with four purposively selected informants (two cooperative chairpersons, one secretary, and one clinic manager) from two pilot KDMPs in the Special Region of Yogyakarta between January and April 2026. Data were analysed thematically and triangulated with regulatory documents and field notes. Six themes emerged within two domains. Regulatory and policy constraints comprised incomplete technical regulations from the Ministry of Health, restrictions on collaboration beyond community health centres, and limited inter-ministerial coordination. Technical and operational challenges comprised difficulties in recruiting medical personnel, financial constraints combined with a preference for faster-return businesses, and demanding infrastructure and licensing requirements. Together, these barriers formed a “chicken-and-egg” cycle in which regulatory uncertainty deterred investment while detailed regulation awaited evidence of readiness. The stalled implementation of KDMP clinics appears to be driven more by outer-setting and process factors than by internal capacity. Transitional regulations, legally protected pilot mechanisms, and flexible collaboration schemes are needed for KDMP to become a partner within Indonesia’s primary healthcare system.

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1. INTRODUCTION

Cooperatives can act as health service providers by extending their role as member-owned and member-governed organisations to the collective provision of medical services, health insurance, and primary care facilities. The mechanisms vary. Some cooperatives operate as networks of providers, such as Unimed in Brazil, which organises physicians within a broader cooperative system, while others combine insurance and medical services (Cruz et al., 2022). Still others take the form of community cooperative clinics that emphasise primary care and member involvement in decision-making (MacKay, 2007).

The effectiveness of cooperatives as intermediaries for health services is mixed. Cooperatives can increase members' access to and use of services when governance, financing, and integration with the wider health system are strong, but their effectiveness is limited when resources, regulation, member participation, and referral pathways are weak. Determinants of success include transparent and democratic governance, managerial capacity, sustainable financing, supportive regulation, and a functional relationship with the public health system (Dacanay, 2019), whereas failures are often associated with insufficient funding, limited management skills, and market pressures that place commercial priorities above services for members (Sheikh et al., 2022). This evidence suggests that cooperatives can complement, but not replace, national health systems, and that success depends on context-appropriate design and supportive policies.

The Red-and-White Village Cooperative (Koperasi Desa Merah Putih, hereafter KDMP), launched on 21 July 2025, is one of the Indonesian government's recent initiatives to revitalise cooperatives as vehicles for economic resilience and social service provision (Presiden Republik Indonesia, 2025). The Ministry of Cooperatives describes the programme as an effort to expand village cooperative services by incorporating health services, such as primary healthcare and pharmacy services, alongside conventional income-generating activities (Arzewiniga & Zulkarnain, 2025). The programme is designed as a community-based cooperative model to strengthen local economic resilience and improve community welfare.

Conceptually, the KDMP clinic is intended to achieve four objectives: (1) improving the effectiveness, efficiency, and sustainability of health services; (2) expanding access to primary healthcare at the village level; (3) encouraging community autonomy; and (4) supporting public health programmes. To this end, KDMP develops integrated health service units that serve as the first point of contact for community members, providing primary care, screening, routine health check-ups, and health education. These clinics are designed alongside village pharmacies and telemedicine facilities to reduce geographical and financial barriers, thereby complementing existing primary healthcare facilities, particularly community health centres (puskesmas) (Feninlambir & Hasanbasri, 2024; Martin, 2023).

Although all KDMPs were intended to provide integrated clinic services, none has yet operated a clinic independently. A limited number of cooperatives have provided health services intermittently, for example once or twice a week, primarily through collaboration with the local puskesmas. Although 80,081 KDMPs were formally launched on 21 July 2025 (Direktorat Jenderal Farmasi dan Alat Kesehatan, 2025), only 1,061 had begun business operations by May 2026 (Gumilang, 2026). Existing studies predominantly address institutional arrangements and macro-level policy (Arzewiniga & Zulkarnain, 2025), and little is known about how KDMP health units navigate regulatory, financial, and operational constraints on the ground. Understanding these empirical bottlenecks is essential to prevent non-functional infrastructure and to ensure effective integration into

the health system. Therefore, this study aimed to explore the implementation challenges that have prevented KDMP from independently delivering health services more than one year after the programme's launch. Its novelty lies in providing early empirical evidence, framed by the Consolidated Framework for Implementation Research (CFIR), on a newly launched cooperative-based model of primary health care in Indonesia.

2. METHODS

This study adopted a qualitative implementation research approach to examine how the KDMP policy was implemented and to identify factors influencing its implementation. When the KDMP initiative was launched on 21 July 2025, eight cooperatives were selected as pilot units: three in the Special Region of Yogyakarta, four in East Java, and one in East Nusa Tenggara. These pilot cooperatives were intended to serve as reference points for the broader implementation of KDMP. Owing to resource constraints, this study focused on the three pilot KDMPs located in the Special Region of Yogyakarta; one cooperative declined to participate, so two KDMPs were included. At the time of the study, neither participating KDMP had provided regular health services, despite possessing the basic infrastructure required for clinic operation.

A purposive sampling approach was used to select key informants based on their direct decision-making and managerial responsibilities in the KDMP health units. In the first KDMP, the cooperative chairperson and the clinic manager were interviewed, whereas in the second KDMP, the cooperative chairperson and the secretary were interviewed, giving a total of four informants. In-depth interviews explored the factors contributing to the absence of regular health service delivery. Data were collected between January and April 2026. All interviews were conducted face-to-face in Indonesian, lasted approximately 46–60 minutes each, and were audio-recorded with the participants' consent.

The CFIR guided data collection (Damschroder et al., 2009; Means et al., 2020). The framework consists of five domains: (1) intervention characteristics, (2) outer setting, (3) inner setting, (4) characteristics of the individuals involved, and (5) the implementation process. These domains structured the interview guide and informed the interpretation of implementation-related findings, while the analysis remained open to issues emerging from the data that were not fully captured by CFIR constructs.

To protect anonymity, each informant was assigned a unique identifier (Informant A, B, C, or D), which was used throughout the transcripts, the analysis, and the reporting of quotations. Direct personal identifiers were removed from the transcripts.

The interview data were analysed using thematic analysis. Microsoft Excel was used to organise the transcripts, identify meaningful data segments, assign codes, compare coded excerpts, and group related codes into categories and overarching themes. The transcripts were read repeatedly to support familiarisation with the data. Relevant segments were coded, related codes were grouped, and candidate themes were iteratively reviewed against the coded excerpts and the full transcripts to ensure that they adequately represented the data. Through this iterative process, recurring patterns, key barriers, and facilitators of KDMP implementation were identified across the two study sites.

CFIR provided the conceptual framework for the interview guide and informed the interpretation of factors influencing implementation. Themes were not restricted to predefined CFIR constructs, allowing relevant patterns emerging from the interviews to be retained where supported by the data. The resulting themes were used to develop context-sensitive policy recommendations.

Source triangulation was employed by comparing perspectives across informants with different managerial roles. Method triangulation was performed by comparing interview narratives with official technical guidelines and regulations, as well as with field observation notes. These comparisons were used to examine the consistency of participants' accounts and to identify similarities and differences across sources. Given the small number of participants and the inclusion of only two KDMPs, the findings were interpreted contextually rather than as statistically generalisable evidence.

Ethical approval was obtained from the Research Ethics Committee of Universitas Ahmad Dahlan (approval number REC-UAD/01/01/12-2025/465). Informed consent was obtained from all participants before the interviews, including consent for audio-recording. Direct personal identifiers were removed from the transcripts, and informants were represented by letter-based identifiers (A–D). Nevertheless, because of the small number of participants and the specific organisational context, the possibility of indirect identification cannot be entirely excluded.

3. RESULTS AND DISCUSSION

Analysis of the interviews identified six themes explaining why the two KDMPs had not been able to establish health clinics independently. These themes were grouped into two domains: regulatory and policy constraints, comprising (1) lack of technical regulations from the Ministry of Health, (2) restriction on collaboration schemes, and (3) limited inter-ministerial coordination; and technical and operational challenges, comprising (4) recruitment of medical personnel, (5) financial constraints and business priorities, and (6) infrastructure and licensing requirements (Figure 1). Mapped onto CFIR, most of these barriers were located in the outer setting and the implementation process rather than in the inner setting or the characteristics of individuals.

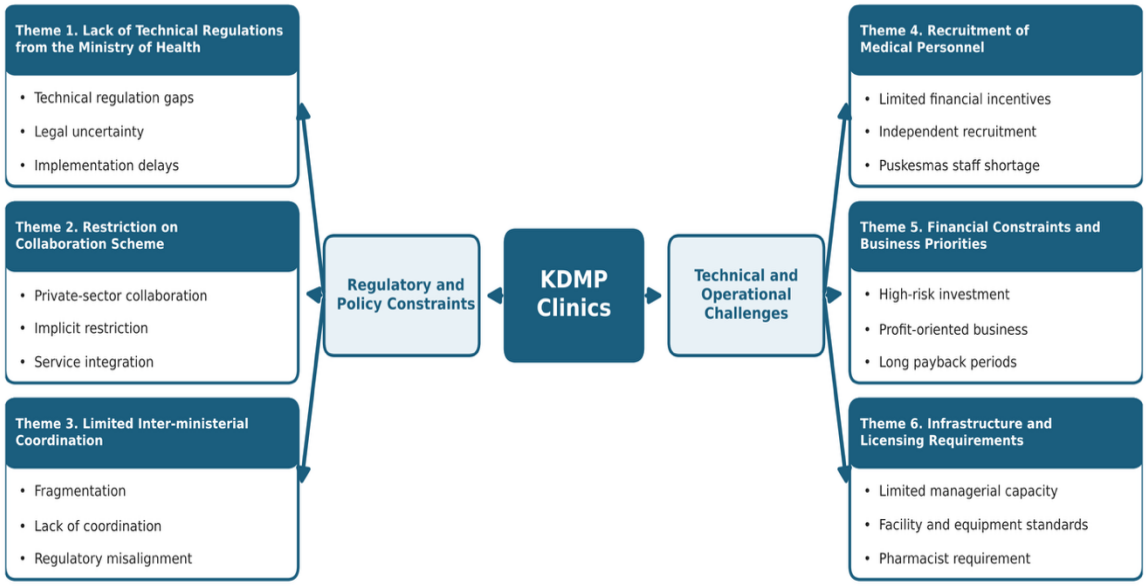


Figure 1. Thematic map of barriers to the implementation of KDMP clinics.

Regulatory and Policy Constraints

The most prominent barrier was the absence of sufficiently detailed technical regulations from the Ministry of Health. Although KDMPs are encouraged to establish clinics to strengthen village economies and basic services, informants described

uncertainty about service standards, delivery models, financing schemes, and monitoring mechanisms, which delayed decisions on investment, the recruitment of health personnel, and infrastructure development. On 18 July 2025, the Ministry of Health issued Decree No. HK.01.07/Menkes/737/2025 as technical guidance for pilot village clinics and pharmacies (Kementerian Kesehatan Republik Indonesia, 2025). Document analysis showed, however, that substantial gaps remain in licensing, financing, staffing, delegation of authority, health information systems, and integration with national health insurance, as summarised in Table 1.

Table 1. Regulatory gaps and governance challenges in establishing and managing KDMP clinics.

Governance domain	Clear technical aspects	Missing technical regulations (regulatory gaps)	Effects on establishment	Effects on management
Licensing and legal status	Village clinics are defined as village health units (UPKDK) within the *puskesmas* network and as business units of KDMP. Formal structure: head of clinic, finance and administration manager, basic care staff, and advanced care staff. Established by converting existing auxiliary health posts (*Pustu*/*Poskesdes*) through cooperation agreements (PKS).	No step-by-step rules for obtaining a clinic licence through the Online Single Submission (OSS) system. No legal guidance on transferring local government or village property to a cooperative. Unclear rules on building permits, safety certificates, and location permits.	Delays in obtaining operating permits because the digital licensing system is not ready. Risk of legal disputes over the ownership or use of government buildings.	High risk during legal audits and uncertainty about the validity of operating permits. Unclear final authority: the *puskesmas* head or the cooperative chairperson.

Governance domain	Clear technical aspects	Missing technical regulations (regulatory gaps)	Effects on establishment	Effects on management
Financial management and revenue sharing	Clear division between basic services (free/government-funded) and advanced services (paid/commercial). Operating funds may come from KDMP, regional and village budgets, and other legal sources.	No accounting rules for separating public funds from cooperative business funds. No standard formula for profit sharing or payment of medical service fees to staff. Unclear rules on the share of clinic revenue owed to the cooperative.	Difficulty preparing an initial budget plan (RAB) for clinic establishment. Uncertainty about which commercial business models are legally permitted.	Risk of misuse when public care funds and business revenue are mixed. Risk of adverse findings by state auditors (BPK/BPKP) on the use of public assets or funds.
Staffing and employment status	Minimum staff for basic care: one nurse, one midwife, and two health cadres. All health workers must hold an active registration certificate (STR) and practice licence (SIP).	No rules on pay scales or additional pay for civil servant (ASN) nurses and midwives working at the clinic. No limits on working hours for civil servants supporting cooperative business services. Unclear employment status (government assignment vs. cooperative contract).	Difficulty recruiting qualified health workers in remote villages without pay guarantees. Complex drafting of employment contracts between the cooperative and health workers.	Conflict of interest for workers dividing time between free basic care and paid services. Risk of labour disputes between health workers and cooperative leaders.

Governance domain	Clear technical aspects	Missing technical regulations (regulatory gaps)	Effects on establishment	Effects on management
Delegation of authority and medical responsibility	Nurses and midwives may provide limited medical care under authority delegated by the *puskesmas*.	No standardised clinical practice guidelines (PPK) or treatment algorithms. Unclear legal liability in the event of medical error or complications. No provision for medical malpractice insurance.	Health workers may be reluctant to work at the clinic because of legal risk. Difficulty developing local standard operating procedures without a national standard.	High risk of malpractice claims against health workers, the *puskesmas* head, and the cooperative. Unclear emergency referral pathways when complications occur.
Health information systems and electronic medical records (EMR)	Medical records must be kept and monthly/annual reports submitted to the *puskesmas* and the cooperative. An internet connection is required for digital reporting.	No technical rules for connecting local EMR to the national SATUSEHAT platform. Unclear rules on protecting patient privacy within a cooperative organisation. No officially approved software for village clinic medical records.	Additional costs for purchasing or developing EMR software. Connectivity problems in villages without stable internet access.	Risk of personal data breaches under the Personal Data Protection Law (Law No. 27/2022). Risk of duplicate or inaccurate reporting of public health achievements.
Integration with national health insurance (JKN)	The village clinic can act as a local care point within the integrated primary healthcare (ILP) network.	No technical rules for registering the clinic with BPJS Health to receive capitation funds. Unclear rules on balancing BPJS funds with cooperative income.	Uncertainty about securing a stable, long-term income stream from national health insurance. Difficulty establishing formal partnership contracts with BPJS Health.	Low-income residents may be unable to afford paid advanced services without insurance coverage. Risk of double claims by the *puskesmas* and the village clinic for the same service.

Source: *Compiled by the authors from the Decree of the Minister of Health No. HK.01.07/Menkes/737/2025 and related regulations, triangulated with interview data. ASN = civil servant; BPJS = Social Security Administering Body; BPK/BPKP = Audit Board/Finance and Development Supervisory Agency; JKN = National Health Insurance.*

These findings reflect a classic gap between policy design and policy execution. Implementation lag commonly occurs when a policy is introduced without adequate technical instruments, resources, and coordination mechanisms (Signé, 2017; Singgir et al., 2025), and is typically triggered by weak derivative regulations, unclear delineation of roles, and coordination problems across levels of government (Łobczowska et al., 2022; Mériade et al., 2023). Studies of health policy implementation in low- and middle-income countries likewise show that unclear operational regulations are associated with delayed investment, stagnant workforce recruitment, and premature termination during early implementation (Breneol et al., 2022; Le et al., 2022; Leonard et al., 2020). In this context, the KDMPs adopted a risk-averse stance and postponed implementation despite strong political support, a pattern reinforced by the absence of integration with the national health insurance scheme and the formal referral system.

The second theme concerned restrictions on collaboration. Presidential Instruction No. 9 of 2025, Minister of Health Regulation No. 19 of 2024, Decrees of the Minister of Health No. HK.01.07/Menkes/2015/2023 and No. HK.01.07/Menkes/737/2025, and the Ministry of Health handbook for village clinic operators do not explicitly prohibit partnerships with private-sector entities (Kementerian Kesehatan Republik Indonesia, 2023, 2024, 2025; Presiden Republik Indonesia, 2025). In practice, however, a KDMP clinic permit requires a cooperation agreement with the local *puskesmas*, which integrates the clinic into its network and governs its monitoring, medical record standards, and pharmaceutical procurement. Informants reported that this implicit restriction had recently been made explicit:

"It was previously permitted prior to October. However, from October onward, following a Zoom meeting with the Ministry of Health, private sector collaboration was no longer an option." (Informant C)

From a health system perspective, this policy is intended to maintain service integration and prevent excessive commercialisation at the village level. For the KDMPs, however, collaboration with the *puskesmas* was perceived as inflexible because of its own constraints on human resources, budgets, and national programme obligations, while the exclusion of private partners limited access to capital, professional management, and non-government health workers. Protective regulation that is not accompanied by appropriate incentives may therefore impede, rather than safeguard, the expansion of primary healthcare access. A recent scoping review of private health sector governance in low- and middle-income countries similarly concluded that effective governance depends on a clear policy vision, inclusive public–private dialogue, and mutually reinforcing regulatory and incentive mechanisms rather than restriction alone (Goodman et al., 2024).

The third theme was limited coordination between the Ministry of Cooperatives, which mandates the development of clinics within KDMPs, and the Ministry of Health, which holds authority over licensing, healthcare standards, pharmaceutical practice, and the integration of facilities into the health system. This misalignment created a policy grey area in which the cooperative mandate to establish clinics appeared to conflict with health sector requirements, leading the KDMPs to suspend clinic plans for fear of non-compliance:

"Yesterday, a deputy from the Ministry of Cooperatives was also confused; they checked with the health authorities, but there is still no further information regarding regulations for the clinics. The issue is that, based on a review by the Sleman District Health Office, this setup would conflict with existing regulations." (Informant A)

Policy grey areas of this kind commonly emerge in cross-sectoral initiatives in which overlapping sectoral mandates are not governed by a unified framework or a clear lead institution (Agyepong et al., 2021). Such fragmentation increases coordination costs, constrains innovation in primary care, and generates tensions among stakeholders (Spicer et al., 2020), while community-based services operating at the margins of the formal health system tend to depend on ad hoc collaboration with public facilities (Alderwick et al., 2024; Dunbar et al., 2023). The resulting ambiguity leaves field implementers uncertain of their regulatory boundaries and undermines the institutional legitimacy of KDMP as a health service provider.

Technical and Operational Challenges

Recruiting physicians and other medical personnel was the primary technical challenge. KDMP clinics are located in rural areas that are structurally less attractive to health professionals, particularly general practitioners and dentists, because of limited financial incentives, supporting facilities, and career development opportunities. Unlike the *puskesmas*, which benefits from government assignment schemes, KDMP clinics must recruit independently, and without assured revenue they cannot offer competitive remuneration:

"If we collaborate with other clinics for daily operations, we do not have the funds yet because the cost of doctors and nurses is quite high." (Informant D)

Borrowing staff from the *puskesmas* was not a viable alternative, because the *puskesmas* itself faces workforce shortages following the implementation of integrated primary healthcare services:

"It turns out that the Puskesmas is also short-staffed; as for doctors and nurses, they cannot provide services every day." (Informant C)

Financial considerations reinforced this barrier. The KDMPs prioritised business activities with faster returns, such as fertiliser distribution, savings and loans, and goods trading, and regarded clinics as high-risk investments with long payback periods that depend heavily on regulatory approval:

"And that is probably because, in principle, KDMPs are expected to be profit-oriented, right? The money should first be invested in business activities that are likely to generate returns, whereas establishing a village clinic or village pharmacy requires an investment." (Informant A)

Village funds and bank financing were available but required strong justification and long-term commitment. One KDMP applied for a loan from the Revolving Fund Management Agency (*Lembaga Pengelola Dana Bergulir*, LPDB) under the Ministry of Cooperatives, but the collateral requirement could not be met without support from the village government. Compliance with infrastructure standards, medical equipment regulations, and pharmaceutical logistics requirements, including the need for a pharmacist, added further burden for cooperatives with limited managerial capacity:

"However, because the clinic units involve health matters, and there are several requirements and regulations that we must comply with, to date we have not yet operated or opened practices for the clinic and pharmacy." (Informant D)

Taken together, these findings reveal a structural chicken-and-egg problem. KDMPs require regulatory certainty and financial viability to justify investment in clinics, whereas detailed technical regulation tends to be deferred until KDMPs are considered ready to

operate. Without formal authorisation and assured revenue, KDMPs cannot attract health workers; without health workers and operational services, they cannot demonstrate the feasibility required for integration into the national health system. Such wait-and-see dynamics are common in emerging health service initiatives at the intersection of the public sector, community organisations, and market mechanisms (Côté-Boileau et al., 2019; van den Hoed et al., 2022), and often confine programmes to the pilot phase rather than allowing them to evolve into sustained or scaled-up interventions (Lee et al., 2020; McCrabb et al., 2023). Regulatory sandboxes, which permit innovations to operate under temporary, supervised regulatory flexibility while rules are refined, have been proposed in the health sector as one way to break this deadlock (Leckenby et al., 2021).

These barriers also have implications for the *puskesmas*. KDMP clinics could act as partners that extend the reach of primary healthcare in rural areas, but without a clear division of roles and responsibilities they may equally become competitors that further fragment service delivery. Partnerships between public facilities and community-based entities are effective only when mandates, referral mechanisms, and accountability arrangements are clear (Alderwick et al., 2021; Valaitis et al., 2018). The cautious stance of the *puskesmas* towards KDMP clinics observed in this study therefore appears to be a rational institutional response to policy uncertainty rather than resistance to innovation.

Theoretically, this study supports the argument that conceptual design and political support alone are insufficient to ensure the success of health service innovation (Kosiol et al., 2024; Leedham-Green et al., 2021); effective implementation also requires clear operational regulations, cross-sectoral coordination, and aligned incentives (Roth et al., 2024). The novelty of this study lies in providing early empirical evidence on a newly launched cooperative-based model of primary healthcare in Indonesia and in showing, through CFIR, that its stagnation is driven primarily by outer-setting and process factors rather than by internal capacity. In practical terms, the findings point to the need for transitional regulations, legally protected pilot mechanisms, and more flexible collaboration arrangements; without such measures, KDMP clinics risk remaining a symbolic innovation that does not progress beyond early implementation.

This study has several limitations. Owing to resource constraints and one cooperative declining to participate, it was restricted to two of the eight national pilot KDMPs and four informants, and the perspectives of health offices, *puskesmas* staff, and community members were not directly captured. Although the core regulatory barriers are national in scope and the interview data were triangulated with regulatory documents, the findings should be interpreted as context-specific insights into early implementation rather than as representative of all KDMPs. Future studies should include a broader range of pilot regions and stakeholder groups and examine long-term operational sustainability and health system integration.

4. CONCLUSION

This study shows that the stagnation of KDMP health units in the two pilot cooperatives is driven less by internal organisational capacity than by external policy and implementation process factors. Regulatory uncertainty, the absence of detailed operational guidelines from the Ministry of Health, restrictions on collaboration, and limited inter-ministerial coordination interact with difficulties in recruiting health personnel, financing, and meeting infrastructure and licensing standards. Together, these factors produce a self-reinforcing cycle in which investment awaits regulation while regulation awaits readiness, leaving KDMP clinics at an early stage of implementation and posing a risk of further fragmenting primary healthcare delivery if coordination with the puskesmas and the formal health system remains unclear.

The Ministry of Health and the Ministry of Cooperatives are recommended to jointly issue transitional technical regulations that clarify licensing, financing, staffing, liability, and integration with national health insurance, and to establish legally protected pilot mechanisms that allow KDMP clinics to operate and learn while full regulations are developed. Flexible collaboration schemes with the puskesmas and, where appropriate, accredited private providers should be considered to address workforce and capital constraints. Future research should involve a wider range of pilot regions and stakeholders to assess the sustainability and health system integration of KDMP clinics.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICAL CONSIDERATIONS

Ethical approval was obtained from the Research Ethics Committee of Universitas Ahmad Dahlan (approval number REC-UAD/01/01/12-2025/465). Informed consent was obtained from all participants before the interviews, including consent for audio-recording. Direct personal identifiers were removed from the transcripts, and informants were represented by letter-based identifiers (A–D). Nevertheless, because of the small number of participants and the specific organisational context, the possibility of indirect identification cannot be entirely excluded.

AUTHOR CONTRIBUTIONS

Muhammad Syamsu Hidayat contributed to conceptualization, methodology, investigation, data curation, formal analysis, writing - original draft preparation, and writing - review and editing. Mariska Urhmila contributed to conceptualization, methodology, validation, supervision, and writing - review and editing.

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DECLARATION OF ARTIFICIAL INTELLIGENCE USE

During the preparation of this manuscript, the authors used Claude (Anthropic) to assist with language editing, formatting according to the journal template, and reference formatting. The authors reviewed and edited all content and take full responsibility for the content of the publication.

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