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ORIGINAL

Who should lead in healthcare: Are doctors still the best fit?: A qualitative study in Indonesia

¿Quién debe liderar en la atención sanitaria: siguen siendo los profesionales médicos la opción más adecuada? Un estudio cualitativo en Indonesia

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ABSTRACT

Introduction: the medical profession has traditionally dominated leadership in healthcare facilities. However, fewer doctors have shown interest in leadership roles in recent years.
Objective: to analyze the perspectives on the role of doctors in healthcare leadership in Indonesia.
Method: a qualitative study involved 49 participants, both civil and non-civil servant health leaders from 31 government institutions in Aceh, Indonesia. Data were collected through in-depth interviews and FGDs, and were analyzed thematically using NVivo version 12.
Results: the study identified five key themes, including physician engagement in leadership, the significance of physician leadership, distinctive traits, leadership development, and the criteria for an ideal healthcare leader.
Conclusions: this study analyzed healthcare leadership from medical and non-medical perspectives in Indonesia. It highlights the critical yet underexplored role of physician leadership, provides culturally grounded insights, and contributes to the discourse on strengthening leadership capacity in low- and middle-income health systems.

Keywords: Health Leadership Competencies; Leaders; Doctors.

RESUMEN

Introducción: la profesión médica ha dominado tradicionalmente el liderazgo en los establecimientos de salud. No obstante, en los últimos años un menor número de médicos ha mostrado interés en asumir funciones de liderazgo.
Objetivo: analizar las perspectivas sobre el papel de los médicos en el liderazgo de los servicios de salud en Indonesia.
Método: se llevó a cabo un estudio cualitativo con la participación de 49 informantes, tanto líderes sanitarios funcionarios como no funcionarios de 31 instituciones gubernamentales en Aceh, Indonesia. Los datos se recopilaron mediante entrevistas en profundidad y grupos focales de discusión (FGD), y se analizaron temáticamente utilizando NVivo versión 12.
Resultados: el estudio identificó cinco temas principales: la participación de los médicos en el liderazgo, la importancia del liderazgo médico, los rasgos distintivos, el desarrollo del liderazgo y los criterios para un

líder ideal en el ámbito de la salud.
Conclusiones: este estudio analizó el liderazgo en salud desde perspectivas médicas y no médicas en Indonesia. Destaca el papel crítico, aunque poco explorado, del liderazgo médico, ofrece aportes con base cultural y contribuye al debate sobre el fortalecimiento de la capacidad de liderazgo en los sistemas de salud de ingresos bajos y medianos.

Palabras clave: Competencias de Liderazgo en Salud; Líderes; Médicos.

INTRODUCTION

The leadership role of doctors in healthcare facilities in Indonesia has declined due to the limited number of doctors. The density of doctors increased modestly, from 6,3 per 10 000 population in 1993 to 6,9 in 2022, but the figure remains below the global standard of 17,2 per 10 000 population. In 2024, the ratio of medical specialists reached 2,13 per 10 000 population, still far from international benchmarks.[1] These values show a persistent structural shortage that reduces the availability of doctors for clinical services and restricts their presence in strategic and leadership roles within the health system.

This shortage is aggravated by high levels of burnout and an increasing number of retirements among doctors, which reduces their involvement in leadership positions.[2] At the provincial level, only 19 of 34 provinces (55,8 %) have doctors appointed as Heads of Health Departments. The problem is more evident at the district and primary care levels: in Aceh Province, only 5 of 23 districts (21,7 %) and 89 of 360 community health centers (24,7 %) have doctors as leaders.[3] These figures illustrate a consistent underrepresentation of medical professionals in leadership positions across different tiers of the healthcare system.

Empirical research on physician involvement in healthcare leadership emerged in the 2010s. An analysis of nonprofit hospitals in California from 2004 to 2008 found that hospitals without physicians on their boards had 3–5 percentage points lower quality of care on several indicators. This study highlighted the importance of physician participation in governance for maintaining clinical quality.[4] Building on this perspective, an analysis of supervisory board characteristics in German hospitals found that the inclusion of physicians on boards was positively associated with one dimension of financial performance, whereas the presence of politicians or nurses showed negative associations.[5] These studies demonstrate the evolution from an initial focus on the quality of care dimension to a broader recognition of how physician involvement in leadership also influences financial sustainability and organizational governance.

However, opinions remain divided. Critics argue that a strong clinical identity, conservative individualism, and limited management training hinder doctors from exercising leadership. Supporters emphasize that doctors play a crucial role in enhancing patient safety, informed decision-making, and overall system performance.[6] In Indonesia, where the shortage of doctors and their limited representation in leadership roles pose challenges for the health system, understanding the perspectives on medical leadership becomes crucial. This study addressed an underexplored aspect of health management by examining how physicians' involvement in leadership was perceived within the Indonesian context.

METHOD

Type of study

This study employed a qualitative design with a phenomenological approach to gain an in-depth understanding of the topic and was conducted by physicians with extensive experience in qualitative research and healthcare leadership.

Universe and sample

The study involved 49 Indonesian health leaders (31 doctors and 18 non-doctors) from 31 government institutions across five districts in Aceh Province. These institutions included Regional Hospitals, Primary Health Centers (Puskesmas), District/City/Provincial Health Offices, and Regional Health Technical Units. Participants were selected through purposive sampling to ensure representation from different levels of the health system and leadership structures. Eligible participants were doctors with at least one year of service in structural or non-structural positions, as well as top regional health leaders. Guest specialists, internship doctors, and acting officials were excluded. Invitations were extended through official institutional channels, and participation was voluntary, with recruitment continuing until data saturation was reached.

Unit of analysis

The unit of analysis was health leaders, including both civil and non-civil servant officials from government institutions in Aceh, Indonesia. The focus of the analysis was on participants' perceptions regarding physician

involvement in leadership, barriers and enablers of medical leadership, leadership development, and expectations of an ideal healthcare leader.

Data collection and processing

Data were collected face-to-face between January and September 2022 from 49 participants representing 31 government health offices. Twenty participants joined two focus group discussions (FGDs), while 29 participated in in-depth interviews. The first author (AK) conducted all sessions in Bahasa Indonesia, which lasted 45–60 minutes and involved only participants and the research team. Each session was audio recorded and supplemented with field notes. Audio recordings underwent verbatim transcription. Thematic analysis followed Braun and Clarke's six-stage framework[7] using NVivo version 12. The first author (AK) generated initial codes, grouped them into categories, and refined them into themes. A second coder (KH) reviewed the coding for inter-coder reliability, and the entire research team resolved discrepancies through consensus. Data collection and analysis advanced in parallel until reaching saturation.

Ethical standards

The study adhered to ethical standards and reported its findings in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.[8] Ethical approval was granted by the Health Research Ethics Committee of Dr. Zainoel Abidin General Hospital, Aceh, Indonesia (No. 008/ETIK-RSUDZA/2022).

RESULTS

The participants comprised Civil and Non-Civil Servants, including doctors employed in government-owned healthcare institutions at the provincial and district/city levels in Aceh.

Table 1. The characteristics of the participants

Characteristics	FGD		In-depth Interview	
	n=20	%	n=29	%
Gender				
Male	9	45	15	51,7
Female	11	55	14	48,3
Age (years old)				
20-35	5	25	1	3,4
36-50	9	45	17	58,6
51-65	6	30	11	38
Employee Status				
Civil Servant	16	100	29	100
Non-Civil Servant	4	0	0	0
Length of Service (years)				
1-5	8	40	0	0
>5	12	60	29	100
Position				
Government and Administrative Leaders	0	0	6	20,7
Health Sector Leaders	20	100	23	79,3
Institutional Levels				
Province	0	0	7	24,1
Regency/City	20	100	22	75,9
Profession				
Doctor	13	65	18	62
Non-doctor	7	35	11	38

This study identified five themes within the theme of healthcare leadership in Aceh, Indonesia: physician engagement in leadership, the significance of physician leadership, the distinctive traits, the development of leadership, and the criteria for an ideal healthcare leader.

Physician engagement in leadership

The findings showed that doctors were present in leadership positions at both local and central levels in

Aceh and Indonesia, but the extent of their representation varied across institutions.

"Approximately 40-50 % of the heads of Port Health Offices across Indonesia were doctors" (Interview – P3).

However, doctors' involvement in leadership positions in Puskesmas was minimal, as other professions predominantly occupied leadership roles.

"Only a few doctors held positions as heads of Puskesmas or as directors, deputy directors, heads of health offices (Kadis), or deputy heads of health offices (Sekdis) in the Bireuen District government" (Interview – P21).

Furthermore, most heads of Puskesmas in Aceh did not come from a medical or public health background; some even lacked healthcare-related qualifications.

"Most heads of Puskesmas in Aceh were not doctors or public health graduates, some had no background in healthcare whatsoever" (Interview – P4).

"In the 13 Puskesmas across the districts of Aceh Barat, none were led by doctors. Currently, it is difficult to compare the leadership performance of doctors versus non-doctors; such comparisons are more feasible in hospitals" (Interview – P19).

Many doctors felt unprepared to take on the role of Puskesmas head, citing administrative burdens, extended working hours, and inadequate compensation as key reasons.

"The income remained the same while the workload increased significantly; I often worked until 1–2 a.m., especially at the fiscal year's end to finalize budgets, frequently shuttling between the health office and the Puskesmas. Many felt unprepared to handle this, as the additional financial benefit was minimal, only about IDR 200 000 to 1 million" (Interview – P10).

Another reason for the limited involvement of doctors in leadership roles was their lack of time, particularly among specialists. Their commitments to continuous education and medical career advancement reduced their interest in managerial positions.

"First, they might not have understood the importance of leadership. Second, in pursuing medical knowledge, especially specialization, we were deeply involved in lifelong education and needed to stay updated with journals" (Interview – P16).

Additionally, doctors often felt unprepared for leadership roles due to the focus of medical education on patient care. Transitioning to leadership required them to broaden their perspectives, build relationships with external stakeholders, and acquire managerial skills not emphasized during medical training.

"When the regent's decree required Puskesmas heads to be doctors, many of us were shocked. Accustomed to focusing on patient care, we suddenly had to manage staff, engage with local officials, and develop new skills, yet leadership training was never part of medical school, making the transition to a managerial role particularly challenging" (FGD – P30).

Personal connections often influenced leadership appointments in healthcare institutions, and doctors rarely took the initiative to build such relationships.

"Leadership opportunities were limited because directors had specific reasons for appointing certain individuals as office heads. Many doctors were less proactive in establishing these connections" (Interview – P3).

Participants noted that many doctors were reluctant to engage in managerial tasks outside medical practice despite the importance of gaining favorable evaluations from superiors. Structural barriers and a lack of interest among doctors were highlighted as obstacles to assuming leadership roles.

"There might have been no clear pathway. A leader appointing someone as head of a work unit involves numerous considerations. The obstacle might have been a lack of interest among doctors. In my opinion, their desire to become leaders was low, which made them less competitive for these roles" (Interview – P3).

There had been a shift in doctors' interest in leadership roles. Previously, doctors were more inclined toward leadership positions but later focused more on specialization. While structural career paths for doctors still existed, some specialists hesitated to pursue these roles.

"In the past, yes. But later, no. They (doctors) were more focused on becoming specialists. If they could not become specialists, they were content being general practitioners. They did not want to be Puskesmas heads because the financial benefits were limited, while specialization offered much income" (Interview – P6).

"From my observation, their career paths were indeed in structural roles, but they refused to take them" (Interview – P9).

The Significance of Doctor Leadership

Participants welcomed the policy of appointing doctors as heads of Puskesmas. They viewed it as a breakthrough because doctors combined technical competence in healthcare services with the ability to coordinate broader functions such as health education, underscoring their strategic role in leading and managing services in an effective and comprehensive manner.

"… entrusting doctors to lead primary health centers, I believed this was a commendable breakthrough. From my experience, when we interacted in areas related to our functional roles, we excelled, and when it came to non-functional areas like health education, we also performed better" (FGD – P30).

Although the involvement of doctors in leadership roles in Aceh was still limited, it was emphasized that doctors should have taken on more leadership positions. It stemmed from the view that leadership, while democratic in principle, was still heavily influenced by political factors and governmental structures.

"Doctors should have taken leadership roles because leadership nowadays was not purely democratic. Even though we strove for democracy, political influence there was still strong" (Interview – P16).

Doctors played a crucial role in clinical management because the role required deep medical expertise that non-medical personnel could not fully master. Administrative management also demanded specialized skills that doctors did not necessarily possess. Considering this complexity, leaders appointed doctors as hospital directors because they could master both areas when supported by a competent administrative team.

"Given the complexity of hospital services, we had to manage both clinical and general administrative functions, which are entirely different. Clinical management required a doctor's leadership, as non-medical staff could not fully grasp it, while doctors might not always excel in administration. Therefore, doctors were considered better suited to serve as hospital directors" (Interview – P31).

The distinctive traits

The health centers' chairperson position was considered well-suited for doctors due to their comprehensive educational background, allowing them to be more agile in addressing various health issues. It indicated that a medical background provided an advantage in leadership effectiveness in the health sector.

"There was a difference when we became head of a health center as a doctor; it differed from other professions that only studied their field. We (doctors) studied all fields, so whatever the problem, God willing, we could handle it. If someone from another profession becomes a leader, they must first study it" (FGD – P30).

Doctors were considered to have the flexibility and the ability to perform various tasks beyond the technical and medical aspects. It indicated that doctors were not only limited to clinical expertise but also had the potential to contribute to various fields, including management and decision-making in the health sector.

"... It could be said that doctors could do anything, find any kind of work, besides medical technical tasks..." (Interview – P3).

Doctors were seen as competent health leaders due to their extensive experience, ranging from community health centers to higher levels, and their comprehensive understanding of the healthcare system. Their dual roles as managers and service providers added value by integrating managerial perspectives with operational needs.

"... If we look at doctors, they have been leaders even before working here. Because most doctors working in the health office had previously worked at the community health center level, they already knew from the start, from the smallest and lowest unit in healthcare services to the provincial level" (Interview – P6).

However, doctors' leadership was often considered to focus more on the technical and medical aspects rather than managerial ones, which could impact their managerial performance.

"Because we (colleagues), lack the approach and the focus to manage, since we were trained to diagnose and prognosticate, so management is indeed lacking, and this might also be part of the evaluation" (Interview – P3).

"Because if we look at the need for doctors in West Aceh, it is more about service. If they are used more for structural roles, there will be obstacles in service delivery" (Interview – P15).

The development of leadership

It was highly recommended that managerial competence development for doctors integrated technical expertise with established managerial indicators, especially for positions such as the Head of the Health Office.

"From a technical perspective, I (as a doctor) was clear on healthcare matters, but the development of leadership and managerial competencies needed to blend … with technical skills. Why …? Because those with

technical capabilities could provide evidence of their managerial competence. They (doctors) should have been assessed based on technical healthcare expertise while evaluating their managerial abilities" (Interview – P2).

Doctors were expected to enhance their managerial competencies to remain competitive for senior leadership positions, mainly when technical competence alone was insufficient.

"If doctors lacked managerial skills, those in managerial posts might come from non-healthcare backgrounds, as strong management alone could ensure success. Ideally, technical expertise should complement managerial capabilities for greater alignment and effectiveness, so medical professionals need to strengthen their managerial competencies" (Interview - P1).

Organizational internal development was crucial and could have involved direct experiences handling public health programs, such as addressing stunting and immunization. This approach fostered a sense of responsibility and managerial skills, ensuring that selected leaders had in-depth knowledge and the capacity to tackle public health challenges.

"Our leadership had proposed regulatory changes to address key programs such as stunting and national immunization, actively taking on management tasks and engaging directly with patients; these hands-on experiences and the resulting sense of responsibility were crucial" (Interview - P29).

The criteria for ideal healthcare leader

On one hand, doctors were considered to have the necessary competencies to lead, mainly due to the increasing number of doctors. On the other hand, challenges arose when doctors had to divide their attention between managerial duties and medical services. Their success in these positions highly depended on their abilities, both in leadership and effectively managing functions.

"There may have been differing views, but having a doctor as head of a community health center is now acceptable given the larger pool of doctors. Ultimately, it depends on individual capacity; some excel in leadership but not management, while others provide good services but lack leadership skills" (Interview - P27).

While doctors primarily provide healthcare services, managerial skills are a valuable asset. When doctors possess such expertise, assigning them leadership roles aligns with the principle of entrusting responsibilities to experts and supports the strategic needs of healthcare.

"The focus is on fulfilling functional or service roles in public health, yet a doctor may also have management competencies and talents. When public health needs align with a doctor's abilities, Islam itself encourages entrusting matters to those with expertise rather than solely relying on educational background. So, if a doctor has these competencies, there is nothing wrong with it" (Interview – P5).

Participants emphasized the importance of a balanced leadership role between different healthcare professionals to facilitate policy-making.

"We wanted balance; balance makes it easier when there are policies... so we are the place for those policies" (Interview – P8).

Doctors in community health centers and health offices played a more prominent role as health consultants in various programs. They were involved in providing input and guidance but not in active structural leadership roles.

"They were involved in all the programs, like many consultations with them, so they were the health and programs consultants" (Interview – P15).

DISCUSSION

The limited presence of doctors in leadership roles in Aceh, Indonesia, reflected personal, structural, and managerial barriers that restrict their opportunities to assume decision-making positions. Physicians acknowledged the importance of leadership in improving health service delivery. Participation in managerial roles remains limited due to barriers such as politicized appointments, bureaucracy, heavy workloads, and limited managerial training, consistent with studies reporting similar challenges in other settings, including Europe and China.[9,10,11,12,13,14,15,16,17]

The absence of formal training and mentorship in Aceh created a more pronounced readiness gap. It highlighted a stage of leadership evolution that is still at the level of individual adaptation rather than systemic development. This study clarified that while physician leadership was internationally recognized as a driver of health system quality, its development in Aceh was constrained by systemic and personal challenges. Whereas earlier studies emphasized administrative burdens or resistant organizational cultures,[13,14,15] this study's findings demonstrated how these challenges intersect with gaps in education and policy. These insights provide

a foundation for designing context-sensitive leadership interventions that align technical expertise with managerial competence, enabling physicians to assume strategic roles in strengthening healthcare governance.

Leadership readiness increased with tenure and exposure to administrative tasks, suggesting a gradual, stage-dependent evolution of capacity that may be strengthened through targeted training and mentorship. Comparisons across different professional stages in this study also revealed variation in readiness, with doctors who have longer tenure or prior administrative exposure demonstrating greater confidence in budgeting and human resource tasks, echoing findings that leadership capacity grows with responsibility and experience.[11,18,19] In contrast, early-career physicians remained hesitant, consistent with the literature emphasizing the need for early integration of leadership education into medical curricula.[20,21,22] It suggests that leadership development is not linear but evolves across stages, from clinical focus to gradual administrative engagement, to consolidated leadership roles.

The evolution from clinical to managerial engagement sets the foundation for recognizing the benefits of physician leadership. Doctors' leadership is crucial because evidence shows that their involvement improves service quality and reduces morbidity,[4,23] with hospitals led by doctors delivering better care[4] and strengthening organizational performance through integrated medical and managerial logic.[24] It underscores that cultivating physician leadership is a strategic priority for ensuring both improved patient outcomes and stronger institutional performance.

CONCLUSION

This study analyzed perspectives on the role of doctors in healthcare leadership in Indonesia and highlighted their underexplored yet critical contribution to health system governance. Physicians' clinical expertise positions them to strengthen decision-making and organizational performance when supported by appropriate structures and capacity-building initiatives. Strengthening physician leadership, therefore, represents an important strategy for enhancing health management and advancing the resilience of healthcare systems in low- and middle-income countries.

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