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| RESEARCH ARTICLE

Collaborative Governance in Improving Health Services in Bangka Tengah Regency

Me Hoa[1]✉, Nurliah Nurdin [2], Mansyur Achmad [3] and Rosmery Elsye[4]
[1]*Doctoral Candidate, Institut Pemerintahan Dalam Negeri, Jakarta, Indonesia*
[2]*Professor, Institut Pemerintahan Dalam Negeri, Jakarta, Indonesia*
[3]*Professor, Institut Pemerintahan Dalam Negeri, Jakarta, Indonesia*
[4]*Associate Professor, Institut Pemerintahan Dalam Negeri, Jakarta, Indonesia*
Corresponding Author: Me Hoa, **E-mail**: mehoacentralbangka@hotmail.com

| ABSTRACT
This study examines collaborative governance to improve access and quality of health services in Central Bangka Regency, Bangka Belitung Islands. Despite constitutional guarantees and the JKN program, delivery remains uneven: several subdistricts lack hospitals, only one inpatient-capable puskesmas operates, health-worker ratios lag standards (e.g., 0.34 GPs per 1,000 vs 1.0), BPJS outpatient use fell from 40.99% (2023) to 26.45% (2024), and non-government participation is limited. These gaps and a research deficit on inter-actor dynamics motivate the study. The study applies Ansell and Gash's (2008) Collaborative Governance framework (Starting Conditions, Collaborative Process, Facilitative Leadership, Institutional Design, and Outcomes) and refines it by elevating "shared mutual understanding" as an antecedent shaping direction. A qualitative design was used with purposive sampling of competent and authorized stakeholders. Data were collected through semi-structured interviews, non-participant observation, and document review. Analysis followed Miles and Huberman's stages (collection, reduction, and verification). Credibility was strengthened through triangulation of sources and methods, cross-checks with partner agencies, and the researcher's participation. Findings show a broad partnership ecosystem (local agencies, NGOs/CSOs, private sector, academia, communities/patients, and BPJS), yet collaboration remains suboptimal. Starting conditions feature resource asymmetries and a reactive stance; the process is constrained by reluctance to share data, low trust, and bilateral rather than multi-directional communication. Facilitative leadership and institutional design are underspecified, yielding output-oriented performance. Recommendations include secure IT-based data-sharing, multi-directional communication, periodic monitoring, evaluation, learning cycles, stronger leadership across the collaboration via liaison officers, and a standing coordination forum. The model adds "shared mutual understanding" and direct effects from leadership and institutional design to starting conditions and outcomes.

| KEYWORDS
Collaborative Governance, Health Service, Bangka Tengah

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1. Background

Health is a fundamental pillar of sustainable human development. Quality, affordable, and equitable health services are both a basic right of every individual and a key indicator of a nation's development success. In advanced countries such as Singapore, Japan, South Korea, and those in Western Europe, health systems have been carefully built with strong financing, an even distribution of medical personnel, and integrated use of cutting edge technology. By contrast, developing countries, including Indonesia continue to grapple with limited funding, uneven distribution of facilities, and geographic barriers that constrain access to adequate care in remote areas. These conditions demand policy innovations that go beyond sectoral approaches, prioritizing

cross sector collaboration as a core strategy. The collaborative governance model has gained global attention precisely because it brings government, the private sector, academia, civil society organizations (CSOs/NGOs), and communities into a formal, consensus-based public decision-making process to achieve shared goals that no single actor can realize alone (Emerson, Nabatchi, & Balogh, 2012; Ibrahim, S. N. K., Leus, J. D. C. N., & Dewi, M. P., 2024). Numerous international studies demonstrate the model's success for example, in the Netherlands, collaboration among stakeholders in low-income communities improved service quality, health-worker satisfaction, and cost control (Grootjans, S.J.M., Stijnen, M.M.N., Kroese, M.E.A.L. et al., 2022), while in the United States hospitals have served as anchors for community health initiatives grounded in collaboration (Totten, Mary., 2016). Research in Pakistan likewise affirms that effective public leadership can spur collaborative administration, which in turn enhances the quality of public health services (Zia ud din, M., Yuan yuan, X., Ullah Khan, N. et al., 2024).

Indonesia guarantees citizens' right to health services under Article 28H(1) of the 1945 Constitution and reinforces it through the National Health Insurance (JKN) program managed by BPJS Kesehatan. Yet implementation still faces serious challenges, including uneven facility distribution, shortages of medical personnel, and inefficient service mechanisms. These issues are clearly visible in Bangka Tengah Regency, Bangka Belitung Islands Province. As an autonomous region formed through administrative division, Bangka Tengah has full authority over health service management, but data show persistent disparities across subdistricts. Several areas—such as Lubuk Besar, Sungai Selan, and Simpang Katis have no hospital, and an inpatient capable community health center (*puskesmas)* exists only in Koba District. Ratios of health workers fall well below national standards: general practitioners at 0.34 per 1,000 population (standard 1), midwives at 0.87 (standard 2), and nurses at 0.97 (standard 2.4). These shortages directly affect service quality, lengthen waiting times, and limit service coverage. Moreover, outpatient utilization by BPJS members in Bangka Tengah declined sharply from 40.99% in 2023 to 26.45% in 2024, with the steepest drops among men and lower-income residents. Beyond capacity constraints, another challenge is the limited involvement of non-government actors in supporting health programs even though Indonesian studies show that the penta-helix collaboration model (government, academia, business, civil society, and media) is effective in tackling issues such as stunting in East Flores (Ibrahim, S. N. K., Leus, J. D. C. N., & Dewi, M. P., 2024) and disease control in Cibeber, Cimahi Selatan albeit with outreach that remains limited (Febriyanti, D., Kurnia, D., & Sukmapryandhika, D., 2025). In Bangka Tengah, there is no routine collaborative forum encompassing all stakeholders; integration between Jamkesda (regional health insurance) and JKN remains suboptimal; and many health programs still operate in silos. This indicates that collaborative governance has not yet been fully implemented to address the region's health challenges.

The urgency of this study lies in the pressing need to improve access to and quality of health services in Bangka Tengah through effective collaborative governance. Gaps in facilities and human resources, declining utilization of health insurance, and the untapped potential of cross-sector collaboration together underscore the importance of this research. From a scientific standpoint, there is a research gap: existing studies are largely descriptive and focus on infrastructure or financing, without deeply analyzing inter-actor interactions within a collaborative governance framework or their links to service outcomes such as patient satisfaction, program sustainability, and the resilience of local health systems.

This study is expected to yield both conceptual and practical benefits. Conceptually, it will enrich the literature on the application of collaborative governance in the health sector, particularly at the level of local government in Indonesia. Practically, its recommendations can help the Bangka Tengah Regency Government and other stakeholders refine collaboration mechanisms, improve integration between health insurance programs, and expand participation by communities and non-government actors. The resulting model can also be replicated in other regions with similar characteristics. Thus, the research is not only academically relevant but also strategically significant for building a health system in Bangka Tengah that is more responsive, equitable, and sustainable.

2. Literature Review

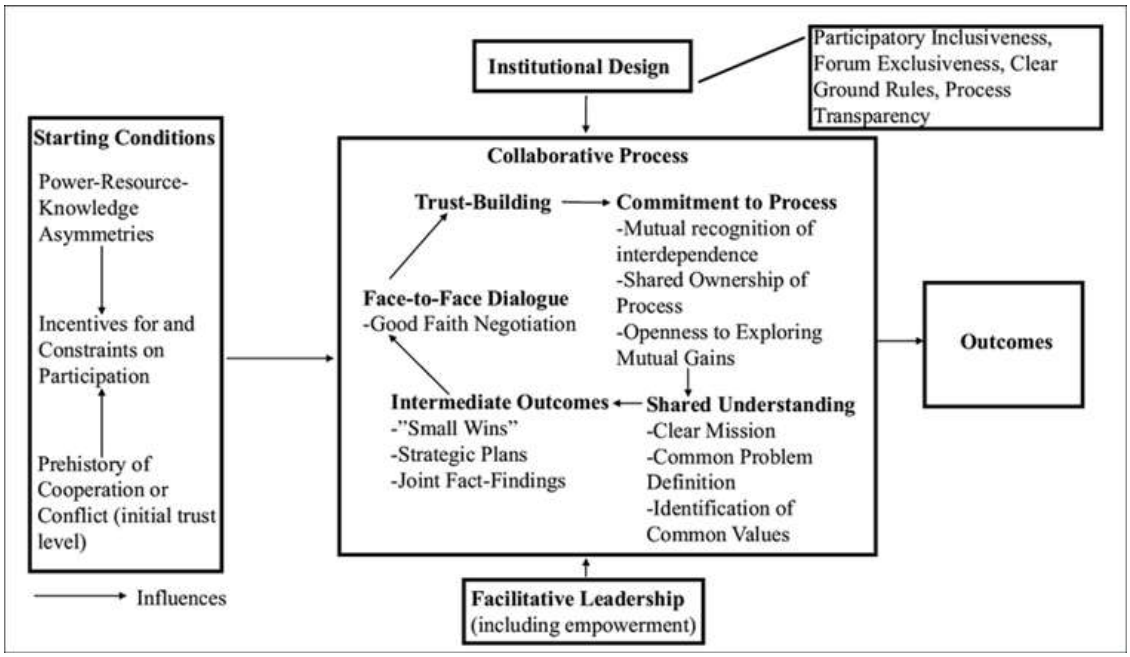
2.1 Model Collaborative Governance Ansell dan Gash

Collaborative governance is the orchestration of multiple public organizations by mobilizing non-state institutional stakeholders within mechanisms that produce official decisions and agreements, enable deep deliberation, and co-create and implement joint programs or co-manage shared resources (Ansell & Gash, 2008).

According to this definition, six conditions apply:

1. Public agencies establish a communication forum, a channel to facilitate the exchange of information, ideas, and dialogue.
2. Participation is broad and substantive, including non-state actors.
3. Participants are directly involved in decision-making with full participation.
4. Joint activities and communications follow formal procedures.
5. The aim of meetings is to reach decisions through consensus (musyawarah).
6. The focus of collaboration is public regulation/governance matters of general public concern.

Figure 1: The collaborative governance model map developed by Ansell and Gash:



Source: Ansell and Gash (2008)

The Ansell & Gash (2008) Collaborative Governance Model places the collaborative process at the core, supported by three other variables: starting conditions, institutional design, and facilitative leadership. Starting conditions encompass resource asymmetries, the legacy of past relationships/conflicts, and the level of trust when these gaps are wide, early collaboration tends to stall. Institutional design provides transparent and inclusive rules of the game (who is involved, how they are heard, and how decisions are made) so that participation carries legitimacy and endurance. Facilitative leadership serves as connector and mediator initiating face-to-face dialogue, managing conflict, sustaining momentum, and aligning timelines, tasks, and shared goals. On this foundation, the collaborative process unfolds iteratively and continuously through dialogue, trust-building, joint learning, and commitment-setting, while the three other variables act as context and levers that determine process quality and the likelihood of achieving outcomes. This framework was chosen because it is structured, stage-oriented, and emphasizes leadership that enables collaboration, helping analyze and design collaborative practices relevant to improving health services (for example, in Bangka Tengah).

3. Methodology

This study employs a qualitative approach to examine phenomena in their natural settings. The researcher serves as the primary instrument, relying on multi-method data collection and qualitative, inductive data analysis. A qualitative method was chosen because it can yield in-depth accounts of the meaning of events rather than merely surface descriptions. The study uses triangulation techniques to verify the validity of the data.

The research background focuses on the governance of local-government collaboration and its influence on health service delivery in Bangka Tengah Regency, using the Collaborative Governance framework of Ansell and Gash (2008). This framework comprises five main dimensions: starting conditions, the collaborative process, facilitative leadership, institutional design, and outcomes.

Table 1: List of Informan

No.	Informant	Role/Position
1	Regent of Bangka Tengah	Informant I
2	Vice Regent of Bangka Tengah	Informant II
3	Chairperson of the Regional House of Representatives (*DPRD*) of Bangka Tengah	Informant III
4	Head of District Attorney Office of Bangka Tengah	Informant IV

No.	Informant	Role/Position
5	Regional Secretary (*Sekda*) of Bangka Tengah	Informant V
6	Head of Regional Development Planning, Research, and Development Agency of Bangka Tengah	Informant VI
7	Inspector of Bangka Tengah Regency Government	Informant VII
8	Head of Financial Management and Regional Asset Agency of Bangka Tengah	Informant VIII
9	Head of Pratama Regional Hospital of Bangka Tengah	Informant IX
10	Head of Health Office of Bangka Tengah	Informant X
11	Medical Personnel of Bangka Tengah Regional General Hospital (RSUD)	Informant XI
12	Medical Personnel of Public Health Center (Puskesmas)	Informant XII
13	Head of Bangka Tengah Regional General Hospital (RSUD)	Informant XIII
14	Private Sector Representative	Informant XIV
15	Indonesian Midwives Association (IBI) of Bangka Tengah	Informant XV
16	Indonesian Doctors Association (IDI) of Bangka Tengah	Informant XVI
17	Head of Division at Bangka Tengah Health Office	Informant XVII
18	Head of BPJS Office of Bangka Tengah	Informant XVIII
19	Residents of Bangka Tengah Regency	Informant XIX

Source: Proceed by researcher, 2025

This study employs purposive sampling to select respondents with competence, experience, and authority in the field of health services. Informants include local government officials, leaders of the legislative body, law-enforcement representatives, heads of relevant government departments, medical personnel from the regional public hospital and community health centers (*puskesmas*), the private sector, and professional organizations.

Data were collected through semi-structured interviews, non-participant observation, and document review. Interviews were used to elicit in-depth information aligned with the study themes, covering the initial state of collaboration, cooperation mechanisms, leadership, institutional design, and impacts on health services. Observation involved watching behaviors, work processes, and interactions among actors within health services without the researcher's direct involvement, including activities at the regional public hospital, *puskesmas*, the health office, and relevant partners. The document study drew on secondary data such as performance reports, regulations, health-resource data, and standard operating procedures (SOPs) to complement the interview and observation findings.

Data analysis followed the Miles and Huberman model, comprising data collection, data reduction to focus on relevant information, structured narrative data display, and the drawing and verification of conclusions. Data validity was ensured through multi-method verification that integrated triangulation of sources, time, and methods, along with cross-checking with partner agencies and the researcher's active participation.

The study was conducted in Koba District, Bangka Tengah Regency, Bangka Belitung Islands Province, selected for its relevance to the research focus and the availability of data. Fieldwork took place from January to July 2025.

4. Result and Discussion

4.1 Collaborative Governance for Improving Healthcare Services in Bangka Tengah Regency

4.1.1 Starting Conditions

The starting conditions for collaboration in health service delivery in Bangka Tengah are underpinned by recommendations from the district and provincial Health Offices and by the legal basis of Bangka Belitung Islands Governor Regulation No. 18 of 2016, which affirms the positions, duties, and work procedures of the agencies as a foundation for implementing collaborative governance. On this footing, diverse actors. the Health Office as the holder of authority and data, the One-Stop Investment and Integrated Services Office (DPMPTSP) as the custodian of licensing and investment channels, health facilities as direct service providers, NGOs/CSOs as drivers of promotive and preventive efforts and community empowerment, the private sector as a source

of financing/technology, and academia as providers of evidence and methodology will bring resources and knowledge that complement one another. Differences in capacity can in fact become a source of innovation when managed as a shared learning process rather than allowed to foster dominance.

In practice, collaboration is marked by asymmetries of power, resources, and knowledge that may allow stronger actors by virtue of budgets, authority, or access to information to dominate the process. Both the literature and informants' voices emphasize the need for equal access to information, inclusive communication forums, and neutral facilitators so all parties are heard and decisions reflect shared goals. Incentives for participation arise from interdependence in problem-solving, collective benefits, and policy legitimacy; constraints stem from coordination costs, divergent priorities, fragile trust, limitations in human/financial/technical capacity, and shifts in political budget priorities. On the user side, communities prioritize easy access (distance, time, simple administration), service quality (competent health workers, adequate facilities, patient safety, communication), and affordability (National Health Insurance/JKN, transparency).

Asset gaps such as facilities, equipment, the distribution and competence of health workers, and data/information constitute the main challenge in the starting conditions. Accordingly, the Health Office plays a central role in comprehensively mapping assets, setting minimum standards for services and assets at each facility, allocating equitably to deficit areas, building a centralized asset management system (inventory, maintenance, redistribution), strengthening workforce capacity across institutions, and mobilizing partnerships (CSR/donors). The substantive agenda remains oriented toward expanding access and improving quality: a promotive–preventive focus (information–education–communication/IEC, the Healthy Living Community Movement/GERMAS, nutrition), control of communicable and non-communicable diseases, reductions in maternal and infant mortality (AKI/AKB), comprehensive, community-oriented services, early warning and rapid response, and consolidation of the 96.83% UHC achievement (2024) toward truly universal coverage.

The history of cooperation as well as early friction needs to be managed through regular, documented formal/informal dialogues moderated by a neutral party, with data transparency as the basis for win–win negotiations. To keep the collaboration on course, more specific local regulations are needed on roles, authority, financing, and cross-actor accountability, along with a roadmap and clear decision-making mechanisms. Success is measured not only by agreements on paper but by tangible changes on the ground: closer and faster access, improved patient experience, affordability, effective and equitable partnerships, constructive conflict resolution, and improvements in priority health indicators. By balancing power, managing assets fairly, and maintaining an inclusive and transparent process, the already strong starting conditions can be transformed into sustainable, high-impact collaboration.

4.1.2 Collaborative Process

To operationalize this "prologue" phase, the Health Office can begin with a structured stakeholder mapping and a shared problem statement that quantifies workforce shortages, maldistribution, and specialist gaps. This is followed by co-defining SMART goals, a time-phased roadmap, and clear role delineation (who does what, by when, with which resources). Early agreements should also cover data governance (standards, sharing protocols, privacy safeguards), ethical considerations (conflict-of-interest disclosures), and resource commitments (funding, facilities, personnel). By front-loading clarity and transparency, the collaboration reduces coordination frictions later, aligns incentives across institutions, and creates a credible basis for joint investment and accountability.

Institutionalizing high-quality face-to-face dialogue requires more than ad hoc meetings; it calls for a legally recognized forum with a simple but robust Terms of Reference. Representation rules should ensure the presence of government, providers, professional bodies, NGOs/CSOs, the private sector, academia, and community voices, supported by a neutral facilitator. Meetings can blend formats periodic plenaries for strategy, focused working groups for technical issues, and rapid stand-ups for emerging concerns while embedding two-way communication loops (advance agenda-setting, real-time feedback, after-action reviews). Publishing decisions, rationales, and follow-up tasks ideally on a shared dashboard deepens trust, enables adaptive management, and keeps all parties synchronized as conditions evolve.

As collaboration matures, tangible service improvements can flow from a few practical instruments: a centralized asset registry to reveal idle capacity and enable cross-facility equipment sharing; standardized referral and counter-referral SOPs to smooth patient flows; joint training and continuing education to equalize competencies; and pooled scheduling or rotation schemes to mitigate workforce bottlenecks. Continuous improvement is sustained through a compact set of shared indicators access (travel and wait times, referral turnaround), quality and patient experience (safety, communication, perceived responsiveness), affordability (JKN utilization and out-of-pocket burden), and system learning (speed of problem resolution, uptake of agreed protocols). With flexible, transparent decision-making and routine feedback cycles, these mechanisms convert collaboration from a set of meetings into a living system that reliably delivers better care for Bangka Tengah.

4.1.3 Commitment to Process

Commitment to process within the *collaborative governance* dimension is understood as the willingness and active engagement of stakeholders to adhere to jointly agreed stages, rules, and principles transparency, open communication, mutual respect, and a focus on shared goals. The literature, such as *Collaborating: Finding Common Ground for Multiparty Problems*, underscores interdependence of aims and resources as a driver of collaboration; without a common purpose, collaboration is prone to fall

short. In the same vein, the Head of the Health Office stresses that collaborative targets are often too large and complex for a single party to handle, so success depends on collective effort and contributions from all actors.

Effective communication is the backbone for aligning the many "moving parts" and diverse viewpoints. Without continuous communication, parties may work in silos, remain unaware of one another's progress, or even duplicate efforts. Therefore, every change in activities needs to be communicated up front; meeting outputs should be documented in clear minutes; and data flows must remain smooth. Findings show that data and information exchange between the Health Office and other government agencies is not yet optimal, gaps that hinder putting specialized expertise to best use and delay the unification of vision and coordinated action.

In terms of specific roles, the Bangka Tengah Health Office holds a central position as the provider of epidemiological data, burdens of communicable and non-communicable disease, coverage of essential services, and other public health information. These data underpin needs identification and priority setting, while situational analysis enables trend detection, problem mapping, and pinpointing areas most in need of collaborative support. The Chair of the Regional House of Representatives adds that the Health Office also serves as a bridge for cross-actor coordination such as local government, CSOs/NGOs, the private sector, and educational institutions while supplying logistical and administrative support (licensing, access to facilities, infrastructure), so program implementation is not stalled by nontechnical barriers.

The durability of commitment to process is also buttressed by an information system for collaboration that enables *sharing* of data, activity documentation, and feedback across parties effectively and efficiently. The district government is encouraged to provide (or develop, if not yet available) an integrated collaboration communication of information platform for health services within the Health Office. This system would be the common venue for data standards, sharing protocols, privacy, and progress reporting, while strengthening communication governance so cross-actor coordination becomes faster, more transparent, and more accountable.

The commitment dimension likewise requires long term and broader shared goals that focus on positive change for the community. The Head of the Pratama Hospital emphasizes the importance of this long-term orientation, while the Head of the Health Office must safeguard collective commitment amid rapid regulatory shifts. If adjustments are unavoidable, collaborating actors should agree on a new commitment through a formal forum, keeping it aligned with the original aims and the desired outcomes.

To prevent commitment from remaining a mere good intention, it needs to be formalized in documents such as a Memorandum of Understanding (MoU) and a Cooperation Agreement (PKS) that set out shared goals, scope, division of tasks and responsibilities, work plans, and reporting/evaluation mechanisms. These written instruments serve as oversight tools to avoid role overlap and to ensure there is evidence of ongoing collaborative activity. The BPJS Office Head underscores the importance of an inclusive, participatory collaboration forum and engaging stakeholders from planning through implementation to evaluation that grounded in clear written agreements.

Field findings also point to inconsistent scheduling of joint activities; agendas already agreed upon frequently clash with each party's availability. This signals the need for technical process rules, coordination SOPs, a shared calendar, and an escalation path as well as continuous monitoring and evaluation at every stage. The Health Office should initiate formal cooperation among district agencies (for example with the Regional Development Planning, Research and Development Agency/Bappelitbangda), because development planning and research determine opportunities for funding in the regional budget (APBD); without inclusion in planning, collaborative programs risk being delayed. Referring to the Ansell & Gash framework, synergy is built through a *shared understanding* of problems, goals, and roles from the outset, consistent with the *starting condition* findings so collaboration becomes not just occasional meetings but a shared, enduring structure for improving health services in Bangka Tengah.

4.1.4 Intermediate Outcomes

Intermediate outcomes are understood as provisional achievements that emerge while collaboration is underway, prior to final goals being reached. They function as early indicators that dialogue, trust-building, commitment, and shared understanding are starting to produce tangible change. Intermediate outcomes are crucial for sustaining momentum, reaffirming trust among actors, and providing a basis to evaluate the effectiveness, efficiency, and impact of collaboration, as emphasized in the Ansell & Gash framework.

In Bangka Tengah, several intermediate outcomes have been identified: a growing collective awareness of the urgency of coordination and the need for more effective patient referral mechanisms; the establishment of early discussion forums that open space for dialogue and information sharing; the drafting of a collaborative framework that guides roles, principles, and mechanisms across actors; the creation of technical working groups to break down large issues into manageable agendas; the development of detailed, resource-backed joint action plans; and recognition of the role of professional organizations such as the Midwives Association (IBI) in strengthening the quality of midwifery services. While these are positive, consistent implementation across all service levels still needs strengthening so these intermediate gains can convert into meaningful final outcomes.

The mechanisms that produce intermediate outcomes rest on high-quality face-to-face dialogue. Direct interaction enables quick clarification to prevent misunderstandings; the exchange of perspectives across actors to align goals and roles; the cultivation of empathy for each party's constraints; negotiation to agree on steps and responsibilities; and the building of interpersonal

relationships that foster mutual trust. In this way, in-person forums become arenas for rich communication, immediate problem-solving, and reinforced commitment.

Rising commitment to the process is visible in multiple ways: active participation by the Health Office, primary health centers (puskesmas), hospitals, professional organizations, and related agencies in forums and working groups; willingness to allocate budgets, personnel, and facilities; action plans with clear metrics and timelines; the creation of participatory monitoring evaluation mechanisms; initiatives to standardize procedures and upgrade health worker competencies; and the development of an integrated information system for data sharing. Together, these signals reflect a shift from discourse to concrete action.

As collaboration proceeds, shared understanding grows dynamically through continuous interaction, hands-on experience solving issues together, learning from successes and failures, the evolution of structures (collaboration frameworks, technical task forces), and deepening trust. In parallel, better communication eases coordination: information becomes clearer and timelier; goals and SOPs are understood consistently; problems are identified and resolved more quickly; misunderstandings are reduced; and inter-organizational working relationships strengthen.

Intermediate outcomes directly influence the speed of action-plan formulation and conflict resolution. Shared understanding reduces debates over direction and role overlap, enabling faster, more relevant technical decisions. Trust creates space for open communication, charitable interpretations of intent, focus on common goals, and cooperative problem-solving reducing the need for rigid rules and enabling flexible, pragmatic resolution.

That said, challenges to achieving and maintaining intermediate outcomes remain. Incoherence in cooperation mechanisms highlighted by informants must be addressed through standardizing and formalizing procedures (especially referral pathways); strengthening routine communication and coordination; clarifying goals and roles; holding regular joint evaluation forums that include community and private-sector representatives; reinforcing performance accountability; and comprehensive socialization and training so all implementers understand shared mechanisms. Consistent with Edgar Schein's work on organizational culture, incoherence often stems from miscommunication; two-way, honest, consistent communication is therefore foundational.

Sustaining intermediate outcomes amid differing priorities and resource constraints requires several strategies: re-anchoring everyone to the higher, shared purpose; facilitating empathetic dialogue (as emphasized by the Regional Secretary); negotiating and compromising on resource allocation (as noted by the Financial department); fair burden-sharing; celebrating small wins to maintain morale; transparent decision-making by the Health Office; and flexibility/adaptation of plans. In line with Ting-Toomey & Chung, clear and adaptive communication keeps all parties informed about progress, challenges, and changes, helping preserve commitment.

Long-term trust is maintained through consistent, transparent communication; aligning words with deeds; acknowledging shared successes; constructive conflict management; mutual respect for differing values and perspectives; clear accountability for roles; and sustained investment of time and energy in relationships. These seven pillars build a positive track record, minimize suspicion, and strengthen the collaboration's resilience to change.

Finally, the linkage between intermediate and final outcomes is direct and layered. Improved coordination smooths referral flows, enhances inter-level communication, enables more integrated patient care, uses resources more efficiently, reduces duplicated services, and ultimately lifts patient satisfaction. Meanwhile, stronger shared understanding boosts program acceptance and participation, ensures designs fit local needs, smooths implementation coordination, improves the efficiency of resource allocation, sharpens monitoring and evaluation, and supports sustainability. In short, investing in intermediate outcomes, especially coordination, trust, and shared understanding lays the cognitive and social foundations for achieving substantive, sustainable final results in Bangka Tengah's health services.

4.1.5 Facilitatice Leadership

Mutual understanding, distinct from the concept of *shared understanding* proposed by Ansell and Gash, plays a pivotal role in collaborative Facilitative leadership is a critical prerequisite for the success of collaborative governance in health service delivery in Bangka Tengah. In line with Parker (2008) and Bens, a facilitative leader does more than simply "run meetings"; they design agendas, create inclusive spaces, manage group dynamics, and ensure the process proceeds productively until decisions are taken legitimately. The essence of this role is to empower the group—through transparency, participation, and a focus on shared goals—so that collaboration yields a strong and actionable consensus.

Interview results indicate the characteristics needed of such leaders: the ability to facilitate discussion and negotiation, identify common ground, manage differences constructively, and ensure that decisions reflect the collective interest. Of the 10 informants, respondents agreed that the Head of the Health Office must be adept at leading mediation, proactively initiating cross-actor meetings, accurately synthesizing core issues, and communicating skillfully to maintain partner relationships. Skills, decision-making, stamina, and knowledge are additional pillars that support facilitative capacity.

Within the Ansell & Gash framework, strong facilitation correlates directly with the quality of relationships and collaborative outputs. This study underscores the importance of adaptive and inclusive leadership: being sensitive in reading situations, able to switch roles to mediator when conflicts arise, and acting as a "shared-purpose reminder" when discussions go off track. Specifically, four informants emphasized a leader's sensitivity in detecting emotional/dynamic shifts, three highlighted the mediating role to

seek mutually beneficial solutions, and three others stressed the reminder function to keep the shared vision front and center and prevent negative dynamics from taking over.

On the implementation side, the study identifies an institutional gap: the current Head of the Health Office has not fully served as the key actor who guarantees the early stages and ongoing process of collaboration—both in technical decision-making and in the role of synergistic connector among parties. The organizational structure of the Health Office lacks a dedicated position for managing partnerships; collaborative tasks are delegated across unit heads, resulting in fragmented management that is difficult to monitor comprehensively. This reduces visibility over the portfolio of ongoing partnerships and risks weakening the consistency of collaborative processes.

Consequently, the research concludes that a dedicated structural position/unit for partnership management is needed to serve as the primary gateway for collaboration: conducting internal–external assessments, managing agreement documents, preparing coordination SOPs, and carrying out integrated monitoring and evaluation. Moreover, facilitative characteristics are required not only of top leaders but also of structural officials and frontline health workers (as liaison officers) who interact daily with partners and patients. This aligns with the literature (Ottens & Edelenbos; Emerson et al.) on safeguarding the integrity of collaborative processes, adherence to agreed "rules of the game," and consistency in pursuing shared goals.

Based on interviews and field findings, the study affirms that strengthening facilitative leadership must be supported by process innovation and the use of information technology. Leaders are expected to mobilize internal and external resources, accelerate accurate and transparent information flows, and ensure that meeting cycles, follow-ups, and evaluations are carried out with discipline. With aspirational, service-oriented, adaptive, and institutionalized leadership backed by the right structural apparatus so the health collaboration in Bangka Tengah is more likely to produce inclusive decisions, consistent implementation, and tangible service impacts for the community.

4.1.6 Institutional Design

Institutional design in collaborative governance refers to the formal and informal rules, structures, and mechanisms intentionally created to facilitate interaction and decision-making across stakeholders. Its purpose is to provide a conducive, fair, and effective arena for collaboration. In line with Ansell & Gash, the study finds that sound institutional design must uphold participatory inclusiveness, anchor decisions in a clearly legitimized forum, and treat process transparency as a core pillar of accountability.

On **participatory inclusiveness**, the research underscores the need for comprehensive stakeholder engagement: the local government (including the regional secretary and inspectorate), the Health Office, public hospitals/primary care centers, the private sector (private hospitals, clinics, pharmacies, investors), professional organizations (e.g., the Midwives' Association), civil society organizations, community leaders, vulnerable groups, and patients. Early, systematic identification of these actors is a prerequisite to ensure that relevant perspectives, needs, and resources are truly represented. Echoing Emerson, Nabatchi, and Balogh, success hinges on diversity and representativeness closely linked to *starting condition* findings that a framework is needed as the basis for institutional design.

Inclusiveness is operationalized through **open collaborative forums** for deliberation and decision-making. Such forums must proactively enable participation (clear information, accessible language/formats), facilitate constructive discussion, and aim for consensus. The study also notes real-world hurdles: designing inclusive structures, rules, and mechanisms is time-consuming and complex; divergent priorities among government, private actors, professionals, BPJS, and communities often impede a shared vision. This calls for deliberate facilitation, mediation, and the search for common ground oriented to public interest.

Regarding **forum exclusiveness**, the study observes that the Selawang Segantang Sehat (FSSS) forum is already legitimized but focuses more on environmental health than on service quality. Deep commitment to a single exclusive forum can bring stability yet risks limiting wider participation, fostering institutional rigidity, and overlooking alternative forums that might be more adaptive to specific issues. The research recommends maintaining the main forum while developing **additional inclusive, thematic forums**, especially to tackle **health-workforce asymmetries** through resource-sharing, joint training, and staff rotation to ensure more equitable coverage.

Strengthening institutional design also requires a clear **legal foundation** for workforce collaboration: Law 36/2014 on Health Workers, Law 36/2009 on Health, derivative Government Regulations, relevant Minister of Health regulations (e.g., standards, telemedicine), provincial/district by-laws, and concrete MoUs/Cooperation Agreements among parties. This framework provides legal certainty for rights/obligations, authority, competence standards, and operational mechanisms so partnerships do not rely solely on informal understandings.

The pillar of **process transparency** is equally critical. The research calls for openness of agendas, minutes, decision documents, decision rules, evaluation criteria, and feedback channels. While the legal spirit is supported by the Public Information Disclosure Law (Law 14/2008) and cooperation procedures in Government Regulations, the study recommends a **local by-law or Head of Region decree** specifically governing transparency in health collaborations: mandatory documentation and publication, standard formats, clear information-access procedures, designated PICs for each process stage, and **sanctions** for non-compliance. Transparency is expected to build trust, legitimacy, and cross-actor accountability.

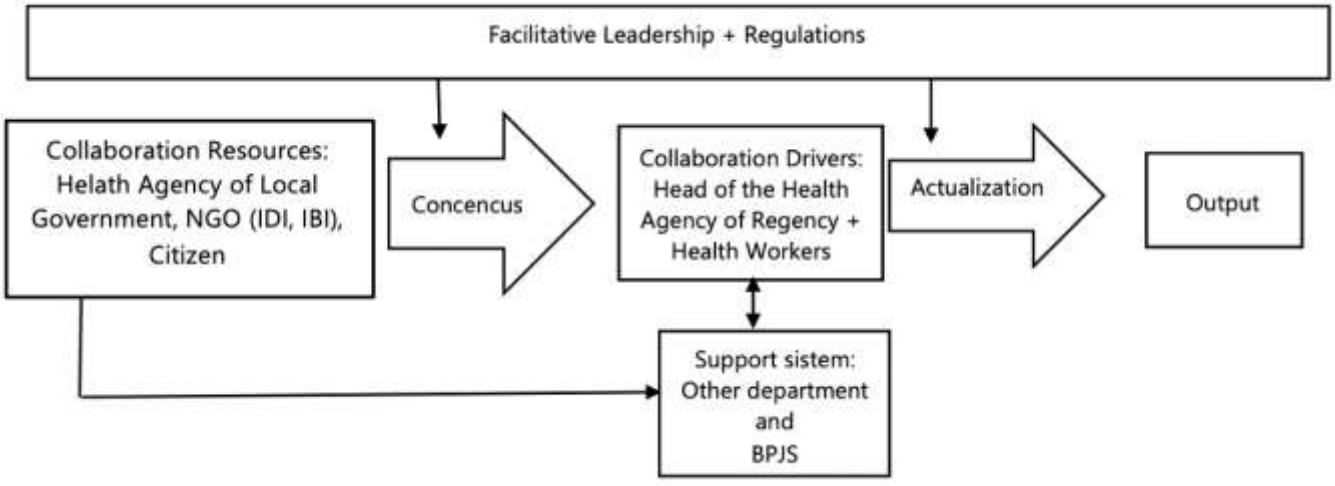
A key bottleneck is the **absence of specific data and evaluation reports** from all parties, which weakens monitoring and evaluation (M&E). Institutional design must therefore ensure **data-driven M&E**: indicators of participation, meeting frequency,

budget use, program execution, and public-health outcomes. Regularly disclosed data should ground shared learning, policy correction, and priority-setting; without it, M&E risks becoming a formality that fails to drive continuous improvement.
In sum, the three pillars such as participatory inclusiveness, a legitimized (yet non-monopolizing) forum architecture, and robust transparency are mutually reinforcing foundations of institutional design. Inclusiveness brings all relevant voices to the table; a recognized forum provides a predictable pathway for decisions without stifling innovation in new thematic forums; and transparency binds the process to public accountability. By closing M&E data gaps, expanding thematic forums (particularly on workforce issues), and strengthening local regulatory scaffolding, Bangka Tengah's institutional design will be better positioned to accelerate collaboration toward more effective, equitable, and sustainable health services.

4.1.7 Outcomes

Outcomes in Bangka Tengah's collaborative health governance hinge on the strength of other dimensions like starting conditions, institutional design, facilitative leadership, and the collaboration process. To keep actors aligned and committed through to results, the Health Office (especially the Head) needs a clear legal umbrella and agreed "rules of the game." The intended outcomes are better quality, accessibility, efficiency, and responsiveness of services for the whole population.
First, policies and programs are moving toward stronger cross-sector integration linking health with education, social protection, public works, and more. This whole-of-government approach targets determinants beyond the clinic (e.g., tackling stunting with nutrition, social support, and sanitation). Such multi actor synergy is expected to make planning more comprehensive and implementation more efficient and attuned to local needs.
Second, collaboration is framed as a mechanism for optimizing resources. Each partner contributes complementary strengths: the Health Office brings mandate and data; BPJS provides financing and insurance architecture; the private sector offers logistics, technology, and capital; and civil society extends grassroots reach. Rather than allowing gaps to persist, differences in capacity are converted into opportunities through burden sharing, eliminating duplication, and leveraging comparative advantages for broader and more durable benefits.
Third, service quality is lifted through knowledge exchange, innovation, and shared standards. Learning platforms (discussions, seminars, workshops) accelerate uptake of good practices from digital queuing to stronger health promotion and targeted prevention (e.g., reducing new stunting cases, tightening TB contact tracing). Referral pathways across facilities are clarified, and information on specialist availability is made more transparent so complex cases are managed faster and more accurately.
Fourth, the expansion of service coverage builds on the Universal Health Coverage status already achieved. The forward focus is to maintain and deepen coverage—especially reaching in-migrant residents lacking local ID so they are not missed by JKN. This requires integrated data systems, proactive outreach, and coordination down to communities and employers to ensure no vulnerable group is left behind.
Finally, patient and public satisfaction are treated as key outcome indicators. The Health Office promotes regular surveys and accessible feedback channels to capture lived experience (wait times, courtesy, clarity of information, quality of care). These inputs feed continuous improvement, keeping services user-centered. Overall, the document argues that integrated policy, resource optimization, quality enhancement, expanded coverage, and stronger patient experience together can deliver health outcomes that are more equitable, effective, and sustainable in Bangka Tengah. In general, the overall findings of this study on the implementation of collaborative governance to improve health services in Bangka Tengah, Bangka Belitung Islands Province, are presented below using the Ansell and Gash (2008) framework:

Figure 2: Collaborative Governance in Improving Health Services in Bangka Tengah today.



The figure above shows that the Bangka Tengah District Health Office, led by the Head of the Health Office implements collaborative governance by building a shared agreement from the very start (the starting condition). This agreement includes cross-agency support within the Regency Government and partnerships with BPJS Health as the social health insurance administrator. The process flow (flowchart) depicts a concurrent working pattern among the Head of the Health Office, health workers, and partners, making communication easier, more targeted, and oriented toward the agreed outputs.

Second, the decision to continue or terminate a collaboration is based on the achievement of the previously agreed outputs. Here, the Head of the Health Office acts as a facilitative leader who ensures the collaboration proceeds in line with regulations, operationalizes (actualizes) the collaboration plan, and oversees the delivery of the expected outputs.

Third, the innovative collaborative governance model draws on the Ansell & Gash (2008) framework with five dimensions: starting condition, collaborative process, facilitative leadership, institutional design, and outcomes. The findings place the collaborative process at the center of the model, while the starting condition, institutional design, and facilitative leadership contribute directly to producing outcomes.

Fourth, field evidence highlights three key dimensions as the most decisive: starting condition, collaborative process, and outcomes. Institutional design and facilitative leadership function as supporting/complementary elements that strengthen these three core dimensions. A strong starting condition especially a shared perspective and common goals becomes the primary reason actors are willing to collaborate and forms the foundation for planning and role allocation. Early facilitative leadership helps enforce the rules of the game, spark participation, and manage resources and information.

Fifth, institutional design and facilitative leadership demonstrably shape the quality of the collaborative process. Institutional design provides the regulatory base, standards, and role allocation (updated to align with Law No. 17/2023 and Government Regulation No. 28/2024), while leaders keep the process on track, mediate differences, and empower health workers as well as the use of information technology. The core of the process is communication: regular meetings, formal internal mechanisms (setting-implementation-monitoring-evaluation-control), and evaluative forums are needed so that field knowledge/practice matures and inter-party trust is maintained.

Sixth, outcomes are strongly influenced by the quality of the starting condition and the process. Process components such as dialogue, trust building, commitment to process, shared understanding, and intermediate outcomes together with the active role of health workers and communication forums determine collaboration effectiveness. Direct interaction between the Head of the Health Office and partners fosters smooth coordination, builds trust, and strengthens commitment, thereby increasing shared understanding/experience and leading to service improvements.

Seventh, the expected outcomes include expanded service coverage, more equitable reach including vulnerable groups, and higher patient/community satisfaction. To realize these, all parties need to actualize (concretely implement) what has been agreed the results of this actualization then serve as feedback and a model for the next collaboration cycle. In short, process quality will be proportional to the quality of outcomes felt by the people of Bangka Tengah.

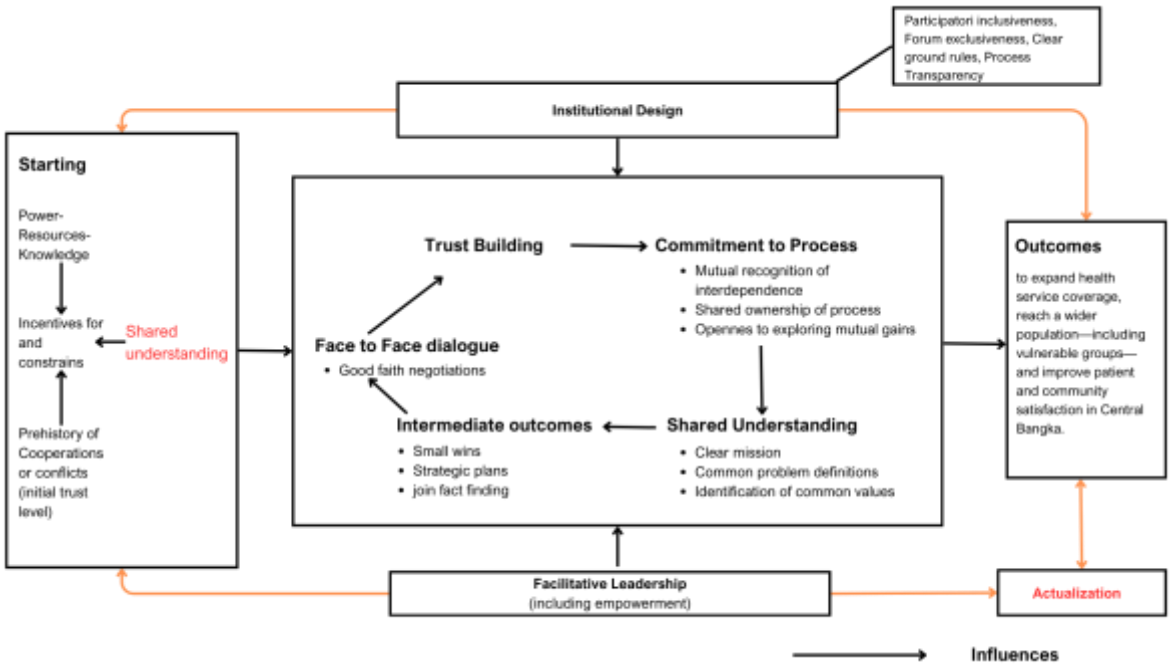
4.2. Collaborative Governance Model for Improving Health Services in Bangka Tengah

Based on the study findings, institutional design and facilitative leadership contribute not only to the collaborative process itself. In terms of institutional design, partner participation is continually encouraged in various ways to ensure the success of collaboration. Regulation functions as a strategic resource such as cooperation guidelines that underpins the collaboration between the Head of the Health Office and partners from the stage of assisting collaboration needs through to completion. In carrying out its duties, the Health Office requires a clear legal umbrella. Likewise, for building a shared understanding, executing the collaboration, and closing it out, the Health Office needs a firm legal basis. Procedures for establishing collaboration from start to finish must be supported by SOPs that serve as guidance for health personnel. This shows that several components embedded in the Bangka Tengah Health Office's institutional design also help prepare the starting conditions.

The same applies to the facilitative leadership dimension. Here, leadership plays a role from preparing the starting conditions through to the outcomes. Leaders unite and motivate the parties involved namely the Head of the Health Office, partners, and the community by securing broad-based support and spurring active participation. Leaders also play a pivotal role in managing the Bangka Tengah Health Office's internal resources as well as external resources to improve public health services. Therefore, strong and active leadership is needed from the initiation of collaboration through outcome management.

In developing this collaboration model, the study also finds the need for external support for actualization (implementation). This is important to ensure that the performance produced by the Health Office and its partners is assessed by a neutral party. Thus, when success is achieved, it is validated and reinforced by external stakeholders who have the capacity to synergize with the collaboration—so results do not rely solely on the claims or roles of the collaborating parties themselves

Figure 3: Collaborative Governance Model for Improving Health Services in Bangka Tengah, Bangka Belitung Islands Province



Source: Compiled by the researcher, 2025

Accordingly, the dimensions of institutional design and facilitative leadership can be mapped in their influence to the starting conditions and to the outcomes. In other words, organizational institutional design and facilitative leadership help support the collaboration from its earliest stage through to the management of results. At the same time, developing a collaborative governance model is not limited to adding lines of influence from institutional design and facilitative leadership to starting conditions and outcomes. There are additional factors beyond the five dimensions of collaborative governance proposed by Ansell & Gash (2007). Chief among these are a convergence of shared organizational understanding regarding the collaboration which includes organizational values and the need for "Actualization" activities carried out by external parties to drive continuous improvement. The shared understanding of vision and mission that underpins the collaboration arises from the combined understandings of the participating organizations; however, that shared understanding of goals must clearly reflect what is to be achieved together and how to achieve it over the long, medium, and short term. Consequently, each party's understanding needs to be aligned with the common interest. The health office and stakeholder understanding/background of organizational goals should project future aspirations, be forward-looking, guide decision-making, avoid rigidity, adapt to circumstances, remain attainable, express the organization's hopes through its activities, and be easy to communicate and understand (Gamble, Peteraf, and Thompson, 2015). These qualities provide a foundation for collaboration in public health services. Meanwhile, how collaborating stakeholders articulate that understanding should reflect the constituencies served, specify the activities (services) provided, delineate the organization's operating domain, describe the use of technology in the organization, demonstrate the organization's commitment to growth, embody its values and beliefs, identify its advantages relative to other organizations, show concern for societal and environmental issues, and reflect its commitment to employees (David and David, 2017). This makes it easier for stakeholders to find common ground in joint efforts to improve health services.

With a shared understanding translated wisely into practice, collaboration is expected to proceed in a more targeted manner. That is, there is clarity and firmness regarding what the organizations actually expect from the collaboration. Thus, the starting conditions in collaborative governance can be prepared more systematically. One expression of this orderliness is the definition of success criteria for the collaboration that support the shared understanding. This makes it possible to determine the extent to which a collaboration can be deemed successful and to inform organizational judgments about the feasibility of future collaborations as well as assessments of those undertaken previously. In this way, organizations can track the history of their partnerships. As noted earlier, institutional design and facilitative leadership influence both the starting conditions and the collaborative process. Within the facilitative leadership dimension, several critical factors must be surfaced. Health Workers (Nakes) are the frontline of the Health Office in collaborations to improve services in Bangka Tengah. They represent the health office in interactions with stakeholders—especially with the community and patients. Their role is therefore pivotal to collaborative success. Health Workers designated as collaboration leads require specific competencies: the ability to collaborate and the ability to carry out health service tasks. Given their centrality, leaders must both build Health Workers' capacities and effectively empower them.

Another factor linked to the performance of collaboration between the Bangka Tengah Health Office and all stakeholders is the use of information technology (IT) for managing collaboration-related information. Managed information includes cooperation

regulations, a directory of health office stakeholders, health service activities, and other data relevant to collaborative health services. At the outset of the collaboration process, IT can make it easier for stakeholders to identify one another. IT can also be used to manage results. All activities undertaken by the health office together with all stakeholders can be captured in an information system, making collaborative performance more measurable. This information can serve as a medium for joint monitoring and evaluation of collaboration by all participating actors. IT is needed to complement business processes and to function as a decision support system for policymakers. Organizational data such as a collaboration history recording successes as well as constraints can be stored more systematically through IT and shared with interested parties. In addition to collaboration histories, other data that can be managed through IT include the regulations that form the basis of each organizational activity. When regulations are well socialized, the potential for miscommunication is reduced so that organizational activities (including collaboration preparation with partners) run smoothly. Because of this strategic value, IT warrants recognition as a distinct dimension that influences the entire collaboration process with partners.

Furthermore, Actualization activities are required from the beginning through the end of the collaboration process to complement the Ansell and Gash (2007) collaborative governance model ensuring the achievement of shared goals and continuous improvement. Actualization does not involve only the Health Office and a single partner within one activity; it also involves all partners and other agencies. Actualization is the concrete expression of the communication, coordination, and discussion forums among all actors engaged in health services. These activities are needed to produce tangible organizational growth whether to be followed up or not within the health service framework. To strengthen the reality of collaboration in practice, Actualization should also be carried out by external parties from other departments and government institutions such as the Regional House of Representatives (DPRD), which has a budgeting function that is crucial to implementing collaborative health services. Based on the research findings, several supporting factors are proposed as part of the development of the collaborative governance model: (1) Mutual understanding, a shared aspiration and common goals as the basis or guide for Actualization in collaborative implementation; (2) appropriate, low-cost information technology to manage organizational data; (3) external Actualization support from government institutions (the district DPRD) and other departments, as described above e.g., the DPRD can initiate or support the enactment of Regional Regulations (Perda) that explicitly mandate cross-sector collaboration on health issues and can promote and approve Perda on budget allocations that support cross-sector health programs (for example, a Perda earmarking a certain percentage of the PUPR budget for village sanitation or DPMD funds for strengthening Posyandu). This ensures sustainable financial support for collaborative initiatives and provides a strong legal umbrella so that all relevant departments have clear mandates and frameworks for collaboration, rather than it being merely voluntary; and (4) formal accommodation of the critical role of Health Workers in implementing collaboration, along with community involvement in collaborative activities.

Building on the Ansell and Gash (2007) collaborative governance model, the researcher has developed a more implementable model namely, a collaborative governance model for improving health services in Bangka Tengah.

Figure 4: Presents the Collaborative Governance Model for Improving Health Services in Bangka Tengah

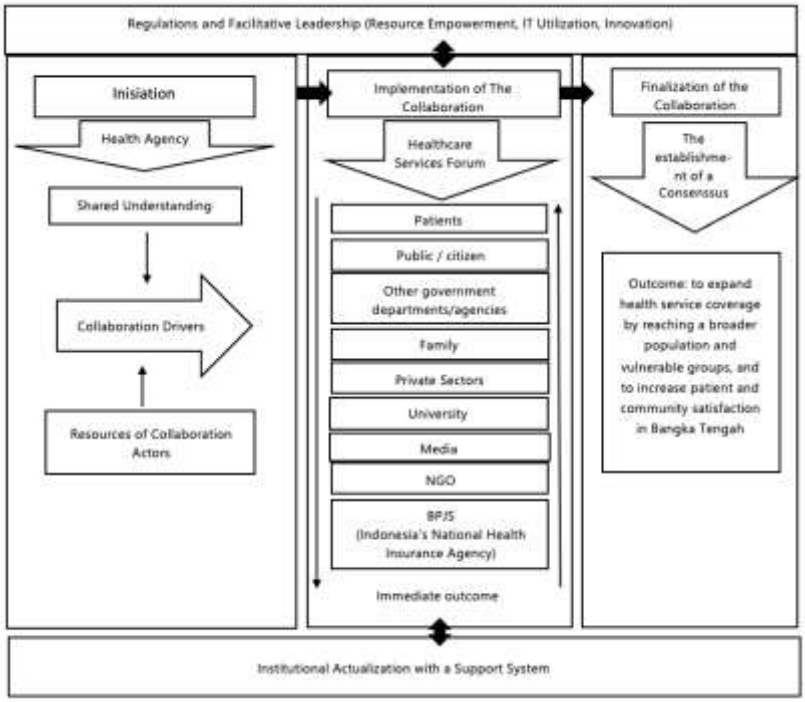


Figure 4 on collaborative governance for improving health services in Bangka Tengah, as shown above, can be explained as follows: the overall collaboration process is divided into three stages collaboration initiation, collaboration implementation, and collaboration completion.

1. Collaboration initiation is the stage where the Bangka Tengah Health Office and stakeholders identify cooperation needs and study mutual opportunities. Early interactions at this stage consider public-health service needs based on health research recommendations prepared by the Health Office, preceded by an assessment of weaknesses and strengths to fulfill those tasks. Building on this needs assessment, the Health Office determines what support is required from stakeholders. From here, the Health Office maps stakeholders who share a mutual understanding and are aligned to collaborate in public-health services. Beyond shared understanding, the Health Office must also recognize each stakeholder's capacities and strengths. The Health Office weighs the benefits that collaboration will bring and, at the same time, considers stakeholder interests like what value the Health Office can offer them bearing in mind that stakeholders are conducting similar internal processes. Regulation is crucial as the umbrella for collaboration. Equally important is the leader's role in attracting prospective partners to engage in health-service programs and in mobilizing internal resources to collaborate with stakeholders.
2. The second stage is the collaboration process, in which the Health Office and all health-service partners integratively design and implement programs and service activities. Communication is the core of collaborative health services. Communication among actors is essential; therefore, there must be channels that enable them to communicate. One of the best ways is to establish a forum for Bapas (Probation Office) and all involved stakeholders to communicate and coordinate from the start to the end of the partnership. Given that this focuses on mentoring terrorist clients, Bapas should provide and facilitate this forum. To streamline communication, each collaborating actor needs a liaison. The Health Office's liaison is the Health Worker. Communication in this forum may take the form of both formal and informal meetings. The first step in collaboration is to build understanding among actors. A fundamental shared understanding is the existence of a clear common goal, constructed around the health-service needs of patients. The Health Office's primary stakeholders are Hospitals and Community Health Centers (Puskesmas), each with specific goals in health management. Other key stakeholders include the Social Affairs and Village Community Empowerment Offices, which facilitate access for Persons with Social Welfare Problems (PMKS) to health facilities through accompaniment, referrals to puskesmas or hospitals, and assistance with health costs for the poor (especially via programs such as the Family Hope Program/PKH that has a health component). This distinguishes services for those unable to pay, who may require assistance mechanisms from those able to access services independently. Additional stakeholders are involved according to community needs, and the intensity of each stakeholder's role is determined by those needs. The Client's role is crucial and forms the basis of collaboration between Bapas and partners; it is the shared objective of the collaborating parties. Therefore, client-focused interventions must be included as one element of the collaboration process.

   Once common goals are agreed by all actors, the next step is building trust. This phase is essentially continuous building, implementing, and strengthening cooperation. Commitment to process is marked, among other things, by formalizing what has been agreed and the trust that has been built into a written cooperation document. This document includes the agreed goals and the programs and activities to be carried out. To improve health services, programs include planning and implementing health-service activities. In collaborative activities, beyond partner institutions, the Health Office also involves active community participation.
3. The third stage is the completion of collaboration, as agreed. All actors jointly ensure that the previously agreed outputs have been achieved, and also that each actor contributes to achieving the outcomes. The shared outcomes expected are affordable access to services and satisfaction with public-health services, so that citizens are healthy and participate actively in development. These outcomes are indicated by better behaviors, consistent positive conduct, and adherence to prevailing social norms. At this stage, each actor may decide to end or extend the collaboration. Key considerations include work priorities (internal policy) and each actor's available resources.
4. Regulations or rules, both related to collaboration and to the mentoring of terrorist clients, underpin and influence all stages of collaboration. In addition, facilitative leadership also shapes the early needs assessment and scoping at the start of collaboration. Leaders ensure that the Health Office has health workers with adequate competencies to deliver services beginning with appropriate designation mechanisms and the provision of sufficient training. The use of technology is also important to facilitate the management of data and information in collaborative health services, including data/information exchange, management of service data for communities, and other needs. Another critical factor is innovation finding new, more effective and efficient ways for actors to deliver services to the community. In collaboration, leaders play a pivotal role in attracting partners to participate in mentoring according to each partner's capacity.
5. Institutional actualization of collaboration is the effort to establish and operate partnerships among multiple parties within an organized vessel or structure to achieve shared goals. This is not merely occasional cooperation, but the formation of formal or semi-formal mechanisms that enable collaboration to run consistently, effectively, and sustainably. To realize effective collaboration, institutional actualization is essential, not only creating a team or forum, but building structures, processes, and a culture that fundamentally support and promote collaboration as the primary way of working.

6. The institutional support system from other government agencies in Bangka Tengah, such as the Social Affairs and Village Community Empowerment Offices, the Public Works and Housing Office, the Environmental Office, Bappelitbangda (planning and research), the Education Office, the Food Security/Agriculture Office, and, crucially, support from the Regional House of Representatives (DPRD) through budget allocations that prioritize programs to improve health services in Bangka Tengah, collectively underpins the achievement of collaboration outcomes. These include expanding health-service coverage to reach broader communities and vulnerable groups, as well as increasing patient and public satisfaction in Bangka Tengah.

Based on the overall review using the Collaborative Governance framework (Ansell & Gash, 2008) comprising the dimensions of Starting Condition, Collaborative Process, Facilitative Leadership, Institutional Design, and Outcome this study confirms that the health-service collaboration ecosystem in Bangka Tengah involves a wide range of partners: other local government agencies, NGOs/CSOs, the private sector, academia, communities, BPJS (the national health insurer), and patients. However, current collaboration is not yet fully ideal for driving service improvement. Within the starting condition dimension, beyond resource asymmetries and the history of cooperation, the factor of "shared understanding" clearly shapes the direction and sustainability of collaboration. A Health Office focus that is reactive to resource constraints has led to sporadic and inconsistent partnerships.

In the collaborative process dimension, the findings underscore the need for an integrated, cross-actor approach that positions communities/patients not only as targets but also as actors. The main obstacles are reluctance to share data, low inter-party trust, and communication patterns that remain partial (bilateral) rather than multi-directional. Without open, secure, and equitable communication mechanisms, role allocation becomes blurred and program overlap increases, making it difficult to convert plans into measurable joint impact.

Facilitative leadership emerges as a crucial lever from end to end. The study identifies gaps in structured cadre development and capacity building for health workers, suboptimal use of information technology, and a still-sporadic innovation culture. Leaders must be charismatic, confident, and communicative—able to empower internal and external resources, mediate interests, initiate cross-actor forums, and uphold process discipline (agenda–follow-up–evaluation) so that consensus is maintained and implementation stays on course.

From the institutional design perspective, collaboration regulations are still generic and do not yet spell out the community's role as an actor, cross-unit accountability, or the institutionalization of a permanent communication–coordination forum. This absence triggers overlapping activities and weakens accountability. As a result, at the outcome level, collaboration performance remains output-oriented (i.e., "activities delivered") rather than focused on jointly agreed outcomes; comprehensive evaluation system support has also not yet formed, limiting feedback for continuous improvement.

As a model enhancement, this study adds "shared mutual understanding" to the starting condition and draws direct lines of influence from institutional design and facilitative leadership to both the starting condition and the outcome. The collaboration process needs to be underpinned by multi-directional communication, secure IT-based data-sharing mechanisms, and periodic "actualization" cycles (monitoring-evaluation-learning) to sustain trust and enable adaptation. Facilitative leadership must be present from initiation through closure/extension of the collaboration, including appointing liaison officers from among health workers to streamline information flows and day-to-day coordination. Overall, the collaboration stages are formulated as initiation, process, and termination/extension.

Based on these findings, the researchers recommend updating health-collaboration regulations to: (1) recognize shared understanding as a prerequisite for scoping; (2) institutionalize cross-actor communication forums and produce guiding documents for achieving outcomes; (3) detail the character and mandate of facilitative leadership (resource empowerment, the health-worker liaison role, IT utilization, and an innovation culture); and (4) appoint a structural manager under the Head of the Health Office to oversee partnerships. They also advise building a policy actualization system such as regular internal forums with external monitoring and evaluation alongside an integrated information system that catalogs regulations, partners, activities, and results, to standardize procedural understanding and ease coordination.

Capacity recommendations emphasize strengthening health-worker competencies (regulations, procedures, collaboration, and service practice) along with clear designation mechanisms. The model treats communication as the core of the process and clients (patients/communities) as both targets and principal actors, so the outcomes pursued are not only expanded service coverage and outreach to vulnerable groups, but also higher public satisfaction and healthier behaviors. The implementation roadmap includes drafting/updating regulations, socialization and capacity building, model rollout, and continuous actualization with potential replication across community health centers, hospitals, and broader scales. Thus, integrating the key dimensions, securing formal structural support, and sustaining consistent facilitative leadership are foundational to converting activity outputs into tangible health outcomes for Bangka Tengah.

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