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Structural constraints and patient agency in diabetes self-management: a critical case study in a primary healthcare center in Indonesia

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ABSTRACT

Introduction: Effective self-management is essential for individuals with Type 2 Diabetes Mellitus (T2DM), yet patients in Indonesia often encounter persistent barriers. This study explores patients' perspectives on the challenges they face as well as the perceived supports available within the primary healthcare system.

Methods: A qualitative case study approach, based on Yin's methodology, was employed. Guided by Habermas's theory of communicative action and Honneth's theory of recognition, data were collected through in-depth interviews with 14 patients, 28 clinical observations of patient–provider encounters, and one focus group with five healthcare professionals. Participants were recruited from a suburban primary healthcare center in Indonesia using purposive sampling. Reflexivity and field notes were maintained throughout the data collection process. Data were analyzed using thematic qualitative analysis. Triangulation across data sources helped enhance credibility and trustworthiness.

Results: Five key themes emerged: (1) Medical dominance in care provision, (2) Communication gaps, (3) Regulation-centered care, (4) Care quality, and (5) Patient self-empowerment. These themes reveal systemic, structural, and interpersonal barriers that constrain effective diabetes self-management in primary care.

Conclusions: Understanding the lived experiences of patients with T2DM is critical to informing practice and policy. To overcome these barriers, a shift toward patient-centered care, improved communication, and more inclusive support systems is essential within Indonesia's healthcare system.

Keywords: critical inquiry, Indonesia, patient perspectives, self-management, type 2 diabetes mellitus

Introduction

Diabetes is a global health concern. Indonesia ranks among the world's top ten countries, with 10.3 million people living with type 2 diabetes, a number projected to reach 16.7 million by 2045 (Sun *et al.*, 2022). Around 70% of patients fail to meet national care targets, reflected in high complication and mortality rates (Permana *et al.*, 2022). Self-management support is essential, and empowerment-based approaches have improved outcomes in many developed countries (Frantz, Schopp, and Rhoda, 2021).

Managing type 2 diabetes mellitus (T2DM) in Indonesia faces major challenges. These include a high and growing disease burden with many undiagnosed cases (adult prevalence 11.3%, with 73% undiagnosed) (IDF Diabetes Atlas, 2024); uneven quality and outcomes in primary-care programs such as *PROLANIS* (the Indonesian primary care–based chronic disease management program), with only about one-third of participants achieving good glycemic control; and marked socio-economic and geographic inequities (Fithriyah et al., 2023). Additional barriers include suboptimal medication adherence and poor glycemic control among outpatients (Suwito et al., 2023; Widyastuti et al., 2021). In particular, little is known about how current primary care services support or hinder self-management, despite the rising prevalence and increasing burden on the health system. Research incorporating both patient and healthcare professional perspectives is vital to identify strengths and weaknesses in practice. This study aims to explore T2DM care approaches in Indonesian primary care, focusing on how they support patient self-management.

Global evidence supports patient-centered care (PCC) and empowerment-based self-management, with meta-analyses showing significant improvement in glycosylated hemoglobin (HbA1c) for interventions lasting at least six months (Cheng et al., 2025). In Indonesia, healthcare financing and chronic disease management are structured under the National Health Insurance (*BPJS*) through the *PROLANIS* program. Evaluations of *PROLANIS* have shown mixed outcomes, demonstrating improvements in access to routine monitoring but also revealing persisting gaps in patient empowerment and sustained behavioral change (Khoe *et al.*, 2020). Qualitative studies highlight cultural, religious, and family influences, but often address "barriers" in isolation from the organizational and policy structures that shape them (Arifin, 2020). Community and peer-support interventions suggest agency-enhancing potential but face access gaps and regional variability (Fritz et al., 2024; Pradipta et al., 2025). Provider-focused research notes resource and policy constraints but rarely integrates patient agency within structural contexts in a single primary care case (Putri et al., 2020; Krisnadewi et al., 2025). This underscores the need for in-depth case studies examining how structural constraints shape and are negotiated by patient agency in T2DM self-management.

To address this gap, research that includes both patient and healthcare professional perspectives is needed to assess strengths and weaknesses in current care. This qualitative case study examines T2DM care in a suburban primary healthcare center in Indonesia, focusing on how existing practices support or hinder patient self-management. The findings aim to inform patient-centered policy, adapt self-management support models to local contexts, and guide strategies to improve diabetes outcomes in Indonesia.

Materials and Methods

Research Design

This study employs a critical qualitative case study design as advocated by Yin (2017), which is well-suited for examining complex, real-world social phenomena. The case study approach was chosen to investigate how diabetes care is delivered to patients. Case study research is particularly valuable when detailed information about a phenomenon is limited (Yin, 2017). In this study, the *case* was defined as the existing diabetes care provided to people with T2DM in the Indonesian primary healthcare (*Puskesmas*) context. A single-case design was adopted to gain an in-depth understanding of the current diabetes care, how it supports patient self-management, and the relevance of a patient-empowerment approach. Within this case, three embedded units of analysis were examined: (1) patients, (2) healthcare professionals (HCPs), and (3) the service context, particularly the approaches and content of patient–provider communication. The use of embedded units within a single-case design is consistent with recommendations for capturing multiple perspectives and levels of analysis in complex settings (Baxter & Jack, 2008).

Theoretical Framework

This study is the first case study to explore empowerment in T2DM self-management within Indonesia's healthcare system through a critical theory perspective. Drawing on Habermas's *Theory of Communicative Action* and Honneth's *Theory of Struggle for Recognition* (Napiwodzka, 2021; Zygmont et al., 2023), it examines how interactions between patients and providers are shaped by dialogue, recognition, and power relations. Habermas emphasizes the role of rational discourse in fostering mutual understanding, providing a lens to analyze whether clinical communication enables collaborative decision-making or is dominated by instrumental reasoning that limits patient engagement (Walseth and Schei, 2011).

Honneth's Theory of Struggle for Recognition highlights that individuals seek recognition in three dimensions: love (personal relationships), rights (legal recognition), and solidarity (social value and respect) (Coburn, 2015). Applied to this theory, it explores how T2DM patients struggle for recognition within the healthcare system, whether they feel valued, respected, and heard by providers, or marginalized by systemic barriers. This perspective is essential for understanding how social and institutional structures influence self-management and patient empowerment. Most published studies on diabetes care in Indonesia, such as in Permana et al. (2022), have focused on medical management or epidemiological. They typically provide epidemiological descriptions, correlations, or experimental findings, capturing only biological aspects of T2DM through interpreting biomarker performances such as levels of blood glucose (measuring as HbA_{1C}), cholesterols (triglycerides, high-density lipoprotein [HDL], low-density lipoprotein [LDL]) and make a statistical correlation with the therapy used or with other physical parameters. While valuable, this type of research limits understanding of patients with T2DM and how they are taken care of. By integrating critical theory, this study goes beyond describing barriers to self-management and instead examines power dynamics, recognition struggles, and communicative practices within Indonesia's healthcare system.

The critical theoretical perspectives of Habermas and Honneth informed both data collection and analysis. In designing the semi-structured interview guide, Habermas's concept of communicative action shaped questions that explored how patients engage in dialogue with providers, negotiate understanding, and express validity claims. For example, prompts elicited patients' accounts of clarifying information, challenging advice, or seeking mutual agreement on treatment plans. Honneth's framework guided questions on patients' experiences of respect, esteem, and care, including perceived acknowledgment of their agency and dignity in self-management decisions.

During coding and theme development, initial deductive codes were derived from both frameworks, for example, "mutual understanding," "normative agreement," and "distorted communication" from Habermas, and "respect," "social esteem," and "care" from Honneth. These were applied in the first cycle of analysis alongside inductive codes that emerged from the data. In subsequent thematic development, we examined how structural constraints disrupted communicative rationality and recognition, and how patients enacted agency within these contexts. This integrated approach ensured that theoretical constructs informed both the conceptual foundation of the study and the interpretation of findings.

Participants and Recruitment

The study was conducted at a suburban primary healthcare center, focusing on patients with T2DM who had been diagnosed for at least one year. While socioeconomic background was not used as a recruitment criterion, variations were documented and incorporated into the qualitative analysis to enrich the understanding of self-management challenges.

Healthcare professionals, including physicians, nurses, and dietitians, with at least one year of direct T2DM care experience were eligible. Administrative staff were excluded since the study sought to capture professional perspectives informed by direct clinical involvement. Recruitment was coordinated through the head of the *Puskesmas,* who received invitation letters and informed consent forms. Interested HCPs volunteered by signing and returning the forms via *Puskesmas* officers.

Patients were recruited using flyers and a standing banner in the waiting area. Flyers were distributed at the front desk, and interested individuals contacted the researcher by telephone or in person during clinic hours.

Data Collection

Triangulation methods were used for data collection: in-depth interviews with patients, direct observations of patient-provider interactions, one focus group discussion with HCPs, and fieldnotes. Interviews were conducted using a semi-structured guide designed to explore participants' experiences of self-management, healthcare access, sociocultural influences, financial barriers, and communication with providers. The guide was informed by the theoretical principles of patient empowerment and self-management, highlighting patients' active roles in managing health, interacting with HCPs, and making informed care decisions. It consisted of ten open-ended questions with optional probes to explore sensitive or complex issues in depth. Both the interview guide and the observation framework were pilot-tested with a small sample to ensure clarity, cultural appropriateness, and relevance. Questions were crafted to encourage deep reflection within these themes. Each interview lasted 40–60 minutes and was audio-recorded with consent.

A Focus Group Discussion (FGD) was conducted with HCPs to explore their views on patient empowerment, current diabetes services, and self-management. The discussion examined professional roles, challenges, and strategies in supporting patients, as well as barriers such as low health literacy, cultural beliefs, and limited resources within the *Puskesmas*. These insights helped identify gaps between professional expectations and patient needs, informing recommendations to strengthen diabetes care in the Indonesian context.

For observations, a structured framework guided data collection, complemented by free-text fieldnotes to capture contextual details, non-verbal communication, and other nuances. This combination allowed for systematic coverage of key topics while retaining the flexibility to document unanticipated aspects of patient–provider interactions. In total, 28 clinical encounters between patients and healthcare professionals were observed to gain insight into real-time communication. Although the study included 14 patient participants, not all interacted with all three types of healthcare providers (doctors, nurses, and dietitians). The number of encounters (n=28) reflects the actual observed interactions during the study period. These encounters were based on real-life clinical situations, in which not every patient was required to meet with each professional—particularly dietitians, whose involvement depended on specific medical needs. The observations focused on the nature of the encounters and whether the interactions were likely to empower or fail to empower the patient's self-care management behaviors. Each observation covered the entire duration of the clinical encounter, which was typically less than 10 minutes.

Across most observations, interactions were highly focused and limited to three recurring topics: discussion of blood glucose levels (whether results were normal or not), requests for prescriptions or copies of prescriptions, and arrangements for referral paperwork. Broader conversations about lifestyle, self-management strategies, or psychosocial concerns were rarely initiated by either party.

For example, in one observed encounter (Fieldnotes 1, January 21st): Today I reflected that patient–doctor clinical encounters typically revolve around only three straightforward topics: patients' Blood Glucose Level (BGL), prescription requests, and referral paperwork. These topics are introduced either by the patient or the doctor, but no other issues are discussed. Once the encounter ends, patients either proceed to the pharmacy to collect their medications or, if they wish to avoid queuing or do not require medication, leave the building directly.

Data Analysis and Ethical Considerations

The collected data were analyzed using qualitative thematic analysis informed by Clarke and Braun's (2014) framework. We adopted a primarily inductive hybrid approach, allowing patterns to emerge organically while incorporating deductive elements from the theoretical framework on patient empowerment and self-management. Thematic analysis was chosen for its flexibility and compatibility with a critical realist perspective (Terry et al., 2017), which acknowledges participants lived experiences within broader social contexts. The analysis aimed to develop themes that explain how patient empowerment supports self-management in diabetes care in the Indonesian context, drawing on principles of critical theory

Interview transcripts and observational fieldnotes were coded systematically using NVivo 12 software. All members of the research team collaboratively reviewed codes and discussed emerging themes and subthemes until consensus was reached, guided by the study's theoretical framework. Three independent reviewers, academic supervisors not involved in data collection, oversaw the coding and thematic development. Before formal analysis, the team conducted a calibration exercise on a subset of transcripts to align coding decisions and refine theme definitions.

Member checking was integrated into the interview process. Immediately after each interview, the researcher verbally summarized the key points as interpreted, and participants confirmed or corrected these interpretations. This immediate, dialogical validation is recognized in the literature as an acceptable and pragmatic form of member checking that enhances credibility, dependability, and trustworthiness.

Ethical approval was obtained from the Flinders University Social and Behavioral Research Ethics Committee (SBREC) Project Number 8464, and a Research Permit Letter from *Depok*-West Java District Health Office to access the primary healthcare center, ensuring adherence to research ethics, confidentiality, and informed consent. All participants provided informed consent, and strict measures were taken to ensure confidentiality, anonymity, and protection of sensitive information.

Results

The vignette captures the everyday realities of patient care and health service delivery at an Indonesian *Puskesmas* in the context of the national health insurance program, *BPJS*, introduced in 2014. As gatekeepers to specialist care, *Puskesmas* carry increased responsibilities under this scheme, including referral authorization, medication prescribing, and initiation of diagnostic procedures. These added duties have notably impacted healthcare providers, especially doctors, whose workloads have intensified. Daily operations reveal systemic bottlenecks, with patient queues forming at registration, consultations, laboratory tests, and pharmacy pick-up—particularly in the diabetes clinic, which serves approximately 80–100 patients daily with only one general practitioner and a nurse. For elderly patients managing chronic conditions such as type 2 diabetes, prolonged waiting times add considerable stress. One 65-year-old participant, for instance, reported waiting for hours each month merely to secure a prescription. He described how he sometimes purchased affordable medications from outside pharmacies to avoid the lengthy queue. Such accounts illustrate the strain placed on both patients and providers in this evolving healthcare setting.

Patient Participants' Demographic Profiles

A total of 14 patients with T2DM who visited the *Puskesmas* were involved in the interviews and observations of their clinical encounters. Table 1 presents the demographic and health profiles of these participants.

The participants' ages ranged from 44 to 79 years. Of the 14, three were male. Eight had only a primary school education, one had a master's degree, three were senior high school graduates, and 2 held diplomas. Twelve were married and two were widowed. Most were housewives, living with a retired spouse and/or their children. Two participants were still in paid employment, one a private Islamic religious teacher and the other an informal private English tutor. All were covered under *BPJS*, and only four were members of *PROLANIS*.

Most participants were in advanced stages of diabetes, as evidenced by long-term complications and, in some cases, poorly controlled BGLs, according to the American Diabetes Association (ADA) 2021 criteria. The majority had at least one or two chronic diabetes complication(s), such as hypertension (five patients), diabetic sensory neuropathy (five), heart disease (two), diabetic retinopathy (three), diabetic gangrene (one), and loose teeth (one). Two patients also had other comorbidities, such as bronchial asthma and osteoporosis. Five participants had high BLGs (random BGLs ranged from 11.0–12.5 mmol/l and HbA_{1C} 64 mmol/mol or 8%), with most of the patients taking multiple oral hypoglycemia medications. One patient was on insulin therapy. Most participants did not have their HbA_{1C} results from the last six months. Duration of diabetes varied, with the shortest estimated as three to ten years (four patients), six patients had had diabetes for

Table 1. *Puskesmas* patient participant profiles

No	Code	Age (years)	Sex	Education	Marital Status	Occupation	Medical Diagnosis	Lab Results (mmol/L)	Year of Diabetes Diagnosis	Treatment	Health Cost Payer	Government Support Program (PROLANIS)
1	P 101	68	F	Primary School	Married	Housewife	T2DM, Hypertension	RBG 7.6	>20	Glimepiride	BPJS-K	Not joined
2	P 102	68	F	Finance Academy	Married	Retired	T2DM, Hypertension	RBG 11.8	22	Metformin, Glibenclamide Amlodipine,	BPJS-K	Not joined
3	P 103	79	M	Primary School	Married	Retired	T2DM, Hypertension, Heart Diseases, Bronchial Asthma	HbA_{1C} 63.9	21	Metformin, Amlodipine, ISDN, Aspilet	BPJS-K	Not joined
4	P 104	71	F	Primary School	Married	Housewife	T2DM	FBG 5.4	5	Metformin	BPJS-K	Not joined
5	P 105	64	F	Primary School	Married	Housewife	T2DM	RBG 7.3	6	Metformin	BPJS-K	Not joined
6	P 106	65	M	Diploma	Married	Retired	T2DM, Hypertension Retinopathy	FBG 4,7 PPBG 6.7	11	Metformin, Glibenclamide	BPJS-K	Joined
7	P 107	70	F	Primary school	Married	Housewife	T2DM Diabetes Neuropathy	FBG 6.7 PPBG 7.5	15	Metformin, Glibenclamide	BPJS-K	Not joined
8	P 108	65	F	Senior High School	Married	Housewife	T2DM, Diabetes Neuropathy	RBG 6,4	15	Metformin, Glimepiride	BPJS-K	Joined
9	P 109	68	F	Primary school	Married	Housewife	T2DM, Diabetes Neuropathy	RBG 7.3	7	Metformin	BPJS-K	Not joined
10	P 110	72	F	Primary School	Widow	Islamic religious private teacher	T2DM, Hypertension	FBG 5 PPBG 6.8	15	Metformin Amlodipine	BPJS-K	Not joined
11	P 111	64	M	Masters of Business Administration	Married	Retired	T2DM Heart Diseases	FBG 4.4	15	Metformin ISDN Aspilet	BPJS-K	Joined
12	P 112	65	F	Primary School	Married	Retired	T2DM	RBG 10.7	13	Metformin, Glibenclamide	BPJS-K	Not joined
13	P 113	72	F	High School	Widow	Private English Teacher	T2DM Osteoporosis	HbA_{1C} 47.5 mmol/mol	20	Metformin Amlodipine	BPJS-K	Joined
14	P 114	44	F	Senior High School	Widow	Unemployed (since with diabetes gangrene)	T2DM Diabetes gangrene Retinopathy diabetes	RBG 15.6	3	Rapid Insulin	BPJS-K	Not joined

Note: T2DM = Type 2 diabetes mellitus; HbA1C = glycosylated haemoglobin; RBG = random blood glucose; PPBG = post-prandial blood glucose; FBG =fasting blood glucose; ISDN =Isosorbide Dinitrate

between ten and 20 years, and four for more than 20 years.

Healthcare Professional Participants' Demographic Profiles

All participating HCPs, shown in Table 2, had general medical backgrounds, though none had public health qualifications. Of the two participating general medical doctors, one was assigned as the sole doctor with daily responsibility for the Special Aged Care Clinic operating within this *Puskesmas,* while the other was the head of the Chronic Illness Prevention and Promotion Program. The two senior nurses had more than 15 years of experience. One had a bachelor's degree and was assigned as head nurse of the Nursing Care Clinic. The nurse with a Diploma of Nursing worked in the Aged Care Clinic. One dietitian held a Diploma in Nutrition and was responsible for all medical cases requiring dietary support, including diabetes. The majority of HCP participants were female, with only one male included. Their ages ranged from 20 to 50 years. None had received additional specific training in diabetes care beyond what was included in their general disciplinary curricula.

Table 2. Demographic profile of participating healthcare professionals at the *Puskesmas*

No	Code	Professional Background	Educational Background	Sex	Age Range (years)	Job Title
1	011	General Medical Doctor	Medical Doctor	F	30–40	Medical Doctor
2	012	General Medical Doctor	Medical Doctor	F	40–50	Head of Community Health Care Centre
3	111	Nursing	Bachelor of Nursing	F	40–50	Head Nurse
4	112	Nursing	Nursing Diploma	M	40–50	Nurse
5	211	Nutritionist	Diploma	F	20–30	Nutritionist

Themes and Subthemes

Phase 1 of Data Analysis

Three main themes and seven subthemes were generated from the 28 observed clinical encounters; five main themes and ten subthemes emerged from the 14 patient interviews; and three main themes and three subthemes were generated from the FGD with HCPs. The list of the themes, subthemes, categories, and the selected codes of each theme and data collection method is presented in Tables 3, 4, and 5.

Phase 2 of Data Analysis

The second phase of analysis yielded four themes and eight subthemes through a cross-case approach (Table 6), derived from triangulated data sources: patient interviews, clinical encounter observations, and a HCPs focus group discussion.

Medical Dominance in Care Provision

The first theme, medical dominance, describes care processes in which clinical encounters are primarily focused on biomedical aspects. Patient's concerns are interpreted through a medical lens, and physicians maintain control throughout treatment by applying medical expertise. Two subthemes illustrate this process:

Care Focuses on Medical Aspects

Medical dominance was evident where clinical interactions prioritized medical testing and treatment over discussions of patient self-management. For example, a 64-year-old male patient with a Master of Education with T2DM for 15 years said:

"In here, they [the staff] are friendly, but there is no real care for diabetes patients. They just check my blood glucose and dispense medicines ... No information is provided; I mean related to my problems. It's just general information". (INTV, P111 line 56–61)

The excerpt highlights that patients perceived that Puskesmas care was limited to technical medical actions, such as checking blood glucose and dispensing medications. The patient also perceived that the information provided by healthcare professionals regarding diabetes was overly general and did not adequately address the specific issues, such psychological and social aspects, he was experiencing as an individual living with the condition. In the observed clinical encounters at the Puskesmas, the interactions between a doctor and a patient were mostly initiated by talking about the patient's BGLs and then continued with diabetes medications.

Physicians Decide the Care

Medical dominance was evident in the provision of physician-authorized care. Patients perceived that the doctor made all decisions independently, without consulting them. Many services at the *Puskesmas,* such as basic lab tests (e.g., random blood glucose) and diet consultations, required a physician's referral. Without it, patients would not be able to access these services. Physicians also determined treatment pathways, deciding whether a patient remained at the *Puskesmas* or was referred to a higher facility, regardless of patient preference. For instance, one female patient stated:

"I am using government healthcare insurance [the BPJS, the self-support one]. But I am not allowed [the doctor did not refer her as her wish to the provincial hospital] ... to be a patient in there [the referral hospital] ... I was not allowed because they [the doctors] said that I was not sick enough, so, the doctor won't send [refer] me to the hospital ... seemingly they waited for me to get a more serious illness, then I will be sent to a hospital." (INTV, P113, line 68–76)

This excerpt highlights the patient's frustration with the doctor's dismissal of her symptoms. She sought acknowledgment but was denied a referral. The doctor

Table 3. Selected codes, categories, subthemes-themes from observations of clinical encounters

Selected codes	Categories	Sub-themes	Themes
Blood glucose lab. Tests Prescribing Dr initiate interaction with BGL results Reducing symptoms Referral issues Ask open-ended questions	Physical issues HCPs driven communication Dispensing medications	Blood glucose evaluations and medication prescribing were the focus of clinical encounters Self-management was not the main issue discussed in clinical encounters	Medical dominance in the interactions
Change the subject/topic Greeting patients Non eye contact Referral issues Waiting for another patient No encouragement to talk No questions to patient No question to doctor/nurse Leave the problem to the patient	Encourage participating Doctor patient language Features of empowerment and disempowerment Communication pattern One direct communication Mechanical behaviors Social Lifeworld	Lack of engagement with patient daily problems HCPs were in control in the clinical encounters Lack of patient privacy Patient confusion on referral procedure	Disempowering clinical encounters
Information provided Queue insite the room Routine care	Routine care Crowded Quick service	Clinical workload and mechanical works	Sub-optimal of health information infrastructure

Note: HCP = healthcare professional

Table 4. Selected codes, categories, subthemes-themes from patient interviews

Selected Codes	Categories	Sub-themes	Themes
Not get a good care	Biological care	Powerless consumers	Care quality
No care on psychology			
Patients psychologically concern was ignored	Medical focus care	Long queue up	
Feel being inferior		Physical focus of care	
Normal blood glucose-oriented care			
Doctor just focuses on glucose lab	Skeptical towards the care	Industrialization of health	
Focus on results and glucose medications and disregards other issues		Routine care	
Long waiting time	Administration issues	Overwhelmed by the referral system	
The quality of care provided is okay for PBJS users			
BPJS service was poor			
Non-humanist care			
Family problem			
Social problem			
Referral issues			
Nutritionists wait for doctor referral	Medical voice dominant	–	Physicians decide the care
Doctors' decision to refer or not to refer			
Reluctant to have discussion with patients	Communications issues	Underestimate patient needs and capacity to learn	Communication gaps
Doctors reluctant to talk			
Hesitance in expressing wishes			
Aged-related stereotyping			
Doctor hesitance to talk to patient		Ageism hindered patients-health care professional communications	
Doctor seem does not have time listen			
Doctors are sources of information but no time to educate			
Misperception on diabetes cause and care	Health education issues	Diabetes related- health literacy	At high risk in making harmful decisions in daily care
Lack of patient knowledge			
Herbs remedies as complementary care			
Unsafe self-management practice			
Information provided by doctors is too general		Uncomplete and too general information provided	
Un-credible source of information			
Friends as a source of information			
Family as learning resource			
'Health education' is too general			
Ignoring patients concern on their body			
Nurse information less relevant			
Being motivated	Family supports		Self-empowered
Family support	High motivations	-	
Herbs remedy	Healthier lifestyle Complementary therapy		
Reading books to find more accurate information	Diabetes care myths		

Table 5. Selected codes, categories, subthemes-themes from a focus group discussion

Selected codes	Categories	Sub-Themes	Themes
PROLANIS the Under- utilized program	Government programs-based Centre care	Mis-match program	Regulations-based care provision
Education program			
100% report			
Restricted to 20			
Indicator of care quality			
Barriers lack of patients interest			
Limited number			
Patient health education is the key standard of diabetes care	HE limited to medication, exercise and diet Helping to understand the diseases	-	Supporting self-management through patient education
Effectiveness of home visit			
Not sure psychosocial care program			
Benefits of HE programs			
Health Literacy	Low in health literacy	Patients-related problems	Barriers in 'empowering'
Lazy patient	Low educational background		
Not motivated patients	Lack of motivation		
Scheduling	Staff schedule		
Time constraint	Lack of human resource	Organizations-related problems	
Human resources			

deemed hospital care unnecessary based on symptom

Table 6. Final themes and subthemes

Themes	Subthemes
Medical dominance in care provision	Care focuses on medical aspects Physicians decide the care
Communication gaps	Lack of patient involvement Discouraging clinical encounters Disjunction between patients' and HCP perceptions on patient education to support self-management
Care quality	Lack of information infrastructure to promote patient self-management
Self-empowerment	Low health literacy issues At high risk of making harmful decisions

severity—a sentiment echoed by other patients.

Communication Gaps

The second main theme, communication gaps, refers to an imbalance in the communication between patients and the HCPs that created an asymmetry of knowledge and power between patients and the HCP. Three subthemes included lack of patient involvement, discouraging clinical encounters, and disjunction between patient and HCP perceptions of self-management support.

Lack of Patient Involvement

Interview data highlight patient concerns regarding their involvement in care. A 72-year-old woman with T2DM for over 20 years described feeling dismissed:

> *"I told the doctor my BGL was below 11.1 mmol/L and asked if I could stop my medication. The doctor said, 'Ma'am, your kidneys were affected ... if you stop, it will get worse.' That response made me feel depressed. I didn't even know my kidneys were affected—why didn't they explain it kindlier?"* (INTV, P113, line 99–106)

This response suggests a lack of empathetic communication. The patient sought involvement in her care but was instead informed of kidney complications in a distressing manner. The absence of prior explanation left her feeling powerless. Similar experiences were reported by other participants, highlighting systemic gaps in patient-provider communication that hinder patient empowerment in diabetes management.

Discouraging Clinical Encounters

Clinical encounters often lacked supportive communication. In one case, a 44-year-old woman with diabetes sought wound care at the *Puskesmas* and informed the doctor about her planned eye surgery, as advised by a referral hospital.

A nurse seated the patient and mentioned the surgery. The doctor, without acknowledging her, checked the records and asked,

> *"When is the surgery? The patient began, "I am not sure," but the doctor interrupted, "You must have it as soon as possible and follow medical procedures. We are treating your diabetes gangrene. Looking exhausted, the patient replied, "Okay, I will ask the doctor [at the regional hospital] about the date," then thanked the doctor, ending the interaction".* (OBS14 P114)

This exchange reflects the doctor's authoritative communication, placing blame on the patient for the delay rather than recognizing her condition. The patient had little control over the conversation and could not explain that high blood glucose was the true cause of the delay. Similar disempowering interactions were common, highlighting systemic communication barriers in diabetes care.

Disjunction Between Patient and Healthcare Professional Perceptions of Self-Management Support

This theme highlights the gap between patient expectations for detailed self-management guidance and HCPs' approach to providing information. Many patients found the information impersonal, general, and insufficient, as one patient expressed:

> *"I wish the doctor explained things clearly ... but I understand ... Here [at the Puskesmas], I was just told to get my blood sugar tested and exercise ... but not what kind, how to do it, or how much ... The explanations were limited ... I understand many patients are waiting, so I was just told to exercise ... I don't know how much or what kind ... If I feel unwell, I just reduce my sugar intake and see the doctor".* (INTV, P108, line 24–34)

This patient expected more personalized guidance but received only vague recommendations, leaving her uncertain. This pattern was evident in clinical observations, where consultations often lasted under five minutes and lacked individualized advice. In one case, a 70-year-old woman with T2DM for 15 years was told:

> *"Could I get your blood sugar test results?" The patient replied, "I did not check my blood sugar." The doctor responded, "Why not? Next time, check it before coming so I can evaluate your medications. You also need to lose weight." The patient, assuming exercise was required, explained, "I might have high uric acid; I can't exercise—I have painful legs".* (OBS, 07P)

The doctor's recommendation to lose weight lacked specificity, reinforcing patients' perceptions that the advice was too general. HCPs, however, did not prioritize individualized education, focusing instead on meeting government targets, as one doctor explained:

> *"Thank God, we've reached 80% from just 30% in patient education coverage. The problem was when patients came in*

the afternoon, and the nutritionist was unavailable … so we just provided adequate dietary advice for that moment". (FGD1, P01, lines 34–43)

This response suggests that meeting numerical targets took precedence over tailored patient education. These excerpts illustrate a fundamental disconnect between patient expectations and HCPs' perceptions of adequate education in clinical practice.

Regulation-Centered Care Provision

The third main theme, regulation-centered care provision, refers to the care and programs provided in the *Puskesmas* that were run according to government regulations. The subtheme is perceived healthcare organization-related barriers to patient empowerment.

HCPs perceived that existing care for patients with T2DM in the *Puskesmas* aligned with Indonesian Government regulations for non-communicable disease management. As one doctor stated:

Our system follows the Indonesian Health Ministry regulations, including diabetes care. Each month, we must report our progress. (FGD1, P01, lines 1–3)

Reports on program achievements were a crucial part of the system. Self-management and patient empowerment were part of *BPJS 's PROLANIS* program, which included an aerobics club and HbA1C testing every six months. A nurse explained:

"The PROLANIS program must reach 100% coverage. If there are 20 members, all must participate in every activity. Otherwise, we don't meet indicators, and capitation funds are reduced". (FGD1, P03, lines 71–77)

Since many patients could not fully commit to all *PROLANIS* activities, membership was limited to 20 to ensure compliance. This restriction meant hundreds of patients missed out on the program's benefits.

Education programs focused on regulatory compliance rather than patient needs. Patients felt their care was limited to measuring BGL and medication management, lacking emotional and psychological support. One participant noted:

"Psychological aspects of care should be considered. Physicians should talk to us, allowing patients to express their problems". (INTV, P111, lines 67–72)

Existing care primarily addressed glucose control and medication, with minimal attention to psychological needs. Although HCPs viewed PROLANIS as an empowerment initiative, it did not fully meet patients' needs.

Perceived Healthcare Organisation-Related Barriers to Patient Empowerment

HCPs faced time constraints, limiting their ability to engage with patients. Doctors had an average of five minutes per patient, while nurses had one to two minutes. A female patient, 65, with diabetes for 15 years, shared:

"At Puskesmas, I am only told to check blood sugar and exercise. I have other issues, like tingling feet, but the doctor just refers me to another specialist without discussion". (INTV, P108, lines 23–47)

The patient felt neglected as her broader health concerns were overlooked due to time limitations. A nurse confirmed that patients often forgot key information:

"Patients need repeated education. One patient ran out of medication but didn't return because he didn't understand. He left a wound untreated for a month, despite a prior amputation". (FGD1, P03, lines 219–226)

Unlike patients, HCPs attributed barriers to patient factors such as low education, poor health literacy, and lack of motivation. One HCP explained:

"Many patients are lazy. When they learned the diabetes aerobics program was at 6:30 AM on Saturdays, they lost interest". (FGD1, P02, lines 213–217)

HCPs believed patients lacked awareness and commitment. Some patients also held misconceptions about diabetes causes, such as a 72-year-old woman who thought she contracted diabetes from a non-sterile needle during a family planning injection:

"Who knows if the needle was used? Maybe that's how I got diabetes". (INTV, P110, lines 2–3)

Patients also reported feeling dismissed due to age-related stereotyping. A 72-year-old woman, diagnosed with T2DM for 20 years, said:

"When I mentioned varicose veins, the doctor said it was just because of my age. The same response came when I had headaches. I hesitated to ask more questions". (INTV, P113, lines 61– 67)

HCPs' focus on physical symptoms as age-related issues discouraged patient engagement, creating barriers to empowerment. These communication gaps highlight the challenges in fostering patient-centered care.

Care Quality

The fourth main theme, *care quality*, highlights perceived low-quality care at the Puskesmas, linked to various patient-identified issues. A key concern was the lack of health information infrastructure to support self-management.

Despite the staff's friendliness, patients felt the care did not meet their needs. Long queues for services, including pharmacy waits and doctor consultations, reinforced this perception. Many saw *Puskesmas* care as limited to diabetes medication and blood glucose tests, with psychological needs overlooked. There was no space to discuss real-life challenges related to diabetes. A 65-year-old woman who had used th*e Puskesmas* for over a decade shared:

"The service [the care] was poor ... But I understand this is just a Puskesmas. I did not blame them [the HCPs]. But to be honest, the care was poor". (INTV, P08, line 44–47)

The excerpt above suggests that patient evaluation of the quality of care was low. The patient implied that the care in this *Puskesmas* was poor, as it happened in *Puskemas* in general.

Lack of Health Information Infrastructure to Promote Patient Self-management

This subtheme refers to the lack of patient-education programs, standards and guidelines, education materials, or interventions in clinical encounters or in programs to improve patient knowledge and skills to foster self-management. In all the 28 clinical encounters, no health education was provided to the patients. Consultations on a diabetes diet with a dietitian were the only patient-education program prescribed by the doctor and were only provided once. When a nurse was asked about the patient-education program in the FGD, she said:

"I acknowledge my weakness is for documenting. I explained a lot of things, but no records on it. One day, a patient came to me and said that we have not explained about a particular thing; in fact, I have, but I didn't have any note to prove". (FGD1, line 120–124)

The nurse in the excerpt above indicated that a component of patient education was provided; however, as there was no planning or evaluation of the education program, no documentation or records were written. The records on patient education were focused on the coverage or number of patients who were referred to the dietitians.

Self-empowerment

Self-empowerment reflects patients' coping strategies to acquire diabetes knowledge, often compensating for inadequate health education from HCPs. Two key themes emerged: low health literacy and a high risk of harmful decision-making. The former highlights misunderstandings in diabetes care, while the latter underscores the impact of inadequate evidence-based knowledge.

Patients sought information from family, friends, books, and religious beliefs, sometimes acting on myths despite their questionable validity. A 44-year-old woman with T2DM, severe diabetic retinopathy, and active gangrene shared:

"I tried cherry and insulin leaves. Many suggested snake's bloods for my wounds, but I don't trust it. Self-care and self-learning matter because I feel the effects. Ignoring treatment makes me ill, so I avoid sugary food and drinks". (INTV, P114, line 38–47)

This excerpt highlights patients' exposure to diverse health information. The patient selectively adopted reasonable advice while rejecting irrational claims, emphasizing self-learning as crucial for mitigating health risks.

Low Health Literacy

The low health literacy subtheme refers to a lack of knowledge and skills about basic health related to diabetes. Some patients had incorrect perceptions regarding managing numbness caused by neurological damage. One of the examples of this was a 68-year-old female participant who had finished her tertiary education with T2DM for 22 years:

"I soak my hands in a warm water to reduce numbness, but I am still having the problem and planning to ask for medications from the doctor". (INTV, P102, line 2–3)

The excerpt above shows that the patient was soaking her hands in warm water to reduce the numbness without realizing the potential injury that might occur when a diabetic uses warm water. The practice shows that the patient has limited knowledge of the impact of using warm water on patients with T2DM, in which many neurological related diabetes complications cases have alterations in temperature sensitivity.

At High Risk of Making Harmful Decisions in Daily Care

This subtheme highlights the risks patients face in managing critical diabetes-related events, such as hypoglycemia. Older adults on hypoglycemic agents are particularly vulnerable. A 68-year-old woman with T2DM for seven years shared her experience:

"I had low blood sugar ... I was nearly unconscious and so weak ... I was taken directly to a clinic. I was afraid that if I put sugar in my drink, my blood sugar would increase. So, I just drank plain water." (INTV, P109, line 84–97)

This patient misunderstood how to manage hypoglycemia, avoiding sugar due to fear of hyperglycemia. Instead of taking immediate corrective action, she relied on medical intervention. Given that hypoglycemia is a medical emergency, her lack of knowledge placed her at high risk for severe consequences. Other patients also reported uncertainty, with some believing that consuming corn sugar or low-sugar tea was sufficient.

These misconceptions likely stem from a combination of low health literacy, limited education, communication gaps with HCPs, and insufficient professional support (Murugesu *et al.*, 2022).

Discussions

Medical Dominance in Diabetes Care in Indonesia

Medical dominance, first conceptualized by Freidson in the 1970s (Looman *et al.*, 2022), describes the power of the medical profession over healthcare systems and other HCPs (Coburn, 2015). The theme of medical dominance in Indonesian diabetes care can be understood more deeply through Habermas's theory of distorted communication. The predominantly one-way and clinician-driven nature of consultations reflects disengaged communication that limits opportunities for collaborative decision-making. Rather than fostering dialogical understanding, many consultations function as purely biomedical instruction sessions, a form of communicative distortion that structurally reduces the patient's ability to express their needs and perspectives (Habermas, 1984; Tates et al., 2020).

Honneth's (1995) recognition theory further illuminates this imbalance by showing how such interactions fail across three domains of recognition. First, *rights*: patients' capacity to participate in decisions is constrained by the gatekeeping structure of the *BPJS K* insurance system, where physicians control access to specialist care. Second, *solidarity*: age-related stereotypes and tendencies to blame patients diminish respect for their capabilities and lived experiences. Third, *care/love*: psychosocial needs are often overlooked in favour of strictly biomedical priorities, signalling a lack of empathy and emotional support (Schmitz, 2019).

Cultural factors in Indonesia—such as patriarchy and high-power distance—intensify these hierarchical structures in clinical encounters. Patients may feel reluctant to question doctors' instructions, a tendency reinforced by *BPJS* policy frameworks and *PROLANIS* indicators that emphasise cost-efficiency and biomedical targets over holistic, person-centred care (Dewi et al., 2013). Together, these cultural and policy factors perpetuate medical dominance and limit interprofessional collaboration in diabetes management.

Addressing this entrenched dominance requires shifting authority and creating space for dialogue between health professionals and patients. Within *Puskesmas*, nurse-led empowerment programs and structured group education sessions can foster a more participatory environment. Storytelling-based approaches and peer-facilitated support groups have been shown to increase openness and trust between patients and providers (Rifli & Yulianah., 2025). Moreover, culturally adapted communication training for doctors and nurses, transitioning from a directive style to shared decision-making, can significantly enhance patient engagement (Puspitasari et al., 2023).

Such strategies have the potential to dismantle hierarchical barriers, enrich the psychosocial dimension of routine care, and strengthen patient empowerment, ensuring that diabetes care in *Puskesmas* is not only cost-effective but also equitable and responsive to the social realities of patients.

Communication Gaps in Patient–Healthcare Provider Interactions

Effective communication between patients and HCPs is essential for optimal diabetes care (Kishimoto *et al.*, 2025), aligning with Habermas' concept of communicative action (Lafont, 2018) and empowered communication (Nolte & McKee, 2008; Palumbo, 2017). However, this study identified significant communication gaps, particularly in health literacy and differing expectations. These gaps hindered both patient and HCP objectives, posing a major challenge to self-management support.

In Indonesia, patient–HCP communication remains underexplored. However, some studies, such as (Rahayu *et al.*, 2024) and (Mulyana *et al.*, 2019), provide insight into the issue. Doctors often adopt a strategic rather than communicative approach (Sindhvananda, 2011 Carter et al 2023), with holistic care constrained by biomedical models (Hoppenot *et al.*, 2022). Studies indicate a paternalistic communication style (Claramita *et al.*, 2013), limiting patient engagement and health education. These gaps stem from structural, social, and cultural factors, reflecting broader issues in healthcare delivery. Addressing these challenges through ongoing HCP communication training may enhance patient-centered diabetes care.

Differences In Patient and Healthcare Professional Expectations

This study revealed differing expectations between patients and healthcare professionals (HCPs) and highlighted communication gaps. Effective patient–HCP communication is essential for improving outcomes (Sharkiya, 2023). Most patients wanted doctors to take time to listen to their concerns, offer kindness, and avoid judgment, rather than focusing solely on prescriptions and lab referrals. In contrast, due to time pressures, HCPs—mainly doctors—expected patients to follow their advice without discussion or explanation.

Open disagreement was rare, influenced by Indonesia's patriarchal culture, low health literacy, socioeconomic constraints, and traditional values. These factors shaped patients' lifeworlds, which sometimes conflicted with HCPs' professional priorities or healthcare system requirements, such as adherence to medical programs not aligned with patient interests

(Scambler & Britten, 2013). Patients often complied passively, engaging minimally in self-management (Soyoon & Ekaterina, 2022; Nolte & McKee, 2008). Communication focused on doctors' goals could lead to dissatisfaction, suppression, and emotional distress (Jensen et al., 2020), while recognising the patient's lifeworld could foster understanding and collaborative decision-making (Jeffrey & Jeffrey, 2020; Ravn Jakobsen et al., 2021).

In Indonesian community health centers, patient satisfaction moderately correlated with communication duration ($r = 0.444$, $p < 0.005$), with an average of 2.96 minutes. Strengthening patient–HCP communication could therefore enhance outcomes (Hickmann et al., 2022). Continuing education programs should be developed using evidence-based strategies known to improve these interactions.

Care Quality

This study identified two key sub-optimal outcomes in diabetes care: lack of self-management awareness and potentially harmful self-management practices. Patients demonstrated limited knowledge of self-management, relying on lay beliefs rather than evidence-based practices. Factors contributing to this issue included inadequate healthcare resources, poorly managed care, and communication gaps.

Diabetes self-management is not emphasized in Indonesian guidelines, which prioritize biological targets like blood glucose control (PERKENI, 2021). Unlike international standards, Indonesian diabetes care does not use self-management as an outcome measure, limiting its integration into routine care. As a result, patient education remains focused on basic diabetes knowledge rather than behavioral change.

Patients' biomedical profiles reflected poor self-management, with most experiencing uncontrolled blood glucose and complications. National data align with these findings, showing high complication and mortality rates (Sun *et al.*, 2022). Current care models focus on acute interventions rather than long-term empowerment strategies. Education and training programs tailored to the Indonesian context are needed to enhance self-management and improve patient outcomes.

Potentially Harmful Self-Management Practices

Diabetes outcomes were suboptimal due to patients' limited understanding and use of unprescribed treatments. Some patients altered insulin dosages without medical advice or relied on low-calorie sweeteners for hypoglycemia. Polypharmacy confusion arose among those seeing multiple specialists, yet they lacked opportunities for clarification. Inadequate facilities, understaffing, and limited consultation time hindered diabetes self-management education.

Despite *BPJS* support, *PROLANIS*, and expanded access initiatives, patient outcomes remained suboptimal, highlighting the complexity of interrelated systemic issues.

Diabetes outcomes were suboptimal due to patients' limited understanding and reliance on unprescribed treatments. Some patients altered insulin dosages without medical advice or used low-calorie sweeteners to manage hypoglycemia. Polypharmacy confusion was common among those consulting multiple specialists, yet opportunities for clarification were scarce. Inadequate facilities, understaffing, and limited consultation time further constrained the delivery of diabetes self-management education (Shah et al., 2024).

These patterns were shaped not only by resource limitations but also by sociocultural dynamics. In Indonesia's patriarchal and high-power *distance* context, patients often refrained from questioning healthcare providers' instructions, even when uncertain, reinforcing gaps in understanding. When combined with institutional constraints—such as *BPJS* reimbursement rules and *PROLANIS* performance indicators that prioritize biomedical targets over individualized counseling—these cultural dimensions perpetuated a system where structured access coexists with insufficient patient empowerment, resulting in persistent suboptimal outcomes despite expanded coverage.

Conclusion

The study showed that most patient participants were aged above 40 years and had little educational knowledge of diabetes care. Five out of 14 patient participants had uncontrolled high BGL; the majority had chronic diabetes complications and did not have the results of their HbA1C level in their medical records. The HCPs were aged 40 to 60 years and had a general educational background in medical and nursing areas.

The healthcare service context showed the role of the *Puskesmas* as a gatekeeper, and physicians were assigned to the role. A high number of patients attended daily, there were long queues in obtaining the services, and short and brief medical encounters. Features of medical dominance in care were shown as the clinical encounters focused on medical aspects, and the care was directed by physicians with little patient involvement in deciding the care. Communication gaps between patients and HCPs were also presented in the clinical encounters, where both patients and HCPs had different expectations in their communication. While most of the patients suggested that the approach used in their care was discouraging, this contrasts with the HCPs, who believed the care included an education program.

The existing diabetes care in the *Puskesmas* also showed care provision centered on government regulations over patient needs and lacked any formal healthcare information infrastructure. It was perceived by the patients as low care quality. Finally, within the existing approach used in care, there was a lack of support from HCPs towards patient self-management that resulted in a low level of health literacy and a lack of capability in making daily health-promoting decisions.

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Availability of data and materials

The Data and Materials of this study are available on request to the correspondence author.

Authors' contributions

Y conducted the research and revised the manuscript. The other contributions were W.A, E.W., and F.S. for supervising the research, drafted, and revising the manuscript.

Declaration of Interest

The authors declare that there are no conflicts of interest in this study.

References

Arifin, B. *et al.* (2020). 'Diabetes is a gift from god'a qualitative study coping with diabetes distress by Indonesian outpatients. *Quality of Life Research*, *29*(1), 109-125.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. The qualitative report, 13(14), 544 – 559

Carter, C. *et al.* (2023). "I don't see the whole picture of their health": a critical ethnography of constraints to interprofessional collaboration in end-of-life conversation in primary care. BMC Primary Care 24: 225

Cheng, Z. *et al.* (2025). Effectiveness of patient-centred care in self-management of type 2 diabetes: a systematic review and meta-analysis. *BMC Health Services Research*, *25*(1), 1-11.

Claramita, M. *et al.* (2013) 'Doctor–patient communication in Southeast Asia: a different culture?', *Advances in Health Sciences Education*, 18, pp. 15–31.

Clarke, V., & Braun, V. (2014). Thematic Analysis. In T. Teo (Ed.), *Encyclopedia of Critical Psychology* (pp. 1947-1952). Springer New York. 10.1007/978-1-4614-5583-7_311

Coburn, D. (2015) 'Vicente Navarro: Marxism, medical dominance, healthcare and health', in *The Palgrave Handbook of Social Theory in Health, Illness and Medicine*. Springer, pp. 405–423.

Davis, T. C. *et al.* (2012). Diabetes Implementation of a Self-management Program in Resource Poor and Rural Community Clinics. *Journal of primary care & community health*, *3*(4), 239–242. https://doi.org/10.1177/2150131911435673Form

Dewi. D. *et al.* (2013). Person-centred care in the Indonesian health-care system. *International Journal of Nursing Practice 20 (6) : 616-622*

Fithriyah, N., Pujilestari, C., & Ng, N. (2023). Exploring inequalities in use, quality, and outcome of a diabetes management program in Indonesia: A mixed-methods study. *Health Equity, 7*(1), 393–401. https://doi.org/10.1089/heq.2022.0122

Frantz, J., Schopp, L. and Rhoda, A. (2021) *Self-management in chronic illness: principles, practice, and empowerment strategies for better health*. Springer.

Habermas, J. (1985). *The theory of communicative action, lifeworld and system: A critique of functionalist reason* (T. McCarthy, Trans.; Vol. 2). Beacon Press.

Hickmann, E., Richter, P. and Schlieter, H. (2022) 'All together now – patient engagement, patient empowerment, and associated terms in personal healthcare', *BMC Health Services Research*, 22(1), pp. 1–11. doi: 10.1186/s12913-022-08501-5.

Hoppenot, C. *et al.* (2022) 'Gaps in patient-physician communication at the time of malignant bowel obstruction from recurrent gynecologic cancer: a qualitative study', *Supportive Care in Cancer*, 30, pp. 367–376.

International Diabetes Federation (IDF). (2024). *IDF Diabetes Atlas* (11th ed.). IDF. https://idf.org

Jeffrey, D. I. and Jeffrey, D. I. (2020) 'Experiencing Empathy in the Patient-Doctor Relationship', *Empathy-Based Ethics: A Way to Practice Humane Medicine*, pp. 43–61.

Jensen, K. *et al.* (2020). Reward and empathy in the treating clinician: the neural correlates of successful doctor–patient interactions. *Translational psychiatry*, *10*(1), 17.

Khoe, L. C. *et al.* (2020) 'The implementation of community-based diabetes and hypertension management care program in Indonesia', *PLOS ONE*, 15(1), p. e0227806. Available at: https://doi.org/10.1371/journal.pone.0227806.

Lafont, C. (2018) 'Heidegger and the Frankfurt School', in *The Routledge Companion to the Frankfurt School*. Routledge, pp. 282–294.

Looman, N. *et al.* (2022) 'Exploring power dynamics and their impact on intraprofessional learning', *Medical Education*, 56(4), pp. 444–455. doi: 10.1111/medu.14706.

Fritz, M. *et al.* (2024). Effectiveness of community-based diabetes and hypertension prevention and management programmes in Indonesia and Viet Nam: a quasi-experimental study. *BMJ Global Health*, *9*(5).

Kishimoto, M. *et al.* (2025) 'Enhancing communication skills in diabetes care: an observational study regarding the impact of role-playing training for medical staff', *BMC Medical Education*, 25(1). doi: 10.1186/s12909-025-06821-8.

Krisnadewi, K. I. *et al.* (2024). Implementation preventive program for diabetic mellitus (PROLANIS) at Community Health Center in Indonesia: A qualitative study. *Journal of Applied Pharmaceutical Science*, *15*(1), 153-161.

Mulyana, D. *et al.* (2019) 'Communication Barriers between Medical practitioners and Patients from Medical Practitioners' Perspective', *Pertanika Journal of Social Sciences and Humanities*, 27(4), pp. 2797–2811.

Murugesu, L. *et al.* (2022) 'Challenges and solutions in communication with patients with low health literacy: Perspectives of healthcare providers', *PLoS ONE*, 17(5 May), pp. 1–16. doi: 10.1371/journal.pone.0267782.

Napiwodzka, K. (2021) 'Communicative action and practical discourse to empower patients in healthcare-related decision making', *Acta Universitatis Lodziensis. Folia Philosophica. Ethica-Aesthetica-Practica*, 1(38), pp. 81–99. doi: 10.18778/0208-6107.38.04.

Nolte, E. and McKee, M. (2008) 'one', *Caring For People With Chronic Conditions: A Health System Perspective: A Health System Perspective*, p. 1.

Palumbo, R. (2017) *The bright side and the dark side of patient empowerment: Co-creation and co-destruction of value in the healthcare environment*. Springer.

PERKENI. (2021). *Penatalaksanaan DM Sesuai Konsensus PERKENI 2015*. PB. PERKENI.

Permana, H. *et al.* (2022) 'Diabetes mellitus patients in Indonesia: management in a tertiary hospital compared to primary health care', *Universa Medicina*, 41(2), pp. 157–168.

Pradipta, I. S. *et al.* (2025). How Does Indonesian Chronic Disease Patient Adhere to Their Treatment? A Cross-Sectional Analysis of 11,408 Subjects. *Patient preference and adherence*, 173-184.

Putri, L. P., Mawarni, D., & Trisnantoro, L. (2020). Challenges of shifting diabetes mellitus care from secondary-to primary-level care in urban and rural districts: a qualitative inquiry among health providers. *Journal of Primary Care & Community Health*, *11*, 2150132720924214.

Puspitasari. *et al.* (2023). The Emergent Literacy Activities Through the Storytelling Method with Flashcard Media for Early Childhood Education. Journal of Digital Learning and Education 3(01) : 32- 39

Rahayu, S. A. *et al.* (2024) 'Does power distance in healthcare teams linked to patient satisfaction? A multilevel study of interprofessional care teams in a referral hospital in Indonesia', *BMC Health Services Research*, 24(1), pp. 1–8. doi: 10.1186/s12913-023-10534-3.

Ravn Jakobsen, P. *et al.* (2021) 'The gap between women's needs when diagnosed with asymptomatic osteoporosis and what is provided by the healthcare system: a qualitative study', *Chronic illness*, 17(1), pp. 3–16.

Rifli, Naurah Assyifa & Yulianah. (2025). Narrative effectiveness in digital health advocacy: Lessons learned from Casemas.id's strorytelling initiative in enhancing national health promotion strategies. Journal of Community Empowerment for Health 8 (2): 81-86

Scambler, G. and Britten, N. (2013) 'System, lifeworld and doctor–patient interaction: Issues of trust in a changing world', in *Habermas, critical theory and health*. Routledge, pp. 45–67.

Schmitz, V. (2019). Axel Honneth and the tradition of radical reformism. In V. Schimtz (Ed 1), Axel Honneth and the Critical Theory of Recognition (1st ed. 2019. Ed). *Palgrave Macmillan*. https://doi-org.ezproxy.flinders.edu.au/10.1007/978-3-319 91980-5

Shah, M. K. *et al.* (2024). *Diabetic patients'knowledge and related factors towards insulin therapy: A systematic review.* Journal of Nursing Reports & Clinical Practice.

Sharkiya, S. H. (2023) 'Quality communication can improve patient-centred health outcomes among older patients: a rapid review', *BMC Health Services Research*, 23(1), pp. 1–14. doi: 10.1186/s12913-023-09869-8.

Sindhvananda, W. (2011) 'Enhancing physicians' communication skills is not enough: an approach by Habermas social theories', *South-East Asian Journal of Medical Education*, 5(2).

Soyoon, K., & Ekaterina, M. (2022). From compliance to adherence in diabetes self-care: Examining the role of patient's potential for mindful non-adherence and physician-patient communication. *American journal of health promotion*, *36*(7), 1094-1103.

Sun, H. *et al.* (2022) 'IDF Diabetes Atlas: Global, regional and country-level diabetes prevalence estimates for 2021 and projections for 2045', *Diabetes Research and Clinical Practice*, 183. doi: 10.1016/j.diabres.2021.109119.

Suwito, W., et al. (2023). Medication adherence and glycemic control among patients with type 2 diabetes mellitus in Indonesia. *Heliyon, 9*(8), e18152. https://doi.org/10.1016/j.heliyon.2023.e18152

Tates, K. *et al.* (2002) 'I've come for his throat: roles and identities in doctor-parent-child communication. Chlid: Care, Health and Development 28(1): 109- 116

Terry, G. *et al.* (2017). Thematic analysis. *The SAGE handbook of qualitative research in psychology*, *2*(17-37), 25.

Walseth, L. T., & Schei, E. (2011). Effecting change through dialogue: Habermas' theory of communicative action as a tool in medical lifestyle interventions. *Medicine, Health Care and Philosophy*, *14*(1), 81-90.

Widyastuti, R. A., et al. (2021). Factors influencing medication-taking behavior among patients with type 2 diabetes in Indonesia: A qualitative study. *Patient Preference and Adherence, 15*, 2103–2114. https://doi.org/10.2147/PPA.S324693

Yin, R. K. (2017) *Case study research and applications: Design and methods*. Sage publications.

Zygmont, A. *et al.* (2023) 'Uplifted by Dancing Community: From Physical Activity to Well-Being', *International Journal of Environmental Research and Public Health*, 20(4). doi: 10.3390/ijerph20043535.

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