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Health Service Quality in Remote Primary Care: The Influence of Organizational Commitment and Digital Transformation

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Abstract:

This study aims to analyze the influence of organizational commitment and digital transformation policies on health service quality in very remote community health centers (Puskesmas) in Tana Toraja Regency. The research involved 32 healthcare workers selected through purposive sampling. A quantitative method was employed, utilizing validated scales for Organizational Commitment, Digital Transformation, and Service Quality as measurement instruments. Data were analyzed using multiple linear regression. The findings reveal that organizational commitment exerts a significant positive influence on service quality ($\beta = 0.890$, $p < 0.001$). In contrast, digital transformation policy was not a significant predictor of service quality ($\beta = 0.074$, $p = 0.367$). Collectively, both variables significantly explain 80.4% of the variance in service quality (Adjusted $R^2 = 0.804$). The results underscore that in very remote areas, human factors, particularly organizational commitment, are the primary determinant of health service quality, while digital implementation continues to face substantial barriers. Therefore, strengthening organizational commitment should be the primary priority, either prior to or in conjunction with digitalization initiatives.

Keywords: *organizational commitment; digital transformation; service quality; community health center; remote area*

INTRODUCTION

The quality public service is a key indicator in achieving good governance. Public services that meet standards, are transparent, accountable, and oriented toward user satisfaction not only reflect organizational performance quality but also influence public trust in government institutions. In the reform era, local governments have been given significant opportunities to develop their regions through decentralization, enabling them to meet diverse public demands and deliver high-quality services (Rudiyanto et al., 2022). However, in practice, the improvements in public service quality are often hindered by various complex factors, resulting in the anticipated changes not being fully realized uniformly across sectors and regions.

In the health sector, the quality of healthcare services is particularly crucial as it directly affects public safety and well-being. As the frontline of the healthcare system, community health centers (Puskesmas) play a vital role in improving public health, especially in remote areas that frequently face challenges related to limited accessibility and resources. Enhancing service quality in community health centers has become increasingly important given rising public expectations for effective, efficient, and responsive healthcare. Therefore, community health centers need to strengthen their service functions to become more effective and efficient, particularly in addressing human resource challenges and technological advancements (Mazdalifah, 2020). Unfortunately, it must be acknowledged that many community health centers in Indonesia both in urban and rural areas, as well as in remote regions have yet to meet public expectations for quality healthcare services.

Limited availability of resources, inadequate infrastructure, and disparities in the competencies of healthcare personnel often constitute major obstacles to delivering optimal health services in community health centers. This situation becomes even more complex in remote areas, where difficult geographical conditions and limited accessibility further compound the challenges of providing quality healthcare to the community (Andiaswaty et al., 2020). Hence, comprehensive and integrated efforts are required to overcome these challenges, and the measures taken must be measurable to achieve health development goals (Fitriyani et al., 2024).

One of the Indonesian government's strategies to enhance the efficiency, effectiveness, and transparency of public health services is digital transformation in the health sector. Digital transformation is expected to create significant opportunities to improve accessibility, efficiency, and service quality through the use of information and communication technology. In this context, information systems play a central role as a complex infrastructure comprising interconnected components—such as software, hardware, and human resources that collectively process data into useful information to achieve organizational objectives (Rokim et al., 2023). Digitalization in the public service sector has become a strategic initiative to improve governance quality in Indonesia (Arifin et al., 2025).

Regulation of the Minister of Health of the Republic of Indonesia Number 21 of 2020 on the Ministry of Health Strategic Plan for 2020–2024 mandates efforts to transform health governance, including the integration of information systems, research, and health development, encompassed within six pillars of health transformation as the foundation of Indonesia's health system. The

Ministry of Health of the Republic of Indonesia has promoted digital transformation through platforms such as SATU SEHAT, ASPAK (Health Facilities and Equipment Application), SIMONA (Pharmaceutical Service Facility Monitoring and Supervision Information System), ASIK (Sehat Indonesiaku Application), and other service systems. Indonesia's health digital transformation aims to produce human resources (HR) capable of analyzing health data, with the goal of formulating data-driven policies in every health institution (Ministry of Health of the Republic of Indonesia, 2021).

Nevertheless, the implementation of digital transformation in the health sector, particularly in remote areas, is not without challenges. According to the Ministry of Health (2024), out of approximately 10,000 Puskesmas in Indonesia, 745 lack internet access, and 1,475 have limited internet access. This means that about 22% of Puskesmas face obstacles in implementing health service digitalization, due to limitations in infrastructure, human resources, and digital technology competencies. Infrastructure disparities and digital literacy are the main barriers to public service digitalization (Arifin et al., 2025). Additionally, other factors such as data security and human resource readiness in adopting new technologies are also critical considerations in implementing this digital transformation (Gusman, 2024).

Working in remote areas with extremely limited access poses significant challenges for health workers. This requires a high level of commitment to continue delivering maximum service, manifested in dedication, loyalty, and willingness to sacrifice in order to provide the best possible care for communities in these regions. Organizational commitment is one of the key factors that greatly influences individual performance, which in turn affects overall service quality, particularly in the context of public services such as healthcare in community health centers. The organizational commitment of health workers in community health centers can influence the success of health program implementation and patient satisfaction.

Organizational commitment can be defined as a psychological state reflecting the extent to which an individual identifies with the organization, believes in its values, and is willing to exert effort on its behalf (Kadar et al., 2019). An individual's organizational commitment involves three dimensions: identification with organizational goals, involvement in organizational tasks, and loyalty to the organization (Kaiyeli, 2021). Individuals with high organizational commitment tend to be more productive, innovative, and loyal to the organization. Thus, organizational commitment is not merely a formality but a psychological foundation that fosters a collaborative, innovative, and service-oriented work environment.

Organizational commitment can be influenced by various factors, including personal factors (job satisfaction, individual characteristics, employment selection factors, etc.), organizational factors, and non-organizational factors (Elvareta, 2021). Meanwhile, individuals working in remote areas are often influenced by unique factors such as geographical isolation, limited facilities, and minimal social support, which significantly differentiate their experiences from those of their counterparts serving in urban areas, who generally have better access to resources and development opportunities (Ayu & Solichin, 2022).

Previous studies have shown that organizational commitment and digital transformation policies are closely related to the quality of public services. Organizational commitment has a positive

and significant effect on service quality (Rahmat & Ardiansyah, 2022). High organizational commitment motivates individuals to go beyond their formal job descriptions, thereby producing higher-quality and more responsive services to community needs (Kaiyeli, 2021). Meanwhile, digital transformation affects public service quality by enhancing efficiency, transparency, and accountability (Winoto & Handayani, 2022). Digital transformation can improve the efficiency and effectiveness of health services through process automation, reduced administrative costs, and improved information accessibility (Rahmat & Ardiansyah, 2022).

Nevertheless, digital transformation also has the potential to create new challenges if not properly implemented, especially in remote areas with limited infrastructure and human resources (Arifin et al., 2025). Digital transformation policies that are not accompanied by adequate improvements in human resource capacity and infrastructure may exacerbate health service disparities. Therefore, this study aims to conduct an in-depth analysis of the influence of organizational commitment and digital transformation policies on the quality of health services in Puskesmas located in remote areas of Tana Toraja Regency. This study is expected to provide strategic recommendations for improving and enhancing the quality of health services in very remote areas through a holistic and sustainable approach.

LITERATURE REVIEW

The quality of health services in primary care settings is a multifaceted construct, influenced by a complex interplay of human, technological, and organizational factors. Among these, organizational commitment has been consistently identified as a critical determinant of employee performance and service quality. Rooted in social exchange theory, organizational commitment reflects the psychological bond between an employee and their organization, characterized by affective attachment, normative obligation, and continuance commitment (Meyer & Allen, 1997). In the healthcare sector, where emotional labor and trust are paramount, committed employees are more likely to exhibit discretionary effort, adhere to protocols, and maintain high standards of patient care (Agustini et al., 2020; Tjahjono et al., 2018). This relationship is particularly salient in resource-constrained environments, where intrinsic motivation often compensates for extrinsic limitations.

Parallel to this, digital transformation has emerged as a dominant policy agenda in public health systems worldwide. Governments, including Indonesia's, have invested heavily in digital health platforms such as Satu Sehat, ASIK (Aplikasi Sehat IndonesiaKu), Healing119.id, PCare, ASPAK and SISROUTE, aiming to improve data accuracy, reduce reporting time, and enhance service efficiency (Sari & Nugroho, 2020). The theoretical foundation for this shift is often drawn from the Technology Acceptance Model (TAM), which posits that perceived usefulness and ease of use are key drivers of technology adoption. In well-resourced urban and semi-urban clinics, studies have reported positive outcomes from digitalization, including reduced administrative burden and improved inter-facility coordination (Rokim et al., 2023).

However, a significant gap exists in the literature regarding the relative efficacy of these two drivers—organizational commitment and digital transformation in the context of highly remote and under-resourced primary care. Most existing research treats them as complementary forces, assuming

that both contribute positively to service quality. Yet, this assumption may not hold in areas with extreme geographical isolation, poor infrastructure, and limited human capital. The concept of cultural lag (Sari & Nugroho, 2020) is particularly relevant here, describing a phenomenon where technological innovation is introduced, but the organizational culture, skills, and supporting infrastructure fail to keep pace, rendering the technology ineffective or even burdensome.

Furthermore, the success of digital transformation is contingent upon a robust ecosystem of infrastructure, human capital, and management support. Without stable internet connectivity, adequate hardware, comprehensive training, and a culture of innovation, digital policies can become mere "paper mandates" with little impact on the ground. This is especially true in Indonesia's *kawasan sangat terpencil* (very remote areas), such as Tana Toraja, where topographical challenges severely limit access to basic utilities.

This study addresses this critical gap by empirically testing the influence of both organizational commitment and digital transformation policy on service quality in a highly remote setting. It challenges the prevailing assumption that technological advancement is a universal solution, proposing instead that in the most isolated contexts, the resilience and dedication of the human workforce may be a more potent determinant of service quality than the sophistication of its digital tools.

METHOD

This study employed a quantitative, non-experimental, cross-sectional survey design (Sugiyono, 2019; Sinaga, 2022). The research aimed to analyze the causal relationship between two independent variables organizational commitment (X1) and digital transformation policy (X2) and one dependent variable health service quality (Y) at a single point in time.

The population consisted of all active healthcare workers at UPT Puskesmas Lekke and UPT Puskesmas Kondodewata, Tana Toraja Regency. A purposive sampling technique was used to select a total of 32 respondents. The sampling criteria ensured representation from various healthcare professions (e.g., doctors, nurses, midwives, pharmacists, nutritionists, administrative staff) to capture diverse perspectives on organizational and technological issues within the community health centers (Puskesmas).

This study utilized primary data collected directly from first-hand sources at the research site. The data collection process employed a triangulation of methods, including structured questionnaires, semi-structured interviews, and a documentary review of relevant literature and prior research to support the study. The questionnaire was developed using a five-point Likert scale, enabling the measurement of the degree of respondents' agreement, ranging from low to high, on a series of statements related to the research topic.

The collected data were analyzed using multiple linear regression analysis, a statistical technique designed to examine the influence of independent variables on a dependent variable. This analysis was conducted using IBM SPSS Statistics version 25 to ensure the accuracy and credibility of the results.

RESULTS AND DISCUSSION

Respondent Profile

The study involved 32 active healthcare workers from two primary health centers (Puskesmas): UPT Puskesmas Lekke and UPT Puskesmas Kondodewata. In terms of distribution, 17 respondents (53.1%) were from UPT Puskesmas Lekke, while 15 respondents (46.9%) were from UPT Puskesmas Kondodewata.

The respondents represented a diverse range of professional roles, reflecting the multidisciplinary nature of primary healthcare services. The most dominant profession was midwifery (Bidan), followed by nursing, doctor, pharmacists, nutritionists, and other health personnel, including health promoters, sanitarians, epidemiologists, pharmacy assistants, and health administrators. Regarding educational attainment, the majority of respondents held a Bachelor's degree (S1), indicating a relatively high level of academic qualification among the workforce. In terms of gender, female respondents constituted a significant majority (84.4%), which aligns with the broader trend in primary healthcare settings in Indonesia, where women are predominantly represented in health service delivery roles.

Table 1. Responden Profile

Variable Demographics	Category	N	%
Gender	Man	5	16%
	Woman	17	53%
Education	Diploma	13	41%
	Bachelor	19	59%
Job	Doctor	2	6%
	Dentist	1	3%
	Nurse	6	19%
	Midwife	12	38%
	Health Promotion	2	6%
	Nutritionist	2	6%
	Pharmacist	2	6%
	Sanitarian	1	3%
	Pharmacist Assistant	1	3%
	Epidemiologist	1	3%
	Health Administrator	2	6%

Instrument Validity and Reliability

Validity and reliability testing are essential in research as they ensure that the measurement instruments used are both accurate and consistent in generating data. Validity assesses the extent to which an instrument measures what it is intended to measure, while reliability evaluates the consistency of the measurement results. Without adequate validity and reliability, research findings may be unreliable, and the conclusions drawn could be inaccurate.

Validity was assessed using Pearson correlation coefficients to examine the relationship between individual item scores and the total score for each construct. The results indicated that all items across the three scales Organizational Commitment, Digital Transformation, and Service Quality exhibited statistically significant correlations ($p < 0.05$). This confirms that each item is valid and effectively measures its intended construct.

The reliability level of a variable or research construct can be determined by the results of the Cronbach's Alpha (α) statistical test. A variable or construct is considered reliable if the Cronbach's Alpha value exceeds 0.6. The closer the alpha coefficient approaches one, the higher the reliability and trustworthiness of the data. The results were as follows:

1. Organizational Commitment: $\alpha = 0.926$
2. Digital Transformation Policy: $\alpha = 0.962$
3. Service Quality: $\alpha = 0.890$

All coefficients exceeded the recommended threshold of 0.60, with values above 0.80 indicating excellent internal consistency. These results confirm that the measurement instruments are highly reliable and produce stable and consistent data.

Table 2. Reliability Test

No	Variable	Cronbach's Alpha	Result
1	Organizational Commitment	0,926	Reliable
2	Digital Transformation	0,962	Reliable
3	Service Quality	0,890	Reliable

Classical Assumption Tests

To ensure the validity of the multiple linear regression model, a series of classical assumption tests were conducted.

1. Normality of residuals was tested using the Kolmogorov Smirnov test. The result yielded a significance value (p-value) of 0.200, which is greater than 0.05. This indicates that the residuals are normally distributed, satisfying the normality assumption.

Table 3. Kolmogorov Smirnov Test

N	32
Asymp. Sig. (2-tailed)	.200 ^{c,d}

2. Multicollinearity was assessed using the Tolerance and Variance Inflation Factor (VIF). The Tolerance value was 0.979 (greater than 0.10), and the VIF was 1.022 (less than 10) for both independent variables. These values indicate the absence of multicollinearity, confirming that the independent variables are not highly correlated with one another.

Table 4. Multicollinearity Test

No	Variable	Tolerance	VIF
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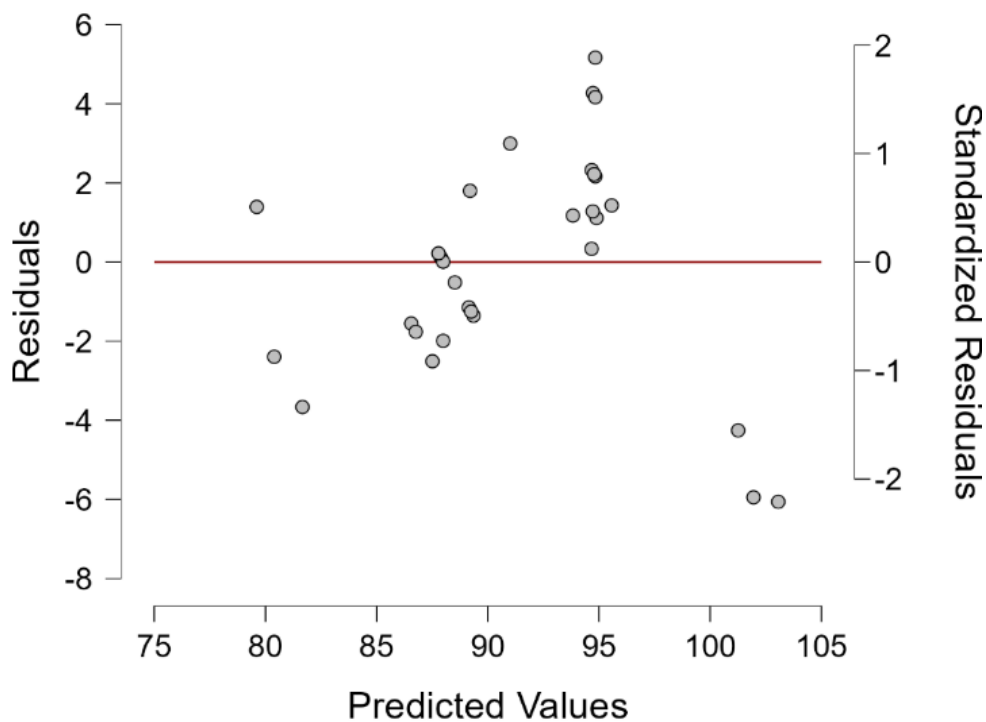
1	Organizational Commitment	.979	1.022
2	Digital Transformation	.979	1.022

3. Autocorrelation was examined using the Durbin-Watson (DW) statistic. The obtained DW value was 1.975, which is very close to 2. This suggests that there is no significant autocorrelation in the model.

Table 5. Autocorrelation Test

Model Summary ^b					
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.904 ^a	.817	.804	2.788	1.975

4. Heteroscedasticity was evaluated through a scatter plot of standardized residuals (SRESID) against standardized predicted values (ZPRED). The plot showed a random dispersion of points around zero, without any discernible cone-shaped or wave-like pattern. This indicates constant variance of residuals, confirming that the assumption of homoscedasticity is met.

Picture 1. Heteroscedasticity Test


Hypothesis Testing

Multiple linear regression analysis was employed to examine the influence of Organizational Commitment (X1) and Digital Transformation Policy (X2) on Service Quality (Y). The resulting regression model is as follows:

$$Y = 27.612 + 0.912(X1) + 0.052(X2)$$

Partial t-tests (t-test) were conducted to assess the individual effect of each independent variable.

1. Effect of Organizational Commitment on Service Quality: The t-statistic was 11.075, with a significance value (p) of 0.000. Since $p < 0.05$, the null hypothesis is rejected. This indicates that organizational commitment has a positive and statistically significant effect on service quality.
2. Effect of Digital Transformation Policy on Service Quality: The t-statistic was 0.916, with a significance value (p) of 0.367. Since $p > 0.05$, the null hypothesis is accepted. This indicates that digital transformation policy does not have a significant effect on service quality.

Table 6. Multiple Linear Regression Test

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
1 (Constant)	27.612	5.852		4.719	.000
Organizational Commitment	.912	.082	.890	11.075	.000
Digital Transformation	.052	.057	.074	.916	.367

The simultaneous F-test (F-test) was used to evaluate the combined effect of both independent variables. The F-statistic was 65.675, with a significance value of 0.000. Given that $p < 0.05$, the regression model is statistically significant, indicating that the combination of organizational commitment and digital transformation policy collectively influences service quality.

Table 7. F-test

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1003.825	2	501.913	64.578	.000 ^b
	Residual	225.393	29	7.772		
	Total	1229.219	31			
a. Dependent Variable: Service Quality						
b. Predictors: (Constant), Digital Transformation, Organizational Commitment						

The coefficient of determination (R^2) was 0.817, indicating that 81.7% of the variance in service quality is explained by the two independent variables. The remaining 18.3% is attributable to other factors not included in the model.

Table 8. F-test

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.904 ^a	.817	.804	2.788	1.975
a. Predictors: (Constant), Digital Transformation, Organizational Commitment					
b. Dependent Variable: Service Quality					

Discussion

The hypothesis testing results reveal a striking contrast. On one hand, organizational commitment demonstrates a positive and highly significant effect on service quality. On the other hand, digital transformation policy shows no significant effect.

First, the significant impact of organizational commitment aligns with Meyer and Allen's (1997) three-component model of organizational commitment affective, normative, and continuance commitment. In remote and isolated regions such as Tana Toraja, non-technical factors such as pride in one's team, moral responsibility, and emotional attachment to the community serve as primary drivers of performance. Healthcare workers who feel a sense of ownership and responsibility toward their Puskesmas are more likely to deliver high-quality services, even under resource-constrained conditions. This finding is further supported by the strong socio-cultural values of the Torajan people, such as gotong royong (mutual cooperation) and kinship ties, which reinforce interpersonal bonds and collective responsibility within the workplace.

Second, the non-significant effect of digital transformation policy is a critical finding that warrants deeper explanation. Although digital transformation is theoretically expected to enhance efficiency and data accuracy, practical implementation often falls short. As indicated by several questionnaire items such as "We often have difficulty accessing digital applications due to poor internet connectivity," "I frequently share computers with colleagues due to limited equipment," and "The digital systems in the Puskesmas are difficult to use and rarely function properly" substantial operational barriers exist.

This finding reflects a policy-implementation gap. While Puskesmas may be mandated to adopt digital systems such as Satu Sehat, ASIK (Aplikasi Sehat IndonesiaKu), Healing119.id, PCare, ASPAK and SISROUTE, the absence of adequate supporting infrastructure (e.g., stable internet, sufficient hardware), insufficient training, and a lack of organizational culture that embraces technological change render these policies ineffective. This phenomenon is consistent with the concept of cultural lag, where technological innovation is introduced, but organizational attitudes and behaviors fail to keep pace. Consequently, investments in hardware and software yield limited returns without parallel investments in human capital and improvements in the work environment.

Interpretation of Key Findings

The primary finding of this study is that in highly remote areas, health service quality is predominantly driven by human factors specifically, organizational commitment rather than

technological factors such as digital transformation. While digitalization is crucial for long-term development, in the current context, high levels of staff commitment remain the most decisive factor in service delivery.

A more intriguing finding is that, despite the non-significant effect of digital transformation, the overall regression model is remarkably robust (Adjusted $R^2 = 80.4\%$). This indicates that organizational commitment possesses substantial explanatory power. The digital transformation policy may have failed to emerge as a significant predictor due to its low variance in the field since nearly all respondents face similar technological constraints thereby rendering it unable to differentiate levels of service quality among individuals.

CONCLUSION

This study concludes that in the context of very remote community health centers (Puskesmas) in Tana Toraja regency, organizational commitment is the primary determinant of health service quality, while current digital transformation policies have not yet translated into measurable improvements in service outcomes. The failure of digital initiatives is attributed to a significant gap between policy and implementation, primarily due to inadequate infrastructure and support.

The key takeaway for policymakers is that technology cannot compensate for a lack of human commitment, nor can it succeed without a solid foundation of support. Therefore, strategies for improving healthcare in remote areas should first focus on building a resilient, motivated, and committed workforce. Digital transformation should be pursued not as a separate, top-down mandate, but as a complementary strategy that is carefully integrated into a supportive organizational culture. Future research should explore longitudinal changes in digital readiness and conduct qualitative studies to deeply understand the lived experiences of healthcare workers navigating this digital transition.

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