

Juridical Analysis of Standard Procedures for Implementing Referrals in Community Health Centers with Limited Health Personnel

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Abstract

The current condition of health workers utilized in Indonesian Community Health Centers still experiences inequality in number and distribution. Limited human resources for health are an obstacle in realizing sustainable health development. The aim of this research is to find out what the Standard Procedures for Referrals at Community Health Centers are regarding Human Resource Limitations, what the responsibilities of Community Health Centers are in implementing the Referral Service System, as well as the impact of excessive performance burdens on Health Workers at Community Health Centers. The research method used is a normative juridical approach accompanied by library data collection. The results of this research were then analyzed qualitatively. Based on the research results, it shows that in principle the referral procedure at the Community Health Center regarding limited human resources is the same as the referral principle in general. Every health worker is still required to be multiskilling in providing health services at the Community Health Center. There must still be health workers accompanying patients in carrying out referrals. Puskesmas also has the authority to place competent health workers as companions if the patient's condition is not good. Workload is a combination of quantitative workload and qualitative workload. The impact of excessive performance burden by Health Workers is stress, fatigue, human error, and vulnerability to disease transmission.

Abstrak

Kondisi tenaga kesehatan yang didayagunakan di Puskesmas Indonesia saat ini masih mengalami ketidakmerataan (*inequality*) dalam jumlah dan sebarannya. Keterbatasan SDM Kesehatan ini menjadi penghambat dalam mewujudkan pembangunan kesehatan yang berkelanjutan. Tujuan penelitian ini adalah untuk mengetahui bagaimana Standar Prosedur Rujukan di Puskesmas terkait Keterbatasan SDM, bagaimana tanggungjawab Puskesmas dalam Penerapan Sistem Pelayanan Rujukan, serta dampak beban kinerja yang berlebihan terhadap Tenaga Kesehatan di Puskesmas. Metode penelitian yang digunakan adalah pendekatan yuridis normatif yang disertai dengan pengumpulan data kepustakaan. Hasil penelitian ini selanjutnya dianalisis secara kualitatif. Berdasarkan hasil penelitian menunjukkan bahwa pada prinsipnya prosedur rujukan di Puskesmas terkait keterbatasan SDM adalah sama dengan prinsip rujukan pada umumnya. Setiap tenaga kesehatan tetap dituntut untuk *multiskill* dalam memberikan pelayanan kesehatan di Puskesmas. Harus tetap ada petugas kesehatan yang mendampingi pasien dalam melaksanakan rujukan. Puskesmas juga memiliki kewenangan untuk menempatkan tenaga kesehatan yang kompeten sebagai pendamping jika kondisi pasien tidak baik. Beban kerja adalah kombinasi dari beban kerja kuantitatif dan beban kerja kualitatif. Dampak beban kinerja yang berlebihan oleh Tenaga Kesehatan adalah stress, kelelahan, *human error*, dan rentan terhadap penularan penyakit.

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1. INTRODUCTION

1.1 Background

Development health is part important and most importantly from development national. Objective development health is for increase awareness, will And ability every person for life Healthy to use reach degrees health public which optimal. Matter This in accordance with Chapter 28H Paragraph 1 Constitution 1945 Which state that every person entitled life prosperous born And inner, located stay, get environment life Which Good And Healthy as

well as entitled obtain service health. Success development health very depends on availability. Health facilities and infrastructure.

The degree of public health in a country is influenced by the existence of health service facilities. Law Number 36 of 2009 concerning Health states that a health service facility is a tool and/or place used to provide health service efforts, whether promoted, preventive, curative, or rehabilitative, carried out by the central government, regional government, and/or public.

The aims of health development include increasing the reach and distribution of quality health services for communities in remote border areas and islands, especially in national priority health centers in Remote Border Areas.

Community health centers (Puskesmas) are the spearhead of health service delivery in Indonesia. Puskesmas is a health service facility that carries out community health efforts and individual health efforts at the first level, prioritizing promotive and preventive efforts to achieve public health in its working area. Puskesmas is a primary individual health service center that functions as a gate keeper or first contact for formal health services and a referral provider according to medical service standards. Community health centers must be able to provide initial treatment for medical cases that can still be handled at the community health center before referrals are made to patients.

The total number of health centers in Indonesia as of December 2021 is 10,292 health centers, consisting of 4,201 inpatient health centers and 6,091 non-inpatient health centers. This number has increased compared to 2020, namely 10,205, with the number of inpatient health centers being 4,119 and non-inpatient health centers being 6,086.

Health Human Resources is an important part of efforts to improve public welfare and health in Indonesia. Health human resources are the spearhead in preventive, promoted, curative and rehabilitative health services. Human resources or health workers at the Community Health Center play the role of implementing health services. In this role, it is hoped that the main duties and functions (tupoksi) of health workers are in accordance with the education and skills they have. Skills are an investment from health workers in carrying out their roles in accordance with their main duties and functions. Apart from that, in their role as implementers of health services at Community Health Centers, as strategic resources, health workers must be able to optimally use physical, financial and human resources in work teams. Physical resources are work support suggestions so that health workers can carry out their role as implementers of health services at Community Health Centers optimally.

The implementation of health services at the Community Health Center must be supported by adequate health personnel to support the function of the Community Health Center. Based on data from the Health Human Resources Information System (SISDMK), only 48.9% of community health centers have 9 (nine) appropriate types of health workers, namely: (1) doctors or primary care doctors; (2) dentist; (3) nurse; (4) midwife; (5) public health workers; (6) environmental sanitation personnel; (7) medical laboratory technology expert; (8) nutrition workers; and (9) pharmaceutical staff.

The level of public health is starting to improve, but it has not yet reached the entire population. Maternal and infant mortality is still high. The capacity of health workers, the maternal referral system, and the management of maternal and child health services, as well as reproductive health services, are not yet running optimally. The distribution of health workers, especially doctors, is not yet available in all health centers. Based on data from the Health Human Resources Information System (SISDMK), in 2021 there will still be 5.0% of community health centers without doctors. The Ministry of Health has held the Nusantara Sehat program (team and individual) since 2015 in order to equalize the distribution of health workers. The province with the highest percentage of community health centers without doctors based on figure 2.5 is Papua province (42.6%), followed by Maluku province (23.0%) and West Papua province (20.4%). Meanwhile, the provinces where all community health

centers in their area have doctors are Bali Province, DI Yogyakarta, West Nusa Tenggara, DKI Jakarta, and Bangka Belitung Islands.

The referral system is a network of health service systems that allows for reciprocal handover of responsibility for the emergence of a problem from a case or public health problem, both vertically and horizontally, to someone who is more competent, affordable and carried out rationally. The referral system is an unresolved problem in our health system. One of the weaknesses of health services is that referrals are not carried out quickly and accurately.

Referral to health services is one of the efforts to handle emergency cases which regulates the reciprocal delegation of duties and responsibilities for health services, both vertically and horizontally. Strengthening the referral system is one way to accelerate the reduction in mortality rates.

At first level health services such as Community Health Centers, they should be able to implement a good referral system in order to achieve this *The SDG's are optimal, however* So far it is felt that the patient referral system is still ineffective and inefficient. There are still many people who have not been able to access services, as a result there is an extraordinary accumulation of patients in hospitals. Health workers are also part of this problem, because there are still patients who are not accompanied by health workers when making referrals. Patients also consider the bureaucratic referral system to be quite complicated so that they refer themselves to get second or third level health care. Then the public's understanding of the referral flow is very low so they do not get the service they should.

Not only in Indonesia, research on emergency referrals in Africa and elsewhere has highlighted similar problems. The patient referral system still cannot be categorized effective and efficient. These obstacles are influenced by several factors, like; there is a lack of communication between health service centers and patients, formalized arrangements regarding the use of transportation are still complicated, human resources who carry it out are still inadequate. Then there are also referral hospitals with inadequate facilities and infrastructure.

The 2006 world health report has shown that in general, countries with fewer than 2.3 doctors, nurses and midwives per 1000 people fail to achieve measles immunization coverage rates of 80%, or the presence of trained midwives at birth. Fifty-seven countries fall below this minimum threshold, mainly in sub-Saharan Africa and Asia. This has a major impact on infant and maternal mortality. A variety of factors, including worsening socioeconomic conditions in much of sub-Saharan Africa, increasing mobility and migration of health workers and the absence of strategies to train and maintain an adequate supply of appropriate health workers, are contributing to resource drain. Human resource depletion is particularly acute at district and community levels, as there are fewer incentives and supports available to attract and retain staff. There is also a lack of understanding of the factors that motivate and attract staff to work at the district and city community level. In the absence of this information, it is difficult to develop effective human resource strategies. The shortage of health workers in Malawi is very serious. African standards, with fewer than 4000 doctors, nurses and midwives serving a population of around 12 million in 2003. There are 156 doctors working in the Ministry of Health and the Christian Health Association of Malawi. There are 10 districts that do not have MOH doctors and four districts without any doctors at all. The average number of nurses in community health centers is around 1.9, an indication that many such centers are run with one nurse or none at all. Fifteen of the 26 districts have fewer than 1.5 nurses per facility, and five districts have less than one. The human resources (HR) crisis has created a shortage of those able to provide health services, especially in rural areas where primary health care is severely disrupted.

A classic problem faced by Indonesia in its efforts to realize fair and equitable health services for the community is the unequal number and distribution of health workers at the basic service level in community health centers. The current condition of health workers utilized in Indonesian Community Health Centers still experiences inequality in number and

distribution. Based on the ratio, the number of health workers in Indonesian Community Health Centers does not yet meet the needs of the large Indonesian population. Based on the distribution of health workers in Indonesian Community Health Centers, it is more concentrated in the western region of Indonesia compared to the central and eastern regions, this is because the population is larger and health facilities in the western region of Indonesia are more complete than in the central and eastern regions of Indonesia, so this This can hinder health development which aims to provide fair and equitable quality services for all Indonesian people. The availability of health services and supporting facilities in Disadvantaged Regions, Borders and Islands (DTPK) is still low. If we look at existing resources, the number of health workers needed, whether engaged in promoted, preventive, curative or rehabilitative fields, is still largely concentrated in big cities. Even though the number of health workers is sufficient, their distribution is uneven. The deployment of local health workers must be optimized, especially to remote areas. Optimizing health workers is an effort to increase the availability, equity and quality of health workers, especially in remote, disadvantaged, border and island areas (DTPK).

Currently, cases of referral to secondary health services for cases that could have been resolved in primary care are still quite high. The ineffectiveness of the referral system in Indonesia has had an impact on the accumulation of patients in secondary health facilities. Apart from that, limited health human resources are also an obstacle in realizing sustainable health development.

Basically, the referral system was created to optimize three levels of health services, so that there is no waste of human and material resources at certain levels. However, limitations at certain levels of health services and referrals to cases that do not need to be referred mean that the referral system will not provide the expected results. Health centers with high referrals are affected by incomplete mandatory services, health personnel not up to standard, and infrastructure not up to standard. Therefore, it is necessary to review standard referral procedures at Community Health Centers to optimize a good referral system.

Research conducted at the Linggang Amer Auxiliary Health Center, Linggang Bigung District, West Kutai Regency, stated that the factors hindering health services in the community were the absence of medical doctors and the lack of facilities and infrastructure to support health services. As per research conducted by Rizkiy Shofiah, There are several factors that cause the availability of promoted and preventive personnel to be unevenly distributed at Community Health Centers. These causal factors include: that is; there is no recruitment from the Health Service, Health Human Resources are bound by policy, and the puskesmas budget is limited.

Apart from that, previous research conducted by Novita shows that the problem that often occurs in referral services, namely the socialization of the general provisions that patients must receive health services at the first level health facility where participants are registered, to the public is still very limited. There is no referral flow mechanism and fixed procedures for implementing referrals. This shows that the Reference Standard Operating Procedures cannot be implemented as they should. Then Research conducted by Hartini, et al shows that referral services are viewed from five referral characteristics, there are two aspects that have not been implemented, namely communication between referring health facilities and referral recipients, recording and reporting of the referral system. According to the results of research conducted by Adawiyah, the Community Health Center needs to increase socialization and provide information related to the referral flow and system that has been established by the government as well as improve its performance and professionalism to increase BPJS (Social Security Administering Agency) patient satisfaction, especially for obtaining referral services.

Improving standard referral procedures at Community Health Centers by adjusting Health Human Resources is very necessary to keep up with developments and updates in the activities carried out, as well as to improve the quality of effective and efficient referral services.

Because, if this is not done it will result in a decline in the health status of residents in remote areas.

Based on the description above, researchers are interested in conducting research with the title "Judicial Analysis of Standard Procedures for Implementing Referrals in Community Health Centers with Limited Health Personnel".

1.2 Formulation of the problem

Based on the background above, the problem formulation in this research is as follows:

- a. What are the Standard Referral Procedures at Community Health Centers regarding Limited Human Resources?
- b. What are the responsibilities of the Community Health Center in implementing the Referral Service System?
- c. What is the impact of excessive performance burdens on Health Workers at Community Health Centers?

2. LITERATURE REVIEW

2.1 Referral System

According to WHO, the referral system is a process where health workers who have limited resources to handle clinical conditions (drugs, equipment, capabilities) at one level of the health system, seek help from health facilities that are better or have certain resources at the same level or in over it, or taking over the handling of a patient's case. This definition states that:

- a. The referral system is carried out by health facilities that have limited resources (drugs, equipment, and capabilities) to health facilities at the same level or above.
- b. In the referral system, the referred health facility has the right to take over handling the patient's case.

Referral is the delegation of authority and responsibility for cases of disease or health problems carried out reciprocally, either vertically in the sense of one strata of health service facilities to another strata of health service facilities, or horizontally in the sense of between the same health service facilities.

The health service referral system is the implementation of health services that regulates the reciprocal delegation of duties and responsibilities for health services, both vertically and horizontally, which must be implemented by participants in health insurance or social health insurance, and all health facilities.

The National Health System differentiates it into two types, namely:

- a. Health Referrals These referrals are mainly associated with efforts to prevent disease and improve health status. Thus, health references basically apply to public health services. Health referrals are divided into three types, namely technology, facility and operational references. Health referrals are connections in sending, examining materials or specimens to facilities that are more capable and complete. This is a reference for money regarding health issues that are disease prevention (preventive) and health improvement (promoted). This reference includes technology, facilities and operational references.
- b. Medical Referral This referral is mainly associated with efforts to cure disease and restore health. Thus, medical referrals basically apply to medical services. Similar to health referrals, medical referrals are divided into three types, namely patient referrals, knowledge and examination materials. Medical referral is the reciprocal delegation of responsibility for a case that arises both vertically and horizontally to someone who has more authority and is able to handle it rationally. Types of medical referrals include:
 - 1) *Transfer of patients*
Consultation of patients for diagnosis, treatment, surgery and others.
 - 2) *Transfer of specimens*
Delivery of materials (specimens) for a more complete laboratory examination.
 - 3) *Transfer of knowledge / personal*

Sending more competent or expert personnel to improve the quality of local services.

2.2 Public health center

Puskesmas is a health service facility that carries out public health efforts and first-level individual health efforts, by prioritizing promoted and preventive efforts, to achieve the highest level of public health in its working area. Puskesmas plays a role in health-oriented development in its area with the aim of realizing community who have healthy behavior (awareness, will and ability to live healthily); able to access quality health services, live in a healthy environment; and have optimal levels of health, both individuals, families, groups and communities.

Puskesmas (Community Health Center) is a functional health organization which is a center for community health development which also fosters community participation in addition to providing comprehensive and integrated services to the community in its working area in the form of main activities. Puskesmas is the technical implementation unit of the district/city health service which is responsible for carrying out health development in the work area.

The Indonesian Ministry of Health states that the Community Health Center is the technical implementation unit of the District/City Health Service which is responsible for carrying out health development in a health area. According to Ilham Akhsanu Ridho, a Community Health Center is an organizational unit that operates in the field of health services which is at the forefront and has a mission as a center for developing health services, which carries out comprehensive and integrated health guidance and services for the community in a certain designated work area. Independently in determining service activities but does not include financing aspects.

According to Trihono, the aim of health development organized by community health centers is to support the achievement of national health development goals, namely increasing awareness, willingness and ability to live healthily for everyone who lives in the working area of community health centers, in order to achieve the highest level of health in the context of realizing Indonesia. Healthy.

According to Mubarak and Chayatin, community health centers have three functions, namely as a center for driving health-oriented development, a center for community and family empowerment in health development and a first-level community health service center. As the first step in the public health nursing program, the function and role of community health centers is not only a matter of medical technical matters but also various human resource skills that are able to organize the social model that exists in society, as well as health institutions that reach communities in the smallest areas and require strategies in terms of organizing the community to be involved in health management independently.

In carrying out its functions, the Community Health Center is obliged to implement health policies to achieve health development goals in its work area and create a healthy sub-district. Structurally or administratively, the Community Health Center is under the administration of the district regional government, where technical guidance is provided by the District/City and Provincial Health Services. The regulations state that the Puskesmas functions as a provider of health services in the form of public health efforts (UKM) and individual health efforts (UKP). The position of the Puskesmas as the "organizer" of health services confirms that the Puskesmas is the first level Technical Implementation Unit of the Health Service. The District/City Health Service is responsible for implementing government aspects in the health sector in the district/city.

Community Health Centers are in accordance with their function as health-oriented development, community empowerment centers, providing and administering quality services to meet community needs for quality health services in order to achieve national health development goals, namely the realization of the highest possible health for the community.

Puskesmas is in accordance with its function as a center for health-oriented development, a center for community empowerment, providing and administering quality services to meet

the community's need for quality health services in order to achieve national health development goals, namely the realization of the highest possible health for the community.

2.3 Health workers

Health Workers according to Law no. 36/2014 is every person who dedicates themselves to the health sector and has knowledge and/or skills through education in the health sector which for certain types requires authority to carry out health efforts.

According to the World Health Organization (WHO), the definition of health Human Resources (HR) is all people whose main activities are aimed at improving health. They consist of people who provide health services such as doctors, nurses, pharmacists, laboratory technicians, management, as well as supporting staff such as departments, administration, finance, drivers, and so on. Roughly speaking, WHO estimates that two-thirds of the world's health human resources are people who provide health services and one-third are health support and management personnel. Meanwhile, the definition of health human resources according to the 2009 National Health System (SKN) is professional health workers including strategic health workers, and non-professional health workers, as well as support/health support workers, who are involved and work and devote themselves to health efforts and management.

Based on the description above, the researcher concludes that a health worker is anyone who dedicates themselves to the health sector and has skills and knowledge in the health sector whose main activities are aimed at improving the level of public health.

2.4 Standard Operating Procedures

SOP (Standard Operating Procedure) is basically a guideline that contains standard operational procedures within an organization which are used to ensure that all decisions and actions, as well as the use of process facilities, are carried out by people within the organization who are members of the organization. So that it runs effectively and efficiently, consistently, standardly and systematically.

Standard Operating Procedures (SOP) are documents relating to procedures carried out chronologically to complete a job which aims to obtain the most effective work results from workers at the lowest possible cost. SOP usually consists of benefits, when it was created or revised, method of writing procedures, and is accompanied by a flowchart at the end.

Standard Operating Procedures (SOP) are guidelines for how employees can carry out their work. Therefore, each position in the organization has a different SOP from other positions.

Standard Operating Procedures (SOP) is a set of instructions or activities that a person carries out in order to complete work safely, without detrimental impacts on the environment (comply with relevant laws and regulations) and fulfill operational and production requirements. This SOP is a written agreement containing rules, policies, technical specifications that must be used consistently to ensure the processes, products and services that are produced are in accordance with the specified objectives and quality.

The purpose of making SOPs is to explain fixed details or standards regarding repetitive work activities carried out in an organization. The purpose of creating standard operating procedures is as follows:

a. Consistency

SOPs are created so that every implementer/officer/employee knows the standards that have been set, so that they are able to maintain consistency and level of performance of officers/employees/executors or teams.

b. Task Clarity

SOPs are created so that every implementer/officer/employee clearly knows the role and function of each position in the organization.

c. Flow Clarity

SOP can clarify the flow of duties, authority and responsibilities of each relevant implementer/officer/employee.

d. Protecting the Organization

Indirectly, SOPs are created with the aim of protecting organizations or work units, as well as officers or employees from malpractices, or errors originating from administration or other factors that could have a negative impact on the survival of the organization.

e. Minimizing Errors

By clarifying tasks, flow, responsibility and authority, each implementer/officer/employee can minimize or avoid failure, errors, doubts and duplication in work.

f. Efficiency

SOPs are created with the aim of making all work more efficient. All work activities are expected to be faster, more accurate and precise in accordance with the goals or results to be achieved, with the help of existing SOPs.

g. Problem solving

SOPs contain certain rules and restrictions, in their implementation there may be friction between employees which can lead to prolonged conflict. Apart from the need for intervention from supervisors or superiors, SOPs can also be used as a basis so that every employee can work according to the corridor again, that is, subject to the rules and restrictions according to the SOP.

h. Defense Limits

Sometimes many external parties want to know things that are very private to the company. For example, a researcher who wants to conduct work behavior research in an organization (institution). With a standard SOP in place, researchers are required to go through several procedures. They cannot go directly to a particular department or section.

Seeing the importance of using SOPs in management, of course there are several benefits or advantages that can be obtained from having these SOPs. However, this can happen if the SOP can be implemented correctly. Because it often happens in several companies that they can run with SOPs that are not appropriate. It is said to be inappropriate because the SOP itself is not strictly enforced, many members work out of habit. Inappropriate SOPs cause the process of achieving the company's vision and mission to not be immediately achieved. So, if the SOP is implemented correctly, the company will get many benefits from implementing the SOP. Following are the benefits of using SOPs correctly according to Fajar Nur'Aini:

- a. Provides benefits for us in providing explanations about activity procedures.
- b. Save time and energy in employee training programs.
- c. Provides benefits for the company to equalize all activities carried out by all parties. Make it easier for supervisors or managers to carry out evaluations and assessments.
- d. Helping employees to become more independent individuals and not depend on management intervention.
- e. Provide information regarding competency qualifications that must be mastered by employees in carrying out their duties.

3. RESEARCH METHOD

The approach method used in this research is a normative juridical approach, namely an approach based on the main legal material by examining theories, concepts, legal principles and statutory regulations related to this research. Juridical factors are a set of rules relating to state administrative law, health law and health personnel law which are basically branches of legal science and are closely related to this research. The nature of the research used in this research is prescriptive design, namely research that aims to get suggestions about what should be done to overcome certain problems. The elements of this research are independent variables. This research uses secondary data obtained from the literature. The data obtained will be presented in the form of descriptions arranged systematically. What this means is that one data and another must be relevant to the problem as a complete, sequential and closely related unit so that the data presented can be easily understood. The data analysis technique in this research uses qualitative analysis techniques. This is a method that places greater emphasis on aspects of in-depth understanding of

a problem rather than looking at the problem for generalization research. The qualitative analysis in this research is used to answer existing problems.

4. RESULTS AND DISCUSSION

4.1 Standard Referral Procedures at Community Health Centers Regarding Limited Human Resources

In PMK No.75 of 2014 concerning Community Health Centers (Ministry of Health of the Republic of Indonesia, 2014) Article 7 paragraph (j) states: Community Health Centers have the authority to carry out referral screening in accordance with medical indications and referral systems. Then Article 41 states: Puskesmas in carrying out health efforts can carry out referrals which are carried out according to the referral system.

Basically, the procedures for health service providers sending referrals are as follows:

- a. Explain to patients or their families the reasons for referral;
- b. Communicate with the destination health facility before referring;
- c. Make a referral letter and also attach the results of the patient's diagnosis and medical records;
- d. Recording in registers and also making referral reports;
- e. Stabilize the patient's general condition, and maintain it during the journey;
- f. **Patient assistance by health workers;**
- g. Submit a referral letter to the authorities at the health service facility at the referral location;
- h. The first referral letter must come from a primary health care facility, except in emergency situations; And
- i. The provisions contained in Askes, Jamkesmas, Jamkesda, SKTM and other health insurance bodies remain in effect.

Based on Guidelines from the Ministry of State Apparatus Empowerment and Bureaucratic Reform:

- a. Inpatient and ER referrals
 - 1) The officer makes a reference letter.
 - 2) Officers contacted the Referral Hospital.
 - 3) Officers contacted an ambulance.
 - 4) The officer completes the patient referral file documents.
 - 5) Officers prepare patient companions.
 - 6) The person responsible for preparing the administration for the patient.
 - 7) The patient is ready to be referred to the receiving hospital.
 - 8) The patient is accompanied by officers and ensures that the patient receives treatment at the referral hospital.
 - 9) Completion of referral administration at the receiving hospital.
- b. Outpatient Referral
 - 1) The officer makes a reference letter.
 - 2) The officer attaches a form of supporting examination results (if necessary).
 - 3) The staff did not accompany the patient.

Communication to the referring health facility is a standard procedure that must be carried out before making a patient referral. Barriers to implementing SOPs regarding communication lie in the lack of smooth communication when referring patients. The absence of binding regulations from the government regarding the referral system for independent patients and commercial insurance patients provides an opportunity for them not to follow the referral flow. In Article 5 PMK No. 001 of 2012, concerning the Individual Health Service Referral System, it is stated that the referral system is mandatory for health insurance or social health insurance participants and also health service providers, while for commercial health insurance participants follow the applicable rules in accordance with the provisions of the insurance policy while continuing to receive health services tiered, and every person who is not a participant in health insurance or social health insurance can follow the referral system.

Because of this article, an opportunity arises for commercial insurance to make provisions within its organization not to follow the tiered referral rules. Likewise, for people who are not participants in social health insurance, they are free not to follow the tiered referral rules.

So that this referral system can be implemented effectively and efficiently, it is necessary to pay attention to the organization and its management, and the chain of authority and responsibility of each health service unit that is visible in it must be clear, including implementation and coordination rules. Below we will explain the criteria for dividing service areas in the referral system and coordination between health service units:

a. Criteria for dividing referral system service areas

Due to the limited human resources and health funds provided, it is necessary to make efforts to use the available medical service facilities effectively and efficiently. The government has established the concept of regional division in the public health service system. In this referral system, each health unit, starting from the Polindes, sub-district health centers, community health centers and hospitals, will provide services to the community in accordance with regional regulations and the level of capability of officers or facilities. This provision is excluded for referrals for emergency cases, so that the division of service areas in the referral system is not only based on government administrative area boundaries but also on other criteria.

b. Coordination of referrals between health facilities

In an effort to provide health services evenly to the community, there needs to be effective coordination in providing referral health services. This coordination can be achieved by providing lines of authority and responsibility for each health service unit. Because the referral system area covers more than one district/city, coordination between the relevant district/city health services is very important.

c. Referral Flow

Due to differences and similarities in classification, area and capabilities of each health facility, it is necessary to develop a general patient referral flow, except for emergency case referrals or special referrals. There are several aspects that must be considered in the referral flow, namely:

1) Classification of Health Facilities

Provincial General Hospitals with classification B as a reference for Regency/City General Hospitals with classification C or D or other health facilities.

2) Location / Regency/City Region

Based on the results of mapping the referral areas of each Regency/City, the referral destination can be based on the geographical location of the health service facilities that are more capable and closest.

3) Coordination of Technical implementing elements

Other reference technical implementation elements as a means of referral purposes that can be coordinated at the provincial level.

As with the narrative above, this shows that in principle the referral procedure at the Community Health Center regarding limited human resources is the same as the referral principle in general. Every health worker is still required to be multiskilling in providing health services at the Community Health Center. There must still be health workers accompanying patients in carrying out referrals. Due to limited human resources, health workers who have driving skills can become ambulance drivers, while other health workers accompany patients in the ambulance. Limited human resources are not an obstacle in providing referral services, because this is one of the obligations of health workers. The problem is that there should be guidelines for providing additional rewards/services for health workers who carry out work outside the shift, and outside their duties and responsibilities, so that this will provide fair benefits for health workers. If this is not done, then indirectly the Puskesmas will not fulfill its obligations.

4.2 Responsibilities of Community Health Centers in Implementing the Referral Service System

Puskesmas is a district/city health service technical implementation unit (UPTD) which is responsible for carrying out health development in an area. Puskesmas as a first level health service center carries out first level health service activities in a comprehensive, integrated and sustainable manner, which includes individual health services (private goods) and community health services (public goods).

Based on Article 3 of Minister of Health Regulation no. 43 of 2019 concerning Community Health Centers, the principles of organizing Community Health Centers include:

- a. Healthy paradigm
Puskesmas encourages all stakeholders to participate in efforts to prevent and reduce health risks faced by individuals, families, groups and communities through the Healthy Living Community Movement.
- b. Regional accountability
Puskesmas drives and is responsible for health development in its work area.
- c. Community independence
Community Health Centers encourage independent, healthy living for individuals, families, groups and communities.
- d. Availability of access to health services
Puskesmas provides health services that are accessible and affordable to all people in their working area fairly without distinguishing between social, economic, religious, and cultural and belief status.
- e. Appropriate technology
Puskesmas provides health services by utilizing technology that suits service needs, is easy to use, and does not have a negative impact on the environment.
- f. Integration and continuity
The Puskesmas integrates and coordinates the implementation of UKM and UKP across programs and across sectors and implements a Referral System which is supported by Puskesmas management.

Based on what is stated in Minister of Health Regulation no. 43 of 2019 concerning Community Health Centers, in carrying out their duties, Puskesmas has the following functions:

- a. Implementation of first level SMEs in their working areas:
 - (1) Develop activity plans based on the results of analysis of public health problems and service needs;
 - (2) Carry out advocacy and socialization of health policies;
 - (3) Carrying out communication, information, education and community empowerment in the health sector;
 - (4) Mobilize the community to identify and resolve health problems at every level of community development in collaboration with regional leaders and other related sectors;
 - (5) Carry out technical guidance for institutions, community health center service networks and community-based health efforts;
 - (6) Carry out needs planning and increase the competence of community health center human resources;
 - (7) Monitor the implementation of development so that it is health-oriented;
 - (8) Providing family, group and community oriented health services by considering biological, psychological, social, cultural and spiritual factors;
 - (9) Carry out recording, reporting and evaluation of access, quality and coverage of health services;
 - (10) Providing recommendations related to public health problems to district/city regional health offices, implementing early warning systems and disease control responses;

- (11) Carrying out family approach activities; And
 - (12) Collaborating with first-level health service facilities and hospitals in the work area, through coordinating health resources in the work area of the health center.
- b. Implementation of first level UKP in its working area:
- (1) Providing basic health services in a comprehensive, sustainable, quality and holistic manner that integrates biological, psychological, social and cultural factors by fostering close and equal doctor-patient relationships;
 - (2) Organizing health services that prioritize promoted and preventive efforts;
 - (3) Organizing health services that are individual-centered, family-focused, and group- and community-oriented;
 - (4) **Organizing health services that prioritize health, security, safety of patients, staff, visitors and the work environment;**
 - (5) Organizing health services with coordinating principles and inter- and inter-professional cooperation;
 - (6) Carrying out medical record management;
 - (7) Carry out recording, reporting and evaluation of the quality and access of health services;
 - (8) Carry out needs planning and increase the competence of community health center human resources;
 - (9) **Carrying out referral screening in accordance with medical indications and referral systems; And**
 - (10) Coordinate and collaborate with health service facilities in the work area, in accordance with statutory provisions.

Based on what is stated in Article 11 (1) of the Regulation of the Minister of Health of the Republic of Indonesia Number 001 of 2012 concerning the Individual Health Service Referral System, it is explained that every health service provider is obliged to refer a patient if an illness or health problem requires it, except for valid reasons and with the patient's consent or his family. Then Article 16 states that transportation for referrals is carried out in accordance with the patient's condition and the availability of transportation facilities. Patients who require continuous medical care must be referred by ambulance and accompanied by competent health personnel.

From the provisions above, it has been answered that the Community Health Center has an obligation to implement a good Referral Service System in accordance with the provisions of the laws and regulations. Puskesmas also has the authority to place competent health workers as companions if the patient's condition is not good. This also answers that Health Workers who participate in making referrals, even if they become ambulance drivers, are a form of delegation of authority from the Community Health Center over their responsibilities to patients. Puskesmas doing this because of limited human resources is not a form of violation.

4.3 The Impact of Excessive Performance Loads on Health Workers at Community Health Centers

According to Suparyadi, occupational health and safety (K3) is defined as a condition where health workers carry out their work free from the possibility of accidents so that they do not feel worried about having an accident. Occupational health is a physical, mental and social condition and not just the absence of disease or weakness when carrying out work. Therefore, occupational health and safety needs to be a concern for Community Health Centers in overcoming the impact of excessive workload.

Workload is a job that has burdens, both physical and mental burdens that must be borne by the workforce according to a certain type of time period which can occur due to many factors, such as the number of physical and mental tasks (lifting heavy loads, workplace conditions, heavy responsibilities that must be completed and carried out), anxiety, job risks, lack of rest time, gender and even age. This workload can appear with various types of severity felt by an individual, for example light workload, medium workload and even heavy

workload. Wijaya is of the opinion that workloads that are too heavy are caused by urgent working hours, unhealthy work environments, work conflicts, the influence of leadership and even other factors such as anxiety and lots of thoughts resulting from demands of roles outside the workplace causing an increased burden on the mind and pressure on a person's psychology or mental state which can trigger even more severe stress.

According to Rivai, work stress is a condition of tension that creates a physical and psychological imbalance that affects the emotions, thinking and condition of an employee. Hadi and Hanurawan explained that the sources of work stress can be divided into two, namely: organizational factors which include excessive workload (work overload), limited workload (work under stimulation), ambiguous positions (job ambiguity), job insecurity, interpersonal relationships and organizational change; as well as individual factors which include: employee personality characteristics that are prone to stress and traumatic life experiences in the employee's past. Munandar defines workload as a combination of quantitative workload and qualitative workload. Quantitative workload arises because there are too many or too few tasks, while qualitative workload is when the worker is unable to carry out the task or does not use the worker's skills or potential.

According to Shoja, Health Workers have a much greater workload compared to other jobs in terms of mental pressure, physical pressure, time pressure and frustration. One of the impacts of excessive performance load is stress. These psychological disorders have a more widespread and long-lasting impact than physical injuries, while there is far less attention to mental health. If health workers experience stress while working, it will have an impact on their services. It could be that the health worker experienced human error. Therefore, health workers must continue to enjoy their rights to decent, healthy and safe working conditions. There is a need to adjust workload by arranging appropriate work shifts, rest hours, and number of health workers.

According to Suma'mur, The longer you work, the more work fatigue will increase. Excessive performance loads will only cause health workers to experience moderate and severe levels of mental and physical fatigue (burnout syndrome). Health workers who work at Community Health Centers have responsibilities and duties that are not easy, especially when there are an influx of patients. In general, Health Workers will experience complaints in the form of frequently feeling unwell, dizziness (headaches), irritability, and difficulty concentrating which are symptoms of work stress. Apart from that, health workers will also experience fatigue due to new types of work related to referrals. Sometimes in community health centers that lack health workers, health workers will change professions to become ambulance drivers, even though that is not their main job, so this will only result in physical fatigue for them, not to mention if it has to be balanced with providing care while in the ambulance. When the body receives a workload, the body will interpret it as an obstacle (stressor) in the limbic system. This system is the part of the brain that functions in forming behavior or emotions such as anger and fear. As a result of this situation, the hypothalamus becomes active and the autonomic nervous system will respond. This system will send biochemical commands to the body's systems so that the body's systems react, including the respiratory system, cardiovascular system, muscle tension and fine motor activity. To reduce the stressor response, the individual's body will react by releasing more energy. If the energy is sufficient, the individual can survive and adapt so that the symptoms of the stressor response will decrease and the body will return to normal. However, if an individual does not have enough energy, the body's resistance will weaken so that the individual will experience stress. Therefore, if the workload is not optimal or excessive and does not match the individual's capacity, it is easy to trigger work stress. Fatigue is regulated centrally in the brain. Fatigue is the body's way of reducing the severity that can occur as a result of working for a long time. The impact of fatigue is loss of ability to do a job, decreased work capacity and body endurance and has an impact on high levels of absenteeism.

5. CLOSING

5.1 Conclusion

- a. In principle, referral procedures at Community Health Centers regarding limited human resources are the same as referral principles in general. Every health worker is still required to be multiskilling in providing health services at the Community Health Center. There must still be health workers accompanying patients in carrying out referrals. Due to limited human resources, health workers who have driving skills can become ambulance drivers, while other health workers accompany patients in the ambulance. Limited human resources are not an obstacle in providing referral services, because this is one of the obligations of health workers. The problem is that there should be guidelines for providing additional rewards/services for health workers who carry out work outside the shift, and outside their duties and responsibilities, so that this will provide fair benefits for health workers. If this is not done, then indirectly the Puskesmas will not fulfill its obligations.
- b. Puskesmas has an obligation to implement a good Referral Service System in accordance with statutory provisions. Puskesmas also has the authority to place competent health workers as companions if the patient's condition is not good. This also answers that Health Workers who participate in making referrals, even if they become ambulance drivers, are a form of delegation of authority from the Community Health Center over their responsibilities to patients. Puskesmas doing this because of limited human resources is not a form of violation.
- c. Workload is a combination of quantitative workload and qualitative workload. Quantitative workload arises because there are too many or too few tasks, while qualitative workload is when the worker is unable to carry out the task or does not use the worker's skills or potential. The impact of excessive performance burden by Health Workers is stress, fatigue, human error, and vulnerability to disease transmission.

5.2 Suggestion

Based on the conclusions above, suggestions that can be proposed in this research are:

- a. The Health Service needs to plan guidelines for providing rewards/additional services to Community Health Centers that lack human resources.
- b. The Health Service needs to propose additional health personnel and also operational personnel who specifically carry out referrals.
- c. Community Health Centers have guidelines regarding clear delegation of authority regarding the responsibilities of health workers when making patient referrals.

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