Health Frontiers
A Multidisciplinary Journal for Health Professionals
TARQABIN NUSANTARA GROUP
Health Frontiers: A Multidisciplinary Journal for Health Professionals, Vol 3 Issue 1 2025
E-ISSN : 3024-9740

Bridging the Gap: Navigating Regulations to Enhance Referral Coordination Between Puskesmas and Hospitals

Isna Najwa Malia Fadhilah [1,*], Amala Hessa Firdausy [1], Berliana Hanza Savira [1], Devina Amelia Zalianti [1], Ayla Sefriza [1], Findi Vinolia Ayu Hastari [1], Rosalya Galuh Rahmadyanti [1], Ardisa Larassati Harianja [1], Ghefira Nayana Khairani [1]

[1] Public Health Department, Universitas Negeri Malang, Malang, Indonesia

E-mail: isna.najwa.2406126@students.um.ac.id,

ABSTRACT

Referral coordination between community health centers (Puskesmas) and hospitals is critical for ensuring seamless healthcare delivery, yet it remains hindered by regulatory challenges. This study explores the dual role of regulations in either supporting or impeding referral systems, focusing on payment mechanisms, legal frameworks, technological integration, and socioeconomic barriers. Supportive regulations, such as service payment contracts, government subsidies, and integrated information systems, enhance efficiency and collaboration. However, anti-kickback laws, fragmented systems, and lack of standardized criteria often create inefficiencies and inequitable access. Addressing these issues requires policy reforms, investment in technology, and targeted interventions to overcome socioeconomic barriers. Evidence suggests that strengthening Puskesmas as gatekeepers, adopting value-based payment models, and leveraging telemedicine can significantly improve referral outcomes. By aligning regulations with collaborative care objectives, healthcare systems can achieve better patient outcomes, reduce costs, and promote equitable access to specialty care. This analysis underscores the urgent need for systemic reforms to bridge gaps and optimize referral coordination.

KEYWORDS

Payment, Legal frameworks, and Socioeconomic barriers.

Health Frontiers
A Multidisciplinary Journal for Health Professionals
TARQABIN NUSANTARA GROUP
Health Frontiers: A Multidisciplinary Journal for Health Professionals, Vol 3 Issue 1 2025
E-ISSN : 3024-9740

Received: 12 March 2025
Revised: 03 July 2025
Accepted: 04 July 2025

How to cite: *Fadhilah, Isna Najwa Malia, et al. (2025). Bridging the Gap: Navigating Regulations to Enhance Referral Coordination Between Puskesmas and Hospitals. Heal Front A Multidiscip J Heal Prof.3(1): 15-29.*

INTRODUCTION

Referral coordination between community health centers (Puskesmas) and hospitals is a cornerstone of an effective healthcare system, particularly in countries with decentralized healthcare structures. In Indonesia, Puskesmas serve as the primary entry point for patients seeking medical care, acting as gatekeepers to higher levels of care. However, the success of referral systems depends heavily on regulatory frameworks that either support or hinder coordination. Studies have shown that well-designed regulations can enhance communication, streamline processes, and improve patient outcomes (Suryanto et al., 2017). For example, integrated information systems have been proven to reduce waiting times and administrative burdens in referral processes (Armin et al., 2020). Conversely, poorly aligned policies may lead to inefficiencies, fragmented care, and inequitable access to services, (Aulianita & Kusumaningrum, 2023). Research highlights that socioeconomic barriers, such as poverty and lack of insurance, further exacerbate these challenges, particularly in rural areas (Ruslang & Puspandari, 2023).

The role of payment mechanisms in referral coordination cannot be overstated, as they directly influence provider behavior and system efficiency. Service payment contracts, such as capitation-based models and bundled payments, have been widely adopted to align financial incentives with collaborative care objectives (Lee, 2016). These mechanisms encourage Puskesmas to manage patients effectively while ensuring timely referrals to hospitals when necessary (Rajagopalan & Tong, 2021). However, challenges arise when fee-for-service models dominate, as they may incentivize unnecessary referrals or underutilization of primary care services (Allard et al., 2011). Additionally, studies have shown that the lack of transparency in payment negotiations and resource distribution often exacerbates inefficiencies, highlighting the need for reforms that prioritize equity and sustainability (Stokes et al., 2018).

Legal and regulatory barriers also play a significant role in shaping referral coordination. Anti-kickback laws and licensure restrictions are designed to prevent

Health Frontiers: A Multidisciplinary Journal for Health Professionals, Vol 3 Issue 1 2025 E-ISSN : 3024-9740

unethical practices but can inadvertently limit collaboration between Puskesmas, physicians, and hospitals (Sabone et al., 2020). For instance, restrictions on direct employment of physicians by hospitals may hinder the development of formal referral networks, reducing opportunities for coordinated care (LeBoit & Cockerell, 1994) . While these regulations are crucial for maintaining ethical standard balanced with the need for flexibility in collaborative models (Manchikanti & McMahon, 2007). Countries that have successfully navigated this challenge often implement legal reforms to clarify permissible arrangements, enabling innovative partnerships without compromising integrity (Liaw et al., 2024).

Finally, addressing systemic fragmentation and socioeconomic barriers is critical to improving referral coordination. Fragmentation between primary, secondary, and tertiary levels of care often results in incomplete referrals, duplicated tests, and higher costs for patients (Vargas et al., 2014a). Standardized protocols and integrated information systems have been proposed as solutions to streamline processes and reduce inconsistencies (Vargas et al., 2015). Additionally, socioeconomic factors such as poverty, specialist shortages, and lack of insurance coverage create significant barriers to accessing specialty care for patients referred from Puskesmas (Schwarz et al., 2021). Telemedicine and expanded subsidy programs offer promising solutions to bridge these gaps, but their implementation requires robust infrastructure and stakeholder engagement [16] (Kern et al., 2019). By addressing these challenges through targeted interventions, policymakers can create a more cohesive and equitable healthcare system.

MATERIALS AND METHODS

This study employed a systematic literature review (SLR) following the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) framework to identify, screen, and synthesize peer-reviewed studies published between 2013 and 2023. The objective was to analyze regulations and policies influencing referral coordination between community health centers (Puskesmas) and hospitals. Databases such as PubMed, Scopus, Web of Science, and Google Scholar were searched using predefined keywords, including "referral coordination," "Puskesmas," "healthcare regulations," "payment mechanisms," and "health information systems." Studies were included if they focused on regulatory frameworks, technological integration, or socioeconomic factors affecting referral systems in decentralized healthcare settings. Eligibility criteria required studies to address key themes such as payment contracts, legal barriers, standardized referral protocols, and access to specialty care. Articles were excluded if they did not

provide empirical evidence or were unrelated to healthcare referral systems. Data extraction involved summarizing findings on supportive and hindering regulations, while thematic analysis was used to synthesize insights into actionable recommendations. This rigorous approach ensured a comprehensive understanding of the regulatory landscape and its impact on referral coordination.

RESULTS

Supporting Regulations

Supporting regulations play a critical role in enhancing coordination between Puskesmas (community health centers) and hospitals through mechanisms such as service payment contracts, government subsidies, integrated information systems, and incentive schemes. Service payment contracts, both non-competitive and competitive, align financial incentives by incorporating cost-sharing agreements that encourage patients to seek initial care at puskesmas before hospital referrals, thereby reducing unnecessary visits and improving primary care utilization. For instance, capitation-based models incentivize puskesmas to manage care efficiently while ensuring timely referrals, though their success hinges on transparent negotiations and equitable resource distribution. Government subsidies and revenue-sharing frameworks further bridge financial gaps between smaller community hospitals and larger tertiary facilities, enabling investments in infrastructure, staff training, and referral systems. However, subsidies must be paired with performance-based accountability to avoid inefficiencies. Integrated health referral information systems (HRIS) streamline communication and data sharing, reducing administrative burdens and enabling real-time patient tracking, though challenges like high costs and interoperability issues persist. Meanwhile, incentive schemes such as bundled payments covering all services for a specific care episode promote collaboration across care levels, improving follow-up care and reducing readmissions. Designing effective incentives, however, requires balancing local contexts and stakeholder interests to ensure fairness and sustainability. Together, these regulatory measures aim to strengthen referral networks, optimize resource use, and enhance patient outcomes within the healthcare system.

Table 1. Regulations Supporting or Hindering Referral Coordination Between Puskesmas and Hospital

Health Frontiers
A Multidisciplinary Journal for Health Professionals
TARQABIN NUSANTARA GROUP
Health Frontiers: A Multidisciplinary Journal for Health Professionals, Vol 3 Issue 1 2025
E-ISSN : 3024-9740

Category	Regulation/ Policy	Description	Impact	Challenges
Supporting Regulations	Service Payment Contracts	Service payment contracts (non-competitive/competitive) to reduce costs and improve efficiency.	Reduces unnecessary hospital visits, encourages initial consultations at Puskesmas.	Transparency in negotiation and equitable financial resource distribution is critical.
	Government Subsidies and Revenue Sharing	Government subsidies and revenue-sharing schemes to support community hospitals.	Enhances community hospital capacity to collaborate with Puskesmas.	Risk of inefficiency if not paired with performance-based accountability measures.
	Integrated Information Systems	Integrated referral information systems to facilitate communication and data sharing.	Reduces waiting times, ensures continuity of care, and minimizes documentation errors.	High upfront costs, resistance to technology adoption, and legacy system interoperability issues.
	Incentive Schemes	Incentive schemes like bundled payments to encourage collaboration across facility levels.	Improves follow-up care, reduces readmissions, and ensures comprehensive treatment plans.	Designing fair incentive structures requires consideration of local contexts and stakeholder interests.
Hindering Regulations	Licensure and Anti-Kickback Laws	Licensing restrictions and anti-kickback laws limit direct collaborations between doctors and hospitals.	Narrows formal relationships between Puskesmas and hospitals.	Balancing legal safeguards with flexibility for collaboration remains a significant challenge.
	Lack of Standardized Criteria	Absence of standardized referral criteria leads to inconsistent referral practices.	Results in inappropriate referrals, delays, and incomplete	Requires evidence-based guidelines and stakeholder

Health Frontiers
A Multidisciplinary Journal for Health Professionals
TARQABIN NUSANTARA GROUP
Health Frontiers: A Multidisciplinary Journal for Health Professionals, Vol 3 Issue 1 2025
E-ISSN : 3024-9740

			medical record transfers.	involvement to develop criteria.
	Fragmented Healthcare Systems	Fragmentation between primary, secondary, and tertiary care levels causes poor coordination.	Leads to incomplete referrals, duplicated tests, and higher costs.	Systemic reforms, including clear referral pathways and shared governance structures, are needed.
	Barriers to Specialty Care Access	Socioeconomic barriers such as poverty, specialist shortages, and poor communication between providers.	Patients face challenges accessing specialty care after being referred from Puskesmas.	Targeted interventions like expanded insurance, increased specialist availability, and telemedicine are required.

Table 2. Recomendations for Improvement

Recomendation	Description	Expected Outcome
Enhance Communication	Build strong communication channels between primary and specialty care providers through regular meetings, shared EHRs, and feedback mechanisms.	Improves trust, speeds up referral processes, and ensures continuity of care.
Policy Changes	Revise reimbursement policies to prioritize collaborative care models and clarify laws governing collaborations.	Encourages teamwork, reduces fragmentation, and improves referral system efficiency.
Investment in Community Health Centers	Increase funding for Puskesmas to enhance their capacity to deliver quality primary care and manage referrals effectively.	Strengthens the role of Puskesmas as "gatekeepers" in the healthcare system.
Develop Standardized Protocols	Establish national/regional standards for referral criteria, documentation, and follow-up procedures.	Reduces inconsistencies, speeds up referral processes, and improves care quality.
Promote Technological Integration	Invest in scalable and interoperable IT solutions to	Facilitates real-time communication, reduces

	connect Puskesmas, hospitals, and other stakeholders.	administrative burdens, and improves data accuracy.
Address Socioeconomic Barriers	Implement social safety nets (e.g., subsidized transportation, expanded insurance) and expand telemedicine access.	Reduces access barriers for low-income patients and those in remote areas.

Hindering Regulations

Licensure and anti-kickback laws, while designed to prevent unethical financial practices in healthcare, often restrict legitimate collaborations between hospitals and physicians. These regulations limit direct employment arrangements, joint ventures, and the formation of formal referral networks by prohibiting certain financial agreements. For instance, anti-kickback statutes can deter hospitals from incentivizing referrals, even when such arrangements might improve care coordination. The challenge lies in balancing legal safeguards against corruption with the flexibility needed to foster integrated care models, as overly rigid policies may inadvertently stifle innovation and cooperation between providers.

The absence of standardized referral criteria exacerbates fragmentation in healthcare systems. Without clear protocols, decisions to transfer patients between Puskesmas, pharmacies, and hospitals become inconsistent, leading to fragmented care and poor interdisciplinary coordination. This lack of clarity results in delayed referrals, inappropriate transfers, and incomplete sharing of medical records, undermining continuity of care. Developing evidence-based, universally accepted criteria would require significant stakeholder collaboration and alignment with local needs, but progress is often slowed by competing priorities and resource constraints.

Fragmentation across primary, secondary, and tertiary care levels further complicates referral systems. Poorly defined roles, overlapping responsibilities, and inadequate communication between providers lead to duplicated tests, incomplete referrals, and higher costs for patient. Navigating these disjointed systems often leaves patients dissatisfied, as they face confusion, repeated explanations of their medical history, and gaps in treatment. Systemic reforms, such as establishing clear referral pathways and shared governance structures, are critical to addressing these issues, but implementation remains challenging due to entrenched institutional

Health Frontiers: A Multidisciplinary Journal for Health Professionals, Vol 3 Issue 1 2025 E-ISSN : 3024-9740

practices and resistance to change.

Socioeconomic barriers, including poverty, specialist shortages, and limited insurance coverage, significantly hinder access to specialty care for patients referred from Puskesmas. Even when referrals are made, long wait times, geographic distance, and unaffordable out-of-pocket expenses prevent many from receiving timely treatment. Poor communication between primary and specialty providers further exacerbates these challenges, leading to fragmented care and suboptimal outcomes. Addressing these barriers requires targeted interventions, such as expanding insurance schemes, deploying specialists to underserved areas, and leveraging telemedicine to bridge gaps in access. However, progress is often constrained by funding limitations and inequities in resource distribution.

Recommendations for Improvement

To strengthen referral systems and healthcare coordination, enhancing communication between primary and specialty care providers is critical. Regular interdisciplinary meetings, shared electronic health records (EHRs), and structured feedback mechanisms can foster trust, clarify roles, and ensure seamless information exchange, ultimately improving referral outcomes. Policy reforms should prioritize value-based payment models that reward collaborative care and patient outcomes over service volume, while clarifying regulations to reduce legal ambiguities around hospital-physician partnerships. Simultaneously, investing in community health centers like Puskesmas through increased funding, advanced diagnostic tools, and expanded insurance coverage can empower them to act as effective gatekeepers, reducing unnecessary referrals and improving primary care quality. Standardized national or regional protocols for referrals, documentation, and follow-ups must be developed, blending evidence-based practices with local adaptability to ensure consistency and equity. Technological integration, including scalable and interoperable IT systems, should be prioritized to connect stakeholders, with training programs to ensure healthcare workers can leverage digital tools effectively. Finally, socioeconomic barriers to specialty care access must be addressed through social safety nets, such as subsidized transportation and expanded insurance, alongside telemedicine initiatives to bridge geographic and financial gaps, ensuring equitable care for all patients.

Health Frontiers
A Multidisciplinary Journal for Health Professionals
TARQABIN NUSANTARA GROUP
Health Frontiers: A Multidisciplinary Journal for Health Professionals, Vol 3 Issue 1 2025
E-ISSN : 3024-9740

DISCUSSION

The Role of Payment Mechanisms in Referral Coordination

Payment mechanisms play a pivotal role in shaping referral coordination between community health centers (Puskesmas) and hospitals. Service payment contracts, whether competitive or non-competitive, can incentivize collaboration by aligning financial interests between these entities (Li et al., 2022). For instance, capitation-based payment models encourage Puskesmas to manage patient care efficiently while ensuring timely referrals to higher-level facilities when necessary (Ghazaryan et al., 2021). However, fee-for-service models may inadvertently lead to over-referrals if not carefully monitored, as providers might prioritize financial gain over patient needs (Tobey et al., 2022). Additionally, bundled payment schemes have been shown to improve follow-up care and reduce readmissions by rewarding coordinated efforts across different levels of care. Despite their potential, the implementation of these mechanisms often faces challenges, such as resistance from stakeholders accustomed to traditional payment systems and the need for robust monitoring frameworks to prevent misuse (Bai et al., 2019).

Balancing Legal Protections with Collaborative Opportunities

Anti-kickback laws and licensure restrictions are designed to prevent unethical practices but can also hinder collaboration between Puskesmas, physicians, and hospitals. These regulations often limit direct employment of physicians by hospitals and restrict financial arrangements that could otherwise foster formal partnerships (Krause, 2013). While such laws are crucial for maintaining ethical standards, they may inadvertently stifle innovative collaborative models, particularly in resource-constrained settings (Resnik, 2010).To address this, some countries have introduced legal reforms to clarify permissible collaborations, allowing for greater flexibility without compromising integrity. For example, value-based payment models have been successfully implemented in certain regions after revising anti-kickback statutes to accommodate collaborative care initiatives (Aaron, 1992). Balancing legal protections with the need for collaboration remains a complex challenge that requires careful consideration of both ethical and operational implications(Mitchell

Health Frontiers: A Multidisciplinary Journal for Health Professionals, Vol 3 Issue 1 2025 E-ISSN : 3024-9740

et al., 2022).

The Importance of Standardized Criteria for Referrals

The absence of standardized criteria for referrals creates significant inconsistencies in how patients are transferred between Puskesmas and hospitals. Without clear guidelines, healthcare providers may rely on subjective judgment, leading to inappropriate or delayed referrals (Smith, 2024) . Standardized protocols can ensure that referrals are based on evidence-based criteria, improving the quality of care and reducing administrative burdens. Developing such criteria requires input from multiple stakeholders, including policymakers, healthcare providers, and patient advocacy groups, to ensure relevance and feasibility (Heitner et al., 2020). Furthermore, standardized criteria can facilitate better communication and documentation, reducing errors in the referral process (Wang et al., 2020). Successful examples from other countries demonstrate that implementing national referral standards can significantly enhance system efficiency and patient outcomes (Rosenthal et al., 2018).

Addressing Fragmentation in Healthcare Systems

Fragmentation between primary, secondary, and tertiary levels of care is a major barrier to effective referral coordination. Poorly defined roles, overlapping responsibilities, and inadequate communication exacerbate the problem, leading to incomplete referrals and higher costs (Vargas et al., 2014b). Systematic reforms are needed to establish clear referral pathways and shared governance structures that align the objectives of all stakeholders (Mendes & Almeida, 2020). Technology can play a critical role in addressing fragmentation by enabling real-time data sharing and communication between Puskesmas and hospitals (Agha et al., 2017). For example, integrated health information systems have been shown to streamline referral processes and reduce waiting times in several countries (Cebul et al., 2008). However, overcoming fragmentation requires more than just technological solutions; it also demands cultural shifts and policy changes to promote collaboration across different levels of care.

Overcoming Barriers to Specialty Care Access

Access to specialty care remains a significant challenge for patients referred from Puskesmas, particularly in low-income and rural areas. Factors such as poverty, specialist shortages, lack of insurance coverage, and poor communication between

primary and specialty providers contribute to this issue (Ezeonwu, 2018). Expanding insurance coverage and introducing subsidy programs can help alleviate financial barriers for underserved populations Pittalis et al., 2019). Telemedicine has emerged as a promising solution to bridge geographic disparities, enabling remote consultations and follow-ups for patients in remote areas (Cummings et al., 2017). However, the effectiveness of telemedicine depends on adequate infrastructure and training for healthcare providers. Addressing these barriers requires a multi-pronged approach that combines policy reforms, technological innovations, and targeted investments to ensure equitable access to specialty care (Sriram & Bennett, 2020).

CONCLUSIONS

In conclusion, the coordination of referrals between Puskesmas and hospitals is a complex process influenced by a myriad of regulatory factors, ranging from payment mechanisms and legal frameworks to systemic fragmentation and socioeconomic barriers. Effective referral systems require a balanced approach that leverages supportive regulations, such as standardized criteria, integrated information systems, and incentive schemes, while addressing hindrances like anti-kickback laws, resource limitations, and inequitable access to specialty care. Evidence suggests that targeted policy reforms, technological investments, and stakeholder collaboration are essential to overcoming these challenges and building a more cohesive healthcare ecosystem. By prioritizing equity, transparency, and efficiency, policymakers can ensure that referral systems not only enhance patient outcomes but also contribute to the broader goal of achieving universal health coverage. Ultimately, a well-coordinated referral system has the potential to transform healthcare delivery, making it more accessible, affordable, and patient-centered for all.

REFERENCES

Aaron, H. (1992). Application of the Medicare and Medicaid anti-kickback statute to business arrangements between hospitals and hospital-based physicians. *Annals of Health Law*, *1*, 53–69. https://consensus.app/papers/application-of-the-medicare-and-medicaid-antikickback-aaron/b581e58706d55b268d52c12e121565a8/

Agha, L., Frandsen, B., & Rebitzer, J. (2017). Fragmented Division of Labor and Healthcare Costs: Evidence from Moves Across Regions. *Political Economy: Government Expenditures & Related Policies EJournal*. https://doi.org/10.1016/J.JPUBECO.2018.11.001

Allard, M., Jelovac, I., & Léger, P. (2011). Treatment and referral decisions under different physician payment mechanisms. *Journal of Health Economics*, *30 5*, 880–893. https://doi.org/10.1016/j.jhealeco.2011.05.016

Armin, A., Akib, H., Limpo, H., Thamrin, A., & Mustari, M. (2020). Collaborative Partnership in Management of Community Health Centers (PUSKESMAS) in Wajo Regency, Indonesia. *Social Sciences Education EJournal*. https://doi.org/10.2139/ssrn.3525911

Aulianita, M. F., & Kusumaningrum, A. E. (2023). TANGGUNG JAWAB PUSKESMAS TERHADAP PEMANTAUAN PASIEN ISOLASI MANDIRI DALAM PENCEGAHAN DAN PENGENDALIAN PENYEBARAN COVID-19. *JISPENDIORA Jurnal Ilmu Sosial Pendidikan Dan Humaniora*. https://doi.org/10.56910/jispendiora.v1i2.582

Bai, G., Zhou, Y., Luo, L., & Wang, Z. (2019). Resource allocation for chronic diseases based on a patient willingness survey. *The International Journal of Health Planning and Management*. https://doi.org/10.1002/hpm.2864

Cebul, R., Rebitzer, J., Taylor, L., & Votruba, M. (2008). Organizational fragmentation and care quality in the U.S healthcare system. *The Journal of Economic Perspectives : A Journal of the American Economic Association*, *22 4*, 93–113. https://doi.org/10.1257/jep.22.4.93

Cummings, J., Allen, L., Clennon, J., Ji, X., & Druss, B. (2017). Geographic Access to Specialty Mental Health Care Across High- and Low-Income US Communities. *JAMA Psychiatry*, *74*, 476. https://doi.org/10.1001/jamapsychiatry.2017.0303

Ezeonwu, M. (2018). Specialty-care access for community health clinic patients: processes and barriers. *Journal of Multidisciplinary Healthcare*, *11*, 109–119. https://doi.org/10.2147/JMDH.S152594

Ghazaryan, E., Delarmente, B., Garber, K., Gross, M., Sriudomporn, S., & Rao, K. (2021). Effectiveness of hospital payment reforms in low- and middle-income countries: a systematic review. *Health Policy and Planning*. https://doi.org/10.1093/heapol/czab050

Heitner, R., Rogers, M., Silvers, A., Courtright, K., & Meier, D. (2020). Palliative Care Team Perceptions of Standardized Palliative Care Referral Criteria Implementation in Hospital Settings. *Journal of Palliative Medicine*. https://doi.org/10.1089/jpm.2020.0296

Kern, L., Safford, M., Slavin, M., Makovkina, E., Fudl, A., Carrillo, E., & Abramson, E. (2019). Patients' and Providers' Views on Causes and Consequences of Healthcare Fragmentation in the Ambulatory Setting: a Qualitative Study. *Journal of General Internal Medicine*, *34*, 899–907. https://doi.org/10.1007/s11606-019-04859-1

Krause, J. (2013). Kickbacks, self-referrals, and false claims: the hazy boundaries of health-care fraud. *Chest*, *144 3*, 1045–1050. https://doi.org/10.1378/chest.12-2889

LeBoit, P., & Cockerell, C. (1994). The effort to decapitate American dermatopathology through laboratory capitation: an urgent and dire warning to dermatologists and dermatopathologists. *Journal of the American Academy of Dermatology*, *31 1*, 98–100. https://doi.org/10.1016/S0190-9622(09)80231-4

Lee, J. (2016). Mechanisms with Referrals: VCG Mechanisms and Multilevel Mechanisms. *Proceedings of the 2016 ACM Conference on Economics and Computation*. https://doi.org/10.2139/ssrn.2987761

Li, N., Pan, J.-W., & Chen, N. (2022). Coordination Control for Hospital Referral With Multitype Patients. *IEEE Transactions on Automation Science and Engineering*, *19*, 2295–2309. https://doi.org/10.1109/TASE.2021.3062852

Liaw, W., Bakos-Block, C., Northrup, T., Stotts, A., Hernandez, A., Finzetto, L., Oloyede, P., Rodriguez, B. M., Johnson, S., Gilbert, L., Dobbins, J., Woodard, L., & Murphy, T. (2024). A Qualitative Analysis of a Primary Care Medical-Legal Partnership: Impact, Barriers, and Facilitators. *Journal of the American Board of Family Medicine : JABFM*. https://doi.org/10.3122/jabfm.2023.230328R2

Manchikanti, L., & McMahon, E. (2007). Physician refer thyself: is Stark II, phase III the final voyage? *Pain Physician*, *10 6*, 725–741. https://consensus.app/papers/physician-refer-thyself-is-stark-ii-phase-iii-the-final-manchikanti-mcmahon/86d0f9874f7653ff85d435cb8d6a97b3/

Mendes, L., & Almeida, P. (2020). Do primary and specialized care physicians know and use coordination mechanisms? *Revista de Saúde Pública*, *54*. https://doi.org/10.11606/s1518-8787.2020054002475

Mitchell, A., Sarpatwari, A., & Bach, P. (2022). Industry Payments to Physicians are Kickbacks. How Should Stakeholders Respond? *Journal of Health Politics, Policy and Law*. https://doi.org/10.1215/03616878-10041205

Pittalis, C., Brugha, R., & Gajewski, J. (2019). Surgical referral systems in low- and middle-income countries: A review of the evidence. *PLoS ONE*, *14*. https://doi.org/10.1371/journal.pone.0223328

Rajagopalan, S., & Tong, C. (2021). Payment Models to Coordinate Healthcare Providers with Partial Attribution of Outcome Costs. *Manuf. Serv. Oper. Manag.*, *24*, 600–616. https://doi.org/10.1287/MSOM.2020.0928

Resnik, D. (2010). Conflict of Interest in Medical Research, Education, and Practice. *Environmental Health Perspectives*, *118*. https://consensus.app/papers/conflict-of-interest-in-medical-research-education-and-resnik/a50fc8e113255a27b2921768ddc42d7a/

Rosenthal, J., Doiron, R., Haynes, S., Daniels, B., & Li, S.-T. (2018). The Effectiveness of Standardized Handoff Tool Interventions During Inter- and Intra-facility Care Transitions on Patient-Related Outcomes: A Systematic Review. *American Journal of Medical Quality*, *33*, 193–206. https://doi.org/10.1177/1062860617708244

Ruslang, R., & Puspandari, D. A. (2023). Korelasi Disparitas Tenaga Kesehatan Puskesmas Terhadap Pelayanan Kesehatan Primer Peserta Jaminan Kesehatan Nasional Kabupaten Poso. *Jurnal Jaminan Kesehatan Nasional*. https://doi.org/10.53756/jjkn.v3i2.162

Sabone, M., Mazonde, P., Cainelli, F., Maitshoko, M., Joseph, R., Shayo, J., Morris, B., Muecke, M., Wall, B., Hoke, L., Peng, L., Mooney-Doyle, K., & Ulrich, C. (2020). Everyday ethical challenges of nurse-physician collaboration. *Nursing Ethics*, *27*, 206–220. https://doi.org/10.1177/0969733019840753

Schwarz, T., Schmidt, A., Bobek, J., & Ladurner, J. (2021). *Barriers to Accessing Health Care for People with Chronic Conditions: A Qualitative Study*. https://doi.org/10.21203/rs.3.rs-959131/v1

Smith, A. (2024). Implementation of a Standardized Screening Process to Increase Palliative Care Referrals in Primary Care: An Evidence-Based Quality Approach. *Journal of Hospice and Palliative Nursing : JHPN : The Official Journal of the Hospice and Palliative Nurses Association*. https://doi.org/10.1097/njh.0000000000001064

Sriram, V., & Bennett, S. (2020). Strengthening medical specialisation policy in low-income and middle-income countries. *BMJ Global Health*, *5*. https://doi.org/10.1136/bmjgh-2019-002053

Stokes, J., Struckmann, V., Kristensen, S., Fuchs, S., Van Ginneken, E., Tsiachristas, A., Van Mölken, R.-, & Sutton, M. (2018). Towards incentivising integration: A typology of payments for integrated care. *Health Policy*, *122 9*, 963–969. https://doi.org/10.1016/j.healthpol.2018.07.003

Suryanto, Plummer, V., & Boyle, M. (2017). Healthcare System in Indonesia. *Hospital Topics*, *95*, 82–89. https://doi.org/10.1080/00185868.2017.1333806

Tobey, R., Maxwell, J., Turer, E., Singer, E., Lindenfeld, Z., Nocon, R., Coleman, A., Bolton, J., Hoang, H., Sripipatana, A., & Huang, E. (2022). Health Centers and Value-Based Payment: A Framework for Health Center Payment Reform and Early Experiences in Medicaid Value-Based Payment in Seven States. *The Milbank Quarterly*, *100 3*, 879–917. https://doi.org/10.1111/1468-0009.12580

Vargas, I., Mogollón-Pérez, A., De Paepe, P., Da Silva, M. R. F., Unger, J., & Vázquez, M. (2014a). Barriers to healthcare coordination in market-based and decentralized public health systems: a qualitative study in healthcare networks of Colombia and Brazil. *Health Policy and Planning*, *31*, 736–748. https://doi.org/10.1093/heapol/czv126

Vargas, I., Mogollón-Pérez, A., De Paepe, P., Da Silva, M. R. F., Unger, J., & Vázquez, M. (2014b). Barriers to healthcare coordination in market-based and decentralized public health systems: a qualitative study in healthcare networks of Colombia and Brazil. *Health Policy and Planning*, *31*, 736–748. https://doi.org/10.1093/heapol/czv126

Vargas, I., Mogollón-Pérez, A., De Paepe, P., Da Silva, M., Unger, J., & Vázquez, M. (2015). Do existing mechanisms contribute to improvements in care coordination across levels of care in health services networks? Opinions of the health personnel in Colombia and Brazil. *BMC Health Services Research*, *15*. https://doi.org/10.1186/s12913-015-0882-4

Wang, J.-J., Li, Z.-P., Shi, J., & Chang, A.-C. (2020). Hospital referral and capacity strategies in the two-tier healthcare systems. *Omega-International Journal of Management Science*, 102229. https://doi.org/10.1016/J.OMEGA.2020.102229