Galore International Journal of Applied Sciences and Humanities
Vol.3; Issue: 1; Jan.-March 2019
Website: www.gijash.com
Original Research Article *P-ISSN: 2456-8430*

Overview of Health Personnel Task Shifting in Hospitals in Jawa Barat (Results of Risnakes 2017)

Wibowo[1], Sefrina Werni[1], Mujiati[1], Harimat Hendarwan[1]

[1]Pusat Penelitian dan Pengembangan Sumber Daya dan Pelayanan Kesehatan
Kementerian Kesehatan RI, Jakarta

Corresponding Author: Wibowo

ABSTRACT

Background: Task shifting is defined as delegating tasks and authority to competent personnel. This can be problematic if not through the right processes and procedures. West Java Province is one of the provinces with a large number of hospitals, namely 289 hospitals, and information about the implementation of task shifting in hospitals in West Java has not been available.
Objective: Obtain an overview of the implementation of task shifting in hospitals in West Java.
Methods: Part of the Research on Employment in the Health Sector (Risnakes) of the Health Research and Development Agency of the Ministry of Health of the Republic of Indonesia in 2017. The research was conducted with a cross sectional approach, with the survey method. Data collection is done by interviewing using a structured questionnaire. Respondents were hospital directors or represented in 289 hospitals in West Java.
Results: A total of 205 hospitals (70.9%) in West Java have health workers who do tasks outside of their educational background and / or competence, and 193 hospitals (94.1%) have health workers working on tasks in the field. governance (task shifting). The availability of assignment letters/ written decrees to strengthen the implementation of task shifting is mostly found in Level IV TNI hospitals (100%). The most common reason for task shifting was due to a shortage of staff, which reached 100% in Level IV TNI hospitals. Almost all hospitals have to report the results of task shifting, even in TNI hospitals reaching 100%. The most reward form given to health workers who carry out task shifting is the addition of distribution of capitation services. While the percentage related to the occurrence of unexpected cases due to task shifting is relatively low at 3.0% -8.3%.
Conclusion: The task shifting of health workers in the hospital area in West Java is sufficient in accordance with Law Number 36 of 2014 and Law Number 38 of 2014.
Keywords: health workers, task shifting, hospitals, West Java

1. INTRODUCTION

According to WHO, delegation of tasks or task shifting is a term that is now used for processes where certain tasks should be performed by competent health personnel but transferred or carried out by other health personnel or cadres who are given training to carry out delegated actions or tasks. Delegation of tasks can make the use of existing human resources more efficient and facilitate obstacles in service delivery. [1] According to Law No. 36 of 2014 concerning Health Workers, Article 63 states that in certain circumstances health workers can provide services beyond their authority. Article 65 states that in performing services, health workers can receive the transfer of medical action from medical personnel with the following conditions: the devolved action includes the abilities and skills possessed by the recipient of the delegation; implementation of actions under the supervision of the deferring agent; the delegator is still responsible for the devolved action and delegated action does not include decision making as the basis for implementing the action. [2] Meanwhile, according to Law Number 38 of 2014 concerning nursing, the implementation of tasks based on delegation of authority must be given in writing, delegated or mandated

by personnel medical to the nurse to carry out a medical action and delegation of responsibility and conduct an evaluation of its implementation. [3]

Reorganization and decentralization of health services in accordance with the task shifting approach can help overcome the current shortage of health workers. This deficiency is particularly acute in countries that face a high HIV burden. However, WHO collaborated with the US President's Emergency Plan for AIDS Relief (PEPFAR) and UNAIDS to recommend that task shifting should be carried out in conjunction with other strategies designed to increase the number of health workers. They also emphasize that task shifting is proposed as an efficient approach but requires significant investment and should not be seen as a substitute for other investments in human resources for health. [4]

According to Pusdatin's 2016 data, Indonesia has 2,325 hospitals. One of the provinces with a large number of hospitals is West Java Province, which is 289 hospitals. [5] However, information on the implementation of task shifting in hospitals in West Java in particular and in Indonesia in general, is not yet available. So that the study of the implementation of task shifting in hospitals is important to do, as a matter of consideration or input in preparing policies related to health services and staffing in health care facilities.

2. MATERIALS AND METHODS

This research is part of the Research on Employment in the Health Sector (Risnakes) 2017. The type of research is descriptive with survey method and cross sectional approach (cross sectional study). Data collection was done by interviewing a structured questionnaire to the hospital director or representing 289 hospitals in West Java Province. Data analysis was carried out descriptively with frequency distribution tables.

3. RESULTS

There are several variables studied, namely education/competency background, the presence of assignment letters/written decrees, reasons for assignment, reporting requirements, forms of compensation and unexpected cases from the assignment in the field of patient management. Following is the frequency distribution table.

Table 1. Hospital frequency distribution with health workers working on patient management tasks outside of their educational and / or competency background in hospitals in West Java, Risnakes 2017

		N	Hospitals have health workers who work on tasks outside of their educational and / or competency background			
			Yes		No	
			n	%	n	%
Provkab	Bogor	24	19	79,2	5	20,8
	Sukabumi	7	7	100,0	0	0,0
	Cianjur	3	3	100,0	0	0,0
	Bandung	2	2	100,0	0	0,0
	Garut	6	6	100,0	0	0,0
	Tasikmalaya	1	1	100,0	0	0,0
	Ciamis	3	2	66,7	1	33,3
	Kuningan	8	7	87,5	1	12,5
	Cirebon	11	11	100,0	0	0,0
	Majalengka	3	3	100,0	0	0,0
	Sumedang	2	0	0,0	2	100,0
	Indramayu	6	6	100,0	0	0,0
	Subang	7	6	85,7	1	14,3
	Purwakarta	9	6	66,7	3	33,3
	Karawang	19	12	63,2	7	36,8
	Bekasi	39	21	53,8	18	46,2
	Bandung Barat	6	5	83,3	1	16,7
	Kota Bogor	15	10	66,7	5	33,3
	Kota Sukabumi	5	5	100,0	0	0,0
	Kota Bandung	31	22	71,0	9	29,0
	Kota Cirebon	11	8	72,7	3	27,3
	Kota Bekasi	30	14	46,7	16	53,3
	Kota Depok	19	12	63,2	7	36,8
	Kota Cimahi	7	4	57,1	3	42,9
	Kota Tasikmalaya	12	10	83,3	2	16,7
	Kota Banjar	3	3	100,0	0	0,0
Total		289	205	70,9	84	29,1

Based on the table above, it can be seen that out of 289 hospitals in cities / regencies in West Java Province, there are 205 hospitals (70.9%) with health workers who work on tasks outside of their educational and / or competency background. Districts with hospitals that have absolutely no health workers working on tasks outside of their educational background or competence are hospitals in Sumedang.

Of the 205 hospitals with health workers working on tasks outside of education and / or competency backgrounds, there are 193 hospitals (94.1%) with health workers doing tasks outside of their educational background and / or competence in the field of management (task shifting). While the other 12 hospitals have health workers who work on tasks outside the back of education and / or their competence in the field of management (multitasking). Of the 193 hospitals, delegation of tasks in the field of governance strengthened by the existence of written assignments / decrees according to the type of hospital, are listed in Table 2.

Table 2. Frequency distribution assignment of patient management fields strengthened assignment letter / written decision letter in hospital in West Java, Risnakes 2017

		Assignments strengthened by written assignments / decrees (SK)							
		Yes, the whole		Yes, a part		No		Total	
		n	%	n	%	n	%	n	%
Type of hospital	General hospital	126	77,3	29	17,8	8	4,9	163	100,0
	Private hospital	21	70,0	6	20,0	3	10,0	30	100,0
	Total	147	76,2	35	18,1	11	5,7	193	100,0
Hospital class	Class A	5	71,4	1	14,3	1	14,3	7	100,0
	Class B	33	89,2	4	10,8	0	0,0	37	100,0
	Class C	76	75,2	20	19,8	5	5,0	101	100,0
	Class D	25	65,8	8	21,1	5	13,2	38	100,0
	Total	139	76,0	33	18,0	11	6,0	183	100,0
TNI Hospital class	Level I	0	0,0	0	0,0	0	0,0	0	0,0
	Level II	2	66,7	1	33,3	0	0,0	3	100,0
	Level III	4	80,0	1	20,0	0	0,0	5	100,0
	Level IV	2	100,0	0	0,0	0	0,0	2	100,0
	Total	8	80,0	2	20,0	0	0,0	10	100,0
Owenership	Non govt. hospital (Non TNI / POLRI)	32	84,2	5	13,2	1	2,6	38	100,0
	Hosp.TNI/POLRI	8	80,0	2	20,0	0	0,0	10	100,0
	Private hosp,	107	73,8	28	19,3	10	6,9	145	100,0
	Total	147	76,2	35	18,1	11	5,7	193	100,0
Hospital funding management	BLU Centre	5	71,4	2	28,6	0	0,0	7	100,0
	BLU Regional	28	90,3	3	9,7	0	0,0	31	100,0
	Non BLU	7	70,0	2	20,0	1	10,0	10	100,0
	Total	40	83,3	7	14,6	1	2,1	48	100,0

Based on Table 2, according to the type of hospital, general hospitals have a percentage of availability of assignment letters or written decrees for all task shifting that are greater (77.3%) compared to special hospitals (70.0%). According to hospital classes, Class B hospitals have a percentage of availability of assignment letters or written decrees for all task shifting (89.2%) compared to Class A, C, and D. Whereas according to the classification of TNI hospitals, hospitals Level IV has the percentage of availability of assignment letters or written decrees for all task shifting that are larger (100%) compared to Level I, II, and III hospitals.

According to hospital ownership, government-owned hospitals (non-TNI / POLRI) have a percentage of availability of written assignments or written decrees for all task shifting (84.2%) compared to hospitals / TNI / POLRI and private hospitals. Whereas according to the pattern of hospital financial management, Regional BLU hospitals have a percentage of availability of assignment letters or written decrees for all task shifting that are larger (90.3%) compared to the BLU Center and Non BLU hospitals.

There are various reasons or causes for task shifting. Table 3 shows the frequency distribution of each cause or the reasons for task shifting in more detail.

Table 3. Frequency distribution is the reason for assigning patient management to health workers in West Java hospitals, Risnakes 2017

		Assigment reasons									
		Less number staff		Less particular skilled staffs		Others		Combination		Total	
		n	%	n	%	n	%	n	%	N	%
Type of hospital	General hospital	47	28,8	42	25,8	42	25,8	32	19,6	163	100,0
	Private hospital	14	46,7	9	30,0	3	10,0	4	13,3	30	100,0
	Total	61	31,6	51	26,4	45	23,3	36	18,7	193	100,0
Class of hospital	Class A	2	28,6	4	57,1	1	14,3	0	0,0	7	100,0
	Class B	11	29,7	9	24,3	9	24,3	8	21,6	37	100,0
	Class C	30	29,7	26	25,7	26	25,7	19	18,8	101	100,0
	Class D	15	39,5	10	26,3	7	18,4	6	15,8	38	100,0
	Total	58	31,7	49	26,8	43	23,5	33	18,0	183	100,0
TNI hospital class	Level I	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0
	Level II	0	0,0	0	0,0	1	33,3	2	66,7	3	100,0
	Level III	1	20,0	2	40,0	1	20,0	1	20,0	5	100,0
	Level IV	2	100,0	0	0,0	0	0,0	0	0,0	2	100,0
	Total	3	30,0	2	20,0	2	20,0	3	30,0	10	100,0
Ownership	Non govt. hospital (Non TNI / POLRI)	15	39,5	14	36,8	3	7,9	6	15,8	38	100,0
	Hosp.TNI/POLRI	3	30,0	2	20,0	2	20,0	3	30,0	10	100,0
	Private hosp,	43	29,7	35	24,1	40	27,6	27	18,6	145	100,0
	Total	61	31,6	51	26,4	45	23,3	36	18,7	193	100,0
Hospital funding management	BLU Centre	0	0,0	6	85,7	1	14,3	0	0,0	7	100,0
	BLU Regional	13	41,9	10	32,3	3	9,7	5	16,1	31	100,0
	Non BLU	5	50,0	0	0,0	1	10,0	4	40,0	10	100,0
	Total	18	37,5	16	33,3	5	10,4	9	18,8	48	100,0

Table 3 shows that the reason most task shifting is done is because of a lack of power, this occurs in all hospitals, both according to the type of hospital, class, classification, ownership, and according to the pattern of hospital financial management. The second most reason is due to the lack of trained personnel in certain fields.

Because under the supervision of the assignor / authority, the implementation of task shifting must be reported to the assignor / authority. The frequency distribution of having to report the results of task shifting in hospitals is shown in Table 4.

Table 4. Frequency distribution of the necessity to re-report the results of assignments in the management of patients in West Java regional hospitals, Risnakes 2017

		Requirement to report back the results of the assignment					
		Yes		No		Total	
		n	%	n	%	n	%
Type of hospital	General hospital	152	93,3	11	6,7	163	100,0
	Private hospital	28	93,3	2	6,7	30	100,0
	Total	180	93,3	13	6,7	193	100,0
Hospital level	Class A	6	85,7	1	14,3	7	100,0
	Class B	36	97,3	1	2,7	37	100,0
	Class C	93	92,1	8	7,9	101	100,0
	Class D	35	92,1	3	7,9	38	100,0
	Total	170	92,9	13	7,1	183	100,0
TNI hospoital class	Level I	0	0,0	0	0,0	0	0,0
	Level II	3	100,0	0	0,0	3	100,0
	Level III	5	100,0	0	0,0	5	100,0
	Level IV	2	100,0	0	0,0	2	100,0
	Total	10	100,0	0	0,0	10	100,0
Ownership	Non govt. hospital (Non TNI / POLRI)	35	92,1	3	7,9	38	100,0
	Hosp.TNI/POLRI	10	100,0	0	0,0	10	100,0
	Private hosp,	135	93,1	10	6,9	145	100,0
	Total	180	93,3	13	6,7	193	100,0
Hospital funding management	BLU Centre	6	85,7	1	14,3	7	100,0
	BLU Regional	29	93,5	2	6,5	31	100,0
	Non BLU	10	100,0	0	0,0	10	100,0
	Total	45	93,8	3	6,3	48	100,0

Table 4 shows that almost all hospitals have to report the results of task shifting. Even in TNI hospitals, 100% must report the results of task shifting.

The form of compensation for implementing task shifting can be in the form of providing additional honorariums, additional distribution of capitation services, and others. The frequency distribution in the form of compensation received by health workers who carry out task shifting is shown in Table 5.

Table 5. Frequency distribution in the form of compensation received by health workers on the assignment of patient management in hospitals in the West Java region, Riskaka 2017

		Additional Honor						Added distribution of capitation services						Others					
		Yes		No		Total		Yes		No		Total		Yes		No		Total	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Kind of hospital	General hospital	29	48,3	31	51,7	60	100	38	63,3	22	36,7	60	100	5	8,3	55	91,7	60	100
	Specific	5	45,5	6	54,5	11	100	8	72,7	3	27,3	11	100	2	18,2	9	81,8	11	100
	Total	34	47,9	37	52,1	71	100	46	64,8	25	35,2	71	100	7	9,9	64	90,1	71	100
Hospital class	Class A	0	0,0	1	100	1	100	1	100	0	0,0	1	100	0	0,0	1	100	1	100
	Class B	4	28,6	10	71,4	14	100	12	85,7	2	14,3	14	100	1	7,1	13	92,9	14	100
	Class C	11	57,9	8	42,1	19	100	10	52,6	9	47,4	19	100	0	0,0	19	100	19	100
	Class D	4	44,4	5	55,6	9	100	5	55,6	4	44,4	9	100	1	11,1	8	88,9	9	100
	Total	19	44,2	24	55,8	43	100	28	65,1	15	34,9	43	100	2	4,7	41	95,3	43	100
TNI Hospital	Level I	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0
	Level II	2	100	0	0,0	2	100	2	100	0	0,0	2	100	0	0,0	2	100	2	100
	Level III	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0
	Level IV	0	0,0	1	100	1	100	1	100	0	0,0	1	100	0	0,0	1	100	1	100
	Total	2	66,7	1	33,3	3	100	3	100	0	0,0	3	100	0	0,0	3	100	3	100
Govt. hospital (Non TNI /POLRI)		6	28,6	15	71,4	21	100	20	95,2	1	4,8	21	100	2	9,5	19	90,5	21	100
TNI/POLRI hospital		2	66,7	1	33,3	3	100	3	100	0	0,0	3	100	0	0,0	3	100	3	100
Private hospital		26	55,3	21	44,7	47	100	23	48,9	24	51,1	47	100	5	10,6	42	89,4	47	100
Total		34	47,9	37	52,1	71	100	46	64,8	25	35,2	71	100	7	9,9	64	90,1	71	100
Centre BLU		0	0,0	2	100	2	100	2	100	0	0,0	2	100	0	0,0	2	100	2	100
Regional BLU		6	31,6	13	68,4	19	100	18	94,7	1	5,3	19	100	2	10,5	17	89,5	19	100
General Non BLU		2	66,7	1	33,3	3	100	3	100	0	0,0	3	100	0	0,0	3	100	3	100
Total		8	33,3	16	66,7	24	100	23	95,8	1	4,2	24	100	2	8,3	22	91,7	24	100

Table 6. The frequency distribution of unexpected cases from the assignment of health workers in the management of patients in hospitals in West Java, Risnakes 2017

		An unexpected case occurred					
		Yes		No		Total	
		n	%	n	%	N	%
Kind of hospital	General	9	9,2	89	90,8	98	100,0
	Special	0	0,0	17	100,0	17	100,0
	Total	9	7,8	106	92,2	115	100,0
Hospital class	Class A	0	0,0	4	100	4	100
	Class B	3	12,5	21	87,5	24	100
	Class C	3	5,1	56	94,9	59	100
	Class D	3	13,6	19	86,4	22	100
	Total	9	8,3	100	91,7	109	100
TNI hospital class	Tingkat I	0	0,0	0	0,0	0	0,0
	Tingkat II	0	0,0	3	100	3	100
	Tingkat III	0	0,0	2	100	2	100
	Tingkat IV	0	0,0	1	100	1	100
	Total	0	0,0	6	100	6	100
Govt hospital (Non TNI /POLRI)		1	3,7	26	96,3	27	100
TNI/POLRI hospital		0	0,0	6	100	6	100
Private hospital		8	9,8	74	90,2	82	100
Total		9	7,8	106	92,2	115	100
Central BLU		0	0,0	4	100	4	100
Regional BLU		1	4,3	22	95,7	23	100
Non BLU		0	0,0	6	100	6	100
Total		1	3,0	32	97,0	33	100

Based on table 5, the most reward form given to health workers who carry out task shifting is the addition of the distribution of capitation services. While the

second most form of reward is the provision of additional honorariums. This happened in almost all hospitals, both by type, class, classification, ownership, and according to the pattern of hospital financial management. Table 6 below shows the frequency distribution of unexpected cases from the implementation of task shifting.

From the table, most of the hospitals did not occur in unexpected cases from the task shifting. Some unexpected cases occur in 7.8% of hospitals by type (general hospitals and special hospitals), 8.3% occur in hospitals according to class (Class A, B, C, and D), 7.8 % occurs in hospitals according to ownership (non-TNI / POLRI Government hospitals, TNI / POLRI hospitals, and private hospitals), and 3.0% occur in hospitals according to financial management (Central BLU, Regional BLU, and Non-BLU)

4. DISCUSSION

Health workers have an important role in improving the quality of health services to realize a society with the highest degree of health. The types of health workers are based on Law number 36 of 2014, namely medical personnel, clinical psychology personnel, nursing staff, midwifery staff, pharmacy staff, public health personnel, environmental health personnel, nutrition workers, physical firepower, medical technical personnel, biomedical engineering personnel, energy traditional health, and other health workers. In the implementation of health services, the limitations of the number and types of health workers allow delegation of tasks and authority or called task shifting. One of the requirements that must be fulfilled by the task shifting of health workers is the recipient of duties and authority is competent health personnel. From the results of the above research it was found that almost all hospitals in cities / regencies in West Java Province had health workers who performed tasks outside of their educational and / or competency backgrounds, except hospitals in Sumedang (0.0%).

The results of studies conducted in low-income countries show that: First, task shifting is an important policy option to help overcome the lack of numbers and types of health workers. Second, although the task shifting provides benefits, there are challenges, for example task shifting in HIV / AIDS health services is at risk for eg quality and security issues. [6] The results of this study indicate that the reason for task shifting is the lack of a number of health workers and a shortage of trained personnel in certain fields. This is in accordance with what was stated by WHO through the 2006 World Health Report which advocated for increasing community participation and systematic task shifting. Task shifting has been carried out in many countries for decades, both in response to emergency needs and as a method to provide adequate care at the primary and secondary levels, especially in rural facilities that lack human resources, to improve quality and reduce costs. [7]

The classic problem of employment in the health sector in Indonesia includes problems with the inadequate quantity and distribution of health workers. The disparity in the availability of health workers between regions has been tried to be overcome by making efforts to utilize health human resources by the Ministry of Health. The utilization includes distribution / equalization, utilization, and development of health human resources aimed primarily at disadvantaged, remote, border and island areas (DTPK) and health problem areas (DBK). [8]

Regarding the type and number of health workers, the results of the study of the availability of health human resources at the first level health facilities in the National Health Insurance (JKN) show that all Puskesmas do not have the type of health human resources according to Minister of Health Regulation No. 75 of 2014, but the types of health workers, midwives and nurses are available in all Puskesmas even

though the numbers are still lacking. In the study also found that changes in planning and procurement of HR in the JKN era, an increase in workload and working hours became a problem that arose in FKTP. From this, the increase in workload of health workers or health human resources in health facilities can be one of the considerations whether the HR can be given delegation of tasks or not, because of course it can affect the quality of the results of the task shifting. [9]

Availability of assignment letters or decrees regarding task shifting is one of the important things. This assignment letter or decree is intended so that officers who receive task shifting can carry out tasks that are delegated with great force because they have legal force. The results of a study conducted in Africa recommended the existence of a regulatory framework compiled by the Government to regulate task shifting implementation. [10,11] In addition, the availability and adequacy of training institutions and adequate resources and support from relevant stakeholders is also needed [12,13] In Indonesia, there is a Decree of the Minister of Health No. 1280 / Menkes / SK / X / 2002 concerning Technical Guidelines for Nurse's Functional Position in which also regulates authority delegation or task shifting. In the Minister of Health Decree, what is meant by carrying out abundant tasks is to carry out activities or actions outside the authority of the nurse in accordance with the standard operational procedure. The delegation of authority cannot be separated from the function of the nurse. Nurses in the role of care (independent) have an independent responsibility based on the inherent authority. This is different from when nurses carry out interdependent roles. Interdependent functions carried out in terms of health services require cooperation with other health workers. For the implementation of interdependent functions, nurses require the delegation of duties / authority from health workers who are members of the collaboration. Delegation is carried out based on a decree regarding the establishment of a health team in the provision of health services. Delegation of assignments in dependent roles is given based on requests, messages, or written instructions from other doctors or nurses as delegation of tasks given. [14,15] In the delegation of authority, the doctrine of the extension of the hands of the doctor applies (verbal arm of the arts / prolonged arm / extended role doctrine) and nurses are not permitted to take their own initiative without delegation or delegation. [16,17] In addition, there is also Law number 36 of 2014 concerning Health Workers, and in it also regulates task shifting.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSION

Task shifting is carried out by more than half of the provinces in West Java, and most of them are delegated tasks in the field of governance. The reason for doing task shifting in hospitals is mostly due to a shortage of health workers. The assignment letter or written decree on task shifting has been applied to health workers who are tasked with, and there is an obligation to report the results of task shifting implementation. [17] The most accepted form of reward received by the recipient of assignment is the addition of distribution of capitation services. The implementation of task shifting is classified as either due to unexpected events or cases from low task shifting. [18,19]

If referring to Law Number 36 of 2014 Article 65, the implementation of the task of shifting health workers in hospitals in West Java is quite appropriate. This is evidenced by the supervision of the implementation of actions under the granting of delegation with the existence of a letter of assignment or written decree, and the necessity to report the results of the implementation of task shifting. This is also in accordance with what is stated in Law No. 38 of 2014 concerning Nursing.

5.2 SUGGESTION

From the results of the discussion, several suggestions were proposed, namely:

1. Task shifting can be done as a solution to overcome the lack of problems in the number of health workers in health facilities, and can be applied in all regions, including the DTPK and DBK areas.
2. The task shifting for health workers should consider the workload of the health personnel concerned so that the task shifting can run optimally.
3. Health facilities should plan employee needs that are truly needed and can be facilitated by the Health Office and the Regional Government.

ACKNOWLEDGEMENT

The author would like to thank the Head of the Health Research and Development Agency and the Head of the Ministry of Health of the Republic of Indonesia Health and Resources Center for giving authorization to write this article using Risnakes data 2017. Thanks to all who helped so that this article can be published.

REFERENCES

1. Undang-undang RI Nomor 36 tahun 2014 tentang Tenaga Kesehatan
2. Undang-undang RI Nomor 44 tahun 2009 tentang Rumah Sakit
3. Peraturan Menteri Kesehatan RI Nomor 75 tahun 2014 tentang Pusat Kesehatan Masyarakat
4. WHO, PEPFAR, UNAIDS. Task shifting: rational redistribution of tasks among health workforce teams: global recommendations and guidelines, WHO, 2008
5. Fulton et al. Human Resources for Health 2011, 9:1 http://www.human-resources-health.com/content/9/1/1
6. Brent D Fulton, Richard M Scheffler, Susan P Sparkes, Erica Yoonkyung Auh, Marko Vujicic, Agnes Soucat. Health workforce skill mix and task shifting in low income countries: a review of recent evidence. Human Resources for Health 2011, 9:1
7. Working together for health. The World Health Report 2006
8. Kementerian Kesehatan RI. Rencana Strategis Kementerian Kesehatan Tahun 2015-2019
9. Mujiati, Yuyun Yuniar. Ketersediaan sumber daya manusia kesehatan pada fasilitas kesehatan tingkat pertama dalam era Jaminan Kesehatan Nasional di delapan kabupaten/kota di Indonesia, Media Litbangkes, Vol. 26 No. 4, Desember 2016, 201–210
10. Kemenkes RI. Pedoman Pengisian Kuesioner Rumah Sakit. Riset Ketenagaan di Bidang Kesehatan (Risnakes). Badan Penelitian dan Pengembangan Kesehatan Tahun 2017.
11. Architha Aithal, and P. S. Aithal ABCD Analysis of Task Shifting – An optimum Alternative Solution to Professional Healthcare Personnel Shortage International Journal of Health Sciences and Pharmacy (IJHSP), ISSN: Applied, Vol. 1, No. 2, October, 2017. Third year Pharma D., Srinivas College of Pharmacy, Valachil, Mangalore, INDIA. Srinivas Institute of Management Studies, Pandeshwar, Mangalore – 575 001, INDIA E-mail : psaithal@gmail.com
12. D. Javadi, I. Feldhaus, A. Mancuso and A. Ghaffar Applying systems thinking to task shifting for mental health using lay providers: a review of the evidence. https://www.cambridge.org/core/terms. https://doi.org/10.1017/gmh.2017.15
13. Jennifer J.F. Hosler, Jasmine A. Abrams, Surbhi Godsay. Combining task shifting and community-based care to improve maternal health: Practical approaches and patient perceptions. Social Science & Medicine journal homepage: www.elsevier.com/locate/socscimed
14. Gabriel Seidman and Rifat Atun Does task shifting yield cost savings and improve efficiency for health systems? A systematic review of evidence from low-income and middle-income countries
15. Jonathan R. Studnek, Allison E. Infinger, Megan L. Renn, Patricia M. Weiss,Joseph P. Condle, Katharyn L. Flickinger, Andrew J. Kroemer, Brett R. Curtis,Xiaoshuang Xun, Ayushi A. Divecha, Patrick J. Coppler, Zhadyra Bizhanova, Denisse J. Sequeira, Eddy Lang, J. Stephen Higgins & P. Daniel Patterson Effect of Task Load Interventions on Fatigue in Emergency Medical Services Personnel and Other Shift Workers: A Systematic Review
16. Uta Lehmann, Wim Van Damme, Francoise Barten and David Sanders. Task shifting:

the answer to the human resources crisis in Africa?, Human Resources for Health 2009, 7:49
17. D. Jerene, M. Biru, A. Teklu, T. Rehman, A. Ruff and L. Wissow. Factors promoting and inhibiting sustained impact of a mental health task-shifting program for HIV providers in Ethiopia
18. Claudia B. Maier, Julia Köppen, Reinhard Busse and MUNROS. Task shifting between physicians and nurses in acute care hospitals: crosssectional study in nine countries
19. Shanti Dwi Kartika. Pelimpahan wewenang dalam rancangan undang-undang tentang keperawatan, posted 29 Agustus 2013, diakses dari https://shantidk.wordpress.com/2013/08/29/pelimpahan-wewenang-dalam-rancangan-undang-undang-tentang-keperawatan

How to cite this article: Wibowo, Werni S, Mujiati et.al. Overview of health personnel task shifting in hospitals in Jawa Barat (results of Risnakes 2017). Galore International Journal of Applied Sciences & Humanities. 2019; 3(1): 114-122.

******