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Implementation of Community Health Center Accreditation Policy in Improving Service Quality at Campaka Community Health Center, Cianjur Regency

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ABSTRACT

Community health centers (Puskesmas) play a leading role in Indonesia's healthcare system, making service quality a crucial public concern. This study aims to analyze the implementation of the Puskesmas accreditation policy and its impact on service quality at Campaka Community Health Center, Cianjur Regency. A qualitative case study approach was used, with data collected through in-depth interviews, participant observation, and document analysis. Data were analyzed using the Miles and Huberman interactive model. The results showed that accreditation implementation was effective during the preparation and survey phases, characterized by improved administrative governance, standardized procedures, improved facilities, and increased staff motivation. However, post-survey implementation showed a decline in consistency due to weak monitoring mechanisms, limited human resources, high administrative workloads, and decreased staff commitment. Accreditation had a positive effect on service quality across all SERVQUAL dimensions: reliability, responsiveness, tangibles, assurance, and empathy, but this improvement tended to be temporary and unsustainable. This study concluded that accreditation at Campaka Community Health Center is still event-oriented and has not been fully internalized as a quality culture. This study contributes to the policy implementation and health care literature by highlighting the importance of post-accreditation monitoring, human resource strengthening, and continuous quality management to ensure continuous improvement in primary health care.

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1. INTRODUCTION

Healthcare services constitute one of the most fundamental public services guaranteed by the state, reflecting the government's commitment to safeguarding citizens' well-being and social welfare. In Indonesia, this responsibility is primarily operationalized through Community Health Centers (Puskesmas), which function as first-level healthcare facilities (Facilitas Kesehatan Tier Pertama/FKTP).

As the frontline of the national healthcare system, Puskesmas plays a strategic role in delivering preventive, promotive, curative, and rehabilitative services to communities. Consequently, the quality of services provided by Puskesmas not only affects public health outcomes but also shapes public trust and perceptions of government legitimacy (Donabedian, 1980; WHO, 2018).

In recent decades, public expectations toward healthcare services have intensified significantly. Communities no longer evaluate healthcare solely based on clinical competence, but increasingly demand services that are timely, responsive, empathetic, transparent, and patient-centered. This shift reflects a broader transformation in public administration, where service users are positioned as citizens with rights rather than passive recipients of care. In response to these demands, the Indonesian government has prioritized quality improvement in primary healthcare through regulatory instruments, one of which is the Puskesmas accreditation policy. Accreditation is designed as a systematic mechanism to ensure that healthcare facilities comply with standardized requirements related to governance, service delivery, patient safety, and organizational management (Joint Commission International, 2017).

The accreditation of Puskesmas is regulated by the Ministry of Health and implemented through periodic assessments conducted by authorized independent institutions. Normatively, accreditation aims to institutionalize a culture of quality and continuous improvement within healthcare organizations. The standards encompass administrative governance, clinical services, risk management, patient safety, and community satisfaction. However, policy success cannot be assessed solely by compliance with formal standards or accreditation status. The critical issue lies in how accreditation policies are implemented in everyday practice and whether they translate into sustained improvements in service quality experienced by patients. Policy implementation theory emphasizes that outcomes are shaped not only by policy design but also by the interaction of actors, resources, organizational structures, and institutional commitment (Edwards, 1980).

Despite the formal objectives of accreditation, empirical observations suggest that its implementation often faces practical challenges. Many healthcare facilities demonstrate significant improvements during the preparation and assessment phases, yet struggle to maintain these standards after the accreditation survey is completed. This phenomenon raises concerns that accreditation may become an "event-oriented" activity focused on passing assessments rather than fostering long-term organizational change. Such conditions reflect weaknesses in post-accreditation monitoring, limited human resources, and declining staff motivation once external evaluation pressure subsides. These issues are particularly relevant in primary healthcare settings, where workloads are high and administrative demands are substantial (Lipsky, 1980; Lestari & Wijoyo, 2019).

Campaka Community Health Center in Cianjur Regency presents a compelling case for examining this issue. Having achieved the highest accreditation status (Plenary), the Puskesmas is normatively categorized as meeting national quality standards. However, preliminary observations and community feedback indicate persistent complaints related to waiting times, service flow inefficiencies, and communication between healthcare providers and patients. This discrepancy between formal accreditation status and perceived service quality highlights a critical implementation gap. The case of Puskesmas Campaka is therefore unique, as it allows for an in-depth exploration of how accreditation policies operate in practice within a highly accredited institution, rather than focusing on facilities with lower accreditation levels.

Previous studies on Puskesmas accreditation in Indonesia have largely concentrated on readiness, compliance, and structural challenges. Research by Ringrih (2022) in Makassar and Lutfiana (2023) in Surabaya, for example, emphasizes administrative burdens and human resource limitations as key obstacles in accreditation processes. While these studies provide valuable insights, they tend to focus on accreditation as a procedural requirement rather than as a dynamic policy implementation process. Moreover, limited attention has been given to the post-accreditation phase and its implications for sustained service quality, particularly from the perspective of service users. This creates a significant research gap concerning how accreditation policies are internalized or fail to be internalized into daily service practices.

This study seeks to address these gaps by analyzing the implementation of the Puskesmas accreditation policy in improving service quality at Puskesmas Campaka, Cianjur Regency. Specifically, the research aims to (1) examine the stages of accreditation policy implementation, (2) identify supporting and inhibiting factors influencing its effectiveness, and (3) assess its impact on service quality using the SERVQUAL framework, which encompasses reliability, responsiveness, tangibles, assurance, and empathy (Parasuraman et al., 1988). By integrating policy implementation theory (Edwards, 1980; Van Meter & Van Horn, 1975) with service quality analysis, this study offers a multidimensional understanding of accreditation outcomes. The expected contribution of this article is both theoretical and practical. Theoretically, it enriches the literature on public policy implementation in the health sector by highlighting the importance of post-accreditation dynamics and street-level bureaucratic behavior in shaping service outcomes.

2. METHOD

This research employed a qualitative method with a case study approach. This approach was chosen because it allowed researchers to explore the phenomenon of policy implementation in depth through direct interaction with relevant actors. The research location was the Campaka Community Health Center in Cianjur Regency, which was chosen because it has achieved full accreditation status but still faces challenges in consistent service quality. The research subjects consisted of the head of the Community Health Center, implementing health workers (doctors, nurses, midwives, administrative staff), and patients receiving services. The object of the research was the implementation of the Community Health Center accreditation policy in relation to the quality of health services.

Data were collected through three main techniques: in-depth interviews with the head of the Community Health Center, implementing staff, and patients. Participatory observation of the service process, from registration to medical services. Documentation studies of accreditation documents, standard operating procedures (SOPs), and Community Health Center activity reports. Data analysis was conducted using the Miles and Huberman interactive model, which includes data reduction, data presentation, and conclusion drawing. Data validity was strengthened through triangulation of sources and methods.

3. RESULTS AND DISCUSSION

Implementation of Accreditation Policy

The accreditation policy implementation process at the Campaka Community Health Center in Cianjur Regency took place through three main stages: preparation, survey implementation, and post-survey. During the preparation stage, the Community Health Center formed an accreditation team consisting of management, medical personnel, nursing staff, and administrative staff. This team was tasked with compiling accreditation documents, preparing physical evidence, and disseminating standard operating procedures (SOPs) to all employees. Field observations revealed significant changes in administrative governance, such as more organized filing of medical records, improvements to patient care flow, and reorganization of the waiting room for greater comfort.

At the stage survey implementation Employee morale increased sharply. All staff strived to deliver top-notch performance, both in terms of medical technical aspects and service delivery. The survey conducted by the accreditation assessment team proceeded smoothly, with the Campaka Community Health Center achieving "Plenary" status. During this phase, improvements in patient friendliness, speed of service, and adherence to standard operating procedures (SOPs) were observed.

However, in the post-survey phase, a decline in consistency was found. Several SOPs that had previously been strictly enforced began to be implemented more laxly. Employee motivation also decreased due to the loss of pressure.External assessment. Patients again complained about long wait times, a lack of clarity in service information, and a less than warm attitude from healthcare workers during the survey.

Several supporting factors that facilitated the implementation process include: 1) Official guidelines from the Ministry of Health, which serve as standard references for the preparation of accreditation documents and procedures. These guidelines provide clear direction regarding the service quality indicators that must be met. 2) Support from Community Health Center (Puskesmas) leaders, particularly the head of the Puskesmas, who plays a central role in mobilizing the accreditation team and maintaining employee motivation. 3) Improvements to physical facilities, such as renovating waiting rooms, providing medical equipment, and adding cleaning facilities. These improvements have a positive impact on patient comfort.

However, several obstacles hinder the sustainability of implementation: 1) Limited human resources, particularly healthcare workers with specific competencies. The high workload makes it difficult for some staff to focus on quality standards. 2) Excessive administrative burden. Preparing accreditation documents requires considerable time and effort, diverting staff attention from direct patient care. 3) Weak post-survey monitoring mechanisms. After the assessment is completed, there is no intensive follow-up monitoring to ensure the sustainability of service standards.

Impact of Implementation on Service Quality

Based on the analysis using the five dimensions of SERVQUAL, the impact of accreditation implementation on service quality can be explained as follows:

- ***Reliability*(reliability)**During the preparation and survey period, services became more organized and compliant with procedures. However, after accreditation, the consistency of SOP implementation began to decline.
- ***Responsiveness*(responsiveness)**: Patient waiting times decreased significantly leading up to the survey, but increased again after the accreditation process was completed.
- ***Tangibles*(physical evidence)**: The Community Health Center facilities have undergone improvements, particularly the waiting room and patient restrooms. Unfortunately, long-term maintenance has been neglected.
- ***Assurance*(guarantee)**: Patients felt more confident in the competence of healthcare workers during the accreditation process, but post-survey there was a decline in politeness and professionalism.
- ***Empathy*(empathy)**: Communication with patients improved during preparation and assessment, but was inconsistent after accreditation was completed.

The results of the study indicate that accreditation implementation at Campaka Community Health Center is more event-oriented than long-term internalization. This is reflected in a significant increase in service quality leading up to the survey, but a decline after accreditation status is achieved. This finding aligns with Edwards III's theory, particularly regarding the disposition variable, where the attitudes and commitment of policy implementers significantly influence implementation success.

Leadership support has proven to be a key factor in driving the accreditation process. The head of the Community Health Center (Puskesmas) is able to motivate staff and ensure the smooth preparation of documents. However, effective leadership should not stop at achieving accreditation but should continue to maintain quality standards. Furthermore, guidelines from the Ministry of Health serve as normative guidance, but are insufficient without ongoing supervision.

Limited human resources and administrative burdens are classic problems also found in research by Ringrih (2022) in Makassar and Lutfiana (2023) in Surabaya. This suggests that accreditation implementation issues are structural, not just at the individual or organizational level. Without additional healthcare personnel and streamlined administrative burdens, accreditation has the potential to become a mere formality.

The impact of accreditation on service quality at Campaka Community Health Center was significant, but temporary. The dimensions of reliability, responsiveness, and assurance increased

during accreditation preparation, but declined again after the assessment. This indicates a reliance on external pressure, rather than intrinsic employee motivation to provide quality service.

From the perspective of Van Meter and Van Horn's (1975) policy implementation theory, post-accreditation quality decline occurs due to weak policy communication and the absence of strong control mechanisms. Meanwhile, Lipsky's (1980) street-level bureaucracy theory explains that high workloads and limited resources often force field staff to take shortcuts, which results in a decline in service quality.

The practical implication of these findings is the need to strengthen post-accreditation monitoring by the Health Office. Furthermore, ongoing training programs for staff, performance incentives, and streamlined administrative processes are needed. This way, accreditation will not simply be a five-yearly ritual but will truly serve as a tool for continuous quality improvement.

The findings of this study reveal a clear temporal pattern in the implementation of accreditation at Puskesmas Campaka: marked improvements in processes, documentation, staff behavior, and visible facility conditions during the preparation and survey phases, followed by a measurable decline in consistency and patient-perceived service quality after accreditation was granted. This pattern underscores that accreditation triggered short-term mobilization of resources and motivation but failed to produce sustained institutionalization of quality practices. Such an outcome aligns with empirical evidence from other Indonesian studies showing that accreditation often results in immediate compliance gains that attenuate without continuous reinforcement mechanisms (Wulandari & Darma, 2025). The Campaka case therefore corroborates recent findings that high accreditation status does not automatically equate to enduring service quality unless post-survey systems for monitoring, capacity building, and incentives are maintained.

When evaluated through the SERVQUAL lens, the differential behavior across its five dimensions offers granular insight into which aspects are most vulnerable to post-accreditation backsliding. Tangibles improved notably physical renovation, waiting room reorganization, better documentation which is consistent with literature indicating that visible, infrastructural changes are the easiest outcomes to achieve and display for surveyors (Parasuraman et al., 1988; Değer et al., 2024). However, dimensions that rely on sustained human practices and discretionary behavior, namely assurance and empathy, showed regression after the external evaluative pressure was removed. This matches cross-national SERVQUAL studies in primary care which frequently report that interpersonal and responsiveness metrics are the hardest to maintain long-term because they depend on intrinsic motivation, staffing levels, and workload management rather than one-off investments (Değer et al., 2024).

The study's identification of key supporting and inhibiting factors provides a theoretically coherent account when read through classic public policy implementation frameworks. Using Edwards's four variables (communication, resources, disposition, and bureaucratic structure), Campaka's experience demonstrates adequate policy communication (clear Ministry of Health guidelines) and episodic resource mobilization (facility improvements and document preparation), but insufficient structural supports for sustained implementation notably weak post-survey monitoring and limited human resource capacity. This pattern is consistent with Van Meter and Van Horn's (1975) emphasis that implementation success depends on specification of standards, availability of resources, implementing agency characteristics, and enforcement mechanisms; where any of these are weak, policy outputs fall short of intended outcomes. Contemporary Indonesian evaluations of accreditation similarly stress that without institutionalized follow-up and accountability, accreditation becomes largely performative (Ringrih, 2022; Sitepu, 2023).

Street-level bureaucracy theory (Lipsky, 1980) further illuminates micro-level mechanisms behind the observed decline. Frontline workers in Campaka Community Health Center faced high workloads and administrative burdens during and after accreditation; in such contexts, discretionary decision-making and coping strategies tend to emerge (eg, shortcutting procedures, reprioritizing clinical tasks over documentation), which reduce fidelity to standards in routine practice. The study's observation

that administrative load during accreditation sometimes distracted staff from direct patient care echoes Lipsky's prediction that street-level actors will adapt policies to manageable routines, especially when supervision relaxes. This theoretical lens explains why reliability and responsiveness improved when external scrutiny was distracted (staff complied and rearranged tasks), but reverted as usual practice reasserted itself in the absence of sustained managerial oversight.

Comparative evidence from national and international studies further supports the study's claim that accreditation's sustainability is an open challenge. Recent evaluations in Indonesia and other contexts indicate that accreditation can raise structural and managerial standards, but long-term benefits for patient experience and outcomes depend on continuous quality improvement systems, strengthening of human resource capacity, and routine external or community-based accountability mechanisms (Wulandari & Darma, 2025; Hussein, 2025). The Campaka findings temporary improvements plus post-survey decline mirror the broader pattern: accreditation is necessary but not sufficient. Sustainability studies argue for integrating accreditation into a cycle of planning, implementation, monitoring, evaluation, and community feedback to avert regression (Hussein, 2025).

The study's recommendation for strengthened post-accreditation monitoring, continuous training, incentive schemes, and simplification of administrative demands is therefore strongly evidence-based. Studies focused on accreditation sustainability have proposed similar interventions: regular supervisory visits, embedded internal quality units, performance-linked incentives, and participatory community monitoring. When combined, these measures help convert event-oriented compliance into organizational routines and norms. In contexts where human resource constraints are binding, targeted investments in task redistribution, digital recordkeeping, and streamlined documentation can also reduce the administrative burden that undermines frontline responsiveness. These practical prescriptions align with the international literature advocating system-level supports to maintain gains achieved during accreditation cycles (Hussein, 2025; Wulandari & Darma, 2025).

Finally, the Campaka case contributes empirically and conceptually by highlighting an accredited Puskesmas that still experiences community complaints challenging assumptions that accreditation status equals experienced quality. This nuance is important for policymakers and accreditation bodies: accreditation metrics should explicitly incorporate longitudinal and patient-centred indicators, and accreditation cycles should be complemented by mandatory post-assessment action plans with measurable timelines and accountability. From a research perspective, the study highlights a gap in longitudinal, mixed-methods evaluations that track accreditation impacts over time and combine staff, managerial, and patient perspectives. Future research should employ cohort or time-series designs to measure whether targeted interventions (eg, periodic supervisory visits, incentive schemes) alter the post-accreditation trajectory observed in Campaka. Such studies would strengthen the evidence base for transforming accreditation from episodic compliance into sustained quality governance.

4. CONCLUSION

Based on the results and discussion above, three main conclusions were drawn that answer the research problem formulation: 1) The process of implementing the accreditation policy at Campaka Community Health Center is event-oriented. Implementation went very well, structured, and effective from the preparation stage to the survey implementation. However, there was a drastic decline in consistency and enthusiasm in the post-survey stage, indicating that the changes had not been internalized into a sustainable quality culture. 2) The main supporting factors for implementation were leadership commitment, clear guidelines, and team solidarity when facing the pressure of the survey. Meanwhile, the dominant inhibiting factors that emerged after the survey were weak ongoing monitoring mechanisms, decreased employee motivation, and limited human resources. 3) The impact of the accreditation policy on service quality was positive but not permanent. There was a significant increase in the five dimensions of service quality (tangibles, reliability, responsiveness, assurance, and empathy) during the accreditation preparation period. However, this positive impact was not

sustainable and tended to decline again after the survey was completed, especially in dimensions related to staff attitudes and behavior (assurance and empathy).

To address this issue, several suggestions were put forward; for the Campaka Community Health Center: It is necessary to strengthen internal monitoring, provide incentives for employees who consistently maintain quality, and instill a work culture that is oriented towards quality, not just formality. For the Health Office: It is expected to provide budget support for post-accreditation maintenance and conduct regular supervision so that the Community Health Center does not return to old work patterns. For the Ministry of Health: The accreditation policy needs to be refined so that it does not only emphasize the survey process, but also on long-term monitoring and evaluation mechanisms after accreditation, one of which is by involving the community as assessors.

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