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DECENTRALISATION AND LOCAL HEALTH DISCRETION: PURSUING THE HAZY PATH BETWEEN LOCAL INITIATIVES AND CENTRAL POLICIES

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Abstract

Introduction

Decentralisation is a process of devolving roles and authorities from a central or national administration to local, subnational or regional unit for various purposes, from economics, political or pragmatic reasons. In Indonesia, decentralisation aimed to increase local responsiveness and efficiency in public services, particularly health. However, more than a decade after decentralisation implementation its impact on Indonesia's health status remains unclear. Some health indicators, such as maternal and infant mortality rates, have shown significant improvement in recent years, but there are also signs of setback in other indicators such as contraception use and mother and child vaccination. These observations prompted questions of how decentralisation policy was interpreted and implemented at the local level, what factors influence policy implementation and what has been the role of central government in interpretation and implementation of the policy. This study explored local discretion in decision making processes, an aspect of decentralisation that has been largely been overlooked in the literature.

Methods

Using a purposive sampling process, qualitative information on local interpretation and implementation of decentralisation policy was obtained from thirty local stakeholders across eight districts. These stakeholders included representatives of the local executive, legislature and technical offices. Districts were carefully selected to represent variations that may influence policy implementation, such as Java and non-Java, affluent and less

affluent and urban and rural districts. Districts were also selected with consideration of interviewer accessibility and familiarity.

In order to explore decentralisation in-depth interviews were performed using an open-ended questionnaire to provide direction but at the same time give local stakeholders flexibility to express their story. There were four foci of discussion: local health planning, local health financing, local health program implementation and program evaluation. Data was organised using the framework approach and later analysed using an interpretive technique.

Results and Discussion

The central government intended decentralisation to increase local responsiveness and efficiency by devolving the power to plan, finance and implement public services to local governments. However, in reality the relationship was never straightforward. The process of planning, financing and implementing public services, besides being determined by local fiscal ability and technical capacity, was also influenced by a number of other factors such as local commitment, local actors' interpretation and interest, central policy and negotiation between local and central governments. As a result, instead of incorporating responsiveness or efficiency, recognised local health programs reflect the negotiation between these potentially opposing factors. Thus, compromise was often the result of decentralisation at the local level.

A particular example of this negotiation was development of the local health coverage program, or *Jamkesda*. This program was the result of a combination of central government inability to provide a program of universal coverage, public demand for free health services, local politicians' response to demand and support of local resources. A free health service has always had strong appeal for both the public and

local politicians. However, as local fiscal ability varies, the extent of coverage offered by each district varied widely. This distinctiveness has been used by local politicians to strengthen and support local identity, especially with the fading and sometimes irrelevant influence of traditional allegiances in some districts. These allegiances, such as ethnicity and historical solidarity were once the major force in shaping local identity, but now such influences tend to be weakening. The void has been filled among other things by local government programs. Local politicians found *Jamkesda* to be a more effective local identification as it has a more direct and tangible benefit for the local public than other traditional bonds.

Implementation of decentralisation in Indonesia was often portrayed within the context of the dominant role of central government. Standardisation of health services, stratified government planning and national health programs, such as *jamkesmas* and *jampersal*, are prominent central government policies that have had considerable influence on local health policy. The national policy has at times collided with local interest that has required local government to find the most suitable solution that balances both central and local interests. One such example was the moratorium on government civil servant recruitment that was applied nationally. Even though the central government formally exempted health personnel from the policy, nevertheless in practice respondents from across the districts were prevented from recruiting health personnel as government civil servants during the moratorium. Some districts defied this policy by employing new health workers on time-limited contracts.

Indonesian health decision making is not all top down. Reciprocally, local government can influence central government policy. An example is the decision of a particular district to open a classless hospital, thereby meeting strong central disapproval. After

countless discussions a compromise was reached, not for a classless hospital, but for an all-third class hospital with a higher standard of care. These examples illustrate that the decentralisation process has been a dynamic and vibrant process.

This study shows that decentralisation has been moving towards greater central government involvement in local affairs, including in the health sector. In Javanese cultural values the central government has become the personification of father (*bapak*) that has the responsibility to nurture, direct, and at the same time limit, local power for the sake of national objectives such as stability and public welfare. Local discretions and initiatives are supported but only within the framework of central government policies and interests. Nonetheless, room for negotiation and 'local defiance' has at times been tolerated.

In conclusion, decentralisation in Indonesia has been a reflection of the national value of *kekeluargaan* that emphasise on uniformity rather than *keragaman*, or diversity. Therefore, decentralisation initiated as devolution of power with a clear distribution of power between central and local governments has become more akin to power-sharing where the power of central and local governments is increasingly fused and less specified.

Key words: decentralisation, health program, local identity, local commitment, fiscal ability, central control, negotiation, local interpretation, shared responsibility.

Thesis Declaration Statement

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Muhammad Syamsu Hidayat

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Chapter 1

Introduction

1.1. Health and Decentralisation: Concepts and Purposes

The World Health Organisation (WHO) framework for health system performance assessment points out a strong correlation between the healthcare performance of a country and the health system in place[1]. Lakshminarayanan, in her review on the role of government in the health system, identified at least four fundamental functions of government in the health system: regulator and enforcer of regulation, policy maker, health promotion, and human resource development and capacity building[2]. However, there are different points of view regarding how much the government should be involved in the health system. With respect to central-local government relations, some countries prefer a centralised system so as to ensure uniformity[3], while others opt for a decentralised approach to be more responsive to local needs[4, 5]. Still, some other countries mix government provision of health with privatisation due to budget constraints[6]. In fact, the choices between these forms of health system are complex, and interwoven with the historical, social-political, economic and cultural background.

According to the Oxford Dictionary, decentralisation is "the devolution of authority from central to local or sub-national government". Similarly, the Webster Dictionary describes decentralisation as "the act of distributing administrative powers or activities, as of government or industry, over a wider area". Decentralisation therefore can be defined as the devolution of responsibility for planning, decision making and resource

allocation from the central or national government to territorial units, sub national governments, autonomous organisations, regional authorities, or non-government organisations[7].

Types of decentralisation in practice are diverse and dependent on the circumstances that triggered the decentralisation policy, for example, whether decentralisation was an initiative of central government or due to regional pressure[8]. In most cases, decentralisation occurs due to a combination of reasons, including giving citizens or their representatives more access in decision making; allocating significantly greater responsibility, authority, and financial resources across different level of governments; and/or shifting government's role towards community groups[9, 10]. Decentralisation aims to localise decision making processes, thus decisions are likely to be more accountable and responsive to local needs and preferences[11, 12]. At the same time, decentralisation policy may also be a practical tool to lessen social tension[13] and a way to promote national unity through equitable distribution of public services[14]. However, decentralisation can cause regional disparity, particularly in less developed countries that lack, among other things, a strong fiscal redistribution system[15].

In terms of decentralising health care, there are at least three considerations as to why the public health service should be decentralised. First, health is regarded as a fundamental right of every human being[16]. This right is protected by the WHO and consequently binds many governments through legal documents – covenants and conventions – that cover many aspects of health. According to the WHO, health policies and programs must be accessible by design and in implementation. However, the notion of health as a human right itself is complicated. It encompasses a wide range of concepts, both from recipient and provider points of view. Rights in health care include

confidentiality, information, life and quality of care[17], and also how patients are treated. Rights in healthcare also include freedom from treatment that is discriminatory, torturing, malicious, inhumane or humiliating[18]. In addition, the provider's rights should also be addressed, such as the right to quality standard working conditions and the right to have their beliefs respected when conducting procedures[19]. Therefore, as a fundamental human right, health has many implications.

Second, health needs vary across different age groups, sexes, geographical locations, and in some circumstances ethnicities and social-economic level[20, 21]. For instance, health needs in one area with specific geographical and demographic traits might be different from another area even though both are located in the same administrative unit, such as a province, thus, different resources may be required. Nevertheless, differences in health requirements are not always obvious. The specific health needs of a minority ethnic group for instance, could go undetected in a larger population. Not necessarily as the result of discriminatory policy, but simply due to their small number and concentrated residential area. For these reasons, some people argue that decentralisation is more preferable to a centralised health system because it is reputed to be more suitable to serving diverse health needs in the local context[22]. Health planning would then be based on local characteristics by local decision makers, rather resting with central government which is more focused on national-interest programs and less on specific local health needs[23].

Third, under decentralisation bureaucracy can be more simplified, enabling decision making processes to be more efficient and accessible to the public[24]. Shorter and localised decision making processes are made possible when the central government ceases to be the main player in health care provision and instead transfers most

authority in planning and financing health services to lower governmental units. It is expected that as public involvement increases so does local sense of ownership[25] and accountability[26]. A wider range of products and services could be allocated accordingly, improving availability and options of health services for citizens[27]. Therefore, health programs would not only be responsive to local needs, but also effective in ensuring the efficiency of health resource allocations.

Decentralisation does not work in all circumstances. Enhanced authority without adequate and proficient human resources seems to be counter-productive[28]. Rather than promoting better public services, in some cases decentralisation has reputedly caused inefficiency due to a lack of competent human resources to supervise programs[29]. In a vast country such as Indonesia, disparity in human resources is so high that inequality has resulted[30] in terms of capacity, accountability or responsiveness among newly decentralised regions. Disparity and inequality are apparent between rural districts and urban districts, but disparity is also noticeable between districts that lie in the western part of Indonesia and the eastern part of Indonesia. Disparity is mostly due to difference in access to education, but there is also an indication that different opportunities for training among local government staff has also contributed to the problem[31]. These differences could potentially influence local government policy in responding to a particular issue. Therefore, local governments are likely to implement different policies that would impact differently on the local people. For example, in reaction to limited local revenue some local governments have imposed additional taxation[32]. However, instead of improving local performance, excessive taxation has weakened public confidence[33]. The absence of a reliable accountability mechanism[34] – an important

prerequisite of decentralisation – has cast further doubt on whether decentralisation would enhance public health services.

1.2. Decentralisation in Indonesia: a Historical Perspective

The health sector was one of a number of public sectors being decentralised in Indonesia. A country's health system policy is usually related to the country's history in some way. The trigger for a decentralisation may seem to have been a recent event, but the policy may have had a much longer history in that country. Looking back over the political history of Indonesia, it becomes clearer why decentralisation is implemented in the way it is today. In Indonesia, when the government decided to implement decentralisation, the official aims of the policy, as stated in law, were to promote public service efficiency and local responsiveness. However, the reason behind the policy was more politically motivated. Decentralisation of the health system in Indonesia was the central government's response to growing local dissatisfaction and, at least initially, had less to do with improving public services[35]. Local governments were demanding for more control over their natural resources and local policies.

The experience of austere central rule has prompted the process, particularly following the collapse of the new order regime, or *Orde Baru*, in 1998. Many local governments saw it as an opportunity to demand broader autonomy as the central authority was crumbling. Legitimacy and justification of central government to exercise power were quickly disappearing as both political and economic stability were shaken by the monetary crisis of 1997-1998. The secession of East Timor further fuelled this crucial demand[36]. Alarmed by the possibility of further disintegration, the central government undertook drastic reform by ratifying Law 22/1999 and Law 25/1999 that gave more authority to local governments in terms of local administration and fiscal control[37].

According to MPR decree No IV/2000 both laws would come into effect starting from 1 January 2001, unless the region opted for delay under special circumstances. As it turned out, not a single region indicated unwillingness despite little preparation for such a major change. The objectives of Indonesia's decentralisation policy were established to encourage local responsiveness in public services, efficient provision and accountability. In doing so the level of government was simplified from three tiers to two tiers.

This socio-historical background has had a profound effect on Indonesia's decentralisation, particularly on the level of decentralisation. Rather than giving more authority and responsibility to the provinces, the central government opted for the district level. Even though smaller in terms of area and population, historically district governments were less likely to cause political problems for the central government than would the provinces[38]. Indonesia is immensely diverse in regard to geographical features, natural resources, ethnicity and social-economic background. The country covers more than 16,000 islands and around 300 ethnic groups. Ironically, there are only a few commonalities that unite this diversity, the Dutch colonisation. After World War II, it was the ordeal under colonisation that gave cohesion amidst the differences. In preventing Indonesia from obtaining full sovereignty, The Netherlands tried to obtain the loyalty of some local Dutch educated-elites by establishing regional states. Subsequently, after four years of bloody war the United States of Indonesia was formed in December 1949. Under Dutch pressure, the government of the Republic of Indonesia reluctantly accepted this arrangement in order to end the war. The federal state would consist of sixteen states including the Republic of Indonesia that by now had been greatly reduced in size to consist of only part of Java and Sumatera. The Dutch intention

was to control the new country through these states. Even though the federal government was short lived - dissolved in 1950 after an existence of less than a year - it has had a deep impact on the relationship pattern between central and local government. This precedent would be the source of central government's distrust of discourse on any form of regional autonomy, including decentralisation.

The euphoria of a unitary country was brief. Later, in the 1950s, dissidents plagued Indonesia for a variety of reasons. An imbalanced economic structure between Java and the outer islands, excessive central government control, military internal conflict and ideological rivalry caused secession movements, not only in Sumatera, Sulawesi and Kalimantan, but also in Java and some other areas closer to the central government. In order to curb the insurgency, the central government offered greater autonomy for local governments through Law no 1/1957. The law made way for regional heads that were not representing, nor were responsible to, the central government. Central government interest in the region was to be exercised by an appointed official. Nevertheless, the law was not effectively implemented due to military opposition and President Sukarno's growing authoritarian rule after 1959. That same year, with the reinstatement of a more centralistic constitution, the President issued decree no 6 that once again put local governments under firm central government control.

Sukarno's regime toppled in 1966 and was replaced by the New Order Regime that shrewdly shifted focus to political stabilisation with the intention of developing Indonesia's economy. In doing so, the central government implemented stricter control over local governments. A new Law no 5/1974 was ratified with strong central authority. Local governments were converted to an extension of central government authority. Local government programs, including planning and implementation, were

rigorously controlled and monitored by the central government. As a result, local governments relied heavily on the central government for almost everything, an effect that endures to this day. The system proved successful in terms of economic development, however at the expense of local initiative restriction. Indonesia's economic performance was the legitimacy of the regime, thus when the economic crisis hit Indonesia hard in 1997-1998 the regime's legitimacy was lost, giving way to a new era named *reformasi*.

The new government's first immediate task was to appease regional demand for broader autonomy. The integrated prefectural system that prevailed in the previous government structure was altered to a functional system to accommodate local aspirations. The new laws of 22/1999 and 25/1999 that focus on decentralisation were ratified in 1999, but took effect two years later. The decentralisation process came in two forms:

1) delegation of administrative and political authority from central government to districts or municipalities, and to a lesser extent the province, and
2) devolution of expenditure responsibilities to local governments. District was chosen instead of province as the forefront of decentralisation because, due to a relatively smaller population and area, a district was regarded less likely to secede.

In order for local government to have the ability in exercising their power, the central government granted a sizeable fund to be allocated according to local needs. A fund called the general allocation fund or *dana lokasi umum* was assigned for each district based on a number of characteristics such as population, land area and poverty rate. In order to prevent disparity amongst local governments the fund was supplemented by a special allocation fund, or *dana alokasi khusus*, for impoverished and isolated areas.

Furthermore, local governments were entitled to shared revenue, such as land and property tax and natural resources income from gas, oil, forestry and fisheries. As the head of each district and municipality was elected by the public, the management of these revenues was expected to be more appropriate for local needs and environment and subject to public accountability, rather than central government accountability.

1.3. Impact of Decentralisation in Healthcare: the Experience in Indonesia and Other Nations

Today, around 80% of developing countries worldwide, including Indonesia, have decentralised public services in various forms[39]. This trend is partly influenced by domestic demands, but was also encouraged by international agencies such as the World Bank, the International Monetary Fund and the European Union. Some public sectors, such as education and poverty alleviation, have seemed to perform well with decentralisation, but this is not always so with health care[40]. Studies carried out on the impact of decentralisation in healthcare show that results have been mixed. According to a study conducted in Indonesia by Simatupang, several public health measures, such as the infant mortality rate and life expectancy, have progressed well after decentralisation[41]; however another study by Heywood and Choi in the same country indicated that other health indicators, such as vaccination of children and mothers, deteriorated following decentralisation[42]. These results however, should be treated cautiously. Some indicators may not be causally associated with decentralisation. Heywood and Choi further explained that some improvement in health indicators, such as contraceptive use and skilled attendants at labour and delivery, for instance, were more likely due to private sector utilisation rather than public service provision[43].

The disproportionate allocation of health facilities and health workers in Indonesia was already apparent since before decentralisation. However, the disparity seems to have

been exacerbated, or at least not improved, with decentralisation. As pointed out by Heywood and Harahap, the reason that the utilisation of private sector health services is on the rise is due to the inequitable number of health workers and public health facilities across the country[44]. A similar situation is also occurring in other countries. In Switzerland, for instance, disparity in financial and human resources between cantons has triggered inefficiency and inequity between different cantons, as pointed out by Wyss and Lorenz[45]. In order to overcome these problems the Swiss federal government, as in Indonesia, arranged an equalisation mechanism through the transfer of funds. Ironically, in the long term this policy could jeopardise local autonomy. Closer to home, the initiative to decentralise health services in the Philippines has also caused inefficiency and less effective health services with the tendency of a growing gap across sub-national regions, as pointed out by Lakshiminarayanan[46]. The problems of decentralisation in the Philippines were partly caused by the very large number of local governments in a decentralised system that consists of at least 1,600 regions, provinces, cities and municipalities, which makes coordination and cooperation between different layers of government difficult.

One of the main problems that some local governments in Indonesia face after decentralisation is limited access to funding, as pointed out by Kristiansen and Santoso[47]. Even though decentralisation policy allocates local governments a number of shared revenues from natural resources and tax, in addition to block grants, the distribution is still one-sided with a relatively larger proportion being allocated to the central government. As a result, some local governments feel that, despite greater power in decision-making processes, the ability to exercise this power is limited due to disparity in revenue allocations. An imbalanced division of revenue is not unique to

Indonesia. Mosca pointed out that devolving fiscal authority in Spain and Italy is also problematic[48]. Both countries delegate health responsibility to regions and autonomous communities, which started in the 1990s for Italy and 2002 in the case of Spain, for effective spending and better performance. However, as financial responsibility still relied heavily on the central government, local government autonomy, in practicality, was non-existent. As a reaction to these kinds of difficulties a small number of affluent countries have recentralised their health care system, which Norway did in 2002[49].

Kristiansen and Santoso indicated in their study that a lack of sufficient funding in Indonesia has encouraged more community health centres, or *puskesmas*, to become self-sufficient, for example by charging additional fees. This approach has been furthered by the latest regulation that allows such *puskesmas* fees to be used to support operational costs and improve employee welfare instead of transferring them to the central government. *Puskesmas* is a community health centre in the sub-district level that provides basic health services for approximately 30,000 people. Because of additional fees, lower income families were withdrawing from the facilities[50], further jeopardising health status amongst the lower income group. The practice of 'privatising' *puskesmas* could broaden the existing gap between the financially stable and lower income groups. As pointed out by Lanjouw *et al*, public health centres have been the most common place where the lower income group receives health services as few people access public hospitals[51]. It is a concerning situation. Although Indonesia's population living below the poverty line has decreased in recent years, both in absolute numbers and proportionally, there are still 60 million people who are categorised as near-poor[52] and there is not much difference between both the poor and the near-poor. Inflation or a catastrophe could easily push the near poor to below the poverty line.

Across the developing countries, the policy of decentralisation seems to focus on one particular goal i.e. a relative increase in local government discretion in decision making, particularly with regard to financial capacity, as shown for instance in a number of studies about decentralisation in Argentina[53], Bolivia[54], and other South American countries[55]. In China this is considered crucial to improving health services with an emphasis on the responsibility to provide accessible health care by minimising geographical and social barriers[56]. A similar development has also taken place in Brazil where local preferences were endorsed through participatory planning and budgeting[57]. With such changes there is a tendency to seek better resource allocation. For example, in India where the community is segregated by the caste system, the implementation of decentralisation and democratisation has enabled lower caste and landless households to have their say in local decision making processes. The priority to invest more on public roads rather than on irrigation, in part, reflects this shift in aspirations[58]. In other developing countries, the policy has also increased the spending for local public infrastructure[59] and health service provision through the enfranchisement of local political institutions[60]. An alignment towards a more local responsiveness is also apparent in the case of Bolivia where local governments, particularly in the poorest districts/municipalities, have spent more on human capital and social services[61]. In Nepal, the government has paid more attention to ethnic minority groups and the population in general by providing more accessible health service delivery[62]. This improvement was made possible through the development of community-managed health services, which are district-based health providers where the communities are engaged in planning, monitoring and decision-making, involved in increasing local ownership and accountability, and participating in improving resource management[63].

However, the benefits of decentralisation are not always uniform as the degree of local discretion and power to generate resources for local use varies across developing countries; this inconsistency can even occur within the same country. A study conducted in China, for example, shows that, even though a previous study had found that decentralisation had improved the accessibility of health care, local public health managers often felt powerless due to difficulty in mobilising additional needed funds[64]. In Uganda, the problem of shortages in supplies of drugs and equipment is still prevalent despite local health workers' enthusiasm for providing better services[65]. In Brazil, despite a better mechanism in meeting local preferences through improved access to primary and emergency care, universal coverage of vaccination and prenatal care, and the huge investment of human resources and technology, former challenges posed by hierarchy and bureaucracy such as disparity of health services and underfunding still largely prevail[66].

The impact of a wide range of degree of discretion may reflect on the provision of healthcare. It is likely that, since decentralisation is a complex process that relies upon local initiatives, the effect within the local areas of a particular country could go either way, for better or for worse. In China, for instance, the decentralisation policy has provided local governments with more control in managing their human resources. In some areas, this authority has enhanced local healthcare provision that has led to better health outcomes, however, in some other areas it has only heightened the disparity of human resources[67]. Poor districts in particular could not prevent the migration of well trained doctors to a more affluent district, leaving these poor districts with less-skilled health resources. In India, the disparity in health services between urban and rural areas across the states seems to have largely remained intact. The absenteeism of doctors and

health providers, poor levels of expertise, an inadequate supply of medicines and unprofessional attitudes are noticeable problems that are still widespread, particularly in rural areas[68]. In Turkey, decentralisation also appears to have had only a slightly positive influence on the quality of health services. One reason for this situation is what seems to be the failure of local decision makers in incorporating local preferences[69]. The remaining problem in the provision of physicians and other health workers, for example, is partly due to local Governments' weak capacity but the problem is also trigger by an ambiguous division of authority between different level of government[70]. The division is often ill-defined and overlapping, making local government discretion largely obscure. This is a situation that is also shared by other developing countries such as Papua New Guinea[71].

Decentralisation seems to be more successful in specific programs that are under the national or international spotlight, such as health programs for the underpriviliged and minority ethnic groups or for HIV rehabilitation. In Nepal, where the government has been focusing on catering for health services for low income and minority ethnic groups, the policy has aimed to increase the coverage of health services among vulnerable groups through the so-called community-managed health services. This initiative seems to be working as a recent study showed higher utilisation among these groups and indications of improved health delivery[72]. The community-managed health services have enabled the community to develop local ownership through greater access to planning, monitoring, and decision making and through better accountability and resource management[73]. Therefore, socio-economic and cultural barriers have been largely overcome by championing local preferences. However, this finding should be

treated carefully as the respondents, due to their vulnerability, may feel compelled to show their satisfaction with the services and over-rate the improvement in health care.

In another example, the decentralisation of the HIV rehabilitation program in Cameroon has also achieved considerable improvement in health care services delivery for this specific health issue[74]. Decentralising the rehabilitation for HIV patients has made the treatment more accessible and less costly as the provision of care is relocated to the district level from the provincial level[75]. The study also indicates that the policy fosters better relationships between patients and counsellors as it has addressed overcrowding and lessened counsellors' workloads. However, the system needs the full support of local government in order to ensure a sustained and reliable supply of drugs and human resources as the key to continued success[76].

In Indonesia, the impact of decentralisation on its health services is not yet clear. At the national level the policy seems to have enhanced the disparity of health human resources, particularly between urban and rural areas as well as between Java and the outer islands[77]. There is tendency towards a decreasing proportion of doctors in rural areas while the proportion of midwives tends to increase. A more comprehensive study conducted by the Indonesia's Planning Body (*Bapenas*) in 2005 when decentralisation had just started, and by the Indonesia Ministry of Health in 2011, has further confirmed the prevalent disparity of health human resources across Indonesia[78,79]. This phenomenon shows how the local governments have been unsucessful in securing the needed numbers of various cadres of health care workers.

Some local government's low expenditure on health in Indonesia is not always related to restricted fiscal resources. There is an indication that some local governments deliberately choose not to increase investment in health care, particularly and

surprisingly some affluent districts, as pointed by Kruse[80], even though numerous studies indicate the importance of public spending on health as it could induce public utilisation and benefit the poor[81]. It appears that the consequence of the spending is not always thoroughly understood by decision makers in the local level. In Uganda, a similar tendency has been described by Akin *et al* in their study on decentralisation where local governments were allocating less of the budget to healthcare in proportion to the budget allocated for other public goods[82]. This phenomenon could be the consequence of local political processes, as shown in the case of decentralisation in the Philippines where it was expected that local government involvement would generate democratisation, development and improved health services. However, with the prevalence of oligarchy amongst notable families and land owners in the Philippines' political system, nepotism was widespread[83]. Local demand was hardly feasible unless resource allocations supported and benefited the elite, and as a result there was a tendency to favour a certain part of the population over the rest of the population and it reflected on local government expenditures. In Poland, post-communism health decentralisation was perceived by the public with lower government share in public services. On the contrary, public health expenditure has plunged since 1991 when Poland was still under a centralised government. When reform was finally made in 1998, public share for health was undeniably further plummeted reaching 65.4% low from the total health expenditure. Nevertheless, by mid-2002 government spending has steadily increased to 71.2%, approaching the proportion prior to decentralisation[84]. The same situation also occurred in Hungary and Slovakia, the difference is that in the latter two countries it materialised in a longer time span therefore less abrupt, giving the public time to adjust[85].

A possible reason for local governments allocating insufficient funding to health budgets may be poor judgement on the part of local decision makers. Even though health expenditure could lead to better service provision and health outcomes[86], it depends on how the decision makers allocate the resources. A larger share of health expenditure is not always directly proportional with improved health services[87]. Health office (in the region) capacity on local condition as well as public active involvement would be a prerequisite for achieving this. A localised decision making process is fundamental in decentralisation. However, studies on this particular aspect of decentralisation are few. How decentralisation is perceived by local health stakeholders and how health policy is developed at the local level is important to be examined. Likewise also the role of local interpretation and characteristics in decision making as local government must take into account local aspirations and resources. What is deemed by outsiders to be poor policy may be 'understandable' to local people due to local circumstances. Therefore, before jumping to a conclusion regarding whether decentralisation is advantageous or disadvantageous to health related indicators, it is necessary to conduct a thorough study of how the policy is perceived and implemented.

1.4. Research Questions

From the above descriptions, there are two noticeable aspects of previous studies on decentralisation. First, the impression of decentralisation as being ambiguous to health-related indicators, and second, the tendency to focus more on local health indicators or other health related indicators, such as the health budget or inequality of access, and less on the process of decentralisation itself. In response to this situation, this thesis focuses on the process and practice of decentralisation as implemented by local government, particularly in regard to local government discretion in health.

Three research questions were formulated as follows:

1. How is decentralisation practiced at the local level, particularly in terms of the implications for local government decision making processes in developing the health program?
2. How is decentralisation practiced at the local level, particularly in terms of the implications for local government interpretation of central government policy?
3. How does decentralisation reposition the role of central government in terms of the central-local relationship?

According to Duncan, a distinguished professor of international relations at the State University of New York State, and his friends in their book World Politics in the 21st Century, decision making by local and national leaders is inherently political in nature, that is to say the final decision is generated from persistent negotiation between diverse interests represented by individuals at the local and national levels[88]. Decision making as he put it, is the art of making compromise. Decision makers are always confronted by a number of options that must be selected to serve the decision makers' purpose. A study conducted by Dobrow et al reinforces the significance of the political nature of decision making besides other aspects such as individual technical capacity, resource constraints, and external uncertainty[89].

Health policy is the product of bargaining and compromises made by powerful individuals and institutions. These individuals in a leadership role perceive public interests through their convictions and preferences as to what they believe to be the best for the country[90]. However, group's and individual interest often plays an underlying factor of a policy[91]. In health policy, these individuals are found at several levels of government and the community. They include local leaders where their sphere of

authority is confined to 'local boundaries' such as the *bupati* and the head of the district health office, or national leaders such as the Minister of Health or even the president. The other individuals that may have considerable influence in decision making are leaders from professional groups. These groups, such as the association of physicians and the association of midwives act as pressure groups. Many of them also hold public office, particularly as heads of health office.

In order to understand why certain health policies have been preferred and selected by the leaders and how the policies were implemented, we have to explore the politics behind the policies[92]. Political factors such as partisanship, voters' views, and the accountability of legislators are interrelated factors that have considerable influence in the decision making process through the election process; and together with the opinion of interest groups and the characters of media coverage form as a pressure group for decision makers in developing health policy[93]. Without a deeper understanding of these political factors, research on health policy or health services can be misleading and can tend to oversimplify the reality. This tendency for oversimplification is apparent in research using a biomedical paradigm that depicts health as merely the result of physical interventions such as the pathology, the biochemistry, and the physiology of a disease without taking into account the role of socio-political factors.

The theory that decentralisation of governance would bring better responsiveness to local needs is recognised by local leaders; however, the suggestions as to how it could be achieved through local health policy are quite diverse. As explained by Terry and Franklin[94], the different policies chosen and implemented are influenced by each respective leader's intuition, experience, authority, and rational consideration. In addition, the organisational dynamic, culture and the environment that surround each

leader can have a significant influence as a public policy or a health program is developed collectively. The relationship between decentralisation and local responsiveness has already been described more thoroughly earlier in this chapter, in terms (respectively) of concept, purpose and implementation; whereas the manner in which organisational dynamics and culture and the social context that surrounds a leader's decisions on public policy and health program implementation will be discussed in chapters 4 and 5 of this thesis.

1.5. Structure of the Thesis

This thesis is organised as follows. The first chapter provides background information on the thesis topic, and this is followed by the methods used in this study as the second chapter. Next, Chapter 3 provides the conceptual framework for Indonesia's policy of decentralisation and the basic rules provided by laws and regulations. These laws and regulations are used to build an understanding of the post-decentralisation structure of government and the division of powers between central and local governments. This conceptual framework helps to broaden analysis of the implications of decentralisation policy: on the development of local health programs in Chapter 4, on local interpretation of central policy in Chapter 5, and on local government's role in Chapter 6. The thesis culminates in Chapter 7 with a synthesis of conclusions from Chapters 4, 5, and 6 to provide give an overview of the implications of decentralisation on local government discretion in health.

Rather than being assigned to a single chapter, the literature review in this study is located throughout the thesis, in order to develop a sequential argument based on evidence, and to discuss the research findings as they are presented. I have found this

approach to be very helpful in understanding the many aspects of decentralisation. Rather than discussing all the literature in one chapter, which may cause a loss of focus, tediousness and confusion, I have considered the relevant aspects of the literature in each chapter alongside those elements of the findings and discussion which have a close relationship to it. With this arrangement, I expect the connection between the literature and the research conducted to be more direct and clear.

Overall, the literature review could be divided into two parts which are met in sequence. Firstly, the literature review begins with a discussion on decentralisation of the health sector and its implementation. This literature originates from within Indonesia as well as from other countries, and is presented in Chapters 1 and 3. This literature provides insight into the policy of decentralisation in general (pages 13-14), the various types of decentralisation (page 14), the objectives at which the policy is aiming (page 14-16), and an historical perspective on decentralisation in Indonesia (page 17-20). This literature also provides an understanding of the implementation of health policies in Indonesia and other countries, with a focus on health indicators and on decision making at the local level (page 21-29).

Secondly, the other aspects of the literature are presented as follows: Chapter 4 contains an analysis of the most important arguments about local initiative (pages 99-147). Chapter 5 considers local interpretation (pages 150-173), local capacity (pages 174-193), and local leadership (pages 196-213). Thereafter, the literature on cultural perspectives to the relationship between central and local government appears in Chapter 6 (pages 217-253).

Chapter 2.

Methods

The aim of this study is to explain the implications of Indonesia's policy of decentralisation on local government discretion in health. Consistent with this aim, descriptive and exploratory qualitative analysis is utilised. The rationale and operation of this research approach is presented in this chapter.

2.1. The Initial Stage: Developing the Analysis

During the initial stage of this study, the idea of measuring the degree of decentralisation in the Indonesian health sector was appealing on a personal level due to the influence by my background where quantitative analysis was seen as superior to qualitative analysis. Indonesian researchers usually quantify social phenomena to obtain a result that is looked upon in academic circles, and by practitioners and decision makers, as more scientific and applicable to a wider population. Another influence was that of previous studies that measured the intensity of decentralisation across different countries and compared this with the performance of the public sector, particularly in health and education (see for example, Bossert[95] and Hooghe *et al*[96]). Hooghe set up a coding scheme that encompassed four local authorisations:

1. institutional depth that measures the intensity of central government intervention into local affairs;
2. policy scope that measures local authority over policy making;

3. fiscal autonomy that measures local authority on public spending and tax revenue; and
4. representation that measures the capacity of local people to elect local office holders.

Each authority was divided into several categories that represent the least autonomous to the most autonomous authority. However, when the schemes were applied to a national level, the indicators became less applicable. If applied in the Indonesian context for instance, the indicators would become meaningless as the lower levels of government in the provinces and districts have a somewhat similar range of functions. In order to make the indicators applicable, these broad and textual indicators must be narrowed down to more specific indicators to capture subtle variations of practice.

My initial thoughts about study design, adapted from the Regional Authority Index[97], aimed to measure variation in local government discretion regarding health policy as subject to central government laws and regulation. Where the Regional Authority Index is based on laws and regulations and less on what happens in practice, the aim of this proposed study would have been to quantify and measure the congruence between formal laws and regulations with local interpretation and practice across different districts. This approach was considered suitable as decentralisation prevails in Indonesia in the form of symmetric decentralisation where each level of government is governed under the same laws and regulations and what matters is local interpretation of the central-derived laws and practices based upon these interpretations.

In my initial study design, local interpretations or discretions of central laws and regulations were divided into four categories: autonomy of decision making, financial independence, managerial authority and technical capacity. For each category a list of

indicators was developed in order to cover the full extent of discretion in local health authorities in each category. For example, in the category of managerial authority five indicators were identified: recruitment of local health workers, alternative financial sources for local health programs, provision of training and education for local health workers, local health office capacity in formulating technical policy, and public participation. The range for the first four indicators was then set on a scale of 0 – 3. Zero would represent full dependence from central control with no role of the local government in decision making; a value of 1 would represent local health authorities exercising some power independently from central power, but central government still having a large influence on local discretion; a value of 2 would represent local health authorities demonstrating a degree of independence from central authorities, but at times seeking support from the central government; and a value of 3 would represent the local health authority being, in practice, independent of the central government authority.

In order to measure discretion, an in-depth interview would have been undertaken for each indicator in the district health office using prevailing laws and regulations as a base line. Take for example the first indicator, the recruitment of health workers; according to Government Regulation No 9 year 2003, the recruitment of new health workers may be initiated by the local government, but consent must be obtained from the central government through the state employment agency. In addition, with the enactment of State Minister for the empowerment of State Apparatus and Administrative Reform Regulation No 197 Year 2012, local governments are not allowed to recruit new staff if the total salary of local public servants accounts for fifty per cent or more of local government expenditure and all districts in this study fall into

this category. However, at the same time it was also obvious that all of the districts needed more health workers. It was to examine and measure how each local authority dealt with this situation – whether they closely followed the central government regulation or alternatively developed an innovative solution – that was my original intention.

2.1.1. The Characteristic of Local Discretion that Prevented Consistent Measurement

During my previous work with local governments over three years, I realised that local government discretion was very fluid, and therefore inconsistent. Partly, this was due to the central government shifting policy, but could also be attributed to the nature of the public policy decision making process[98]. I used to have the assumption that local government discretion would follow a linear pattern, moving away gradually from a much centralised reliance with minimum innovation, if any, through a continuum that finally reached self-reliance, supporting local policy independently and restricting central government involvement to the most basic principles prescribed in laws and regulations. However, I realised that in reality the linear approach was not emerging as initially thought.

Public policy is the product of scores of processes and interactions between individuals and interest groups trying to influence policy to suit their own agenda, as pointed out by Walt *et al*[99]. Shifting priority back and forth between extremes is common, and dependent on the social, economic and political situation. It was during my time working with the local governments that I found out that it was not unusual for local government to be subject to central government intervention, but at other times, or in other situations, local government freely exercised authority without central government involvement. At times, these two very different levels of discretion occurred

simultaneously. For example in terms of health programs, local government may obtain central government operational funding for health, or *bantuan operasional kesehatan*, to increase local *puskesmas* capacity in local health services, but at the same time other health-related programs did not receive financial support from central government. However, there are many types of health policies. It would be a huge task to measure each separately, let alone compare between them.

2.1.2. The Problematic Correlation between Degree of Discretion and Health Indicators

The fluid and dynamic nature of the local government-central government relationship makes measurement of local government discretion difficult. While not impossible, the problem is largely what these numbers, if determined, may actually represent; and more importantly how measurement values correlate with other variables, such as health indicators. For example, the degree of discretion of a district could be measured as high in a certain year and sharply drop to be categorised as low in the following year. I observed that the changes in local decisions are sometimes so drastic and abrupt, that any hypothesised relationship between the measurements on some health indicators could be potentially confounded and to some extent misleading, particularly in a cross-sectional analysis. Also, in certain cases discretion was not necessarily about lack of local government commitment to local decision-making, but instead was concerned with the little low level of funds in the budget. A measurement approach to examination of local government discretion may be appropriate in a longitudinal study or time-series analysis for a reduced number of health policies. Unfortunately, such an analysis would not be possible in the Indonesian setting as the earlier stage of policy implementation is practically non-existent. Development of the infrastructure for the measurement of some health indicators, such as the infant mortality rate or life expectancy for example, take

years of development and are influenced by a large number of factors. Government policy is a major factor, and by only using the degree of discretion at one point in time it would be an overgeneralisation and oversimplification to ignore the dynamics of the process of decentralisation, as pointed out by Bossert and Beauvais in their study in Ghana, Uganda, Zambia and the Philippines[100].

The concept of local health discretion has different meanings. Health discretion was not simply the disparity between central government laws and regulations on the one hand and district government health policy on the other hand. Local government health discretion encompasses a wide variety of 'actors' in the decision making process that need to be taken into account. Consequently, the decision as to who should represent local discretion becomes more complicated. In addition, the role of provincial government is also problematic, in terms of whether provincial government should be considered as a part of central authority or local government. This complexity is the result of the ambiguous decentralisation system in Indonesia that was intended to simplify the government structure, but in practice the process has turned out to be not simple. The provincial government has a dual role as a central government representative and as an autonomous unit. While the role of provincial government is less essential nowadays, in my view it could not be simply overlooked.

2.1.3. The Solution

The complexity of the local government discretion pattern in Indonesia meant that adjustments had to be made to the original study design. Potential participants were expanded to include not only persons from the district health office, but also health-related decision makers in the region, such as heads of district, district legislators, district public hospitals and provincial health offices. This step was taken to obtain a

thorough understanding of implementation of policy at the district level by incorporating perspectives of different stakeholders. Laws and regulations derived from central government were still used as the base line to assess and analyse district health policy. However, the approach used was significantly different from initial plans. The participants of this study were not directed to identify the practice in their respective institution in a certain range or numbers; instead they were encouraged to tell their stories regarding policy and how and why the policy was finally determined. The tools that had been developed previously – an open structured questionnaire – were preserved, discarding only the 'quantitative' section as it had ceased to be an objective of this study.

From my point of view, the decision to use qualitative analysis instead of the initial mix of qualitative-quantitative analysis was necessary bearing in mind the circumstances of the data and the character of the policy that this study aimed to assess. This shift made the study more robust and reliable. By using qualitative analysis, this study explored the phenomenon without discounting the hierarchical nature of the level of government. It also assisted this study in identifying subtle phenomena that otherwise could go unnoticed or remain undetected using quantitative analysis.

2.2. Qualitative Analysis: the Advantage

I would like to share one of my favourite anecdotes to describe the essence of qualitative research which helped me develop my understanding of this research paradigm when I had just begun my research journey.

> A student was discussing his research findings on the illiteracy rate of a village with his supervisor. The supervisor asked the student, "What is the illiteracy rate of the village?" The student answered, "Two per cent." The supervisor responded that a two per cent illiteracy rate had no significant

> meaning statistically. However, the student disagreed as one of the two per cent was the village secretary.

The anecdote shows that qualitatively the two per cent illiteracy rate is very significant. Some may ask how the person was elected if they were illiterate, while others would ask how the village secretary could complete their tasks and responsibilities without the ability to read and write. These types of questions can only be addressed using qualitative research.

The power of qualitative research is not merely in understanding outlier phenomena as described in the anecdote. The method enables the investigation of a phenomenon in its natural setting with a more holistic understanding of the phenomenon. It can also facilitate explanation of more common phenomena, such as – using the example above – why the literacy rate in the village may be higher than that of a neighbouring village, or how the village could achieve a higher literacy performance as compared to a neighbouring village. The aim of qualitative research is to draw evidence from various individuals, population groups, written documents and contexts by observing, exploring and understanding evidence more thoroughly[101]. This evidence can be in a wide range of forms, from more common types such as data from research interviews, group discussions, observations, and reflection field notes, to more specific types of data such as photographs and pictures, official and public documents, personal documents, historical items, images in the media, literature, and many more. Qualitative data is therefore less structured and less measurable than quantitative data. Qualitative analysis puts more emphasis on understanding meanings and experiences, social constructions of reality, and the close relationship between subject and object of the research[102].

The challenge in qualitative research is dealing with data which can be overwhelmingly immense and diverse. It is essential to choose the right methods to bring together

different viewpoints, capturing data in a meaningful and comprehensible way[103]. In this perspective, qualitative analysis offers a wide range of methods, depending on the research objectives. However, it is not easy to choose the most suitable methods. Based on my research question, amongst other things, I decided to use the framework approach described later in this chapter.

2.3. Location of Study

This study was conducted in eight districts across two different provinces, with four districts from the Special Region of Yogyakarta, namely Gunungkidul, Kulon Progo, Sleman, and the municipality of Yogyakarta, and another four districts from the province of East Kalimantan including the districts of Kutai Kartanegara, Bulungan and the municipalities of Balikpapan and Samarinda. I selected these districts for two reasons. First, the districts were chosen with consideration of time and effectiveness. I have set out to network with various stakeholders in the eight selected districts for some time. An established network increases accessibility and ease of field work, including reducing red tape when organising a research permit, choosing the respondents who potentially have in-depth knowledge of the situation and becoming familiar with potential respondents, and other practical and useful factors, such as finding a place to stay and local transportation. Second, the districts were selected to facilitate investigation of patterns of the decision making process, other decentralisation related practices and the relationship of these with differing proximity to central government, fiscal ability and demographics. From the eight selected districts three are urban, four are rural, and one is an urbanised rural district. I had decided to omit the district of Bantul in the Special Region of Yogyakarta as I wanted to have a balance between the rural and urban districts in this study. In general, each district has its own specific

characteristics in terms of demography, geography and economic capacity. A brief summary of each district follows:

2.3.1. Gunungkidul

With a total area of 1,485.36 km^2, Gunungkidul is the largest district in the Special Region of Yogyakarta, but also the least populated with around 454.7 thousand people/km^2 (2011). The district is considered one of the two underdeveloped districts in the province. In terms of local revenue, for instance, Gunungkidul received less than 70 billion rupiah in 2013, far below Sleman or the municipality of Yogyakarta which received approximately 300 billion rupiah. Gunungkidul also has the highest infant mortality rate (IMR), maternal mortality rate (MMR), and with Kulon Progo, shares the highest percentage of under-five malnutrition in the province (see Table 2.1, below).

Table 2.1 Selected Health Indicators in the Four Districts in Yogyakarta

No	District	MMR (/100,000)	IMR (/1000)	Under 5 Malnutrition (%)	Low Birth Weight (%)
1	Kulon Progo	105	1.8	11.5	4.7
2	Gunungkidul	161	6.1	11.1	3.9
3	Sleman	123	3.5	8.8	1.0
4	Yogyakarta	126	5.8	9.5	4.9

Source: BPS 2011

The topography of Gunungkidul is hilly – particularly in the south – and dominated by limestone, making cultivation only feasible during the rainy season (90% of the arable land is rain fed). Gunungkidul is known as one of the sources of migrant workers in Indonesia, with most working as informal sector workers in many urban areas around Indonesia. Consequently, there is a unique demographic profile where a large portion of the productive population work elsewhere, leaving behind the infants and the elderly.

2.3.2. Kulon Progo

In the past, Kulon Progo was considered a backwater district, along with Gunungkidul, in the Special Region of Yogyakarta. However, in recent years Kulon Progo has been in the spotlight due to the local government's ambition to transform this district into the gateway for the Special Region of Yogyakarta, with projects such as the new international airport of Yogyakarta and the controversial construction of a seaport. However, unlike Gunungkidul, Kulon Progo is a fertile area with an advanced irrigation system thanks to the Progo River which runs north to south in the eastern part of the district. In terms of health indicators, Kulon Progo performs quite well with an MMR of 105 out of 100,000 births and an IMR of 1.8 of 1000 births; the lowest in the province (see Table 2.1, above). However, for less than five malnutrition and low birth weight, Kulon Progo has amongst the highest rates in the province.

2.3.3. Sleman

Sleman lies at the foot of Mount Merapi – one of the most active volcanoes in Indonesia – making it a vulnerable place to live. However, due to its proximity to the municipality of Yogyakarta and more pleasant climate, Sleman has become one of the most densely populated districts in the area with nearly 2000 people/km^2 in 2011, second only to the municipality of Yogyakarta. Sleman is also one of the wealthiest districts in the province with local revenue of more than 298 billion rupiah in 2012. Its health human resource is also one of the most advanced in the province with 185 specialists, 242 general practitioners and 410 midwives (see Table 2.2, below). Many of Yogyakarta's leading universities and medical schools are located in Sleman due to space limitations in Yogyakarta.

Table 2.2 Selected Health Human Resources in the four Districts in Yogyakarta

No	Districts	Specialist	Ratio of Specialist and population	GP	Ratio of GP and Population	Midwife	Ratio of Midwive and Population
1	Kulon Progo	27	17425	79	5956	216	2178
2	Gunungkidul	29	23289	131	5156	214	3156
3	Sleman	185	5437	242	4156	410	2453
4	Yogyakarta	457	963	377	1167	332	1326

Source: BPS 2011

2.3.4. Yogyakarta

Yogyakarta is a geographically small municipality which covers an area of only 32.5 km^2. Not only is Yogyakarta city the smallest administrative unit in the province, it is also the most densely populated with 13,543 people/km^2. The municipality is the capital city of the Special Province of Yogyakarta. As such it is the centre of economic, political and cultural activities for the other four districts in the province, and surroundings areas. Yogyakarta is famous as a centre of learning and has a rich history stretching back to the ninth century. However, in term of health indicators, despite its relatively large number of health resources, Yogyakarta's health performance is poor. For example, of the four health indicators shown in Table 2.1 above, Yogyakarta trailed behind the other districts in all four.

2.3.5. Kutai Kartanegara

Until 1999 Kutai Kartanegara encompassed a much wider area that included districts such as Kutai Barat, Kutai Timur and Bontang. According to Warta Ekonomi, a well-known economic magazine in Indonesia, Kutai is considered to be one of the richest districts in Indonesia thanks to abundant natural resources. For example, in 2009 Kutai Kartanegara received 2.5 billion rupiah, and in 2011 5 billion rupiah, as shared revenue for a population of 600,000 while in the same time periods Sleman, Kulon Progo, and

Gunungkidul received between 7144 and 146 million rupiah annually (See Table 5.1). Surprisingly, Kutai Kartanegara is also the largest receiver of *beras miskin*, a subsidised rice program for the poor, in East Kalimantan[104]. In terms of health, Kutai Kartanegara is falling behind other districts in East Kalimantan, especially for maternal mortality (see Table 2.3, below).

Table 2.3 Selected Health Indicators in the Four Districts in East Kalimantan

No	District	MMR (/100,000)	IMR (/1000)	Under 5 Malnutrition (%)	Low Birth Weight (%)
1	Kutai Kartanegara	173	6.5	3.6	6.8
2	Bulungan	41	9.8	3.2	18.5
3	Balikpapan	50	2.6	0.9	4.7
4	Samarinda	84	2.8	0.5	4.5

Source: BPS 2011

2.3.6. Bulungan

Similarly to Kutai Kartanegara, Bulungan was once a vast district covering the districts of Nunukan, Malinau, Tana Tidung and Tarakan. However, unlike Kutai Kartanegara, Bulungan has a far more modest fiscal capacity. Compared to the three other districts of East Kalimantan selected in this study, Bulungan has the lowest revenue with less than 1 billion rupiah in 2012 (See Table 5.1). However, Bulungan is significantly less populated with a little over 100,000 people in 2011. Another characteristic of Bulungan is the relative isolation. Nevertheless, this may change in the near future as Tanjung Selor, the capital of Bulungan, was selected as the capital city for the newly founded province of North Kalimantan (Bulungan was eventually separated from East Kalimantan to form the new province of North Kalimantan in 25 October 2012 but this only effectively started from 22 April 2013, right after I had finished my data collection.

2.3.7. Balikpapan

Even though Balikpapan is not the capital of East Kalimantan, it is known as the hub for the rest of this province thanks to its strategic position and accessible airport. Both Balikpapan and Samarinda have a sizable area for a municipality, especially when compared to municipalities in Java, such as Yogyakarta. As a municipality, Balikpapan has relatively better endowed public facilities, including for health, as compared to other districts in East Kalimantan. However, it is surprising that in terms of the ratio between general practitioners and population, and midwives and population, Bulungan performs better than Balikpapan and the other two districts in this study (see Table 2.4 below).

Table 2.4 Selected Health Human Resources in the Four Districts in East Kalimantan

No	Districts	Specialist	Ratio of Specialist and population	GP	Ratio of GP and Population	Midwife	Ratio of Midwive and Population
1	Kutai Kartanegara	0	0	60	10725	227	2835
2	Bulungan	9	12518	45	2504	157	718
3	Balikpapan	122	5238	109	5863	333	1919
4	Samarinda	130	6731	182	4808	287	3049

Source: BPS 2011

2.3.8. Samarinda

Samarinda is the capital city of the province of East Kalimantan. It lies on the banks of the Mahakam River, one of the longest rivers in Indonesia. As such Samarinda is prone to flooding[105] and diseases like malaria and dengue fever[106]. Environmental degradation due to excessive coal mining further upstream[107] is a problem. The interrelated problems of coal mining, environment degradation and the implications for public health and welfare have characterised the city and become public concerns in the last fifteen years. These characteristics were taken into account when the district was selected.

The illustrations above show that there are similarities and at the same time difference accross the districts. In order to provide a clearer picture on the district commonalities I developed table 2.5. The degree of each indicator is expressed through the intensity of each colour. Similar characteristic from each indicator is expressed through the intensity of colours (the more intensive the colour the more favourable are the indicators).

Table 2.5 Commonalities and Differences in Basic Indicators between Districts

Districts	Density (/km2)	Literacy Rate (%)	District Revenue (IDR)	Poverty Rate (%)	Health-related Indicators			
					GP Ratio	Midwife Ratio	MMR (/100000)	IMR (/1000)
Balikpapan	Urban with the density of 1270	92	1,647,132,000	4.07	1:5863	1:1919	50	2.6
Bulungan	Rural with the density of 86	79	985,995,000	14.57	1:2504	1:718	41	9.8
Gunungkidul	Rural with the density of 455	76	1,010,100,000	22.05	1:5156	1:3156	161	6.1
Kulon Progo	Rural with with density of 803	92	800,878,000	23.15	1:5956	1:2178	105	1.8
Kutai Kartanegara	Rural with the density of 25	97	4,234,469,000	8.68	1:10725	1:2835	173	6.5
Samarinda	Urban with the density of 1240	76	1,944,556,000	5.21	1:4808	1:3049	84	2.8
Sleman	Rural with the density of 1750	92	1,383,011,000	10.7	1:4156	1:2453	123	3.5
Yogyakarta	Urban with the density of 13543	87	899,626,000	9.75	1:1167	1:1326	126	5.8

Source: BPS 2011

2.4. Sampling and Data Collection

This study focused on the implications of decentralisation on local government discretion in health. An essential step of the study was to identify local public health decision makers. For this I used purposive sampling. Respondents were selected based on a number of characteristics used by Patton[108]:

1. Criterion, the respondents are local stakeholders that are involved in health-related decision making;
2. Intensity, the respondents have rich and intensive information on local decision making process; and

3. Maximum variations, respondents represent the wide variety of local actors and interests.

These characteristics would assist a comprehensive understanding of this study. I began the respondent identification process by examining relevant laws.

I used Law No 32/2004 to identify potential respondents from each district. In each district, local actors align with two main entities: the *bupati* as the head of the district supported by the local apparatus and the district House of Representatives as the district legislative body that represents the local public. The district apparatus itself consist of various entities with different roles, but in general can be divided into three groups: district secretary who assists the head of district in preparing district policy and coordinating district technical agencies (Law No 32/2004 Article 121), district House of Representatives secretary who supports the functions and tasks of the district legislative body (Law No 32/2004 Article 123), and district technical agencies that support the head of district on more specific policies (Law No 32/2004 Article 124). In this study all groups took part, except for the district House of Representatives secretary as this role is mostly administrative with very limited influence on the decision making process.

In all, forty seven local stakeholders were contacted, and thirty six took part in this study, twenty three male and thirteen female. The respondents were clustered as follows:

a) Four participants from the district executive consisting of one district head and three district secretaries.

b) Four participants from the district legislature consisting of one chairman of a district House of Representatives and three chairmen from the commission supervising health care.

c) Twenty-four participants from various district technical agencies consisting of fourteen persons from district health offices (five heads of health office and nine staff, mostly the head of planning and budgeting sections), six participants from district hospitals (one hospital director and five staff, mostly the heads of planning and budgeting sections), one participant from a district planning office, two participants from a district research office, and one participant from a district office.

d) Four participants from the provincial health office to account for likely different perspectives and roles in decentralisation.

The proposed sampling was defined during the development of this study. However, the final number of respondents from each cluster was determined during the fieldwork. The number of thirty six respondents was sufficient to meet the purpose and objectives of this study as it had become apparent that no more new information could be obtained from sampling further respondents[109]. As not all government officials that I intended to interview accepted the invitation to participate, alternate respondents were selected based on local advice. For example, at the initial stage of this study four heads of district were invited to participate, but in actuality only one accepted the invitation. Even with a network that was carefully and rigorously developed beforehand, three out of four heads of district were not approachable, with each providing a standard answer that they were currently busy and the session must be rescheduled at a later time without providing any tentative schedule. Later I found out from reliable informers, being local

staff, that an interview was unlikely. These heads of district gave an impression of being accessible, but at the same time refused politely in a culturally acceptable way. The improbability of engaging with these potential participants was a sign that it was time to find alternative participants. I have developed Figure 2.1 below to clarify the sampling process and response. The respondents that refused to participate due to various reasons mentioned above, are in red.

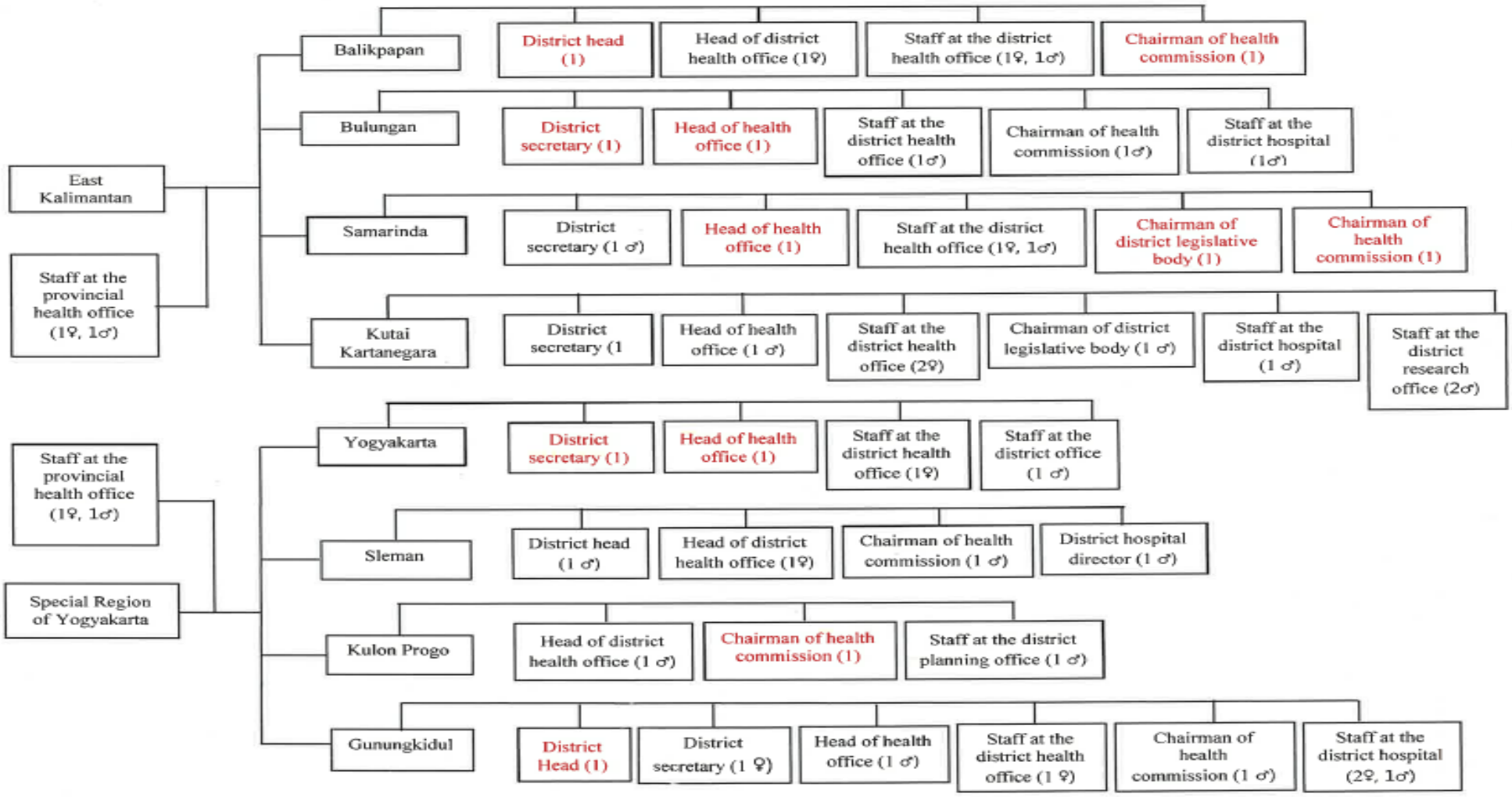


Figure 2.1 Sampling Process and Response

My choice of the district secretary as a substitute for the head of the district was not unfounded. This eventuality had already been considered during the development of my study as it was anticipated that the head of the district would not be easy to engage. In addition, it was also proposed by local informants. Even though the district secretary is not in a political position like that of the head of district, the role in developing public policy with the head of district (Law No 32/2004 Article) makes them inevitably exposed to political negotiation, albeit indirectly, between different political institutions and diverse political leadership. This context makes the district secretary an appropriate substitute for the head of district. In addition, as a government civil servant, district secretaries are mostly senior officials who tend to have considerable experience due to long service in government. Thus, their experience and knowledge enabled a thorough exploration of the practice of decentralisation.

I decided to use in-depth interviewing as my main method of data collection as the study timeframe prevented thorough field observation which takes considerable time[110]. Furthermore, past events that may be important for this study can be more readily recalled using an in-depth interview[111]. For this study in-depth interviews were conducted with respondents from each cluster individually, as group interview or focus group was not possible due to the tight schedule of each participant. In addition, the focus group method was avoided because some respondents, due to cultural reasons, would be expected to be reluctant to speak in the presence of persons in a more superior position.

Interviews followed the semi-structured interview format using a question guide developed for each group. Using semi-structured interviews, the list of questions is less strict as compared to structured interviews. Thus, the question guide gives focus to the

interview, but at the same time allows flexibility for changes that may happen during the interview process[112]. The question guide was divided into four topics: planning, implementation, human resources and budget according to the key activities that the district acquired post decentralisation (Law No 32/2004 Articles 12, 14, 16, 129, 150, 151, and 152). The emphasis of the question guide for each cluster was different. The question guide for the district executive and legislature was more general in nature, exploring the political process in developing public policies, the relationship between the executive body and the legislative body, and the interaction with the central government; while the question guide for technical agencies, and district health offices in particular, was more specific regarding health policies, focusing on planning and budgeting patterns, the implementation of local health policies and the impact of possible dual loyalty.

The interview process began with a standard procedure of filing for authorisation from the provincial government, district government and subsequently the respective district office. For each level a specific requirement had to be fulfilled before endorsement and continuing to the next level. The requirements were varied, but generally consisted of a cover letter, a copy of the research proposal and a copy of my identification card. In the end, after all the different levels of authority provided endorsement four essential documents were enclosed for each participant: an information sheet, a copy of the ethics approval, a participant approval sheet and the list of questions.

Each document provided to participants had a different purpose. The information sheet contained basic information, such as the purpose and methods of the study, with a focus on anonymity and protection of privacy. Ethics approval from the University of Adelaide ensured that the design of this study acknowledged potential risks and

minimised these for both the researcher and respondent. The participant approval sheet emphasised the participant's rights and consent to participate. The list of questions, or question guide, contained the outline for the interview. Each participant was given time to consider their decision to participate.

The waiting period, from the invitation to participate until consent was given, varied from one potential participant to another. Some invitations to participate went smoothly and agreement to participate in an in-depth interview took less than a week, but in other cases significant negotiation and back and forth rescheduling was required. A solid local network was necessary to resolve this kind of situation as finding people familiar with local procedures and custom were important to securing some interviews. Furthermore, I found the local network very useful for finding alternative ways to get paper work completed efficiently.

Once the interview schedule was established and agreed upon by both parties, the participant signed the approval sheet as evidence of consent to participate. It is very important to ensure that participation is voluntarily as the nature of the researcher-participant relationship may influence the outcome of the interview. In order to create a comfortable atmosphere, the interviewee was given the opportunity to determine the venue, and all participants decided to be interviewed in their respective office. The first few minutes of the interview were crucial in developing trust between the interviewee and interviewer. One of the strategies that I developed to gain trust was by starting the interview with general conservation. Such talk was meaningful as a way to find a common ground before asking more serious questions. This common ground included past experience or recent issues relevant to both of us. The trust that was established

based on shared similarities opened the door to information and led to a more fruitful result as the interviewees were more engaged and at ease with the process.

The interviews were all conducted in Bahasa Indonesia, the Indonesian national language, and at times were interspersed with local languages/dialects or English terms to express certain issues more precisely. The interview followed the list of questions already prepared. However, probing questions were necessary to get more in-depth and clearer answers regarding the issues being discussed. During the interviews it was also important to cross check the data obtained from other respondents. Therefore, the study covered different angles and points of view. As agreed, all conversations were recorded to support data validity. The anonymity of participants was guaranteed. Nevertheless, participants were fully aware that, due to the limited numbers of eligible participants in this study, their participation could potentially be identifiable in research products. To minimise the chances of this happening from their quoted words, each respondent was given a unique identifier known only to the researcher.

Along with verbal data, nonverbal data such as secondary data from respective institutions and local newspaper articles were also collected and recorded through various field notes. Secondary data in this study mostly consisted of local government profiles and reports, health indicators, local regulations, annual budgets and newspaper articles.

This study also incorporates observations, though limited to the respondent's body language and tones that may give an indication of respondent's concerns on particular issues. In the event that respondent concern was identified it was important to react quickly so that the respondent's concern could be addressed and would not jeopardise the data collection process or the quality of the data. My understanding of important

local activities, such as the technical officers' forum (*forum SKPD*) where local government integrates proposed programs from the public, technical office and local legislature, or the development of local budgets, relied on respondent's recollections. All sources of data, from in-depth interview to secondary data and observation, were later triangulated to build a more rigorous analysis[113].

2.5. Transcription and Data Analysis

The recorded interviews were transcribed using the standard transcription method in spelling for all verbal utterances. As all interviews were conducted in *Bahasa Indonesia* this meant that interviews were transcribed according to the Indonesian formal spelling system or *Ejaan yang Disempurnakan* whenever possible. Colloquial Indonesian, such as the widely used common unstandardized affixes, was transliterated accordingly. For example affixes 'in' in *dibuka'in'* and *diganti'in'* were transcribed as *dibukain* and *digantiin* instead of the standardised *dibukakan* and *digantikan*. Both variations are mutually intelligible and the meanings are not ambiguous. In addition, some non-Indonesian words and expressions, mostly in Javanese and English, were transcribed according to the respective spelling system to prevent ambiguity. Other non-verbal utterances, such as pausing and laughter, were included as these may have significant implicit meanings. Laughter, for example, has different meanings in different contexts and it is true that in some Indonesian cultures laughter often conveys different meanings. Laughter may be an expression of happiness or a funny incident, but it can also have a much deeper connotation of paradox, approval or disdain. Laughter is a way for local cultures, as pointed out by Kurniawan and Hasanat, to maintain public harmony[114].

Punctuation played important role in understanding interview transcriptions. Punctuation marks, such as comma, question mark and full stop, were used frequently. Even though punctuation may appear insignificant, it is essential in conveying the accurate meaning of a passage. Thus, punctuation must be used cautiously or it can create a totally different meaning to that intended. For example a quote from one head of a district office (in Indonesian): *"Kemudian untuk program kewenangan pusat tetap kita harapkan…"* Without a comma the sentence can be translated to: "Afterwards we will still expect central authority program(s)…" But this was not what the respondent intended to express. The person meant to say that, in terms of programs, the district governments are still expecting the involvement of central authority. Hence, there should be a comma after the word program. The other problem with Indonesian transliteration, particularly if using the less formal variant as in these interviews, is the widespread use of simplified sentences. Thus, understanding the transcription clearly without proper punctuation marks is not possible. Sometimes a statement, an interrogative or an imperative sentence can all have the same structure, but what distinguishes them are punctuation marks. It must be understood that, although the Indonesian language is not a tonal language, tones are often used to emphasise certain meaning in a sentence.

2.6. The Framework Approach

After the interview transcriptions were ready the next step was to analyse the data in the original language of Bahasa Indonesia. This was a laborious task as it involved a large data set that, if not handled carefully could be overwhelming. In order to overcome this problem, a coherent and systematic approach was required. For this study I used the framework approach that is suited for policy relevant qualitative research. This

approach is particularly useful as it provides systematic stages for analysing the data, from initial data management to the development of descriptive and explanatory accounts, as pointed out by Smith[115]. In addition, as emphasised by Ritchie and Lewis, the approach also provides a transparent track of the researcher's interpretation[116], therefore the approach supports study validity.

The framework approach is a qualitative method that, unlike other qualitative analysis, tolerates the use of deductive reasoning in its approach. In fact, it combines deductive reasoning through the researcher's *a priori* issues and inductive reasoning through respondent-generated themes to develop the research framework[117]. In general, the method consists of two sequential activities: data management, where data is synthesised and simplified using a combination of thematic and case analysis, followed by data interpretation. The use of both analytical techniques ensures the themes extracted during the synthesising process do not lose their context. The framework approach generates three different types of analytical output: categories of things (thematic), categories of people or processes (typologies) and explanatory[118] that are useful to answer various types of research questions. The framework approach involves a four stage process of: familiarisation, indexing, charting, and mapping and interpretating, as described in more detail in the following paragraphs.

The first step of data analysis in this approach is familiarisation with data that in this study consists of interviews transcripts, field notes and government and public documents. I familiarised myself with the verbatim transcripts and field notes by reading and rereading each several times. Even though I undertook transcription myself and therefore have an overall impression of the data through that aspect, I developed potential key concepts and themes for the research as words and phrases constantly

emerged. However, word or phrase frequency must be treated cautiously as not all recurrent words or phrases have the same significance. A word or phrase may be only mentioned once, but the message may be so powerful that it just cannot be ignored. The output of this stage of the analysis was some notes on tentative concepts, keywords and ideas that resulted from this activity.

The second step of the analysis was to develop the thematic framework. For this stage, I used the notes taken during familiarisation and some key points and concepts from the laws associated with decentralisation to develop the thematic framework. Initially, themes were created from both sources using the process of constant comparison in which I constantly compared the concepts, key points and ideas to establish a theme. In this way, themes were shaped, improved, confirmed, and altered if necessary. However, subsequently I found this exercise resulted in a drift of the framework from my initial research questions. Therefore, I decided to use more concepts and key points that had been acquired from the laws as the basis of my thematic framework, even though I understand that this method recommends prioritising themes extracted from the respondents of the study. The reason for my approach was, as mentioned earlier, that the framework needed to be adjusted to only address the research questions. The result of this activity was a thematic framework for the overall data that provided a detailed index of themes as the framework for the next step of data analysis, indexing.

The third step of indexing was where I identified a segment of the data compatible with certain themes from the framework developed in the previous step. In doing so I marked the section of the data using numbers to correspond to the themes. I started the indexing from four particular transcripts which I found very rich in information, adding more

transcripts one at a time until all data were indexed accordingly. In this stage the indexed data were still intact in their respective context.

Following indexing the fourth step was charting. This step involved putting indexed data from the previous stage under respective themes on a chart (see Figure 2.1 for an illustration of this step). However, this is not simply a cut and paste method as charting involves the extraction of respondents' views and experiences – the context – that otherwise would likely be lost during the process. In order to keep the context intact, each of the indexed data items is to have synthesised information of the context.

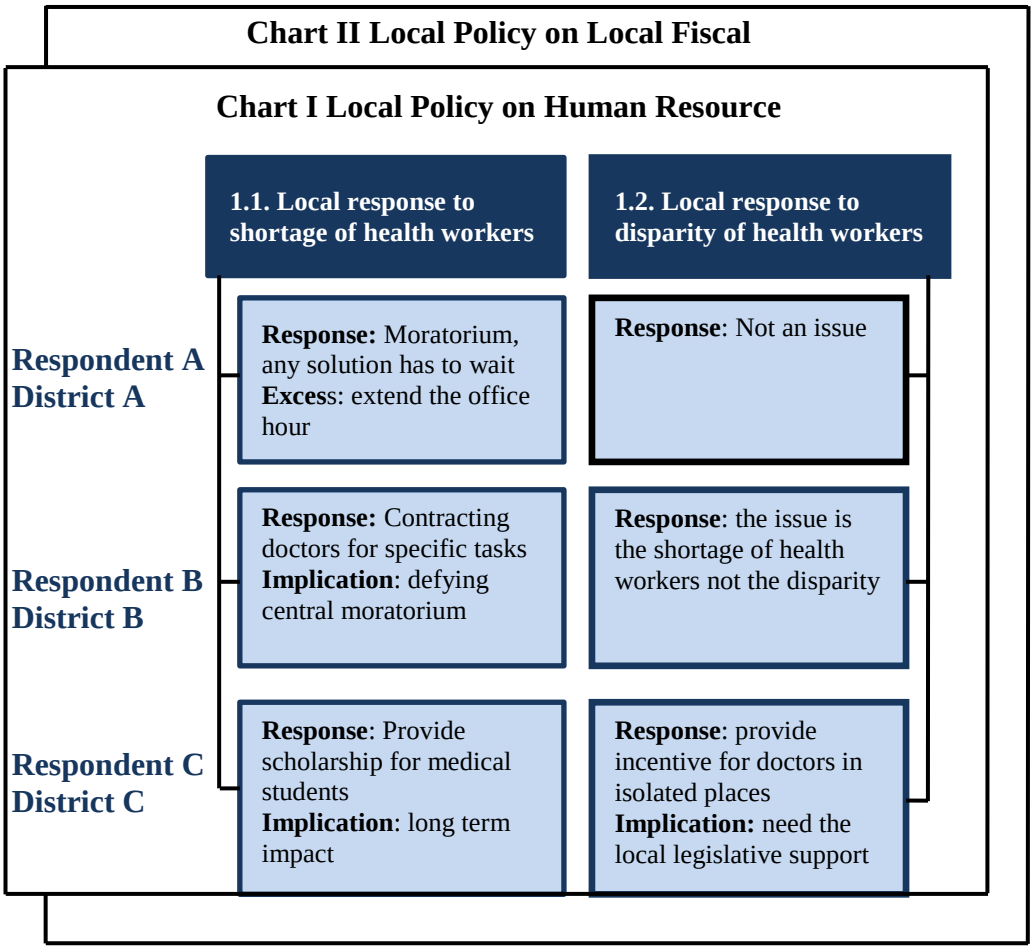


Figure 2.2 Illustration of Charting Diagram

The fifth and final step in the framework approach is mapping and interpretation. The aim was to finalise the concept of each theme, map the extent and nature of the theme and develop the association between different themes. This stage is very much defined by the objective of this study. From my interpretation of the range of themes and of the relationship between themes I then developed explanations of the findings of this study.

The Framework approach has been widely used to analyse qualitative data, particularly for policy-oriented studies[119]. The method has been useful in exploring personal views, both among lay persons and health professionals, that would affect policy development and program implementation. For example, a study on patients suffering from cancer

has increased our knowledge about how to improve clinical practice, patient-clinician relationships, and more effective treatment from the patient's point of view[120]. In another study, the method was used to investigate the experience of a patient suffering from larynx cancer using an unsolicited diary (the author happened to meet a patient who was fond of writing and who kept a diary)[121]. The Framework approach has also been used in exploring the opinions of children with obesity[122], the carers of COPD patients in their final years in life[123], and COPD patients with a telehealth service[124].

The Framework approach is useful in organising people's psychological complexities into simpler and more comprehensible categories. At the professional and organisational level, and with regard to policy development and implementation, the approach has also been used effectively to explore the views of health workers. In a study about improving palliative care, for example, the Framework approach was applied to guide a discussion with nurses to improve the quality of care for patients[125]. Similarly, the approach has been used to investigate policies, protocols and processes to improve outcomes for various health conditions such as venous thromboembolism[126], asthma, coronary heart disease prevention, depression, epilepsy, and menorrhagia[127]. The use of this approach has also been effective in exploring factors that motivate health care workers using newer technologies, such as the use of IT by emergency department staff[128], to investigate the views of NHS stakeholders in providing local paediatric care[129], and to assess the effectiveness of treatment[130]. In all of these studies, the Framework approach has been highly effectively used to analyse policy and practice oriented qualitative research.

The Framework approach is not without some weaknesses. There are three shortcomings that are associated with this approach: the time and labor intensive nature,

the temptation to focus on the research process rather than on the outcome, and the possibility of data being coerced to fit into the prescribed stages of analysis[131]. Firstly, as with other qualitative methods of data analysis, the Framework approach has to deal with the task of encoding a huge body of qualitative data; often involves long narratives in a wide range of forms, from in-depth interviews (in the form of stenography, audio recording, video recording or written notes) and direct observation (the data could be recorded as in in-depth interviews or through pictures, photos and drawings) to written documents (such as newspapers, magazines, books, websites, memos, transcripts of conversations or annual reports). Even with the development of computer-based analysis programs such as Nvivo, analysing qualitative data is still quite time-consuming as it requires intensive reading and examination. In this, the Framework approach is no exception.

Secondly, more specific problems regarding the Framework approach involve the risk in focusing too much attention on the process and by that overlooking the result. The Framework approach endorses traceable analysis with well-defined stages to follow. However, these definite procedures could potentially put pressure on researchers to make the analysis compatible with the stages prescribed, even though this may not always be possible. Consequently, effort could unintentionally shift towards assuring the compatibility of the process rather than on the outcome of the analysis.

This chapter has presented the methods of this study, from sampling and data collection to transcription and data analysis; from how respondents were selected to how interviews were conducted; from my decision to transcribe and analyse data in *Bahasa Indonesia* to the decision to use the thematic framework as a tool for data analysis. I have also, in this chapter, described the background of my decision to use qualitative

analysis, my initial plan to measure decentralisation and the subsequent alteration made. Last, but not least, I also included descriptions of the location of the study, including the main characteristics and reasons of selection.

After the thesis was fully developed and written, the final draft was edited by an English language editor and a proof reader for minor English language editing.

Chapter 3

Laws, Government Structure and Distribution of Power

This chapter provides an understanding of the legislative and policy framework of decentralisation in Indonesia. Post-decentralisation government structures and division of power between central and local governments are described and analysed using the laws that regulate policy. Laws referred to are Law No 22/1999 and Law No 25/1999 valid from 1st January 2001 until the 14th October 2004, and the more recent Law No 32/2004 and Law No 33/2004 in effect starting 15th October 2004 onward. Law No 22/1999 and Law No 32/2004 are analysed separately as both laws have distinct implications for the policy of decentralisation. However, Law No 25/1999 and Law No 33/2004 are analysed jointly as these laws are complementary in nature. This chapter begins by discussing Law No 5/1974 that was in force prior to decentralisation in order to provide an overview of the situation prior to the push for decentralisation.

Descriptive analysis will be used to interprete and compare the laws. Analysis will focus on the prominent features of each law and how changes in law have influenced government structure and distribution of power between the central and local governments. By exploring the five laws mentioned above, it is clear that the policy of decentralisation is not static. This chapter presents decentralisation policy as an ongoing process that has constantly demonstrated the interchanging interest between central and local governments. Currently, central government power is increasing at the expense of

the power of local governments. This shift in power is reflected in local government discretion, a topic explored in subsequent chapters.

3.1. Brief description of Law 5/1974, the Law prior to Decentralisation

Decentralisation as a concept was usually understood by the public in Indonesia as the devolution of authority and responsibility for public functions from central government to local government. Even though this understanding is not completely incorrect, it is an oversimplification as authority devolved to sub-national governments took different forms. In general, decentralisation encompasses the transfer of political, administrative and fiscal power[132], in terms of one aspect or as a combination of the three. The main power transferred varies depending on the context and objectives of each country, and the relevant laws and regulations represent a good place to begin the analysis. In Indonesia, decentralisation involves Law No 22/1999, Law No 25/1999, Law No 32/2004, and Law No 33/2004. However, before these laws are discussed in detail, it is essential to examine the law that prevailed before decentralisation, Law No 5/1974.

As pointed out by Haris[133], Law No 5/1974 was often regarded as too centralistic with disproportionate central government involvement in local affairs. The law tried to create a local government structure favourable to supporting national policy by focusing on economic development[134]. One aim of central government was to ensure stability of local government so that central policies could be implemented with minimal disruption. Thus, local Houses of Representatives were given authority to propose the candidates for heads of local government (Article 15 Section 1 and Article 16 Section 1, Law No 5/1974), but approval of these heads of local government rested with the central government (Article 15 Section 2 and Article 16 Section 2, Law No 5/1974). A chosen head of local government then acted both as head of an autonomous government

and at the same time as a central government representative; as such the head of local government was accountable to the central government (Article 22 Section 2, Law No 5/1974) not to the local House of Representatives. In addition, even though the law supported three principles: decentralisation, deconcentration and assistantship, in practice local government's role as an autonomous unit was superseded both by deconcentration, in which local government acts as central government's administrator at the local level (Article 1 Section f, Law No 5/1974) and by the assistantship principle in which local governments were given the task to implement the central government programs[135] (Article 1 Section d, Law No 5/1974). In both deconcentration and assistantship principles the policy were directed by the central government and as such the local governments were held accountable to the central government.

The central government's stronger control of local government was manifest through the uniformity of local government structure (Consideration point c, Law No 5/1974). Different forms of local administrative units existing at that time, such as *nagari* in west Sumatera, *mukim* in Aceh and *banjar* in Bali, were gradually dissolved and transformed into a more homogenous structure that applied nationally. The aim was to streamline coordination between central and local governments. Existing forms of local administrative units were deemed too diverse for effective coordination. Each traditional administrative unit had varying size in terms of area, population and regulations. The population of a *banjar*, for example, covered around one fifth of the area and population of a village, but a *mukim* covered at least the equivalent of four villages. In addition, each traditional administrative unit sometimes had specific regulations that did not align with the national interest. For example, only local Hindu-Balinese could be members of a *banjar*, while other local residents who were not

Hindu-Balinese were not entitled to become a member of a *banjar* no matter how long the person had lived in that *banjar*. The three-tiered Indonesian government structure prior to decentralisation is shown in

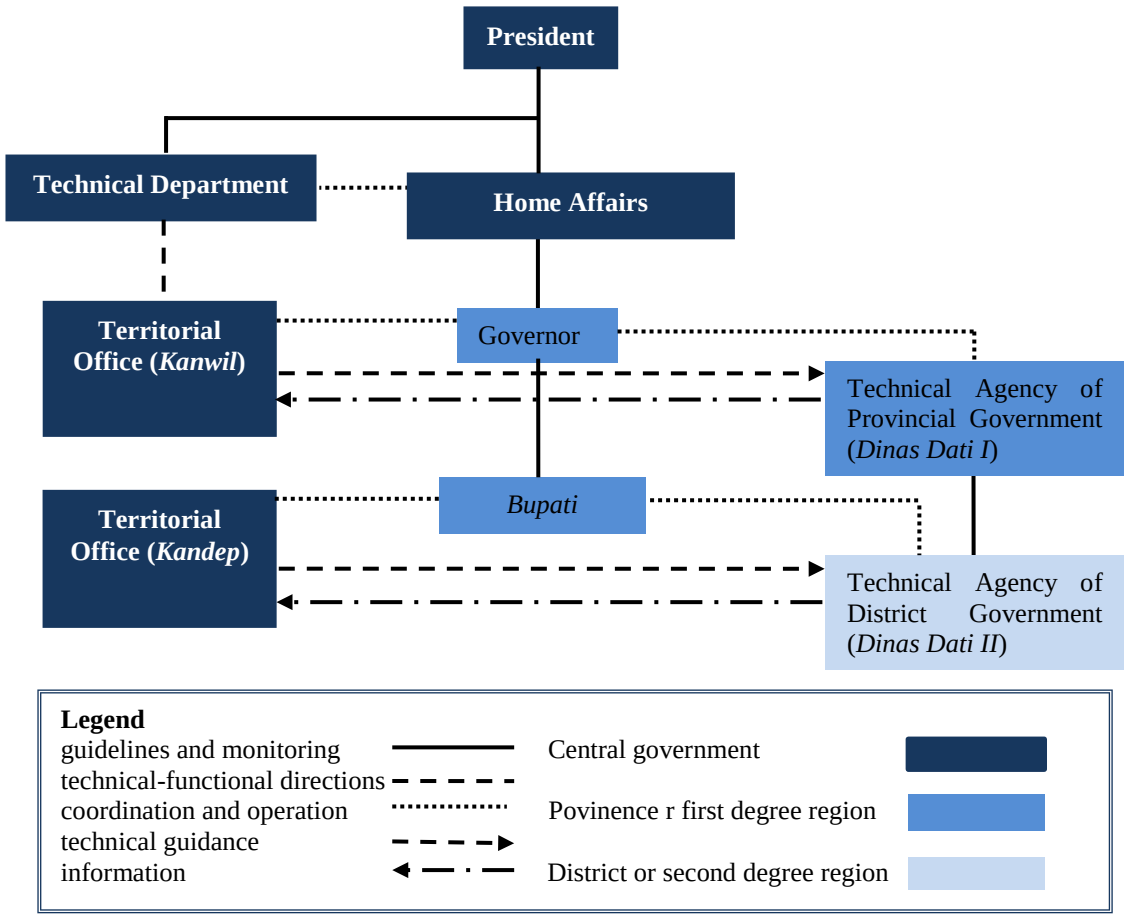


Figure 3.1 Prior to Decentralisation: Indonesia's Three Tier Government Structure

3.2. Law No 22/1999, the First Law on Decentralisation and its Impact on Government Structure and Power Division

Beginning in 2001, central government control that had ensured political stability and national unity was relaxed. As a counter to Law No 5/1974, the new Law No 22/1999 was enacted to give strong foundations for implementation of decentralisation. The new law endorsed more active local roles and increased public participation in local decision making through public consultation (commonly known as *musrenbang*) that would lead to more diverse local administration[136]. Law No 22/1999 was the product of a volatile

time in Indonesia during which the country was hit hard by the monetary crisis that eventually destabilised the core of the political establishment. The change was seen as an immediate and potent response to regions drifting apart and the central government was losing its grip on control, being unable to sustain the very essence of its justification: political and economic stability. To a degree, the law has achieved its purpose and has prevented possible secession by providing an opportunity for regional areas to participate in local politics and giving these regions greater access to, and opportunity to benefit from, their natural resources. In saying that, however, as the law was the product of the need for a quick response to destabilising events, some shortcomings were to be expected.

Law No 22/1999 attempted to develop a simpler and less hierarchical structure of government (Figure 3.2). The hierarchy between provincial government and district government was abolished and with it also the rank of *daerah tingkat I* and *II* for province and district, respectively (Article 4 Section 2 and Article 121, Law No 22/1999). The impression that a district is somehow secondary to the province, as shown in the earlier law (Law No 5/1974 Article 16 Section 2 and 3, Law No 22/1999), was no longer applicable. The new law gave a strong message that district government was by no means subordinate to provincial government. The relationship between provincial and district government changed from dependent and subordinate to dependent and coordinate[137]. The diminished provincial government role was further emphasised as the law only specified three roles for provincial government: facilitating cross district cooperation, assisting districts that could not yet perform certain functions and implementing central government programs (Article 9 Section 1, 2, 3, Law No 22/1999).

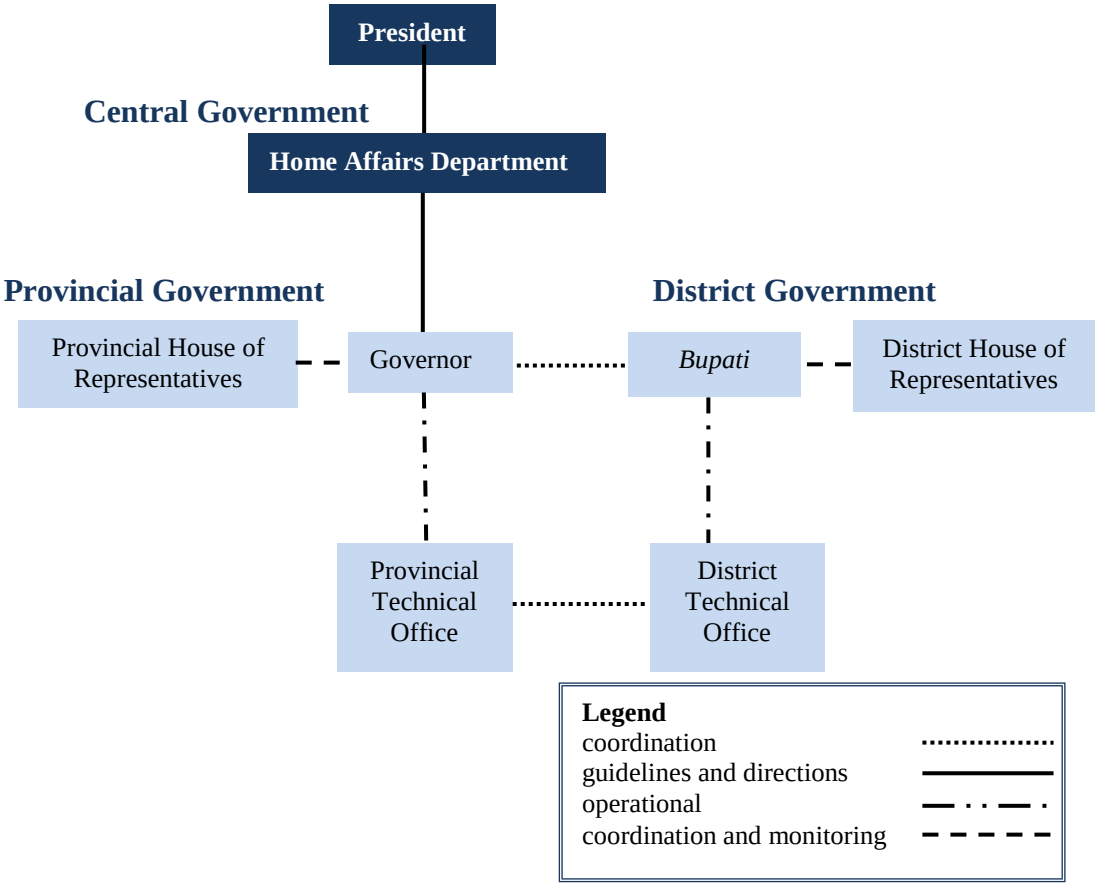


Figure 3.2 Post decentralisation: Indonesia's two tiers government structure with province and district at the same level

As the focal point of decentralisation, districts were designed to have much stronger identity than that of province. Accordingly, the district's role as a central government representative was abolished so it could perform as a fully autonomous unit with more definite division of powers in place (Article 7 Section 1, Law No 22/1999). The district was given a wide range of authority for planning, funding, implementing and evaluating various public sectors such as education, healthcare, transportation and many more (Article 11 Section 2, Law No 22/1999). A further step was taken to strengthen local autonomy when provincial authority to elect the head of the district was handed to the district level House of Representatives (Article 34 Section 1, Law No 22/1974).

Therefore, the heads of districts were no longer held accountable to the provincial government, but instead were fully accountable to the district House of Representatives (Article 32 Section 2, Law No 22/1974).

In each region, the central government is represented by the provincial government that retain a dual function as central government's representative as well as an agent of decentralisation, although with significantly reduced authority compared to the district. The main roles of the provinces are to deliver national-interest programs such as *Indonesia Sehat* 2010 (Healthy Indonesia 2010) and disease outbreak (*kejadian luar biasa*) and as the coordinator for cross-districts programs such as on communicable disease eradication. Assisting low performance districts is also part of provincial responsibility, provided that it is requested by the district government. Nonetheless, overlapping roles between provincial and district government – such as the overlap between *jamkesmas* (national health insurance) and *jamkesda* (district health insurance) – is common sight even with the later introduction of Law 32/2004 that intend to redefine district and provincial authorities.

The new law was a big shift that resulted in less power resting with the central government. Even though the central government asserted that decentralisation was initiated to boost local responsiveness and efficiency, there is reason to doubt the claim. As pointed out by Aspinall and Feally[138], the reason to decentralise was motivated more by political pressure rather than to support efficiency or local responsiveness. The policy would not have been developed if the political and economic situation had been stable in the late 1990s. During the political chaos that followed the economic meltdown in Indonesia, demand for federalism and even secession was looming. In response, decentralisation within a unitary state of the Republic of Indonesia was finally

adopted. With decentralisation, central government power was drastically curtailed even though the central government retained roles associated with the national interest, such as foreign affairs, defence and security, judiciary, religion and monetary policy (Article 7 Section 1, Law No 22/1999). In addition, the central government is entitled to establish national standardisation and planning, such as national development planning, to which local development planning must refer in terms of financial management, human and natural resource utilisation, and national standardisation (Article 7 Section 2, Law No 22/1999). Thus, despite outwardly declining power, the central government has in fact maintained some decisive roles, though not as visible as before, in local affairs[139]. It appears that the central government still – to some extent – mistrust local governments, therefore they left loop holes in the regulation that enable them interfere in the local whenever necessary. The above-mentioned central government role specified in Article 7 Section 2 Law No 22/1999, for example, seems to be a loophole left in as assurance to safeguard the parity of public services across districts.

Government civil servants, once considered to be bonding agents for the nation, were now segregated according to administrative units as each district had the authority to appoint, transfer and dismiss civil servants, and stipulate pensions, salaries, allowances and employee welfare, as well as provide education and training for civil servants (Article 76, Law No 22/1999). There were concerns that this situation would further fragment national cohesion. It was suggested that the number of government civil servants could become unmanageable as appointment, promotion and transfer could be based on nepotism instead of merit[140]. This practice could also increase disparity of local civil servant capacity. However, local authority was not yet fully autonomous as the law also indicated that the norms, standards and procedures in appointing,

promoting, transferring, dismissing and stipulating local civil servants would still be regulated by the central government (Article 75, Law No 22/1999).

The law also introduced a new definition of local government that now consisted not only of terrestrial territory, but also maritime territory (Article 3, Law No 22/1999). In relation to Article 3, local governments were given the right to explore, exploit, conserve and manage their respective maritime territory (Article 10, Law No 22/1999). Local fiscal ability was further strengthened with the definite provision for local revenue that consists of local taxes and levies, local government-owned corporations, transfer funds and local loans (Article 79, Law No 22/1999). The previous Law No 5/1974 had already anticipated the need for local government to access local revenue (Article 8 Section 2, Law No 22/1999), however it was not clearly defined in the law and never materialised except for the transfer fund. As in the provision of local government civil servants, items of taxes and levies that could be collected by local government were regulated by the central government (Article 82 Section 1, Law No 22/1999), but local government was entitled to determine the rate and collection (Article 82 Section 2, Law No 22/1999). Local fiscal policy was regulated separately through Law No 25/1999 which is described later in this chapter.

3.3. The New Law No 32/2004 and Its Impact on Government Structure and Power Division

Law No 22/1999 was in force for less than four years and was subsequently revised with Law No 32/2004. The central government argued that new legislation was necessary due to changes in circumstances, constitution and public expectation (Consideration point c, Law No 32/2004). This new law was intended to scale down some excessive articles and clarified a number of articles that contained ambiguous

meaning as well as incorporating some recent alterations to government structure. In addition, there was an indication that this change was also encouraged by excessive district government direct consultation to the central government as implied by a respondent below:

> "…earlier, if we encounter problems or concerns (*jika ada masalah*) we always consulted directly (*langsung*) with the central government without any requirement (*tidak perlu*) to consult with the provincial government, but now we are required by the law to consult the provincial government first. If the provincial government could not solve it then we will consult the central government…" *(J-4)*

The central government seems to have been overwhelmed and through the new Law No 32/2004 tried to re-empower the position of provincial government as a gate-keeper. Provincial government roles are clarified in the law to include coaching and monitoring of district government administration, coordinating between districts and province in matters of central government programs, and coaching and monitoring implementation of central government assistance across districts and the province (Article 38 Section 1, Law No 32/2004). Compared to the previous law, the provincial role in the new law is more definite with emphasis on coaching and monitoring each district government in terms of the local program as well as central government interest in the districts.

The new law not only revived the provincial role, but also reintroduced a subtle hierarchy. The change is implied by Article 2 Section 1 that describes Indonesia as a country that consists of provinces and each province is further divided into districts. The message is different from the previous law that described the country as consisting of provinces, districts and municipalities. The new description seemed to re-emphasise the unitary nature of the state of Indonesia where local governments are a subsystem of

central government[141]. However, the relationship between provincial and district governments is not easy to define. The law, as mentioned earlier, provides provincial government with the power to coach and monitor district government. The provincial government carries out this role on behalf of the central government. However, district government is not accountable to the province.

This complex relationship between district and province is further aggravated by division of authority between province and district. Both are assigned to implement a list of public services that are identical (Articles 13 and 14, Law No 32/2004). The difference is in scale. For example, while the district is assigned to carry out services within its boundary, the provincial government is required to implement similar services within the province. For example, both the district and province are responsible for preventing and eradicating communicable disease, implementing health promotion, preventing malnutrition and so on. In fact the thirty tasks for the respective provincial and district health offices are almost the same. Overlap in terms of area is definitely occurring as a district's area and population is a subset of that of a province's area and population. This arrangement was deliberately developed by the central government to encourage cooperation between both entities as they share the same geographical area. Later, this intention was confirmed by respondents in this study who mentioned how provincial and district health programs should be in harmony and supportive. Moreover, the respondents also confirmed that the tasks allocated between the districts and province can vary from district to district. Thus, health program delivery depends on agreement between each respective province and district.

By having identical authority, this law is likely to restore central government presence in local government affairs, including in sectors that according to the previous law (Law

No 22/1999) were considered to be the domain of local governments. Central government influence was made possible with the redefinition of local government affairs. Some local government affairs, such as healthcare and education, are redefined as concurrent in nature (Explanation point 3, Law No 32/2004). Authority on healthcare, for instance, was to be redistributed to all level of governments. The responsibility shared between the central government, provincial government and district government (Explanation point 3, Law No 32/2004). Therefore, the central government role was broadened to include program planning and implementation. However, the range of authority for each level of government was not defined in the law. It appears that ambiguity was intentional to promote negotiation between the three levels of government involved, as confirmed by respondents in this study. The requirement of the law was for programs planned and implemented to be synchronised, interconnected and interdependent (Explanation point 3, Law No 32/2004). Therefore, local health programs are part of the broad national health program.

The district's position was further redefined by the new law. The notion of district independence of the previous law is not found in the new law. But rather, central government's grip on district government is reinforced through firmer supervision. For example, in the case of corruption or other misconduct considered to jeopardise national security, the president is entitled to dismiss the head of the local government without prior consent from the local House of Representatives (Article 31, Law No 32/2004). The House itself is free from external intervention, but legislators are now governed by a set code of conduct and an honorary board that oversees how roles and authorities are executed (Article 47, 48, and 49, Law No 32/2004). However, the new law also compensates for the firmer central government role with greater public access to local

politics as suggested by direct election to the local executive and legislative body. This law introduces direct election for all heads of executive at both provincial and district levels (Article 24 Section 5, Law No 32/2004). An election is held every five years. Local accountability endorsed by the previous law was further strengthened with this direct election provision. A summary of the differences between Law No 22/1999 and Law No 32/2004 is presented in Table 3.1, below.

3.4. Local Government Sources of Finance: Law No 25/1999 and Law No 33/2004

Besides the impact on government structure and power division, Law No 25/1999 and Law No 33/2004 also have implications for local financing. With decentralisation a district government has four sources of financing:

1. original revenue or revenue that comes from within the district such as local taxes, levies and assets,
2. transferred revenue from the central government,
3. other legitimate revenue, and
4. central government spending (Figure 3.3).

However, according to Law No 25/1999 only three sources of finance were managed directly by the district government as part of the district budget (*Anggaran Pendapatan Belanja Daerah*): original revenue, transferred revenue, and other revenue (Article 3, Law No 25/1999). The same arrangement persisted in the more recent Law No 33/2004 (Article 5 Section 2). Of these three revenue sources, original revenue, or *pendapatan asli daerah*, was often considered the genuine measure of local fiscal ability. However, the contribution of original revenue to the total district budget has always remained low. According to the Ministry of Internal Affairs, the average proportion of original revenue across the districts is less than 10% of the total, but the actual amount can fluctuate[142].

With the ratification of Law No 28/2009 on Regional Tax, local government was given three additional taxes as part of original revenue. Therefore, overall, the district government was entitled to collect eleven forms of tax, the most significant being land tax under Law No 28/2009 (Article 2 Section 2).

Table 3.1 Differences between Law No 22/1999 and Law No 32/2004

No	Subject	Law No 22/1999	Law No 32/2004
1	District-province relationship	a. Districts and province do not have a hierarchical relationship (Article 4 Section 2).	a. Implicitly states hierarchy between districts and province: "Indonesia is divided into provinces and each province is divided further into districts" (Article 2 Section 1). b. The relationship between province-province, district-district, and district-province are interrelated, dependent, and synergistic (Article 11 Section 2).
2	Division of government affairs	a. Provincial authority encompasses cross-district issues and district authorities that could not be implemented without definite limitation (Article 9 Section 1). b. District government authority encompasses all government authorities except those assigned to the central government and provinces. District governments have the obligation to implement public services such as healthcare, education, culture, agriculture, transportation, industry and	a. Regional government authority still encompasses all affairs assigned in the previous Law. However, they are classified into mandatory and optional. Mandatory affairs between district and provincial governments are very similar (sixteen items); the difference is only in the scope and that provincial government has the authority to implement cross-district affairs (Article 13 and 14). b. Mandatory affairs will be implemented according to a standard determined by the central government (Article 11

No	Subject	Law No 22/1999	Law No 32/2004
		trade, capital investment, environment, cooperation, public work, employment and land affairs (Article 11 Section 1 and 2).	Section 4).
3	Local government	a. Local heads of government are elected and held accountable by the local House of Representatives (Article 18 Section 1, Article 19 Section 1, Article 31 Section 2, and Article 32 Section 3). b. Local regulation could take effect after receiving approval from the local head of government without needing central government approval (Article 69). c. Local governments could determine their own structure according to local needs (Article 60). d. Local government has a higher fiscal capacity due to general allocation fund and revenues from natural resources (Article 79, 80, 81 and 82).	a. Local heads of government (whether district or province) are popularly elected by the public and held accountable to the local House of Representatives (Article 24 Section 5, Article 42 Section 1 and Article 56 Section 1). On the other hand, the governor as the central government representative is accountable to the president (Article 37 Section 2). b. Local regulation is subject to central government approval (Article 145 Section 1-7). c. Local government can still determine their own structure according to local needs; however the requirements also include fiscal capacity, total area, target, total population and density, geographical location, local potential and existing infrastructure (Article 128 Section 1). In addition, the process will be supervised by the central or provincial government

No	Subject	Law No 22/1999	Law No 32/2004
			(Article 128 Section 2).
4	Human resources	a. Local governments have the authority to recruit, change, dismiss their own government civil servants as well as determine their pensions, wages and allowances (Article 76).	a. Local governments have the authority to recruit, mutate, dismiss their own government civil servants as well as determine their pensions, wages and allowances, however under the consent of central government (Article 129 Section 1 and Article 135 Section 1-2).

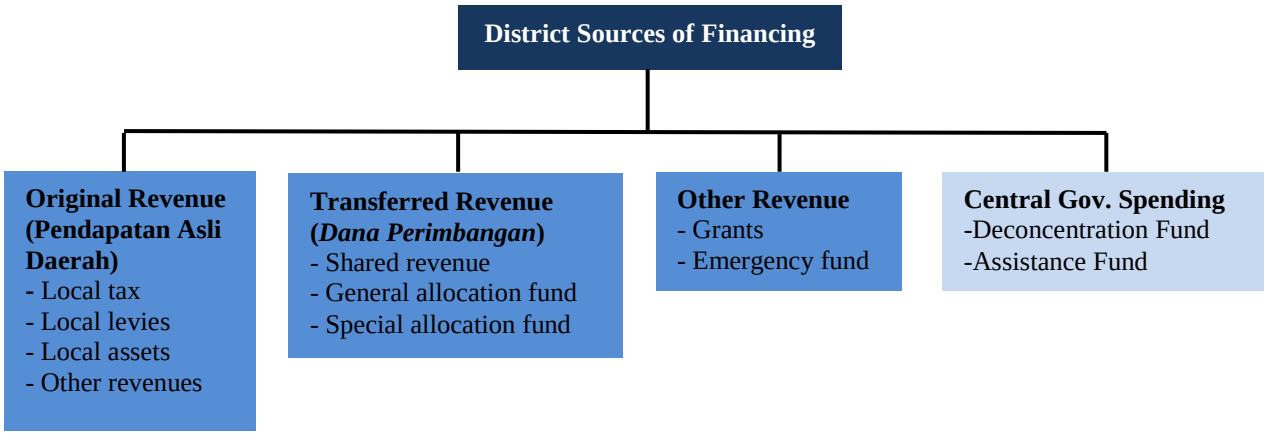


Figure 3.3 District Sources of Financing

The second component of district finance is the balanced fund or *dana perimbangan*. The balanced fund is divided into three types: shared revenue or *dana bagi hasil*, general allocation fund or *dana alokasi umum*, and special allocation fund or *dana alokasi khusus*. These allocations were unchanged from Law No 25/1999 (Article 10 Section 1) to Law No 33/2004 (Article 5 Section 2). In natural resource-abundant districts, shared revenue is an important source of local income. With oil revenue for instance, according to Law No 33/2004 Article 19 Section 2 and 3, 15% is assigned to local government (3% to the province and 6% each for the producing district and across the other districts within the same province). For natural gas, revenue was divided with 70% to the central government and 30% to local government (6% for province and 12% each for the producing district and across the non-producing districts within the same province). For other natural resources, such as forestry, fisheries and general mining, the division was 20% to the central government and 80% to local government.

General allocation funds (*dana alokasi umum*) and special allocation funds (*dana alokasi khusus*) form the remaining bulk of balanced funds. The general allocation fund, in particular, was one of the most important single sources of local income, especially in

the scarce natural resource districts. This fund has become the source of district operational expenditure. In fact, for 2010-2011 around 87-88% of the fund was used for this purpose, increasing by 10% in just three years[143]. Under Law No 25/1999, the allocation of the fund was regulated by the central government based on certain criteria, such as local needs and local economic potential (Article 7 Section 8). In the new Law 33/2004, local needs are further specified based on population, area, poverty rate and construction cost index (Article 28 Section 2). In addition, local fiscal ability is also one of the determinants (Article 28 Section 3, Law No 33/2004). Both laws state the aim of promoting equal fiscal ability among local governments (Article 1 Section 18, Law No 25/1999; Article 3 Section 2, Law No 33/2004).

In order to endorse particular programs, such as healthcare and education, an additional grant was introduced called the special allocation fund. Unlike the general allocation fund, the provision and utilisation of the special fund was partly guided by the central government. It was clearly stipulated in Law No 25/1999 that the fund would be allocated for national commitment or priorities (Article 8 Section 2b). In the new Law No 33/2004 this directive is more subtle as central commitment and priorities are not the only determinants (Article 40 Section 2) and local fiscal ability and local characteristics are also taken into account (Article 40 Section 3 and 4). In addition, in order to encourage local government responsibility, local governments must contribute 10% of the total special allocation fund (Article 41 Section 1). With local priority taken into account in terms of allocation of funds, the new law is more accommodating towards local government needs and initiatives than the previous law.

The last principal source of local government financing is central government spending. As the name suggests usage of this fund is determined exclusively by the central government. Even though local discretion has little relevance, this fund has significant

influence in supporting a number of health programs. The aim of the fund was not explicitly stated in Law No 25/1999 or Law No 33/2004. However, Articles 17 Section 1 and 18 Section 1 in Law No 25/1999 and Articles 88 and 95 in Law No 33/2004 implied that allocation of spending depends on the central government work plan. Thus, the fund may be used for family planning or immunisation, but could also be used for another policy with little relevance to local government interest. As the fund is not part of the district budget, the district government is often bypassed in the funding allocation process[144]. It became evident in this study that bypassing district government often caused overlapping and duplication of programs as district government runs similar programs.

There are two types of central government spending: the deconcentration fund and the assistance fund, each with slightly different terms and conditions. In terms of provision the new Law No 33/2004 is more specific than the earlier Law No 25/1999. The deconcentration fund is assigned for non-physical activities, such as planning, training and supervision (Article 87 Section 7). In contrast, the assistance fund is assigned to support physical projects, such as provision of land, buildings and equipment (Article 94 Section 7). The deconcentration and assistance fund has supported a number of prominent health programs such as *jampersal* (health cover for childbirth) and *BOK* (operational fund for health), and these health programs seem to have contributed significantly to local health performance. Siti Fadilah Supari, the former Minister of Health during a National Meeting for Local Health Offices in Medan stated that local government health budget in general account only 5% of APBD, much less than the central government has instructed, 10-15%[145]. Therefore, central government has used the deconcentration fund from APBN to improve the performance of local health programs.

Post decentralisation, local government financing has derived from two main sources: one fully controlled by local government and sources controlled by the central government (central government spending and to some extent the specific allocation fund). The revenue under full local government control would then be distributed to each government technical office, such as the local health office to support local health programs and services.

3.5. Respondents Perception on Law No 32/2004 and Law No 33/2004

From my interviews, it was apparent that the respondents have a range of views on Law No 32/2004 and Law No 33/2004. depending on their position in the government structure. Local legislators are mostly aware of the law as are *bupati* and heads of the district health office. The laws were better understood among structural officials involved in policy work than by functional officials, such as doctors and teachers who were more concerned about technical expertise. One respondent who now worked on policy commented:

> "...when I used to work in the *puskesmas* I not interested with all these laws. My concern was to treat my patients and that was it (*bekerja sebaik mungkin*). However, now it is different. I have to understand local bureaucracy and stuff. I have to know how it works and our relationship with the central government..." *(K-16)*

The law was important for local decision makers in providing guidance on local government organisation, the range of local power and the relationship between central and local governments:

> "...I would not say that I have read through all the articles of the law, but I have the general idea of the law. How the law will effect the operational of local government, the range of local powers and so on..." *(J-6)*

However, as these laws only regulate the broad concept of local government and the division of financial resource between central and local government, for workable operational guidelines local government relies on what are known as implementing guidelines (*petunjuk pelaksana*) and technical guidelines (*petunjuk teknis*).

3.5.1. Shared Responsibility

One prominent aspect of Law No 32/2004 that noticed by the respondents is the larger role of central government in local affairs. This larger role is exercised through shared responsibility in a number of public services that in the previous law were devolved as local government affairs. Public services, such as healthcare and education are considered strategic and have a wide catchment area; therefore, the responsibility to implement the service, according to the law, should be shared with the central government, as described by a respondent below:

> "The responsibility in providing public services is shared between central, provincial and district. The law regulates that the central government and the local government must work together as the welfare of the people is a joint responsibility..." *(J-13)*

It is interesting that most respondents supported this arrangement. Their reasoning mostly involved the issue of distribution of public services across the country, as described by one respondent below:

> "...it should be like that, the central government has the responsibility to assure that public services, such as healthcare and education, could be evenly distributed to all citizens in this country..." *(J-1)*

Another respondent stated:

> "…the law mandated that healthcare is the right of every citizen. Therefore, the central government deservedly has more roles in policy making and funding. However, the provider of health services is still the responsibility of district government…" *(J-9)*

However, respondents' views were split on the desireable extent of the central government role. Most respondents would like to see the central government have greater role in funding health programs, as described below:

> "…through the shared responsibility, the central government role should be limited in providing more funds to support local government health programs. They have a large amount of money (*mereka punya banyak uang*)…" *(K-2)*

In term of local programs and policies though, respondents from more affluent districts opt for less central government involvement. For them, the central government should act as regulator and devolve the implementation to local government, as stated by a respondent:

> "…the central government should stay as regulator and not implementer. They should stop purchasing medical equipment and distributing it to local governments; what is the point of doing that (*tujuannya apa*)? Central government should be the decision maker on regulation not in procurement…" *(K-5)*

Another respondent stated:

> "…I understand that central government is concerned with our ability. They want to ensure that we provide good health services, however their policies at times overlapped with ours and as the result it is inefficient. For example, we have initiated the standardisation of *puskesmas* services since 2012 so that all *puskesmas* in our district, whether in urban areas or in rural areas, have standard services, in quality as well as in quantity and supporting infrastructure. Recently, central government started the program of *puskesmas* accreditation. There are some similarities and we could harmonise (*menyesuaikan*) it, but still I feel unease about it. There should be clear division of authority between central and local government…" *(K-7)*

The respondents viewed shared responsibility as a division of responsibility where central government provides regulation and fund while local governments are responsible for program implementation.

If offered, respondents from less affluent districts would also opt for less central government involvement. However, they tend to emphasise cooperation (*kerjasama*) and consensus (*kesepakatan*) between central and local government. A commitment to respect central authority and maintain a harmonious relationship with the central government was very visible, as described by one respondent below:

> "…we still need central government involvement to support our health program. The law regulates that the health sector should be overseen by both central and local governments. There should be consensus on each government role so that there would not be overlapping programs. The problem nowadays is there is no communication and coordination…" *(J-6)*

Local fiscal capacity, as will be more evident in the subsequent chapters, seems to have considerable influence on respondents' views and perception of the law and the relationship between central and local governments.

3.5.2. Division of Financial Resources

The respondents had strong views about the division of financial resource between local and central government. Law No 33/2004 that regulates the fiscal balance between local and central government, in particular, was highly criticized especially by respondents from the natural resource–rich districts, as described by a respondent below:

> "...according to Law No 33/2004 shared revenue from natural resources should be (*seharusnya*) main contributor for our APBD, our district only received 6.2% from petroleum and 12.2% for natural gas and that is after being deducted for tax and other expenditure..." *(K-14)*

The demand was to raise the revenue for local government from its present range of between 6-12% to 30%.

> "...we only receive 6%, it is supposed to be 30%. Even for us 30% is not sufficient because our district is very vast and we have to rehabilitate the damage cause by the exploitation..." *(K-14)*

The respondent further stated:

> "...we are not selfish. We just want to have more fair formula for everyone, not only for the districts and provinces with natural resource but also those districts and provinces without significant natural resources (*daerah penghasil*)..." *(K-14)*

A lot of disappointment was reported. A number of districts and provinces felt that they did not receive fair treatment from the central government, as described by one respondent below:

> "…we have strengthened our determination to request for judicial review on Law No 33/2004. For example, there are no definite criterioa for the general allocation fund. Among the thirteen districts in this province some districts receive the same amount every year, some have increased but others have decreased over the years. Our district previously received 75 billion IDR but now we only receive 48 billion IDR. What is this number based on? We contributed 30 trillion IDR but we only received 48 billion in return, it is only 0.15 precent. The central government should consider this unfairness…" *(K-17)*

However, the central government stance is quite clear. Law No 32/2004 was introduced to limit local autonomy that tended to be uncontrollable using the previous Law No 22/1999. The division of financial resources regulated by Law No 33/2004 also reflects central government prudence in devolving more power to local governments even though the regulation could be adverse for some local government progress, including in combating local disparity.

The disparity between districts and provinces is a problem with a long history. The uneven development between Java and other islands, particularly Kalimantan and the eastern islands is still very visible. One respondent argued that Law No 33/2004 is insufficient to overcome regional disparity, as described below:

> "...there is always inequality (*ketimpangan*) between central and local governments. We have never received equal treatment (*perlakuan yang adil*) such as for infrastructure, economy, and so on. The quality of roads in Java is better and smooth. Flyovers and more toll roads has

> been built in Java while here in Kalimantan the central government has prevented us from building it even though we only propose for one. The law should provide us with more access to financial resources...”
>
> *(K-12)*

Another respondent stated:

> “...we felt that the development is still not yet evenly distributed (*merata*) as mandated by our constitution. I could say it is far from fair. East Kalimantan is one of the largest contributors to national income (*devisa negara*), but take a look. The people are poor and public infrastructure is in a poor condition (*rusak dan berlubang*)...”
>
> *(K-3)*

However, decentralisation has made local government more confident and assertive. The policy has encouraged natural resource-rich districts in East Kalimantan to demand a larger share of the revenue. Besides judicial review, some local governments also demand special autonomy, such as given to Papua and Aceh, as stated by a respondent:

> “...we are demanding special autonomy (*otonomi khusus*) for equal treatment within the frame of the Republic of Indonesia. It is unnegotiable *(harga mati)* and the demand does not violate the constitution 1945. Special autonomy is the only way (*satu-satunya jalan*) for prosperity...” *(K-14)*

These local governments were quick in stating that they were using legal and constitutional means, therefore departing from a more confrontative approach seen in Papua or Aceh couple of years ago. The issue of secession appears less appealing amongst these local elite. As a considerable number of them are Javanese descendants, this stance is understandable. However, even among local residents in the four districts

of East Kalimantan in this study the prospect of independence seems to be less alluring. A respondent stated:

> "...we will unite with our people to fight for special autonomy (*otonomi khusus/daerah istimewa*) but not treason (*makar*). We do not support violence (*kekerasan*) but we support dialogue..." *(K-16)*

Another respondent stated:

> "....the unitary state of Indonesia is inviolable, but welfare and justice above all else. We want to fight within the constitutional framework and we encourage other districts to work together for this cause because it is the only way to obtain a better result. We do not want to be castrated (*dikebiri*) where we do not receive our rights as the spirit of decentralisation..." *(K-3)*

Another respondent added:

> "...we are demanding special autonomy for equal treatment within the frame of the Republic of Indonesia. It is non-negotiable (*harga mati*) and the demand does not violate the constitution of 1945. Special autonomy is the only way (*satu-satunya jalan*) for prosperity. Demanding special autonomy is allowed by the law in order to advocate (*memperjuangkan*) for the rights of our people as the citizens of Indonesia..." (K-5)

However, not everyone agrees with the proposal for special autonomy. It is very likely that central government will reject the proposal otherwise it will trigger other districts and provinces to demand the same thing and the central government does not want this situation to happen. This view is shared by a respondent below:

> "...I am pessimistic about the demand (*tuntutan*) for special autonomy. I am sure that if special autonomy is granted, other areas in this republic with considerable natural resources will follow suit. I doubt the central government will approve it (*menyetujuinya*)..." *(K-8)*

Central government would be more likely to revise Law No 32/2004 and Law No 33/2004 rather than fulfilling local demand for special autonomy. A respondent agrees on this view:

> "...what is important is how to increase local revenue.Special autonomy is not the only way, there are others that would be more reasonable. For example, by revising Law No 33/2004..." *(K-8)*

3.6. From Law No 22/1999 to Law No 32/2004: A Reflection of Constant Change

This chapter provides the legislative framework for decentralisation policy in Indonesia. As reflected by relevant laws, decentralisation is a dynamic process that has been constantly changing to adjust with shifting interest, particularly between the central and local governments. The shift is noticeable through changes in central and local governments' roles, positions, relationship and distribution of power. The position of the central government, for example, was considerably diminished when decentralisation was enacted in 2001 under Law No 22/1999. However, Law No 32/2004 subtly reintroduced a greater central government role through redefinition of the public sector, such as healthcare and education, as concurrent affairs. This redefinition has justified the return of central government involvement in health and other affairs at the local level. In addition, the less hierarchical government structure introduced by Law No 22/1999 was slightly revised through Law No 32/2004 with the

rekindling of provincial authority. Even though district government is no longer held accountable to provincial government, provincial government as a central government representative has the authority to monitor implementation of district government programs and policies.

My view on the nature of Law No 32/2004 differs from Hendratno who argued that both Law No 22/1999 and Law No 32/2004 increased the degree of decentralisation[146]. While Law No 22/1999 undeniably has devolved a considerable amount of central government power to the local governments, I argue that Law No 32/2004 has reversed the division of power by giving more power to the central government. Despite introduction of direct election processes that would potentially strengthen local accountability, in terms of local government affairs Law No 32/2004 could potentially increase central government power. With the enactment of Law No 32/2004 the central government seems to re-emphasise the nature of Indonesia as a unitary state and not a federal state. This is the law in force in Indonesia while this study was being conducted and as such the law has considerable influence on understanding how decentralisation in the health sector is interpreted and implemented across the districts as presented in subsequent chapters.

Chapter 4.

Developing Local Health Programs

Decentralisation in Indonesia brought considerable changes to the role of local government in regard to public services, including healthcare. Prior to decentralisation, local initiatives in health programs, if any, were strictly monitored by the central authority as suggested by the hierarchical lines of coordination between central and local governments. Even though coordination lines were intended to improve health program effectiveness it was apparent that the balance of power between local and central government was skewed. Local governments were co-opted to work alongside central government bureaucracy to implement central-derived health programs. Changes brought by decentralisation redressed, at least initially, this power imbalance. With the newly gained power, local government has the authority to develop local initiatives by absorbing and synchronising locally-derived proposals and at the same time taking into account central regulation and policies as part of the top-down process. This chapter explores how the newly-gained power has influenced and shaped local health programs. The chapter is presented in three parts: the local government actors; local initiatives in developing health; and one example of a local initiative, the *jamkesda* that has become a point of distinction between districts but also between some districts and the central government. This chapter and the following two chapters represent the views and opinions of my respondents on decentralisation, how it is practiced and interpreted.

4.1. The Actors in the Local Government

Six different actors within local government will be described in this chapter even though my study focuses on only three: the *bupati*, the district House of Representatives, and the District Health Office. All three are the main actors in decentralisation in Indonesia. The governor, the provincial House of Representatives, and the provincial health office will not be discussed in great detail due to their minor role in these matters.

4.1.1. Head of District (Bupati)

Following decentralisation, the district holds an important role as the prime mover of decentralisation. The head of the district is called a *bupati*, or *walikota* for a municipality (Henceforth, only the term *bupati* will be used to avoid confusion). A *bupati* assisted by the district technical offices or *perangkat daerah* forms the core of district government. As the executive of the district, the *bupati* is expected to outline district policy in a formula called *rencana pembangunan* or development plan that encompasses the district vision and programs, including health, over a five year term, as described by one respondent, below:

> "...if we talk about what we have done after decentralisation it was all dependent on our visions (*visi*) and objectives (*misi*). We have a vision to create a thoroughly prosperous (*sejahtera lahir batin*), gender equal (*berkeadilan jender*) and highly competitive community (*berdaya saing*)." *(J-4)*

In forming the development plan, the *bupati* engages with all district technical offices; in the case of healthcare this is the district health office. The full document needs to be approved by the district House of Representatives. It is later used as reference for the

annual district general program called *rencana kerja pembangunan daerah* or the regional development work plan as well as for the more specific health program conducted by the district health office called *rencana kerja dinas kesehatan* or the district health office work plan. The district health vision is broken down into several applicable programs in the annual district health office work plan, as described by one respondent, below:

> "…in principle (*prinsip*) every born baby in this district would be healthy. In the attempt to achieve this we have several programs, one such program was the maternal counseling (*pendampingan ibu hamil*) program. In regard to nutrition it would not be an issue for those women from a middle-high income family (*kalangan mampu*). Nevertheless, these women would still need some support on other health education (*pengetahuan kesehatan*). As for the women from a low income family (*kalangan tidak mampu*) they would need our support to have sufficient nutritional intake (*asupan gizi*) in order to deliver healthy babies. They would need additional nutrients (*tambahan gizi*), vitamin etc that would be monitored by the government..." *(J-4)*

Subsequently, the role of the *bupati* is to ensure that health work plans are implemented accordingly so that established targets can be achieved.

4.1.2. District House of Representatives

The district House of Representatives is the legislative body at the district level. Its main role is to ensure that public interest is taken into consideration in district policies with the purpose of maximising public wellbeing. In order to achieve this purpose, the House of Representatives scrutinises local budgets, monitors implementation of local policies and programs, and passes necessary legislation to support effectiveness of

district policies and safeguard policy at the same time, as explained by one respondent, below:

> "…we have three inherent authorities (*kewenangan yang melekat*): budgeting (*penanggaran*), supervising (*pengawasan*) the district executive, and legislation in the form of district regulation (*peraturan daerah*). The district regulation would strengthen (*menguatkan*) district programs; legitimising that these programs were based on community needs (*berbasis kebutuhan masyarakat*)." *(J-2)*

One particular activity, budgeting, was considered more pronounced than other roles, as explained by a respondent:

> "...our role (*peran*) was more in budgeting (*penganggaran*), particularly in the relation to the utilisation of local revenue and expenditure (*anggaran pendapatan belanja daerah*)..." *(J-3)*

As local legislators, the House of Representatives' position appears comparatively weak when contrasted with the *bupati*. Therefore, the role as controller of the *bupati* is likely to be ineffective, as mentioned by a respondent, below:

> "...initially, how much funding that was needed would be proposed (*usulan*) by them (the executive). We only looked (*melihat*) at whether it matched (*sudah pas*) the budget and the regulation because there is always disparity (*keterbatasan*) between budgets and need..." *(J-3)*

In terms of program initiative, legislators are relatively passive even though the House of Representatives is granted by the law the opportunity to identify peoples' need through the session called gathering public aspiration, or *penjaringan aspirasi*. However, it appears that information was used as verification for district government programs, rather than for developing initiatives, as described below:

> "…regarding activity identification (*identifikasi kegiatan*) the district executive would provide a general policy budget or *kebijakan umum anggaran* and a temporary priority maximum budget or *prioritas plafon anggaran sementara* before the district revenue and expenditure (*anggaran pendapatan belanja negara*) was determined. In this document each district technical office (SKPD) has developed and identified activities that were considered priority (prioritas) in each district technical office…" *(J-2)*

This practice was common in all district government affairs, including healthcare, as suggested below:

> "...initiative always comes from them (district health office). They know better how to reach the objectives and what they need (*yang dibutuhkan*) in order to achieve them. We were more supporting with good intention (*iktikad*), good intention by making things possible. For instance, if there is a need for additional funds e will push for it to happen..." *(J-3)*

This comparative weaker position of the local House of Representatives as compared to the *bupati* may partly be attributed to changes in law by the introduction of Law No 32/2004. This law ended the legislative body's authority to appoint the *bupati*. Instead, under this law the *bupati* became publicly elected. This strengthened the bargaining position of a *bupati*. However, the passive stance of the local House of Representatives indicated by a number of respondents in this study may also explain the absence of legislators' capacity in budgeting, as pointed out by Winarna and Murni[147]. Sopanah[148], Murni and Witono[149] indicated lack of capacity was the result of a low educational background or lack of experience and not a result of political allegiance or other personal background, such as age or gender. In line with these studies, the prerequisite

for someone to run for legislator was raised to those who had graduated from senior high school or *Sekolah Menengah Atas*.

For effectiveness, the local House of Representatives is divided into several commissions. The number of commissions depends on the main area of work that the district government focuses on, but in general consists of at least four commissions: government affairs, economy and development, social welfare and finance. Healthcare is usually grouped in the social welfare commission.

4.1.3. District Health Office and District Public Hospital

After decentralisation the district health office has a much clearer role in Indonesia's health system. The health office is responsible for developing local health program by referring to the district midterm development plan (*rencana pembangunan jangka menengah*) and then implementing it into applicable programs through the *puskesmas*, as explained by one respondent, below:

> "…according to the Minister of Health decree (*peraturan menteri kesehatan*) the district health office was not so much an implementer. The ones that were directly involved (*bersinggungan langsung*) in the services were the *puskesmas* and the district public hospital (*rumah sakit*). So we acted more as a regulator of district health policy and supervisor that monitored (*mengawasi*) them…" *(K-7)*

In the new district government structure, the district public hospital is no longer accountable to the district health office, but is directly accountable to the *bupati*. The district public hospital is at the same level with the district health office thereby making up the district technical offices. The relationship between the district public hospital

and the district health office is confined to coordination, as described by one respondent, below:

> "…what remains between district health office and district public hospital is coordination. As an analogy, the district health office is the Ministry of Health while this district public hospital – because Indonesia is so vast – is Cipto Mangunkusumo Hospital, Pirngadi Hospital in Medan, Sutomo Hospital in Surabaya, etc. As a hospital we provide direct services (*langsung pelayanan*) to the public." *(J-11)*

With the distribution of authority, the district health office is more responsible for community-based health or health promotion, whereas the district public hospital focuses more on individual health or curative care. District public hospitals still offer some promotion care, such as family planning and immunisation, although not their main focus, and always under the coordination of the district health office as the institution in charge, as discussed below:

> "Thus, in general the difference was between health development (*pembangunan kesehatan*) and health service (*pelayanan kesehatan*), community-based health (*upaya kesehatan masyarakat*) and individual-based health (*upaya kesehatan perorangan*). Hospital assisted the *bupati* in providing health services for the individual who was fallen ill (*individu yang mengalami sakit*), while the district health office assisted the *bupati* in providing communal health services for the community (*pelayanan kesehatan yang bersifat komunal*)" *(J-11)*

However, the coordination that seems ideal on paper is not always run smoothly. One respondent described below:

> "…in managing the health sector at the district level there is one particular obstacle (*kendala*). The district health office as the holder (*mempunyai hak*) of local health authority should be able to coordinate the district public hospital. I am still working on it. Starting this April I am working (*merintis*) on how to control (*mengendalikan*) the district public hospital. They could not be stand-alone (*tidak berdiri sendiri*)…" *(K-5)*

There seems to be mistrust between the district health office and the district hospital as described by one respondent below:

> "…we have worked hard to develop *puskesma's* capacity in providing health services. We focus our program on public satisfaction (*kepuasan pelayanan*). I am not talking about output anymore but outcome, the benefit that the public should receive. We have strengthened and improved our human resources and facilities for each *puskesmas*. We have also produced the guidelines (*kerangka acuan*) for each *puskesmas* to provide direction on what to achieve (*apa yang harus dicapai*). We have also assigned qualified supervisors to monitor *puskesmas* performance. We have reached the stage where our *puskesmas* have obtained international ISO recognition (*pengakuan*) in hospital administration. From the survey conducted by the district research and development board (*badan penelitian dan pengembangan*), the public has approved the improvement of *puskesmas* services. However, the situation is different with the district public hospital. The data said that from one hundred people sampled only two are satisfied with the services provided by the hospital…" *(K-5)*

Even though there are many issues that may have influenced the results of the survey such as who are the respondents, their socio-economic background, where did the interview take place and might that have influenced the replies, the quotation itself gave

the impression that the district health office considered that the district public hospital has not done their share of work properly. In the immediately prior quotation, the respondent even planned 'to control' the district public hospital in relation to the problem of coordination. It was this tendency to control that appeared to build the distrust between the district health office and the district public hospital as described by a respondent below:

> "…we do not want the district health office to interfere with our internal affairs. We should trust each other as both of us are the part of the district technical office. Sometimes it is as though we are competitors (*rebutan*). For example, once we trained a number of nurses as part of our program but unfortunately the nurses were taken over (*diambil alih*) by the district health office …" *(K-15)*

When asked about this issue the district health office argued that what the respondent meant by 'to control' was merely synchronising the district health office program and the district public hospital program:

> "…the district health office is not trying to interfere with hospital management or finance. I am just trying to synchronise our health promotion programs with the hospital curative care. The hospital seemed to fear that we are somehow going to meddle with their management or financial arrangement. That is not true. Our concept is to bridge between the two technical offices so that the local health system has both a public health component and an individual health component. The problem was that the individual health component wants to stand alone (*berdiri sendiri*)…" *(K-5)*

The problem seemed to be caused by the struggle over authority between the district health office and the district public hospital as described below:

> "…this situation is what we try to solve. We just want the hospital to cooperate with us. If they provide health promotion they should give us access (*kasihkan ke dinas*) and report (*lapor*) to us as the authority for health promotion…" *(K-5)*

Another respondent added:

> "…we provide basic health services in our hospital such as vaccination and family planning. It is not part of our main services but we must provide it. There are people who prefer to go to the hospital rather than to the *puskesmas* I guess…" *(J-11)*

4.1.4. Head of Province or Governor

The governor (in Indonesia spelled *gubernur*) is the executive head of a province, similar to the position of *bupati* in the district. However, in terms of role the position of governor is more complicated because of its dualistic nature. On one hand, the governor is the head of an autonomous jurisdiction, the province, with authority to make policy, as is permissible under the law. However, on the other hand, the governor also acts as a central government outpost in the region with the main role of ensuring central government interests are incorporated into district government policies.

As the head of a province, the authority of governor has remained indistinct compared to that of a *bupati*, even after the introduction of Law No 32/2004 that was supposed to clarify the role. The previous chapter described how this indistinct definition was intentionally designed and embedded in the law to encourage cooperation between

provincial and district governments. Respondents confirmed this when asked about the role of provincial government, as described below:

> "…we are not supposed to develop our own program that is utterly distinct from the district. The responsibility to provide public services is the districts. Our role is to support the district programs…" *(J-5)*

Another respondent stated:

> "…the province does not have the minimum standard of services because they do not have the responsibility to provide such services. Usually we will discuss and allocate which activity could be supported by the province and which activity could be implemented by the district…" *(K-6)*

As suggested in the previous chapter, decentralisation policy in Indonesia, as shown by changes in law, moved from the clear division of central and local authorities to a model that promotes joint responsibility for certain public services. The law did not specify a distinct provincial role in health, as compared to the district. One respondent argued that the central government intentionally did this to encourage cooperation between district and health office:

> "...provincial and district government have similar authority in health so that both of them could work together. For example, the provincial health office is authorised in eradicating communicable diseases exactly the same as the authority for the district health office. The idea was to give the same responsibility so that both could then work this out jointly, maybe in the form of co-founding or some other things..." *(J-15)*

It seemed that the idea of joint responsibility has had a profound effect on the view of some local stakeholders regarding local programs, as expressed by a respondent, below:

> "…our health program does not stand alone (*berdiri sendiri*), it is part of the national health program…" *(K-1)*

Another respondent shared a similar view:

> "…our program supports the central program. We could not propose a program that is not in line with national development objectives (*tujuan pembangunan nasional*). Therefore, we could not develop a program that is against (*bertolak belakang*) the national policy…" *(J-9)*

However, in terms of the provincial and district relationship, coordination has not always worked smoothly. This arrangement has caused some concern, as shown by a respondent, below:

> "…many people are confused because of the uncertain (*tidak pasti*) arrangement. So who actually has the authority for healthcare because the same authority was shared (*bersama*) as it was considered joint responsibility [the respondent used the term concurrent but I believe what the respondent meant was joint responsibility]. I am not sure, do we have a division of work (*pembagian kerja)* or is it actually homogenising the work (menyamakan) ..." *(K-8)*

There seemed to be some resentment and prejudice from both sides. This is addressed further in the next two chapters.

4.1.5. Provincial House of Representatives

The provincial House of Representatives has a similar role to the district House of Representatives. The difference is only in scope, as the provincial House of Representatives responsibility is at the provincial level.

4.1.6. Provincial Health Office

The provincial health office has a similar role to its counterpart in the district government, but with a wider scope of service in terms of geographical area. However, the provincial health office could not carry out their programs without the coordination functions of the district government as the beneficiaries of the provincial health office are also the beneficiaries of the district health office.

> "…it is because the provincial health office does not have (*tidak punya*) direct beneficiaries (*masyarakat*); they belong to the districts and municipalities (*kabupaten kota*)…" *(K-1)*

In addition, as a consequence of the dualistic position of provincial health office (as there is two directional accountability), one towards the provincial government and seconds toward the central government, as described by one respondent:

> "First, we were held accountable (*tanggungjawab*) to provincial government, in this case the governor (*gubernur*) as the highest local decision maker in the area. Number two, towards the Ministry of Health (*kementrian kesehatan*). Therefore, both responsibilities must be performed well…" *(J-5)*

In contrast to the district health office, the provincial health program tends to be dominated by central government-derived programs, as suggested by a respondent, below:

> "…at the implementation level the province carried out (*mengampu*) central government authorities (*wewenang pusat*) in the region, particularly within the scope of (*ruang lingkup*) basic health services (*pelayanan kesehatan dasar*) such as disease alleviation (penanggulangan penyakit), environment health (*kesehatan lingkungan*), medication (*pengobatan*), health promotion (*promosi kesehatan*), mother and child health (*kesehatan ibu dan anak*), family planning (*keluarga berencana*) and nutrition (*gizi*)" *(J-5)*

The provincial health office also has a responsibility to monitor district health policy making to ensure that they do not breach regulations, as described by one respondent:

> "…for instance, we proposed (*usulan*) certain activities (*kegiatan*) and the provincial health office would verify them. They verify whether the activities are aligned or not (*sesuai tidak*) with the regulation (*aturan*). For example, oh this honorarium is not allowed (*tidak boleh*) or our transfer is above the standard general cost (*standard biaya umum*). They will control. It is their job (*tugas*)" *(K-1)*

The provincial health office role includes assisting the district health office where required, as explained by one respondent, below:

> "Therefore, programs that could not yet be carried out (*belum bisa diampu*) by the district should be taken care of (*diampu*) by the province as part of the provincial task as the representative of the central government" *(J-5)*

4.2. Public Policy: the Local Initiative

In general, public policy is defined as the actions that a governmental entity undertakes[150]. Public policy is often associated with the government, as Rusli pointed out only government has the authority and power to govern the people with the purpose of developing public justice, involvement and prosperity[151]. In Indonesia, the government encompasses the central and local governments, the House of Representatives and other state institutions. The policy of decentralisation brought significant changes as the central government yielded significant power to local governments. One virtue of decentralisation is the relative freedom to which local government is entitled. Instead of awaiting 'instruction' from a central authority or their agencies, as pointed out by Sandi and Lignawati[152], local government has the power to develop health policy within the designated corridor. It seems that the boundary of freedom to develop policy is understood by local stakeholders, as revealed by one respondent:

> "Freedom (*kebebasan*) but not uncontrolled, it is freedom within the corridor that is allowed by the central authority. We have guide lines (*rambu-rambunya*) that we need to follow…" *(K-1)*

Another respondent stated

> "...yes, we do have the power (*wewenang*) to plan our own health program, for instance, but we also have the responsibility (*tanggungjawab*) that the program we have initiated benefits the people... *(J-8)*

The statements above revealed that the power to plan under decentralisation brings a responsibility to benefit the public. However, it is not a boundless freedom. As the

respondent above has mentioned, local power is bounded by central regulations and policies.

4.2.1. The Relationship between Responsibility to Plan and Empowerment

For some respondents the power to plan a local health program that can benefit the local community is empowering, as expressed by one respondent:

> "Decentralisation has empowered (*memberdayakan*) local government. It enabled us to have the authority to plan (*merencanakan*) and to draw up a budget (*menganggarkan*) according to our own development plan." *(J-3)*

Another respondent added:

> "With decentralisation we have responsibilities (*tanggungjawab*). It is this new responsibility that has made us more empowered…" *(J-1)*

A similar view was expressed by another respondent:

> "…nowadays we could make our own policy. We also have our own financial resource that we could use for our own program. But it has somehow been empowering for us. There is less bureaucracy and we could discuss things directly (*langsung*) with the central government. I know it has not always worked perfectly. Everything must be taken step by step, not just rush in (*ora grusa-grusu*). Everything must be planned and evaluated (*dipilah-pilah mana yang baik mana yang tidak*). I believe the central government has thought about it…" *(K-2)*

The statements above suggest the sense of local empowerment was the result of devolution of authority from the central government to local governments. The local authorities refer to (1) authority to plan a local program and implement it, and (2) the authority to fund the program using local resources. A similar understanding of the term

empowerment is also discussed by Ahmad and Abu Talib in their study among local communities and local government in Pakistan[153]. These authors argue that local empowerment is associated with local government or community ability to participate actively in local decision making. Another study in an Ethiopian farming community conducted by Snyder *et al* also supports the concept of local empowerment as the ability of the local community or government to actively participate in planning and implementing local programs[154]. In both studies active participation generated locally responsive decisions that would eventually improve local wellbeing.

The empowerment to which a number of local stakeholders in this study referred was confined to having authority to plan and execute local programs. This has less to do with improvement of local 'ability' and more to do with expanding local 'authority'. This is noticeable through the word choice of many respondents. Rather than using the Indonesian term '*kemampuan*' that corresponds to 'ability' in English, most respondents used '*kewenangan*' that corresponds to authority, as shown in respondent quote below:

> "…with decentralisation local authority (*kewenangan*) will be larger than under centralisation…" *(J-4)*

The term used is consistent across different stakeholders:

> "Decentralisation can be interpreted as devolving of authority (*wewenang*) from the central government to the local government in taking care of local problems…" *(J-5)*

Widespread use of the term authority, and not ability, is not surprising as the policy was designed to devolve authority, rather than promote local ability. Without exploration and analysis, respondent views on empowerment may be misleading. It can be argued that empowerment has as much to do with developing local ability as increasing local

authority. Bennis and Nanus[155] view empowerment as developing subordinate skills in management along with devolution of authority, or as Kanter[156] suggests empowerment is the sharing of power between superiors and subordinates. The feeling of empowerment experienced by many respondents was very likely an expression of enfranchisement associated with transition from powerlessness; a phenomenon similar to the experiences and feelings of minority groups (women, Afro-Americans and the people with different abilities), as pointed out by Conger and Kanungo[157]. Further the respondent added that in fact there is a difference between the power to execute and ability to execute local policy. In terms of local ability there seems to have been little change under decentralisation, as suggested in the statement below:

> "…the problem is how our human resources provide services, so weak (*lemah*) and unsuitable (*tidak bagus*). The quality is the same as years ago." *(K-10)*

Another respondent said:

> "…you could see the staff here. I could not expect much (*tidak bisa diharapkan*). Things could only be done bit by bit. You cannot expect to get it done quickly (*tidak bisa sekaligus*)…" *(K-13)*

A study conducted by Indonesia's Central Planning Agency on the capacity of local government planners in eleven districts and four provinces revealed that generally local capacity is still low and needs improvement[158]. Findings of that study pointed indicated a lack of access to technology and information, in addition to limited work experience. However, it would be unfair to assume that all districts or all staff within the same district are homogenous. During fieldwork I met with a number of local planners who have a clear vision and a well-developed systematic plan to achieve. Nevertheless,

whether or not the plan can be implemented depends on support of other local parties, particularly the local House of Representatives. In addition, some respondents pointed out that a good plan is meaningless unless strong support is given by the implementer in the field. The problem of disparity in capacity seems to hinder local progress in developing capacity. When decentralisation was implemented, people expected local ability would follow and become well developed when local governments utilised the newly designated authority, but it appears that improvements in local human resources move at a slower pace than devolution of power to local government. A respondent stated:

> "Our program such as the 24 hours *puskesmas* is actually good but again we need to strengthen (*dikuatkan*) our human resources in addition to the system and equipment." *(K-13)*

4.2.2. Developing Local Health Program

The local health program is initiated by the local health office. Respondents in this study gave the impression that program evaluation played a central role in devising local health programs. In fact, evaluation seems to be the basis of the local government health program, as expressed by a respondent below:

> "…the process to propose an activity started from the evaluation of previous year's implementation program, particularly the performance (*pencapaian*) on some of the targets." *(J-9)*

Another respondent supported the opinion above:

> "Of course we have program evaluation. It is an important part of our program planning. We developed our health program by evaluating previous year's program..." *(K-8)*

Another respondent expressed the importance of evaluation:

> "…we have conducted monitoring and evaluation regularly. We will use the data to develop our argument in convincing the *bupati* and the local House of Representatives. Nowadays you do not expect to receive any government funds without proper data to justify it…"
>
> *(K-6)*

It appears that there was no standardised evaluation procedure that applied to all districts. Each district developed evaluation techniques and approaches dependent on available resources. One common method is by measuring the difference between the target and the performance. A wide difference between target and realisation is an indication that a problem has occurred and therefore could be considered for focus of interest or priority. A comprehensive measure could then be carried out to comprehend full understanding of that particular problem, as described below:

> "From the problem we explore (*telusuri*) the community, their lifestyle (*gaya hidup*), health service pattern (*pola perawatan kesehatan*), and the environment (*lingkungan*). Each factor would then be elaborated further, for example from the pattern of health service a close observation (*sisir*) would be carried out regarding infrastructure (*sarana prasarana*), human resources (*sumberdaya manusia*), and regulation." *(J-9)*

Differences in approach to local evaluation should not jeopardise local health programs as long as the local planner is fully aware that the purpose of evaluation is to examine the process and measure the outcome of a particular program, thereby assuring distribution of local resources occurs efficiently and effectively in achieving objectives and not merely collecting data as a formality, as indicated by a respondent below:

> "…it sounds embarrassing (*saru*) but sometimes it is difficult to conduct a reliable evaluation. We do not have the ability and expertise (*kemampuan)* to conduct a thorough evaluation…" *(J-16)*

The respondent added that the problem was also partly due to the difficult work environment:

> "…sometimes we would like to speed up but the senior staffs are not always supportive. They do not want to be left behind (*nek ditinggal nyeneni*) but they could not keep up with our pace (*keponthal-ponthal*). That is why we prefer an external evaluation to get it done. We could then just use the recommendation…" *(J-16)*

This situation is not extraordinary. The importance of seniority often influences decision making processes, particularly in an environment where seniority is highly respected, such as in a government institution. Acts of decision making are often determined by seniority, not necessarily seniority in age, but also position. Those with a senior position and age are considered as more knowledgeable and experienced. Possibly this view has influenced some appointments of structural staff, as indicated by respondent *J-16*:

> "…The role of the head office (*kepala*) or division (*bagian*) is very influential (*sangat menentukan*) unfortunately some of them I think were appointed based on their age than their capacity. It is a difficult environment because we could not work swiftly (*dengan cepat*) if we rely on the senior staff…" *(J-16)*

According to government regulation (*peraturan pemerintah*) No 13/2002 structural officials (*pejabat struktural*) should be appointed according to education qualification, performance and competency, but the regulation also includes other considerations such as seniority, rank (*kepangkatan*) and experience. This study found a strong indication

that consideration of seniority, rank (automatically promoted every four years) and experience, all related to age seniority, has a significant influence on appointment of local structural officials.

Recently, the district government has started to adopt a pro-poor planning, budgeting and monitoring program for the purpose of planning, monitoring and evaluating local programs. The program was initiated by the World Bank and introduced by the central government through the National Development Planning Agency. It was considered relatively simple, but at the same time enables a far reaching impact that could improve local responsiveness:

> "The idea was to incorporate planning through budgeting. So our program and activities budget (*anggaran program dan kegiatan*) would be based (*sesuai*) on the extent of the problem (*masalah*). We could see from the map, the dark coloured (*gelap*) must be given a higher (*banyak dikasih*) proportion from the budget. We start from there. The head of our division for example, every meeting (*rapat*) on monitoring and evaluation she will give us maps (*peta*) of the five sub-districts that we supervise (*membawahi*). In each of these maps there are indicators, maternal mortality (*angka kematian ibu*) in sub-district A is high (*tinggi*) for example, and therefore, the budget and development (*anggaran dan pembinaan*) would be focused (*difokuskan*) in that area without ignoring (*mengesampingkan*) the other sub-districts. We attempt to maintain (*mempertahankan*) the areas that have been coloured green not to become yellow or red. The green area would still receive some portion of the budget but not as much as (*porsinya tidak sama*) the darker one." *(K-6)*

One local government presented specific maps showing health indicators for each sub-district and village in various colours:

> "...we used different colours (*warna*) to indicate health indicators in those areas. The darker the colour the more serious is the problem. In this way it is easier to detect where we should pay our attention..." *(K-12)*

4.2.2.1. The Role of Local Government Commitment in Supporting Health Program

In order to be implemented, a local health program proposed by the local health office must receive support from local government. Respondents in this study used the term local commitment to describe this support, referring to active support from the *bupati* and local House of Representatives that has defining role in authorising local programs[159], as expressed by a respondent below:

> "...it depends (*tergantung*) on the commitment of the local House of Representatives and the heads the local government to support (*mendukung*) or not support the health program..." *(J-1)*

Another respondent had a similar opinion:

> "…local commitment is essential to ensure the sustainability (*keberlanjutan*) of local health programs. Without the support of local government, local health program sustainability will be in jeopardy..." *(K-6)*

Local government commitment can materialise in various forms. For example, with the intention to increase public access to basic health services this commitment could be in the form of providing funding, building more *puskesmas*, recruiting more physicians, diversifying the availability of health services, and/or issuing local regulations.

4.2.2.2. Local Government Commitment: Local Regulation

Local regulation, or *peraturan daerah*, is the first manifestation of local government commitment explored in this section. While not all health programs need to be regulated, *peraturan daerah* has a significant role in certain health programs. Any initiative for local regulation is proposed by the local House of Representatives and must be approved by the *bupati*. The regulation itself has a number of functions, such as to interpret higher regulation, support local policy, promote local diversity and improve public welfare[160], but it could be also used to protect local policy and ensure sustainability of local programs. In some cases where local initiatives interfere with central government policy, local regulation acted as a guarantee, ensuring legality of policy and, therefore, sustainability of the local health program, as supported by one respondent, below:

> "…but the program has been regulated (*diperdakan*), therefore it has a strong basis. Central government still could revoke it, but they could not accuse us of violating any laws as it has received the approval from the local House of Representatives…" *(J-1)*

This was similarly expressed by another respondent:

> "Local policy has to take into account (*mempertimbangkan*) its justification and legality, if not the person in charge could be in trouble…" *(K-1)*

Local regulations also serve to increase public awareness and participation. In some cases local regulation also regulates sanctions in order to encourage public participation even though the sanction is rarely applied as explained by a respondent, below:

> "…with the local regulation there are several principles that we want to preserve (*pertahankan*) to support a strong system (*sistem yang sehat*). We have the regulation that mandated (*mengamanatkan*) every resident (*peserta*) could access the service only after two months (*jeda dua bulan*) since registration. We teach the public to be more responsible. I hope that the public could register as participants as soon as possible and not to wait until they are sick. This regulation actually ordered (*memerintahkan*) the public to participate (*jadi peserta*). It is an obligation (*kewajiban*) and if not there are sanctions…" *(J-1)*

Local health programs supported by *peraturan daerah* tend to receive special attention, particularly in the form of financial support, such as stated by a respondent, below:

> "...the House (of Representatives) has promised that if there is any shortage of funds they will add to the budget so we do not need to be worried. They already gave their commitment..." *(J-1)*

4.2.2.3. Local Government Commitment: Fiscal Support and Fiscal Utilisation

The second aspect of local commitment is in the form of financial support provided by local government. In order to provide financial support it is important that the local government has strong fiscal ability and involves the head of local government and local House of Representatives. The budget, proposed by the *bupati* in the case of a district and governor in case of a province, must receive support from the district or provincial House of Representatives, respectively. In Indonesia, the budget is called *Anggaran Pendapatan Belanja Daerah* (APBD). Generally, it covers local revenue, sources of revenue and proposed expenditure for a specific year. The APBD indicates the commitment of local government in specific sectors, such as healthcare, education and other public services. The APBD may also indicate local fiscal capacity in general.

The importance of local fiscal capacity has been studied from various perspectives. For example, Zhang discusses the strong relationship between local fiscal capacity and provision of public goods[161]. This author adds that accessible public goods are an investment to support development in other sectors. A Chinese study, conducted by Uchimura and Jütting, demonstrated an association between local government fiscal capacity and improvement in the infant mortality rate[162]. However, higher local government fiscal capacity has its own hazards, particularly if funds are ill-used. Rather than supporting local health or other public services, higher fiscal capacity may induce local elites to allocate larger budgets for their own vested interests[163] or districts with a stronger fiscal ability may misuse funds to increase salaries of the local elite[164].

Nonetheless, local fiscal capacity has a considerable influence on local health programs. A respondent stated:

> "Yes, budget (*anggaran*) would follow (*mengikuti*) the program but to some extent the program must follow what resources are available…"
>
> *(K-6)*

The same respondent described how, in local districts with a relatively strong fiscal ability, budget allocation is relatively flexible:

> "At the moment for budgeting (*penganggaran*) we used output-based (*berbasis pada output*) as we have seen in the division of community health development (*bina kesehatan masyarakat*), disease eradication program (*program pemberantasan penyakit*), healthcare services (*pelayanan kesehatan*). Each division receives a portion of the budget based on their performance (*hasil kinerja*)…" *(K-6)*

In this case, performance referring to health indicators where better performance improves the chances of more funding from the local government:

> "…it is shown by the trend. The increasing (*peningkatan*) trend of public health indicators (*derajat kesehatan masyarakat*)…" *(K-6)*

Allocation of funds based on performance in *K-6's* district may give the impression of a carrot and stick approach to the budgeting of the local health program. This practice could possibly increase the disparity on health indicators between districts. The practice is feasible in only those few districts where local fiscal capacities are relatively strong. In most districts, the situation does not favour such practice. Most respondents in this study grumbled that their government has limited fiscal capacity, as expressed by respondents, below:

> "…you could see that we do not have sufficient (*tidak cukup*) budget to support all the programs that we had planned. Therefore, we still need the central-derived fund (*dana dari pusat*)…" *(J-6)*

> "…Our original income (*pendapatan asli daerah*) is pretty low. We practically depend on central government transfer (*dana alokasi umum*) to pay our local government staff salary. Consequently, not all divisions in our office will receive sufficient funds to operate normally. We have just recruited two staff for surveillance to develop our communicable disease surveillance and response, but unfortunately that has to wait as we could not allocate any funds (*tidak ada dana*) for this activity…" *(K-7)*

The lack of fiscal capacity means that local government often has to prioritise and make difficult decisions by supporting some activities and rejecting others. However, this does not mean that the cheapest program is automatically prioritised, as discussed below:

> "We developed a number of solutions due to limited availability of budgeted funds (*terbatasnya anggaran*). The solution that had the priority would subsequently be drafted (*dituangkan*) into an activity." *(J-9)*

Another respondent added:

> "The priority setting is not always easy to define. There are various considerations that need to be taken. Central government priority, local priority, available funds are some of the main considerations. What intervention we are going to use is also important. For each priority usually there were various programs being proposed. Of course we could not accommodate all. We have to decide which one is the most effective, not necessarily the cheapest…" *(J-8)*

The situation to which the above respondents referred is akin in principle to a cost-effectiveness criterion. However, most respondents in this study were not familiar with the term cost-effective. Rather, the term often used was 'most effective'. Thus, emphasis was mostly on effectiveness or output, and less on input such as cost. Cost-effectiveness is widely accepted as a suitable criterion for local health priority setting because it helps to allocate resources from ineffective to effective intervention. However, whether respondents effectively used cost-effectiveness specifically during priority setting was unclear based on respondents' explanations which were unconvincing and frequently contradictory, as exemplified below:

> "…for example, if we were given two different interventions to choose from with the same effectiveness, one expensive and the second one is cheaper, we will choose the cheaper. If the more expensive is more effective we would probably choose the one that is more expensive. However, we have not evaluated the cost of our program, why expenditure for a certain intervention is high and so on…" *(J-9)*

This respondent indicated that the process of local priority setting emphasised program cost compared to the maximum possible outcome, adding:

> "…what we did was we chose those programs that are cheap (*biaya rendah*), but with the best (*tinggi*) result." *(J-9)*

In practice though, the notion above is not always feasible. The most effective intervention often cost more than the least effective intervention. In other words, there are trade-offs between cost and outcome.

The effectiveness of intervention was considered along with cost, however determining effectiveness was not always feasible either, as described by a respondent, below:

> "…we have not measured the effectiveness of our intervention thoroughly. We should be but unfortunately we have not reached that stage. What we have done was identify if our performance on certain indicators is below target. For example for maternal mortality rate we refer to a number of intervention programs, one of them is K4 (antenatal visits). Regular antenatal visits, at least four times, could reduce maternal mortality rate. If the maternal mortality rate is high we then evaluate the antenatal visit program. Why the visit is low, what needs to be done, etc...?" *(K-1)*

However, when asked how the respondent could be sure that the K4 program was one of the most effective intervention programs to combat maternal mortality rate, the respondent was less confident:

> "…I do not know. May be it is based on the World Health Organisation. But I am sure that it is based on empirical study…"*(K-1)*

A similar situation was described by a respondent when asked about the effectiveness of the local malnutrition program:

> "Usually we provide food supplement for a month through the *puskesmas* or *posyandu*. In principle (*pokoknya*), it depends on our ability to visit the area, we will provide counselling, food supplement, milk and so on. If you ask me whether the intervention is effective or not, I could only say sometimes it is effective…" *(K-9)*

Local health program priority setting is not all based on unsound judgment. The situation in districts is complicated. Some respondents indicated that a lack of resources, poor coordination or a lack of concern impact on the development of a health program. My observation is that some programs are selected based on the fact that the program has been implemented for many years. Thus, given the longevity of the program an examination of effectiveness is overlooked. This was particularly true for programs that are funded by the national government where the interventions are implemented based on what has been dictated by the central government. Some programs may be based on a well thought consideration, such as research evidence or local experience. However, economic evaluation in local program priority setting currently has a limited role as is the case in other countries, as pointed out by Togerson[165].

This study uncovered a number of examples of programs initiated and supported by external funds which were not sustainable. One example was the district health account, a program funded by the World Bank to provide a health-related data base in a number of districts in Central Java and Yogyakarta. The program developed a wide range of information useful in health program evaluation. However, the initiator of the program ignored the sense of self-ego and individuality that each technical office has that often hinders effective coordination between the district technical offices. The situation subsequently resulted in termination of the program. Thus, an unsound basis for local health programs results in ineffectiveness, and even disastrous results, as described by a respondent:

> "…we had a program providing iodine for pregnant women. Usually we gave the capsule to every pregnant woman through the *puskesmas* or *posyandu* (community-based early childhood health services). But from research that was conducted locally we now know that not all pregnant women need the capsule. Only those pregnant women with low iodine require taking the capsule. The others who have normal or excess concentration of iodine have the risk of experiencing miscarriage or premature delivery when taking the capsule. We have used the finding of the study as a reference. It has had a significant impact on the number of stillborn in this district." *(J-16)*

Unfortunately, local decision makers are not often exposed to the latest research findings. Local government ability to fund and conduct research is limited and little research is undertaken in the local context.

A participant describes the problem:

> "…we need to access more research for our program evaluation. For example, there is an interesting situation in this district where the maternal mortality rate has increased despite improved health facilities better access to health services, abundant doctors and midwives, and the health coverage program. We have tried to identify and map the problems, but I am not sure that it is accurate enough…" *(J-16)*

It is also evident that many studies conducted by local universities are seldom made available to local decision makers, as implied by the respondent's statement below. In addition, priority setting and decision making can be described as impulsive:

> "…it was not extraordinary that at times the head of the office decided to support an activity that was not even our priority. Usually it was triggered by a recent trend or phenomenon. Just like during avian influenza last time, he impulsively decided to support a local campaign on avian influenza. I know it was necessary to take precaution, but we did not really know the situation back then and we had finalised our work plan. At the last minute we had to sacrifice (*mengorbankan*) other priorities because of his impulsive decision (*mendadak*)…" *(J-10)*

Personnel interest in a program *titipan* comes into play here. Prominent local elite can interfere in the priority setting process, particularly the *bupati* during program development or the House of Representatives during the costing negotiation session.

4.2.2.4. Cross-sectoral Cooperation: Support and Challenges

Cooperation with other offices within a district is another alternative option for considering local government budget constraints, as indicated by one respondent:

> "...as for family planning it is under joint coordination with the BKKBN (National Family Planning Coordination Board). We report it, but it is funded and implemented by the BKKBN..." *(J-6)*

This is also indicated by another respondent:

> "…not all activities (*kegiatan*) would be part of heath office work plan (*rencana kerja*). We would trace (*menyusuri*) our other technical offices (*satuan kerja perangkat daerah*) that could cooperate in conducting some part of the proposed activity…" *(J-9)*

In fact, cooperation between local government's various technical offices is encouraged by local government with the establishment of *Satuan Kerja Perangkat Daerah*, or SKPD, a forum for all local government technical offices to prioritise and synergise their respective work plan with findings from *musrenbang*, or the development planning session and to initiate cross-sectoral cooperation if possible, as described below:

> "...the result from *musrenbang* will be matched (*dicocokkan*) with the program priority proposed by the technical offices, including the health office, will be finalised in forum SKPD." *(J-18)*

The notion that government affairs cannot be conducted separately within each sector was emphasised by most respondents, as expressed below:

> "...for certain we could not tackle health problems without cooperation with other local technical offices. The problem with the relatively the high infant and maternal mortality rate in this district for instance

> should be handled comprehensibly *(tidak setengah-setengah)*. The future mothers and fathers for example should be better educated to equip them with sufficient knowledge as parents and for that we need to cooperate with the education office (*dinas pendidikan*)..." *(J-6)*

Another respondent stated:

> "...our promotion for healthy lifestyle for example, it could not be the responsibily of the health office alone, but it must be supported by other offices in the government. We have limited resources for such a big responsibility..." *(K-4)*

Cooperation between different technical offices is encouraged by the local government, facilitated by the Local Planning Board or *Badan Perencanaan Pembangunan Daerah*, better known by its abbreviation *Bappeda*. However, even though cooperation is possible, it is very difficult to accomplish. One respondent stated that the reason cooperation is difficult was the ego of each sectoral office:

> "...it is because of the sense of ego and individualism that each office has. They tend not to accept other offices' advice including during the forum SKPD. At the end, each office will implement their program separately..." *(J-14)*

In the researcher's experience there are two other possible reasons that it is difficult to build cross-sectoral cooperation. First, when a program priority is presented in the forum SKPD, it has previously been agreed internally by each technical office. Therefore, it is difficult to shift priorities since they are related to budget allocation. An alteration affects the compromise made internally, including regarding the allocated funds, between different subdivisions in each technical office. Thus, a major alteration disrupts the 'harmonious' resolution arranged beforehand. In this study I did not secure the data

to support this observation, but one respondent statement indicated that this may well be the case:

> "We decide our health program based on the priority and urgency. However, we still allocate some funds for the least prioritised. Maybe not that much but we have to allocate some portion for these activities (*ra ketang sithik ning keduman*). They could not be left without any budget could they?" *(J-8)*

Second, this rigidity is related to local government accountability. For this purpose of accountability, the central government has established a list of indicators, called *Standar Pelayanan Minimal* or minimum standard services, which lists public services that local government must provide, as mentioned by a respondent:

> "We report our performance to the central authority using the SPM, therefore we also refer to it in developing our health program" *(J-9)*

According to Law No 32/2004, with a specified minimum standard of service local government performance would be more measureable and at the same time have a sense of focus for work priorities (The SPM will be further discussed in Chapter 6). However, as performance indicators were developed exclusively within each sector, there was minimal effort among local offices to relate to each other's indicators of performance.

4.2.3. Public Participation: Promoting Public Involvement in Government Program

Along with promoting local government initiative, the policy of decentralisation has also prompted community-based approaches to developing government programs. Public participation is said to increase government accountability and transparency, as highlighted by Bräutigam[166] and Bishop and Davis[167]. In addition, as pointed out by Anderson *et al* [168], allowing the local community to take part in government decision

making increases government responsiveness to local needs. However, whether this is the case in practice remains to be proven, particularly in developing countries. A study conducted by Boulding and Wimpler showed that public participation slightly increased local government spending in health and education among Brazilian municipalities, but there was little evidence that this spending materialised in local health and education indicators[169]. Another study, conducted by Besley *et al*, showed a positive relationship between participation and local program responsiveness among villagers in *Gram Sabha* meetings in India[170]. However, other studies delivered different findings, such as a study conducted by Francis and James in decentralised Uganda where public participation did not improve accountability or improve public services[171]. According to Speer[172], the absence of strong civil society, rampant poverty, lack of central government active support and people's relatively low capacity to engage with public discourse contribute to the problems of public participation in developing countries.

One well-known community-based program in Indonesia was the *Progam Nasional Pemberdayaan Masyarakat* or National Program of Community Empowerment (NPCE). Initiated by the central government as a poverty eradication program, the NPCE encouraged active community involvement in developing a customised program, from identifying local needs through implementation and evaluation. A similar mechanism was designed for public participation in developing local government programs. The mechanism specified two forms of public participation: the *musyawarah perencanaan pembangunan* or development planning session and *penjaringan aspirasi masyarakat* or procuring community aspiration and each is described below.

4.2.3.1. Musyawarah Perencanaan Pembangunan or the Development Planning Meeting

In terms of developing local government programs, district government facilitates discussion sessions at the village level, sub-district level and district level in order to provide the wider community a voice in local policy. A respondent stated:

> "…from *musrenbang*, or development planning meeting, consultation (*musyawarah*) with the community from the lowest unit (*paling bawah*), from hamlet (*dusun*), village (*desa*), and sub-district (*kecamatan*) up to district (*kabupaten*)…" *(J-2)*

Community participation is a laborious process as discussion sessions must be accomplished in a relatively short period of time, from January to March every year, as described below:

> "We have just accomplished our *musrenbang*. Usually we have around one month to complete it, but this time we have started a bit late. I was particularly busy as I have to facilitate the meetings in the villages..." *(J-7)*

In regard to healthcare, the community encompasses lay persons and professionals, such as physicians from local *puskesmas*, midwives, health-related NGOs, the physician's association and, representatives from the local hospital. Development planning meetings are designed using a participative approach where members of the community can meet and discuss local development, assess their needs, propose problem solving and identify short term priority programs. Meeting results are amalgamated into a higher level session with outputs from other areas to be further synchronised and prioritised. The bottom-up process was initiated to improve the absorption of public aspirations.

However, public involvement in local decision making has not been accepted as necessary by some study respondents, as suggested below:

> "… [The] public could not understand much about public health program (*orang kesehatan saja yang tahu*) if it is too technical. Therefore, during *musrenbang* they do not understand (*tidak tahu*). What they know was mostly about infrastructure (*sarana prasarana*). However, it could still be considered as part (*sebenarnya juga*) of the public health program…" *(K-2)*

The important role of local facilitator during *musrenbang* was not totally understood by study respondents. The local facilitator is supposed to explain concepts and events in words that the local public can understand and debate, however rather than facilitating the process of community involvement, some misjudging of public ability to understand concepts is apparent, particularly at the village level, and this kind of misunderstanding seems to be widespread[173]. As a result, not everyone can participate freely in the activity or only 'selected' people[174] are invited, as implied by the statement below:

> "…in *musrenbang* for health, public participation is limited (*tidak banyak dilibatkan*). The data comes from the community, but the contribution of musrenbang in developing local health program is limited. I could say local community did not involve and influence much (*tidak terlibat*) in local program…" *(K-2)*

Study findings suggest that the mechanism of public participation was not totally embraced by some respondents. This does not mean that these respondents consider *musrenbang* unimportant, but as stated by Joko Widodo, now the president of Indonesia and previously the governor of Jakarta, the mechanism of public participation has become merely procedural and therefore uninteresting[175]. Participation has become

monotonous where the emphasis is not on the result itself but more on the process, like ticking the box that it has been done regardless how effective or meaningful.

Another aspect of *musrenbang* that could potentially result in participant's lack of excitement or engagement is the loss of some proposed activities due to the hierarchical nature of the process. For example, after the village level of *musrenbang* proposed activities are brought to the sub-district level and reassessed along with the proposals from other villages. During this process some initiatives from the local government level may be overlooked and misplaced[176]. On average only 30% of the proposals from *musrenbang* are realised[177]. The problem is that there is no assurance that the other 70% of proposals have been considered.

> "…I have to admit that for some the process might become tedious (*membosankan*). The general public (*masyarakat*) does not know that we could not accommodate their entire proposal, it is just not possible. What we should have done was to publicise (*mengumumkan*) which proposal has been implemented and which has not been done. Therefore it will be clear for the public. Recently, we have started doing this." *(J-18)*

4.2.3.2. Gathering Public Aspirations

Penjaringan aspirasi is another mechanism to hear public aspiration. Where *musrenbang* is facilitated by local government, in this case the executive, *penjaringan aspirasi* is facilitated by the local legislative body. In addition, where *musrenbang* is conducted based on administrative unit such as village, sub-district and district, *penjaringan aspirasi* is conducted based on each legislative constituency, as described below:

> "…the other outlet came from the House of Representatives (*dewan*) during their recess, the time for embracing aspirations (*penjaringan aspirasi*) from each legislator. Initially, the inducement (*kail*) came from us. Automatically if we go to the community they would raise their concern (*menyampaikan aspirasi*). What kind of program they need (*butuhkan*), healthcare (*kesehatan*), education, infrastructure etc…" *(K-2)*

The aspirations of the legislative constituency (as this respondent put it) would match or at least be in line with public aspirations from the *musrenbang* and the local government-initiated program.

> "…we wish that both outlets would match (*bertemu*). They [the results from *penjaringan aspirasi* and *musrenbang*] would meet in the activity and program formulation (*perumusan*) when we developed the local government revenue and expenditure (*APBD*)…" *(K-2)*

Discussion with respondents indicates that the activity of gathering local aspirations may potentially have greater impact if the mechanism of *penjaringan aspirasi* was used rather than *musrenbang.* Legislators can influence the *bupati* or the head of the district health office more effectively and persistently, as described by a respondent, below:

> "…it is common for legislators (*anggota dewan*) to approach us. Lately it was regarding the *jamkesda*. They were concerned that some of their constituents could not access the program…" *(J-6)*

The relationship between legislators and constituents was more direct, as compared to participants of *musrenbang* with the district government as the facilitator. The consequence for a legislator of not supporting public demand is low popularity in the

next election. Legislator perseverance was described by a respondent in the following remark:

> "…a number of legislators phoned me some time ago to allow one of their constituents to receive the government free health program. I just do not get it. We have discussed it (*membicarakannya*) before and they agreed (*setuju*) on the rule (*peraturan*) that everyone will receive the free health service only two months after they are registered…" *(J-1)*

Another respondent stated

> "I would not say it could be classified as a lobby. I saw it as a discussion where we exchanged ideas (*tukar pikiran*). Of course they have their own opinion and I also have my own opinion. It is understandable; they have constituents to take care of (*perhatikan*)…" *(J-13)*

A local legislator commented:

> "Surely we will do our best to accommodate our constituent aspirations. It is our job and responsibility to fight (*memperjuangkan*) for their aspiration…" *(J-3)*

In contrast to the statements of respondents presented above, a study conducted by *Bappenas*, the National Planning Board, found that local legislators have relatively low accountability towards their constituents based on performance measures including the number of visits and reports[178]. A similar study conducted by the Indonesian Parliamentary Centre found that legislators failed to promote the public interest[179]. This low accountability of legislators is due to a combination of reasons including the absence of pressure from local stakeholders, lack of public awareness, lack of clarity in laws and regulations and reluctance from legislators and the House of Representatives to

provide better communication with constituents. The role of public participation is discussed further in the next chapter.

4.3. *Jamkesda,* the Local Health Coverage Program: a Local Initiative

Along with describing local actors, this chapter shows how local procedures, such as program evaluation, public participation and political process, have shaped local health programs and policy in Indonesia. In addition, local health programs and policy are also determined by, among other things, local government commitment and local financial resources. These aspects of local health programs suggest that local health policy and programs are the result of interaction between policy content, local actors, context and processes, as identified by Walt and Gilson[180], rather than clear cut sequential stages of agenda setting, formulation, implementation and evaluation as suggested by Brewer and deLeon[181]. This issue is further addressed in the next chapter.

The localised process of decision making and empowerment of local government has polarised local self-identification through consolidation of local identity. Brown highlighted how local identity, be it ethnicity, religion or socio-historical characteristics, has strengthened with the introduction of decentralisation[182]. For some ethnic groups the policy of decentralisation in Indonesia presented an opportunity to reposition their ethnicity in a unitary state. The overt expression of ethnic identity and other potentially divisive activities, in Indonesia abbreviated as *SARA* (ethnic, religion and race relations), let alone politicking, and were prohibited by the New Order regime in the name of national unity. However, as the central government position weakened with the introduction of decentralisation, local elites used local symbols to revive localised solidarity and identity. This was particularly visible in the tendency of the on-going '*pemekaran*' or proliferation of provinces and districts frequently based on ethnic and

religious lines[183]. The new districts and provinces, even among those that appeared to be genuinely committed to improving public services, subsequently strengthened ethnic identity, as shown by Seitte[184] and Hasanudin[185].

The most visible expression of ethnicity as local identity is shown during local elections where candidates accentuate closeness to local voters by using local symbols, such as dress, language and traditional ceremonies, as discussed by Duncan[186] and Buehler[187]. In more heterogeneous districts and provinces though, election candidates (*bupati* or governor) are deliberately selected to reflect the two major ethnic groups or religions in that particular district or province. It is a common sight during local election campaigns to see the candidates' portraits in public spaces wearing local dress or religious symbols to emphasise shared ethnicity or religion with most voters in the area.

4.3.1. Developing the Jamkesda

Local identification by emphasising factor, in particular ethnicity, was not always relevant and workable. Aspinall[188] suggests that the waning of ethnicity as local identity was due to the absence of ethnic and regional parties, with the exception of Aceh, and ineffective institutionalisation of ethnicity at the local level. Erb and Sulistiyanto argued that while ethnicity was still regarded as an important mobilisation force in local elections, there was a gradual shifting to other factors, such as candidate performance, programs, media campaigns and links to local power structure[189]. A particular health program of interest was the *Jamkesda*, a local government program that aims to assist the public in paying their health care costs. *Jamkesda* was started from various local government initiatives to assist the public in accessing health services, as described by a respondent, below:

> "...we used to give some contribution (*bantuan*) for anyone who was sick. They just needed to show their ID and they would receive 5 million IDR. However, the central government forbade this practice..." *(J-1)*

It seems this was a common practice. A different respondent from another district stated:

> "...previously we have various grants that we allocated for different types of programs. We gave scholarships for students and donations to those who were hospitalised. But this program has ceased as the central government prohibits all programs that provide direct grants to the public (*bagi-bagi uang*)..." *(K-14)*

The initiative to provide this type of assistance was partly a response to the central government program of *Jamkesmas*, the central government health coverage program for the poor, which started in 2004[190]. However, the discourse about a more accessible health service had already drawn attention from local government and the public. One of the pioneers in developing the health coverage program was the district of Jembrana in Bali that initiated a free basic health and dental service in 2003. Later this innovation was imitated by other districts into a number of health coverage schemes. One district in this study provided free basic health services in *puskesmas* and free referral health services that are assessed as being needed provided the patients agreed to receive the treatment in class three, as described below:

> "…since we launched *jamkesda* all basic health services (*seluruh pelayanan dasar*) provided by *puskesmas* are free (*kita tanggung*) without any cost-sharing. As for referral services (*rujukan*) we offer packages. If the treatment was performed in class three (*kelas tiga*) of a district public hospital (*RSUD*) or equivalent (*setara*) to it we would cover the treatment 100%..." *(J-1)*

Another district contributed five million rupiah per year for each resident to be used for accessing health services. However, if the fund assigned for each individual is exhausted they have to find other sources as explained by a respondent:

> "…the rest of the district population not covered by central health insurance (*jamkesmas*) and provincial health insurance (*jamkesos*) will be covered by the district health insurance. We call it universal health insurance (*jamkesta*). It also covers the well off (*tidak miskin*) as long as they agree (*mau*) to the intended facilities, the third class (*kelas tiga*) if referred to hospital and must be referred from a *puskesmas*. We could not contribute much because our fiscal capacity is not as strong as some other districts…" *(J-13)*

Still another district targeted low income or near poor families not covered by the national *jamkesmas* program. The coverage is to be expanded to reach the whole population in the future:

> "…with the presence of a technical unit (*unit pelaksana teknis*) called *jamkesda,* low income residents (*penduduk miskin*) are entitled (*dijamin*) to healthcare coverage. It is expected (*harapannya*) that in the near future it could be total coverage…" *(K-7)*

The idea for these schemes often attributed to the *bupati*, as expressed by one of the respondents below:

> "...our exceptional (*unggulan*) health program is the *jamkesda*. It was initiated (*diusulkan*) by our head of district to assist the public..." *(K-6)*

Another respondent had the same opinion:

> "...our *bupati* had the idea (to provide affordable health services) from other countries. He envisioned having a robust health system where local citizens would not have to worry about hospital fees whenever they need it. It would be less catastrophic ... *(K-1)*

However, the *bupati* is not the only factor that contributes to the idea of providing health coverage. As pointed out in the statement above, decentralisation brings more opportunity for comparative studies and training and better information that contributes to the idea, as described by another respondent below:

> "…I have the vision (*bercita-cita*) to transform public services in this district just like in Singapore. Some people think that I am daydreaming but it is possible you know. We are working on it. Sending our human resources to study and train abroad…" *(K- 5)*

One particular respondent claimed that it was their idea to initiate the *jamkesda* program in the district, and the respondent was not a *bupati* nor a legislator:

> "...I was promoted in this office because of the breakthrough (*terobosan*) that I have initiated with *Jamkesda*. It was not an easy process. I was fortunate because I was working at the *sekretaris daerah* (the *bupati's* secretariat) back then. Therefore, I have access to the *bupati*. It was not easy convincing him as we have a limited budget. But I never gave in because we have to start or we never have a chance (*harus dimulai dari sekarang*). We need to take the risk. I approached different stakeholders, after the *bupati* gave his approval I went to discuss the importance of the program with the legislators. Their support was crucial in order to regulate the program (*di-perdakan*). There was plenty of opposition. Even the doctors were sceptical (*menganggap jualan kacang saja*). They were concerned that with the system they would be underpaid..." *(J-17)*

According to the respondent, the key to success was to persevere with the program and to gain the interest of local elites. The most important support was from the *bupati* and local House of Representatives, particularly for a program that required a considerable amount of financial support, such as *jamkesda*. The respondent added:

> "…both the *bupati* and the legislators are politicians and just like in any other professions they would like to stay in office as long as possible. However, the nature of their office depends on public electability. They need to be relevant (*nylondoh*) to public interest. That is why this type of program would definitely be of interest to them…" *(J-17)*

This respondent further explained how legislators in particular would claim the respondent's idea and work as their own:

> "...any program must be mutually beneficial. If any of them claim that it was theirs, I do not mind. It happens occasionally. When I was working for the local House of Representatives I used to assist local legislators to find additional funding from various ministries. In the Ministry of Health they have what was called non-quota expenditure. I could get 60 million IDR, 40 million IDR, the last one was 38 million IDR to assist patients who were not covered by any health coverage or for those whose coverage had dried up. Local legislators always claimed that it was their efforts (*iki lho tak usahake neng Jakarta ben gratis*). Sometimes we need to let them do what they want to do (*terserah mereka*) as long as my idea could be implemented..." *(J-17)*

This respondent, *J-17*, presented an example of how ideas and initiatives become known and later developed and consented to. The approach of *J-17* was culturally appropriate. By sharing the idea of the *jamkesda* program or other programs with legislators and *bupati*, everyone becomes engaged (*diajak rembugan*) and treated according to their

position (*diwongke*). This is very important in a hierarchical society, such as Indonesia, where new ideas and opinions from subordinates can be considered to transgress higher authority. The practice of engaging with stakeholders also suits the idea that decisions should be discussed in deliberation with stakeholders, or in Indonesia called *musyawarah*, so that as many concerns as possible can be addressed, as described below:

> "…I have to share my idea with key figures (*tokoh kunci*) in the district. It was for the practical reason to get their support, but also so that they do not feel that I have ignored (*mengabaikan*) them…" *(J-17)*

In terms of the local House of Representatives, by continuously giving favours to legislators *J-17* was, according to Fahmi *et al*[191], 'taming' the legislators. As many study respondents are from Java where owing favours is an uncomfortable feeling they try to repay a favour as soon as possible[192]. The respondent admitted that this was his intention:

> "...in this way every time we need support they will readily say yes (*mereka siap*). If I request to fund programs such as jamkesda or *beras miskin* they will throw their support without thinking twice (*tanpa berpikir dua kali*). They would not fuss (*tidak model corat-coret*) for this kind of program. As long as it is for the poor they would totally agree (*bulat-bulat*) whatever the budget is..." *(J-17)*

The local government does not approve any pro-poor program unconditionally, as local governments have financial constraints. However, the health coverage program or *jamkesda* was often used by politicians, *bupati* and legislators alike to gain voters during an election[193]. A respondent commented on this phenomenon:

> "…they were using health programs as campaign material because health programs are attractive (*gampang menarik perhatian*). People are easily lured with promises of free health services. Sometimes it is not even a local health program; it is a central health program. But people seem to be unaware of it…" *(K-7)*

The intention of *bupati* or governor to project an image as if local government provides a free health service is common as a vote buying strategy. It was confirmed by a respondent that:

> "…whenever the *bupati* goes public promotion (*sosialisasi program*) he always mentioned about the *jamkesda*. Unfortunately, he often overstates (*kebablasen*) the program as free health services while it supposed to be free basic health services. I could only remind him gently (*mengingatkan pelan-pelan*)…" *(J-1)*

Another respondent stated:

> "…it (the concept of free health service) is indeed very appealing (*menarik*) to receive public support. The politicians know how programs such as free education and free health services could easily lure public votes. The public are interested everything that is free…" *(J-10)*

There seemed to be different roles in the local health program between *bupati* and legislators on the one hand, and health practitioners in the district health office on the other. While *bupati* and legislators tend to use the health program as a vote buying strategy by providing generous funding, the district office acts as a controller and is more cautious with local capacity in terms of human resources and fiscal capacity and is not directly concerned with public demand regarding issues like the possibility of free health coverage. However, as pointed out by Fatmawati, some local governments did

realise what they have promised during the campaign and a number of them were fairly successful[194]. The key was to use local resources efficiently and effectively and to this end the role of district health office was very important. In terms of *jamkesda*, the program has expanded health cover that was only partly achieved by the central government health cover, such as *jamkesmas* for the poor, *askes* for government civil servant, *jamsostek* for formal workers and *asabri* for the military personnel. According to National Health Ministry data, the *jamkesda* has contributed to health cover of around 33 million people, or approximately 14% of the population in 2011, while central government schemes accounted for slightly over 50% of the population[195]. However, health schemes, including central government schemes, have so far has not reinforced the quality of health care, as pointed out by Aspinall[196].

4.3.2. Potential Conflict with Central Government: Jamkesda as a Local Distinctive Feature

The description above shows local dynamics in developing *jamkesda* as a process developed in the district between local actors following decentralisation. Furthermore, *Jamkesda* has been established as one of the most visible local health programs in Indonesia. It is reasonable that some local governments, as mentioned earlier, considered this as one of their leading health programs. In addition, unlike other principal health programs, *Jamkesda* is neither directly related to central minimum standard indicators nor is it associated with the central government. Therefore, there is strong attachment between local government and *Jamkesda*. The program has become a distinguishing factor between districts, but also for the central government.

The problem started with central government initiative to implement the *Sistem Jaringan Sosial Nasional* (SJSN), or the National Social Security System, that incorporates universal coverage for health care. The concept was not new to most local

stakeholders as it was already authorised by Law no 40/2004. Therefore, the concept of universal health cover precedes any local initiative on *Jamkesda*. In fact, many local regulations (*peraturan daerah*) that deal with Jamkesda refer to Law no 40/2004. As the central government has the capacity to develop the system, local government has shown initiative to develop health care, as expressed by one respondent below:

> "…it was urged by SJSN that we must develop a health coverage program in order to achieve universal coverage…" *(K-1)*

When the central government effectively implemented the program starting on January 2014 local government was anxious. The timeline of *Badan Penyelenggara Jaminan Sosial Kesehatan* (BPJS), or the executive body for SJSN, stated that local *Jamkesda* would be merged into the national program starting as late as 2019. The feeling of unease was apparent among some respondents. One respondent expressed their concern:

> "I don't get it why the law on SJSN does not mention the local government role. Does central government have the capacity to handle (*mampu menangani*) it by themselves? Why don't central government allow those local governments that have the capacity to continue (*memberi jalan*) what they have started?" *(J-1)*

Another respondent suspected that *Asuransi Kesehatan* (ASKES), or the national health insurance for government civil servant and their families, was behind this program, as expressed below:

> "…we still have a lot of questions on the arrangement (*penyusunan*) of BPJS. We have thought that this was the idea of ASKES to monopolise the system…" *(K-1)*

However, it was the new program of *Kartu Indonesia Sehat*, or the Indonesian Health Card, initiated by the new president, Joko Widodo, that triggered some local government rejection of the program. Particularly when some central government legislators started to demand the abolition of *Jamkesda* by 2015 as the local program was alleged to increase blinkered local feelings and restrict wider public access to health services[197]. One *bupati* from a district in this study refused the program as the *bupati* alleged that the central government program coverage would not be as comprehensive as the local *jamkesda*. In local media the *bupati* expressed the following concern:

> "I doubt that the program will be implemented in this district. We have our own programs, free education and *jamkesda* to cover local residents with an ID card (KTP). I doubt that the program offered by the central government is better than ours. For example we have covered the treatment of one of our residents who got lupus (systematic lupus erythematous) and that cost 600 million IDR. Will the central government pay for that?"[198]

The *bupati* added:

> "…we have allocated one midwife to every village, and for a member of *Jamkesda* if the local hospital could not treat them, we could refer the patient to Samarinda, Balikpapan, or even Surabaya and Jakarta for free…"[199]

Another respondent made the following statement:

> "Why does the president have to interfere in our program? We are the ones that have to take care of local health affairs, not him…" *(K-14)*

Some view this strong opposition to be a result of political alliances. However not all *bupati* who oppose the central government program are from opposing political parties,

at least one came from the ruling party[200]. A number of local stakeholders were concerned that, instead of developing the already existing SJSN-BPJS, the president initiated a new program which for some local governments was seen as self-imaging of the president, rather than introducing anything new or improving the existing program[201].

4.4. Conclusion

Based on the information provided to me by the respondents which I have analysed using the framework approach, I am able to reach several conclusions regarding decentralisation and the development of local health programs. Decentralisation has introduced a bottom-up process, in addition to the top-down process, in developing local health programs. Finding out about local public aspirations was facilitated through the mechanism of *penjaringan aspirasi* and *musrenbang*, where development planning sessions were established throughout the villages and sub-districts to cover the wider communities and interests. However, in practice the bottom-up process has been less effective and less defining compared to the top-down process. Public participation in local decision making remains limited, while the local government plays a larger role.

There are three main actors at the local level that share the responsibility in developing health programs and policies: *bupati* and district House of Representatives that determine local health policies and district health office that implements the policies into applicable programs. However, in practice the development of local health programs was more dynamic and influenced by numerous factors.

The first factor was local capacity. Decentralisation has devolved the authority to plan, develop, and implement health program to local governments. However this does not mean that local ability to carry out the authority has moved at the same pace. There is a

strong indication that local actors' capacities were unevenly distributed. Local staff opinion on health programs for instance is based on routine practice and assumption rather than well thought consideration. This is particularly visible as many health programs were dictated by the central government. Therefore, examination of effectiveness is largely overlooked. The strong paternalistic system has also influenced how a local health program is developed. The practice of reliance on seniority, not always in terms of age but more on position, rather than individual capacity has tended to hamper the process of decision making. Instead of direct discussion, any new idea often has to go through a lot of exchange talks just to make sure that the senior office-holder be it the head of district office or *bupati* is well informed and does not feel left out.

The second factor was political process. Even if a local health program has gone through a proper evaluation and priority setting by local government, the final decision will depend on the political process in the local House of Representatives. The roles of local legislators were therefore important in supporting local health programs. This support is manifest in the local regulation and financial provision, both of which are known as local commitment. The process relies on negotiation between *bupati* and local legislators. This situation has made the political process a profound factor in local health decision making. This is particularly true for any program that has a high appeal for the public such as *jamkesda*. In fact both the *bupati* and local legislators were the driving force behind this prominent health program.

Jamkesda is one of the few local health programs that are less associated with the central government has contributed to two local impacts: public preference in electing the *bupati* and the strengthening of local feature. In terms of public preference in local elections, local solidarity through shared ethnicity and socio-historical background

which used to be crucial in local elections has shifted to local programs, such as *Jamkesda*, that have more profound and real benefits to the public. The importance of ethnicity and socio-historical background has not gone away. However, their role has diminished considerably in local politics particularly in the eight selected districts in this study.

The other profound effect of *Jamkesda* was the strengthening of local feature. The initiative of central government to implement the national health coverage program of *Kartu Indonesia Sehat* has received strong opposition, particularly from well-funded districts. In these districts, local government has invested a large amount of funds to support the local health system, particularly *Jamkesda*. This program has served as distinction of local program from the central government program. Local government distrust of central government program effectiveness and comprehensiveness and doubt that the program will bring significant improvement to the current system were some of the reasons expressed by respondents in this study. For the moment it seems that these views have aggravated local elites. Whether the same sentiment is shared by the larger public remains to be seen.

Chapter 5

Local Health Policy and Programs:

Factors Influencing Local Interpretation

Chapter 4 has described how the policy of decentralisation has been put into practice, analysing local government initiatives in developing health programs and the bottom-up approach where public aspirations are planned and proposed; and how both processes have contributed to local health programs such as *Jamkesda* that subsequently bolstered local identity amidst the weakening of traditional allegiances. This previous chapter has discussed local government discretion as the result of negotiation between different local actors. In this chapter, local discretion is examined through several local government interpretations of particular central government policies, namely the moratorium on local government civil servant recruitment, district to district cooperation and the commercialisation of local public hospital. Differences in interpretation and practice between districts are influenced by local fiscal capacity, local leadership, locally specific conditions and the urgent need for more health personnel.

5.1. More than Local Initiative: Local Health Policy Decision Reflecting Varying Interpretation

An earlier study of Indonesian decentralisation by Toyamah *et al*[202] argued that there were no significant differences in implementation of decentralisation across districts, whether due to local fiscal capacity or proximity to central government. The authors claimed that a more visible difference can be found between the districts and provinces.

Districts tended to be more enthusiastic than provinces as they were designated with more independent authority. However, after a decade, differences between the districts have become apparent during my interviews. Indeed, Podger[203] had noticed such differences between districts from an early stage of implementation. Differences in implementation of decentralisation across districts were likely due to differences in interpretation of central government policies and decentralisation-related laws as highlighted by Eilenberg[204]. This was a manifestation of local government initiatives to meet local needs and other locally-related context that will be further discussed in this chapter on the central government policy of a moratorium for local government civil servants.

In discussing the theory of the policy-administration dichotomy, Goodnow[205] divides government authority into two different roles: politics and administration. According to Goodnow, politics is defined as the formulation of public policies or the formulation of the expression of the state, while administration is related to the implementation of public policies. In relation to this division, the separation of government powers into legislative, executive, and judiciary is the basis for the division of politics and administration. The legislature assisted by the judiciary interprets state intentions while the executive administers public policies in an equitable manner, impartial, and apolitical.

In reality, overlap in implementation between politics and administration is unavoidable. The president and the *bupati* hold a political office. White[206] defined the interrelationship between politics and administration as interpenetration where the division of government authority is not an absolute separation but rather a division that requires strong cooperation so that the implementation of public administration can run

well. In the Indonesian context of decentralisation, the situation is a little bit more complicated as in practice there are two levels of political and administration process, in central government and in local government. The authority for state policy formation is in the hands of the national House of Representatives and the president after being formulated and discussed with the ministries. The president with the ministries would be responsible for the administration of the state public policies by providing operational regulations that are in line with the state policies in the form of implementation (*petunjuk pelaksana*) and technical guidelines (*petunjuk teknis*). These guidelines are then used by local governments as references for carrying out their public administrative function.

At the local level, a similar political and administrative process is underway on a smaller scale to accommodate local aspirations and objectives. Differences in interests and points of view exist between actors at the centre and actors in the local political process, at times requiring *bupati* as the person in charge of local administration to interpret central government policies.

In addition, the need for local interpretation could also be attributed to the fact that there was no transitional period or time-gap for local government to equip themselves with the necessary skills or for the central government to provide public education for such drastic changes. To assist local government, the central government issued government regulations, or *peraturan pemerintah*, which provided technical guidelines for implementation of these laws. However, even these guidelines were not sufficient to anticipate local specific challenges as expressed by a respondent below:

> "...the central government treated us (the district) as though each had the same condition and problems. Of course that is not true. What has been the challenge we are facing here will be different from what can be found in the districts of Java or West Papua. It is not reasonable (*masuk akal*) that the central government treated us the same way. There should be specific laws for certain regions that share certain traits, not the same law applying across all districts..." *(K-11)*

Another respondent added:

> "…regulation should not be applied (*berlaku*) nationally. It should be applied regionally. For example Jakarta and the surrounding areas should have a different set of regulations from Yogyakarta or Papua. The social-economic condition is different as well as the challenges and prices…" *(J-10)*

The momentum for different central laws for different districts was apparently desirable despite not being appealing to the central government in its strong stance to uphold Indonesia as a unitary state. The most recent central policy that could be related to different central laws was the special autonomy given to Papua and West Papua in 2001, Aceh in 2001 (further defined in 2006) and Yogyakarta in 2012. However beyond that central government seems reluctant to give any more special autonomy to other regions. Central government has emphasised that Indonesia has actually implemented asymmetric decentralisation since the birth of the republic with special regulated regions call *daerah istimewa* among the general administrative units of provinces and districts. The acknowledgement of special regions was a compromise between those who supported unitary as compared to federal states[207]. However, the number of these special regions has been gradually reduced and those special regions that survive have most of their power curtailed. Therefore the existing special regions before *reformasi*,

the Special Region of Aceh and the Special Region of Yogyakarta are special in name only.

Change from a centralised to decentralised system was so abrupt that for some respondents, it was an uncertain process:

> "…it was full of uncertainty (*penuh ketidakpastian*). We were not used to having such authority, particularly the authority to allocate our own budget. In the past we also had some sort of discretion but we had very limited (*terbatas*) access to funds. At times we are just not sure whether we have done the right thing. Did we exceed the authority that was given to us? The regulations provided by the central government often overlapped between departments making us unsure which to follow…" *(J-13)*

This situation was particularly apparent in the first years of implementation, during which time some respondents felt they as though they were left to figure things out for themselves. It was not that the respondents did not like the idea of having their newly acquired powers, but it was unprecedented during the last thirty years under the New Order regime. One of the respondents pointed to the struggle they went through after being left unguided and expected to learn on their own. The respondent described it as a 'learning by doing' process:

> "...however, as structural officers (*pejabat struktural*) we did not receive any particular training (*pelatihan*). We need to be autodidacts (*secara otodidak*). No one told me what I should do. The central government expects us to be fast learners. It was difficult [talking about the policy of district health program]…" *(K-1)*

It was the local actors described in the previous chapter that locally interpreted central government laws and regulations. Their interpretations of central government laws and regulations defined the extent of local discretion:

> "...decentralisation that is understood (*dipahami*) in one area is dependent (*tergantung*) on the stakeholders (*pemangku kepentingan*) in that area particularly their supra-system, such as the *bupati* (including the mayor), the governor and then the district offices (*kantor dinas*)..." *(K-5)*

Another respondent added:

> "The condition of each district is different. Actually we need some flexibility (*keleluasaan*). A regulation may be suitable for one district, but may not be the case for another district…" *(K-2)*

The notion that 'interpretation' has played a major role in local government discretion does not mean the local actors could exercise power in a less constrained way. The central government has repeatedly emphasised that Indonesia's decentralisation is based on a unitary state[208]. As such, local policy interpretation was endorsed as long as it did not conflict with the national interest and national laws. However, the point where local policy was considered to be beyond what was permitted by national policies was not always clear. It was reported that different departments in the central government occasionally issued overlapping regulations[209]. One very recent example of overlapping laws was illustrated by a respondent below. The central government initiated a replacement of Law No 32 Year 2004 with Law No 23 Year 2014 to regulate the relationship between the central and local governments. However, the central

government has not issued the *peraturan pemerintah* (government regulation) as implementing guidelines for the new law:

> "At the moment local government is confused (*galau*) about how to develop their local development plan (*rancangan kerja pembangunan daerah*). Which regulation should they refer to (*dijadikan acuan*)? Is it Law No 23/2014 or could we still refer to Law No 32/2004? If we refer to the new law we have to adjust (*menyesuaikan*) with the newly attained authority, but local government still use the previous government regulation (*peraturan pemerintah*) as reference for local authority. In addition, with the new law, the previous law is automatically revoked (*dicabut*). Based on the consultation of a number of local governments to the Department of Internal Affairs, for the time being (*sementara*) we should refer to government regulation No 54/2010 that in turn refers to Law No 32 /2004, the now defunct law. I am amazed (*heran*) with the central government. They 'smartly' made (*pintar membikin*) laws to regulate local governments but have done it inconsistently and left the local governments in disarray (*membikin pusing*)." *(J-14)*

According to the Indonesian legislative system, any central government law should be accompanied by government regulation (*peraturan pemerintah*) that provides technical guidance on implementation[210]. With a new law in place, the old law is automatically invalid. In this case, however, the new law was not yet supplemented with regulation and this caused confusion. Local governments had to make decisions between following an applicable but redundant law or a valid but inapplicable law. The mayhem of the situation was described by one of the participants below:

> "Law No 32/2004 has already been revoked, but the new Law No 23 Year 2014 has not yet been supplemented with any government regulation. The local government development plan (*rencana kerja pembangunan daerah*) still refers to the local government midterm development plan (*rencana pembangunan jangka menengah daerah*) that still refers to the revoked law. The central government should have issued a new government regulation or they should have made the revoked law conditional until the government regulation is issued. Whatever we do it will be considered illegal." *(J-15)*

Another example of overlapping regulation was pointed out by another respondent:

> "The central government regulation No 42/2002 prohibits local government from funding any commemortive celebration including the anniversary of the Indonesian Independence Day. However, every year the state secretary issued a letter (*surat edaran*) for the bupati and governor to fund the celebration using local revenue (*APBD*)..." *(K-11)*

Another respondent added on the issue of the authority to give mining permit:

> "…according to the minister of energy and natural resource regulation (peraturan menteri ESDM) No 7/2012 it is the central government that will issue (*memberikan*) the permit for mining (*izin usaha pertambangan*) on behalf of the bupati. It contradicts (*bertentangan*) the decentralisation law that has given the authority to the local government…" *(K-7)*

Another respondent stated on the issue of local budget and expenditure:

> "…the national financial examiners board (*Badan Pemeriksa Keuangan; BPK*) always used the most recent central government regulation to inspect (*memeriksa*) our budget and expenditure (*APBD*). Meanwhile our *APBD* was compiled (*disusun*) using the old regulation that was valid (*berlaku*) at that time. As a result during the audit conducted by *BPK* we were considered noncompliant (*tidak patuh*). The problem was actually the regulations overlap…" *(J-13)*

The above situations must be handled sensitively by local government as mishandling has consequences. A poor decision could lead to an accusation of breaching the central government regulations by the *BPK*, or the National Financial Examiners Board.

For some districts, ambiguity provides space for local initiatives while other districts would prefer to wait and see how other local governments interpret and implement local policy. The particular policy stance taken by district governments, as will be discussed later in this chapter, is influenced by various factors including local resources, cultural context, local leadership and distance from Jakarta.

The distance from Jakarta has influenced the pattern of local government discretion, particularly if this distance is combined with special autonomy status, such as given to the provinces of Papua and Papua Barat. The district governments in these two provinces are given more tolerance in terms of local government spending. Even BPK (National Financial Examiners Board) seems reluctant to investigate strong suggestions of local fund discrepancies. The latest incident was the discriminatory local regulation issued in Tolikara, a small isolated district in Papua. This regulation restricted other religions from practicing their faiths within the district. The district argument was this

regulation had been ratified by the local House of Representatives, even though it had not been reported to the Ministry of Internal Affairs.

In terms of culture, the local bureaucracies in Java, Sumatera, Kalimantan, Sulawesi and Papua has somewhat different characteristics due to the influence of the locally dominant culture. This feature is particularly noticeable in the decision making process, where most bureaucrats in Java will be more cautious in making a decision than their counterpart elsewhere. This caution is taken especially if the discretion would affect the relationship with the central government. However, as the decision making has taken a longer time, it would be likely to cause delays in providing public services as will be discussed on the impact of the central government moratorium below.

The ambiguity of some central government policies, as also endorsed by the previous Law No 22/1999, was the reason why a number of districts started to develop communication lines with the central government bypassing the provincial government, and left the province as less relevant - as highlighted by Miller[211]. The situation was described by one respondent below:

> "...with decentralisation we have a more direct link to the central government. It was not necessary to involve the province, at least not back then. Anyway even if we have consulted the province they would very likely refer us to the central government..." *(J-13)*

Another respondent stated:

> "...we often consulted the central government to assure (*memastikan*) ourselves that we had interpreted the central policy correctly..." *(J-7)*

5.1.1. The Moratorium on Local Government Civil Servants

This was one starting point where differences in policy between districts began to accumulate. An example of a situation which eventually forced local government to take a particular stand on central policy was the moratorium on the recruitment of new local civil servants, starting from 1st September 2011 and continuing for sixteen months until the end of 2012.

> "It used to be a problem (*sempat jadi kendala*). The central government through their regulations barred (*tidak boleh*) any new staff recruitment whatever the mechanism was (*apapun bentuknya*) whether it was through outsourcing or honorary workers. The recruitment of government civil servants was forbidden (*tidak boleh*) when the moratorium was introduced…" *(K-6)*

The central policy of a moratorium on government civil servant recruitment aimed to reduce local government expenditure, particularly with regard to the cost of government civil servants[212]. In 2011 there were 124 districts where government civil servant salaries consumed more than 60% of APBD and sixteen of that number was over 70%. In addition, this policy was intended to promote better use of the already excessive number of government civil servants[213]. However, the central government ideal of a robust and cost-effective budget was not always in line with the situation faced by local governments. Central government demanded local governments reduce expenditure for government civil servants so that more funds would be available for public services. However, this policy was considered problematic in situations where there was a shortage of staff. The moratorium was intended to exempt medical personnel such as

doctors and nurses[214] but in reality there was no recruitment of medical personnel as civil servants during the moratorium, as described by a respondent below:

> "…until very recently we have not recruited any government civil servant including for the health sector. I do not know precisely why. In order to meet the shortage of health personnel we recruit honorary staff…" *(K-7)*

Statements were consistent across the districts, such as that by a respondent below:

> "…for the moment (*sementara ini*) there is not any recruitment for health personnel as government civil servants. The central government has decided to stop recruiting new government civil servants…" *(J-12)*

Another respondent stated:

> "We would like to increase our health personnel but it is not possible at the moment because of the moratorium. The policy has ended last year but let's see what is going to happen this year…" *(J-6)*

It was not clear why there seemed to be deviation between what had been legislated by the central government and implementation at a local level. However, the consistent response across the districts showed that, although the recruitment of health personnel as government civil servants was not prohibited, it was effectively discouraged. That local government could only propose recruitment with the final decision being determined by the central government explains why no health personnel were recruited during the moratorium. For recruiting temporary health personnel though, local governments have opposing views. Some districts considered the practice as permissible while other districts considered it outlawed as stated by a respondent below:

> "It was a hurdle (*sempat jadi kendala*). Through the central government regulation we could not recruit any new staff of any sort. Not honorary staff, outsourcing or anything (*apapun bentuknya*)..."
>
> *(K-3)*

These different views were probably caused by different emphasis on the reading of the regulation. Ramli Naibaho, the deputy Ministry of State Apparatus and Bureaucracy Reform for Human Resource, has stated that honorary staff were part of the moratorium but only those who were recruited after 1st January 2005[215]. Nonetheless, the statement one district was still recruiting honorary staff until very recently was an interesting phenomenon as it showed the different opinion and the reasons behind specific interpretation taken by each district. This matter is discussed further below.

5.1.2. The More Assertive Process: the Case of East Kalimantan

Local government interpretation of the moratorium seemed to be influenced by locale-specific conditions. One of these conditions was a shortage of health personnel to carry out public health services. Practically all districts in this study experienced these shortages. However, the shortages varied from district to district. Some districts had issues with geographical accessibility such as Kutai Kartanegara and Bulungan while others experienced scarcity of more specialised physicians such as Gunungkidul and Kulon Progo, as specialised doctors were drawn to more urban and profitable centres. Nonetheless, even the most ideal district in terms of the GP to population ratio, the municipality of Yogyakarta (see Table 2.2 and 2.4) disclosed that the district needs more health personnel as described below:

> "We definitely need to recruit more doctors. The doctors that we have today had either recently passed away or are going to retire soon…" *(J-9)*

Even though local stakeholders acknowledge that these problems would not be overcome by simply recruiting more health workers, most districts felt that recruitment of health workers was important for the betterment of public health services. Therefore, the moratorium that prohibited local governments recruiting civil servants was seen as detrimental to the district public health service. One respondent stated:

> "…of course we disagree but the moratorium is the central policy and they have a different consideration (*pertimbangan lain*) from us. From the point of local government view it jeopardises our health efforts (*usaha kesehatan*) …" *(J-16)*

Another respondent supported this:

> The policy of moratorium has impacted on our health services. We need to recruit more but I guess we have to wait until this year…" *(K-12)*

Another respondent added:

> "I am not in the position to agree or disagree with the moratorium. It is part of central government policy and we have to conform, but at the same time we have to find a solution because it has impacted our public services…" *(K- 13)*

One visible pattern that distinguished the districts in East Kalimantan and Java was how the districts in East Kalimantan interpreted the moratorium. While most districts in Java seemed to be more passive and conforming, districts in East Kalimantan interpreted the

moratorium as preventing local government from recruiting permanent staff, but not temporary staff. Therefore the practice of contracting health personnel was widespread among districts in East Kalimantan:

> "…if we recruit permanent staff (*mengangkat pegawai*), it would not be allowed. Permanent staff required a government decree (*surat keputusan*) that would not be possible. However, contracted staff is temporary and they perform certain duties (*kita ada kerjaan, siapa yang bisa menyelesaikan*) that we could not cover due to the shortage of manpower. We have no other responsibility after the contract is over. We never promised (*menjanjikan*) that they would later be recruited as permanent staff…" *(K-9)*

Another respondent added:

> "Amidst the moratorium, contracting health workers in East Kalimantan districts, such as in Bulungan, Berau or Kutai Kartanegara, is widely practiced (*sudah umum*), but I guess not in Java…" *(K-3)*

It was not clear whether different interpretations taken by the local governments indicated that due to being closer to Jakarta, districts in Java were more compliant than the districts in East Kalimantan. With respect to this, another assumption that districts in Java were more strictly controlled by the central government compared to the districts in East Kalimantan was also unverified. From my interviews with local stakeholders from both areas, there were no strong indications that the central government treated the regions differently, at least not among the districts in this study due to proximity to the central office. All central laws and regulations, besides the few articles regarding special rights for the four special autonomous regions, were applicable without exception for all districts and provinces. The perception that districts in Java were more

compliant than districts in East Kalimantan may be due to the former's relative fiscal dependence to central government as a source of funds compared to the natural resource-rich districts in East Kalimantan. According to Meliana[216] and Sirait[217] shared revenue from natural resources in particular has a strong influence on local government self-sufficiency. The studies also show that the general allocation fund that comprises a considerable portion of local budget, particularly in Javanese districts, also makes a strong contribution to local-sufficiency. However, as the allocation is less defined in the law it is subject to central consideration.

Another explanation for the different policy interpretations between Java and East Kalimantan is related to different circumstances in the respective regions. One of the most likely factors was the different scale of urgency for recruiting health workers. While both regions complained of shortages of physicians, nurses and midwives, the scarcity was more apparent in East Kalimantan, and rural districts in Java (See Table 2.2 and 2.4). In the districts of Java and in the urban districts of East Kalimantan, staff shortages had less impact due to a larger number of private practitioners. In rural districts it is far more difficult to attract private practitioners as patient demand and capacity to pay for such private services is relatively low. Rural and remote districts of East Kalimantan are very sparsely populated, expensive to access, and therefore, heavily reliant on the government to provide basic health services. The following respondent described the situation:

> "…I have lived in the hinterland (*pedalaman*) as a doctor for some time. I used to deliver health services for one village and move to the next village the next day. Therefore, to reach five mobile *posyandu* will take a trip of five full days. Each night I spend in a different village. In the hinterland the cost of transportation is expensive

> (*biayanya mahal*). The cost of gasoline could be twice or even more of the price in town and I would say that is lucky because sometimes there is not any and we have to walk (*harus berjalan*) all day…" *(K-9)*

It appeared that, in part at least, with their desire to increase public satisfaction, local governments were interpreting central government moratorium policy in a particular way to acquire more health workers, as explained by a respondent:

> "…in the end the activities and health services that we delivered are aimed for public satisfaction (*kepuasan masyarakat*). Of course we did not only fix the input but also the process…" *(K-5)*

In part, this interpretation was due to pressure to meet central government's performance indicators. This minimum standard of health services encouraged local interpretation of moratorium policy, as discussed by a respondent, below:

> "...if we did not take any action (*diam saja*) we would not be able to deliver (*tidak bisa berjalan*) to the extent that we expected, with our geographical condition, limited human resources and restricted government civil servants; without new recruits we could not reach our targets. We would not be able to reach the minimum standard of services (*standar pelayanan minimum*) without additional human resources (*kalau tidak ada tambahan tenaga*)." *(K-3)*

Even before the moratorium, a number of districts in East Kalimantan already struggled to meet their targets of a minimum standard of health service – let alone after the moratorium.

> "…the minimum standard of services is the minimum services that a local government could deliver. Later, we would like to develop that to include additional health services. But right now, we are already (*ini saja*) struggling (*masih terseok-seok*) to meet (*mencapai*) our minimum standard of service targets…" *(K-5)*

Even though there are no definite consequences if a target is not reached, it appeared that a number of local governments considered that their integrity was at stake – particularly if their district is rich in natural resources but had a poor performance.

> "How can you think it is impossible (*masak tidak bisa*)? We must and we can (*harus bisa*)! Look at other districts (*seperti yang di luar-luar*). If they can then we also can do it. It is embarrassing (*memalukan*) if we cannot do it…" *(K-3)*

This rivalry has also influenced how districts interpret the moratorium policy, as pointed out by a respondent below:

> "We have decided to contract some health personnel as the other district was also doing the same thing. If we do not do the same thing we could be left behind (*tertinggal*)…" *(K-3)*

Competition has also influenced the development of other local initiatives as each district could compare their best practice with that of the others. In fact it appears that it was the need as the districts lacked local planning skills and the support from the central government was less, hence districts need to learn from each other. This involves not merely replicating another district's programs, but sometimes enriching this program to fit local conditions. Which programs had and had not worked in the past, what could be improved in these programs, and what needed to be adjusted were things that each district could learn from their neighbours' programs.

> "…in order to reduce our maternal and infant mortality rate, we have adopted the mother, new born baby, baby and infant health regulation (*peraturan daerah kesehatan ibu, bayi baru lahir, bayi dan anak*) that has been successfully implemented in Kutai Timur. With this regulation, every child will own a mother and child card that will gather all information and the medical records of each child until they become an adult…" *(K-6)*

The regulation on maternal, new born baby and infant health commonly known by its abbreviation *perda* KIBBLA (*peraturan daerah kesehatan ibu, bayi baru lahir, bayi dan balita*) is an example of a local health program that has been imitated by various districts. Usually the mechanism of imitation is through comparative study (*studi banding*) where some staff from the district health office makes a short visit to another district's health office for discussion and to conduct observations of the program. This worthwhile process of learning is popular among local government officials as it is permitted by their local government. However, the activity is often criticised by the central government Department of Health as unnecessary and a waste of money, soaking up unexpended funds at the end of the financial year.

While disliked by central government officials on the pretext of inefficient use of money, the central government's discouragement of such local interaction may also reflect a concern that the centre should educate the local. So far, such *ad hoc* mechanisms for local district to district interaction have emerged and there is also a set of forums for district to district interaction facilitated by their provincial government. However, there are no regular opportunities for decentralised districts to learn from the experience of other districts across the nation.

5.1.3. The More Cautious Process: the Case of Java

The practice of imitating the example of other districts' policy and program implementation was also common amongst districts in Java. However, more caution was apparent in Java in implementing local interpretation. The specific example of contracting staff such as physicians and midwives was adopted much later in Java than in the districts of East Kalimantan. When the research survey was conducted in early 2013, contracting health personnel was still in a preparatory stage in the municipality of Yogyakarta, but was not yet heard of in other districts of The Special Territory of Yogyakarta. At the time, this practice had already been in place in Balikpapan, Bulungan and Kutai Kartanegara since the previous year. However, though the districts in Java were also facing similar shortages of human resources, the situation seemed less urgent than in East Kalimantan. During the interview, not a single district in Java indicated concern that shortages of health workers may influence the minimum standard of health services performance. The target for a minimum standard of service seemed to be under control, but having fewer health workers meant that they were required to operate longer service hours and that people were forced to wait longer for service.

> "We are short of human resources (*kekurangan tenaga*), but we agreed that this year (2014) we will start recruiting contracted employees to make up sufficient numbers (*kecukupan tenaga untuk pelayanan*) of physicians, nurses, and midwives in the *puskesmas*. It was the idea of the head of our health office as a response to the moratorium over the last couple of years. From year to year more and more (*semakin banyak*) physicians passed away, resigned, or retired. Consequently, our service is pretty much affected by this policy (*pelayanan menjadi terhambat*). The physicians would need to work longer hours. The usual four hours service would not be possible anymore. The patients

> would also need to wait longer (*menunggu lebih lama*) to get their treatment" *(J-9)*

A more conservative interpretation of the actions by districts in Java may also be the consequence of relatively weaker fiscal capacity. It appeared that, with their higher fiscal dependence on central government funding, districts in Java found it more difficult to interpret the central policy in way districts in east Kalimantan interpreted the policy.

> "…We have calculated (*menghitung*) with the government and I could say that we are short (*kurang*) of human resources. We do not have a sufficient number of general practitioners. We are having a moratorium and at the same time we do not have the financial ability (*kemampuan*) as our expenditure for human resources already accounts for 70% of the total budget. That is higher than regulated by the central government. Even if we want to recruit more staff, it is not possible as we are not allowed to do that (*tidak boleh*) by the central government…" *(J-6)*

The situation was in stark contrast to a number of districts in East Kalimantan which were relatively less dependent on central government funding. The more abundant natural resources and the introduction of Law No 33 Year 2004 allow greater allocation of natural resource revenues for the provinces and districts compared to the previous laws.

> "...for us the budget is not the problem (*tidak masalah*). Moreover, our health expenses are still under the central government's requirement. At the moment we are still around 5% of APBD. We need to change our strategy and make a breakthrough to get the funds (*membuat*

> *terobosan untuk mendapatkan anggaran*). We need to convince the legislators…" *(K-3)*

However, it needs to be re-emphasised that fiscal capacity was not the only reason for varied interpretation. Districts within Java differ in terms of their relative financial capacity. Not all are highly dependent on central government funds as shown below:

> "…compared to other districts in Java our budget is relatively unrestricted (*lebih leluasa*). And as for healthcare, you can check in the district health office or the district development planning body how much we have spent for local health services. We have spent a lot (*tidak sedikit*)…" *(J-4)*

However, like other districts this district was also facing a shortage of health personnel:

> "In regard to the number of staff and their competence (*kuantitas dan kualitas*), it has been our concern (*menjadi keluhan*). Definitely we have a shortage of health workers…" *(J-1)*

The moratorium has further exacerbated the shortage of local health personnel. From a local government point of view, the moratorium was seen as unfair, as revealed by the head of district health office:

> "…healthcare is unique as we have a large variety of functional officials (*pejabat fungsional*). Therefore, it is not adequate for a *puskesmas* to have only physicians and nurses because a nurse cannot perform a laboratory test or nutrition counselling. That is why the proportion of direct expenditure (*belanja langsung*) in healthcare is high. The moratorium that is based on this conception is not right (*tidak pas*)…" *(J-1)*

However, by the time the interviews were conducted in early 2013, this particular district had not initiated plans to interpret the moratorium like their fellow districts in East Kalimantan despite their relatively strong fiscal capacity:

> "…since the moratorium started we have not been able (*tidak ada*) to recruit more staff. We just optimise what we have…" *(J-1)*

The real reason for not contracting health workers was not clear. The respondent further gave the explanation that it was just not possible because the central government policy disallowed it:

> "It is the central government policy and we as local government we are bound (*terikat*) by the policy…" *(J-1)*

This justification was supported by another local actor that local policy must be in line with central government policy. The respondent added that, in principle, decentralisation must not be seen as an unlimited local autonomy - central and local governments should not be seen to work as opposing forces. Rather, they rely and depend on each other and, though each has their respective authority, they must work in harmony.

> "…in principle in decentralisation the central and local government must keep their communication and network (*berjejaring*). It is not possible for us to stand alone (*berdiri sendiri*) and ignore the central government. Our relationship with the central government is to support (*memperkuat*) what has become (*apa yang dilakukan*) the central government policy. Our relationship is intertwined (*kait-mengkait*). We cannot limit ourselves (*hidup sendiri*) in a small community called a district." *(J-4)*

However, another explanation as to why this specific district seemed reluctant to take a more locally relevant interpretation was probably caution. The decision makers from this district seem wary not to repeat mistakes made by the former *bupati*. The previous *bupati* was accused of using the non-budgetary funds to purchase text books for local schools without consent of the local House of Representatives. A local staff member stated that it would not have been a problem if the regime at that time did not change. However, when the regime changed the *bupati* was tried and convicted as the *bupati* had caused a third party who gained an illegal benefit – even though the *bupati* did not receive any gratuity.

This example shows the strengthening of central scrutiny through the National Audit Board (BPK) and Corruption Eradication Commission (KPK) on local government governance, particularly when involving the use of funds as also stated by Badjuri[218] and Nugroho[219]. Further, a study conducted by Mustikarini and Fitriasari[220] pointed out that BPK scrutiny has a positive impact on local government prudence in using local funds. The strengthening of local control was also described by one respondent:

> "…we have to be careful in making a decision and interpreting central policy especially in using funds. We must make sure that the decision is in line with the regulation in place…" *(J-1)*

Another respondent stated:

> "…nowadays I would prefer not to be in charge in such a position that I need to make a decision that involves the use of local budget funds (APBD). The process for local tender for instance is very risky. There are too many interests involved in the process. Some people in the government, local legislators, political parties and so on. We could easily get in trouble with the BPK…" *(J-13)*

5.2. The Defining Role of Fiscal Capacity in Local Interpretation

As previously mentioned, local interpretation was also influenced by local fiscal capacity which is central to the policy of decentralisation. Providing local governments with access to financial resources was the foundation of Indonesia's decentralisation policy. This has two implications: First, the significant role of local fiscal ability in the context of local government autonomy, as without access to financial resources it was highly unlikely that local government could exercise their full autonomy. Second, as mentioned in Chapter 3, the idea of decentralisation was not new to Indonesia's constitutional system. The term decentralisation was actually already introduced through the previous laws that regulated local government structure. Law No 5 Year 1974 for instance, which people associate with the centralistic rule of the New Order regime, established decentralisation as one of the three basic principles that regulate the relationship between central and local governments. Nonetheless, there was a missing element in the implementation, and that was local government access to financial resources. This shortcoming was anticipated in Law No 25 Year 1999, but especially in Law No 33 Year 2004. The latter law specified in considerable detail the fiscal balance between central and local governments.

The first noticeable effect derived from local government's fiscal capacity was the sense of self-reliance. There was a tendency for stronger fiscal ability of local government to translate to stronger self-reliance, as described by Helvyra[221] in her observations of the relationship between fiscal ability and autonomy across districts in West Sumatera. Each local government was assigned more or less the same range of autonomy. However, the policy provided a different allocation of funds for each district and province depending on the type of funds and local characteristics, as described below:

> "…our local health program could be supported through various resources that we have. It could be from the general allocation fund, the specific allocation fund, deconcentration, and local income. However, all resources are subject to approval. The general allocation fund and local income come from the local government with the rest from the central government. We have the right to propose, but it will depend (*tergantung*) on their approval…" *(J-9)*

For instance, a central government transfer fund, such as the general allocation fund or *dana alokasi umum,* was allocated based on local fiscal needs such as population, area, per capita gross regional domestic product (*Produk Domestik Regional Brutto per Kapita*), construction cost index (*Indeks Kemahalan Konstruksi*), and human development index (*Indeks Pembangunan Manusia*). Therefore, each district and province has varying amounts of funds from this particular resource, the *dana alokasi umum*.

Another important resource, as already mentioned in Chapters 3 and 4, is revenue from local natural resources. Districts with abundant natural resources will potentially have more funds than those that do not. However, a district with less significant natural resources may still have funds from this source if the district happens to be in the same province as a natural resource-rich district.

Local government has full authority over the APBD. Therefore, when referring to local capacity, one refers to the capacity of the APBD which consists of the local revenue (*pendapatan asli daerah*), natural resource shared revenue (*dana bagi hasil*), general allocation funds (*dana alokasi umum*), and other legitimate revenue (*pendapatan lain yang syah*) (see Table 5.1).

Table 5.1 Shared-revenue and APBD in 2011

Shared-revenue and APBD (000,000 IDR)	Gunungkidul	Kulon Progo	Sleman	Kota Yogyakarta	Bulungan	Kutai Kartanegara	Balikpapan	Samarinda
Shared-Revenue	28,627	28,553	69,426	32,180	480,316	3,424,574	675,976	712,000
Per capita Shared-Revenue	0.04	0.07	0.06	0.08	3.96	5.08	1.13	0.91
Per km2 Shared-Revenue	19.27	48.70	120.78	990.15	364.37	133.17	1,343.09	1,009.31
Revenue (APBD)	1,010,100	800,878	1,383,012	899,626	985,995	4,234,469	1,647,132	1,944,556
Per capita Revenue	1.48	2.03	1.24	2.29	8.13	6.28	2.74	2.48
Per km2 Revenue	680.02	1,365.99	2,406.08	27,680.80	747.99	164.66	3,272.66	2,756.55

Source: Department of Finance Republic of Indonesia

Apart from local government budget and expenditure, other sources that are derived from the central government are special allocation funds, or *dana alokasi khusus* and the operational aid for healthcare, or *bantuan operasional kesehatan*. For districts with lower fiscal capacity, the central government-derived funds are essential in supporting local public services. In many districts, it has become the main source of local program funding as the APBD has been exhausted to pay local civil servant salaries, as expressed by one of the respondents below:

> "…our APBD is not large (*tidak besar*), and from that APBD around 70% is used to pay local civil servant salaries. That 30% left is for various local programs. That is why we still expect (*tetap kita harapkan*) central government funds such as DAK and BOK…" *(J-12)*

There is also the inclination, particularly among districts with a low fiscal ability to 'commercialise' public hospital care by increasing user fees to increase local government revenues[222]. Kuntjoro Adi Purjanto, the chairman of the association of local public hospitals even confirmed that a treasurer of one local hospital complained that a local financial official had asked to use the hospital revenue for paying the legislators' salaries. This phenomenon is also a sign of local interpretation. It showed that the nature of interpretation is influenced by local fiscal capacity, whether high or low fiscal

capacity. In order to stop this practice the central government introduced a local public service board or *badan layanan umum daerah* for local public hospitals. With this reorganisation, a local hospital has the autonomy to manage its own finance and administration. Hospital revenue is not allowed to be used for other than health and hospital related developments.

The commercialization of public sector health services can be observed in many districts across Indonesia. For example, various district hospitals in Jakarta have implemented a policy about fees whereby in the morning hospitals require the patients to pay a government-approved tariff, while for services during rest of the day they instead charge their own level of tariff. This practice has transformed these local public hospitals from not-for-profit entities in the morning to for-profit centres in the afternoon when the services become expensive. As Tulus Abadi, the head of the Indonesia Consumers Foundation (YLKI), puts it, the impression is that "low income families are not allowed to get sick other than in the morning[223]". He later added that the policy has contributed, at least partly, to a number of incidents where a low-income patient has been unable to access care, leading in some cases to their untimely death.

The commercialization of public health services is under watch by the civil society organisations. For example, Uchok Sky Khadafi, the director of investigation and advocacy of the Indonesia Forum for Budget Transparency (FITRA), claims that the government of Cirebon in West Java has collected an excessive revenue of IDR 115 billion (AU$ 11.5 million) by charging for health services provided through *puskesmas* and the two public hospitals[224]. Such commercialisation is common practice now: Mohammad Hafidzi and Isa Mahdi, legislators from Jember in East Java, report that using the *puskesmas* or the public hospital as a local government source of revenue is

widely advocated by local decision makers[225]. It is quite common for local governments to give targets to public hospitals in order to support local revenue as further elaborated by Ribka Tjiptaning Proletariyati, a central government legislator, who suggested that the classification of hospital wards into III, II, I and VIP classes is a manifestation of the commercialization of health services and that the classification of hospital wards is not only about facilities in these wards but also about different levels of medicine use and doctors' fees[226].

Commercialisation in preventive and health promotion activities is also occurring to some extent. Fogging, as part of malaria and dengue control, is principally free of charge, being funded by the local governments. However, at times with claims that the funding is due to long delays in acquiring the next tranche of funding from within government resources, local communities/groups are asked to cover the cost of fogging as claimed by Ahyani Raksanegara, the head of Bandung health office[227]. According to the Ministry of Health, communities are at times required to cover the cost because of this shortage of resources[228]. The charge can vary depending on local availability, but is usually around IDR 10,000 (AU$ 1) per household, as testified by members of the local community from Cianjur[229] in West Java and from Nganjuk[230] and Trenggalek[231] in East Java.

A high proportion of expenditure on local civil servants was also mentioned a respondent from another district:

> "…around 70-71% of our district APBD is used for paying (*digunakan untuk membayar*) local human resources. That is the reason why (*menyebabkan*) we cannot (*tidak bisa dilakukan*) implement several policies…" *(J-6)*

These central government funds, unlike the local government budget, or APBD, are subject to central government policy. Consequently, their use is more aligned with central government priorities than local interests as explained by one of the respondents:

> "…*bantuan operasional kesehatan* is allocated by the central government for each district, including the figure (*ukuran-ukuran*) for each of them, the activities, and the guidelines. So we just need to follow their guide (*mengikuti panduan*), what kind of activities (*kegiatan*) need to be implemented, and so on…" *(K-3)*

However, this is not to suggest the central government funds are incompatible with local programs. On the contrary, the funds have supported a considerable number of local government programs as stated by one participant below:

> "…more or less the activities dictated through the *BOK* are the same (*sama saja*) as under the local-initiative program. We always coordinate with the *puskesmas* to choose which activities should be funded through the *APBD* and which should be allocated through the *BOK*. For example, where a *puskesmas* is covering five working areas (*wilayah kerja*) or villages, it is possible (*diperbolehkan*) that two villages will receive the *BOK* while the remaining three villages will receive funding from the *APBN*…" *(K-3)*

However, it seems that respondents from districts that rely heavily on the central government were more conformist to central policies. Their views on the implementation of decentralisation also tended to be normative, such as the response provided below:

> "…decentralisation went well (*berjalan dengan baik*) here. Of course we have problems here and there, but overall everything is okay..." *(K-2)*

Another respondent had a similar view:

> "We have implemented local autonomy properly (*sesuai ketentuan*). We have a good relationship with the local House of Representatives. They support our program and initiative. Public aspiration has also been taken aboard through the *musrenbang* process..." *(J-3)*

Respondents from the better-off districts, on the other hand, were more assertive and critical as shown below:

> "…my understanding (*pemahaman*) of decentralisation is that it is fainthearted (*banci*). There is ambiguity because what is understood in the central (*pusat*) government is not the same as what is understood in the local level (*daerah*). There is not yet a common understanding (*meletakkan kacamata melihat*) on policy. Therefore, no one anticipated (*memikirkan*) the impact of the decision that has been made (*pengambilan keputusan*)…" *(K-5)*

However, saying that districts with a low fiscal ability tend to rely on central government funds for their public services does not mean that these funds were not also anticipated by the better-off districts. Their financial resources were not unlimited; all districts in this study were actively seeking funds, including from the central government, whenever possible. A respondent described the situation:

> "There are several funds from the central government in our district such as central government health insurance (*jaminan kesehatan masyarakat*), child birth insurance (*jaminan persalinan*), and operational aid for healthcare (*bantuan operasional kesehatan*). There are other funds such as the specific allocation fund (*dana alokasi khusus*) and assistantship fund (*tugas pembantuan*), but the central government believes that we already have sufficient in our budget. Maybe that is why we do not receive any funds from the special

> allocation fund this year. It is not that we do not need them (*bukan tidak mau*). We asked (*kita minta*) for more funds including through the provincial government, but the central government may have a different viewpoint (*pertimbangan*). I have heard it is because of the previous criminal charge (*terkena pidana*) in the district that they dropped our proposal. We need the funds for a couple of programs. First, they are going to be used to upgrade (*tingkatkan*) a number of *puskesmas* from *puskesmas pembantu* (lower level puskesmas) to become main *puskesmas (induk*). Second, for some remote areas we need to upgrade the *puskesmas* to become *rumah sakit pratama* (a type of hospital that offers basic health services for 24 hours including emergency, outpatient, and inpatient care)." *(K-3)*

The second noticeable impact of local fiscal capacity was the assertiveness in exercising their authority that some of the district personnel have shown during the interviews. All respondents seemed to agree that decentralisation has given more power to the local governments. However, when it came to implementation there were different opinions across districts. For some respondents, decentralisation was embraced with confidence as they were now able to exercise their own programs and policies. However, a number of respondents were less enthusiastic. Not that they disagreed with local autonomy, but they had practical problems due to relatively constrained fiscal capacity.

Chapter 4 has already described how local fiscal capacity may influence the provision of public goods. However, as policy in Indonesia encouraged shared responsibility between central and local governments and not separation of responsibility, local discretion was becoming more regulated and directed by the central government. Therefore, the challenge was how to balance between conforming to central policies and at the same time taking local interests into consideration. This situation often required local government to negotiate and interpret central government policies.

Local fiscal capacity seemed to influence how local governments interpreted central policy. Without adequate fiscal capacity it was difficult to balance between conforming to central policies and observing local interests. For some districts, however hard their determination to exercise their new power, they could not be realised effectively as fiscal ability was relatively weak. This disadvantageous situation is described below by one participant:

> "…autonomy is about local government readiness (*kesiapan*) in wide-ranging development (*membangun semua*) from the system, inter-relationships (*hubungan*), etc. We realised that our ability in terms of fiscal budget is low. Our revenue (*pendapatan asli daerah*) is under 10 billion IDR (equivalent to AU$ 1 million). Therefore, you could imagine after decentralisation was implemented: how can we support our health programs adequately?" *(J-13)*

A similar sentiment was shared by respondent from a different district:

> "…it is not yet in line (*sesuai*) with the aim (*tujuan*) of decentralisation as it relates (*terkait*) to our ability (*kemampuan*). Our district budget (*anggaran*) is around 1 trillion IDR. From that AU$ 70 billion must be allocated (*untuk*) for government civil servant (*pegawai negeri sipil*) salaries (*gaji*)... *(J-12)*

A different response came from a better-off district:

> "I would not consider our district exceptionally affluent (*daerah kaya*). However, especially for education and public health, regardless of how much we propose (*berapapun yang kita ajukan*) it will be approved (*akan diberi*)…" *(K-1)*

A similar response was provided by another respondent:

> "As far as I know the budget for health is sufficient (*memadai*). What I mean by sufficient is that we can allocate a health budget that exceeds the central government provision (*lebih dari ketentuan*). The provision is 10% but last time we had already reached 13% and now we are around 18% of the APBD. This means that we are really serious (*benar-benar*) in supporting local health programs. It is more than enough (*lebih dari cukup*)…" *(J-2)*

With stronger fiscal capacity a district has more alternative solutions available when dealing central government policies and regulations, while districts with weaker fiscal ability have fewer alternatives. The availability of a local budget seems to have triggered local governments to seek alternative solutions whenever necessary:

> "…of course one of the factors we could perform better (*capaian yang tinggi*) than the other districts is due to our relatively large budget (*anggaran*). We are also able to be more flexible in term of programs. When the moratorium was imposed we were still able to contract doctors as temporary staff. The central government did not seem to mind…" *(J-5)*

In some districts, alternative solutions for shortage of specialists were initiated by providing high salaries and other benefits as implied by a participant below:

> "…I could say that a hospital is unique as it is labour intensive (*padat tenaga kerja*). The people who work in a hospital have high salaries. They would refuse to receive the standard salary for other civil servants. They have their own standard and it is not cheap, especially for a specialist who has a different standard that we have to bear in mind. As a comparison, with school teachers for maths, physics and literature, they all have more or less the same standard of salary. In a

> hospital an ophthalmologist and a surgeon have significantly different standards of salary compared to a clinical pathologist. Their report evaluation will be different and the reward will also be different…" *(J-11)*

Other districts initiate longer term solutions by providing scholarships for medical students. They are then contracted to serve as doctors in remote areas.

> "…it has become an issue recently as it is a kind of debt bondage (*mengijon*). Some districts provide scholarships for medical doctors, but in return they are contracted to provide services in remote areas…" *(K-4)*

The situation seems to be exacerbated by the various health coverage programs implemented by local governments as people are taking advantage of free basic health service, as described by a respondent below:

> "…in every hospital and *puskesmas* now we could see patients queuing (*menunggu*) as it is not possible to hire more doctors. Possibly, the situation is also exacerbated by the various health cover programs. People become more irresponsible (*kurang bertanggungjawab*). Even for common flu, people will go to the *puskesmas* just to get free medicine. Whereas in the past traditional medicine would be enough…" *(J-10)*

As for districts with weaker fiscal capacity there seemed to be less room for interpretation, leaving little wiggle room in term of policies, as expressed by a respondent below:

> "Fiscal ability is very important (*sangat berpengaruh*) for local autonomy. As a comparison, from our APBD of 1.2 trillion IDR, around 70% is used for government civil servants. This expenditure is

> in effect central government expenditure (*belanjanya pusat*) as the funds usually come from the general allocation fund. Therefore, the funds that we allocated for direct expenditure are less than 20 billion IDR. That is for various activities such as government development projects (*proyek*), infrastructure (*kegiatan membangun*) and capital investment (*belanja modal*). We need to stick to a rule…" *(J-13)*

However, so far, the advantage of having greater fiscal ability and broader room for interpretation has not been reflected in better health outcomes. Kutai Kartanegara for instance, with its large fiscal capacity (see Table 5.1) finds its health personnel and in terms of health outcomes still trailing the other districts in this study (see Table 2.1, Table 2.2, Table 2.3 and Table 2.4).

5.2.1. Does Fiscal Capacity Really Matter?

In discussing whether local fiscal capacity is substantial enough to support local government discretion in health, the case of Kutai Kartanegara is noteworthy. Kutai Kartanegara with an APBD, or local revenue of more than 7 trillion IDR (2014 data), is one of the most affluent districts not only in East Kalimantan but the whole of Indonesia. It owes this wealth to rich natural resources, particularly oil and coal. However, Kutai Kartanegara is also known as the largest receiver of *beras miskin*, or rice for the poor, in East Kalimantan[232]. In terms of health performance, Kutai Kartanegara nearly always lags behind the other districts (see Tables 2.1 and 2.3). One might then question local government discretion in utilising the advantage of having strong fiscal ability. But, there are other local characteristics apart of local fiscal capacity that are visibly contributing to the realisation of local health policies and programs. From my discussion with the respondents, there were at least three factors

that contributed to this situation in Kutai Kartanegara: local specific conditions in this case coordination issues, poverty, and the availability of reliable data.

5.2.1.1. Inter-district and District-Province Coordination

It has been widely recognised that the relationship between geographic access and utilisation of health services can potentially influence health outcomes, as highlighted by Yao *et al*[233] and Wang[234]. This situation is apparent in developing countries where poor transportation infrastructure has hampered access to health services. This view is supported by one particular participant in this research who stated that the large area to be covered was not the real problem, rather substandard transportation was the reason for poor access to health services. In some districts, *puskesmas* are inaccessible for part of the year. This means that some patients go to other districts in order to receive health services, as described below:

> "…accessible roads are few. Many people here depend on the rivers as an alternative means of transportation. However during a long dry season the river can no longer be navigable. Some places become isolated and can no longer access health facilities (*tidak bisa menuju layanan kesehatan*). In some other areas there is no alternative but to cross the border to receive health services in other districts…" *(K-12)*

This situation is often called cross-border flow. It does not necessarily mean that the sickest people would travel to another district. It is more that the people who live near the border who often access a cross-border health service due to it being geographically convenient and the road being better. This situation seems common in Kutai Kartanegara where a large proportion of its population reside in the eastern part of the district which borders districts with better health facilities such as Balikpapan, Samarinda and Bontang, as explained below:

> "…the people that live in the eastern part of this district often access health facilities from the neighbouring districts because it is more convenient. That is why we had talks with our neighbouring districts about this matter…" *(K-5)*

Similar issues do not apply in Java, despite the relatively lower fiscal capacity the districts in Java are well developed due to historical input by the central government. Even among the most underdeveloped districts, infrastructure is generally more developed than in East Kalimantan. However, there were always a few exceptions as explained by one respondent, below:

> "…In general I think access to *puskesmas* in term of location is not an issue in this district. But of course there are some pockets particularly in the southern coast and in the mountainous north part of this district that are difficult to cover by the *puskesmas*. The people that live there are just too dispersed…" *(J-3)*

However, it is not always easy to construct and maintain roads. The priorities between district technical offices, in this case between district health offices and district public work offices, are not always the same. This re-emphasises the poor coordination between district offices as mentioned in Chapter 4, in this case between the district health office and the district public works office. Even with district office coordination through the *forum SKPD,* extensive cooperation between district offices is not easy to achieve, as described below:

> "…actually the main problem is the insufficient (*minim*) access to a road (*akses jalan*) not the health services itself. It is the infrastructure and unfortunately it is not under local health office authority…"
>
> *(K-13)*

It is not only the coordination between district offices that is lacking. Some of the roads are not part of the district authority, but the province and central government authority[235]. Synchronising district and provincial interests is not always easy, let alone central government interests. The provincial government and central government have priorities in other districts, and the district government does not allocate money to projects that are not under their authority.

> "…I did not ask (*bukan minta jatah*) the provincial government and the central government to allocate more of their funds in our revenue (*anggaran pendapatan belanja daerah*). But I demanded that both governments be more responsive (*memperhatikan*) to our needs for better roads as part of their responsibility (*menjadi tanggungjawabnya*)…" *(K-14)*

The Kutai Kartanegara government was convinced that they performed their share in developing local infrastructure, but were not convinced that provincial and central governments has done so. This situation seemed to cause jealousy and accusations that the provincial government gives privileges to certain districts. This accusation was quickly countered though by the provincial government:

> "…we do not give special privilege to certain districts. Each district in this province was assisted proportionally…" *(K-15)*

Both district and provincial staff did not hide the strong disagreement between them. It was even covered in the local newspaper after a war of words broke out during a public event.

> "…I am not angry (*tidak marah*). The governor is my uncle. We also belong to the same political party (*satu partai*)…"[179]

The open conflict between district and provincial government is difficult to imagine in Java, particularly in the four selected districts as conflicts tends to be more subtle and indirect. It does not mean that there is no disagreement, rather in Java open conflict is avoided if possible, especially in public.

> "…it is true that we have a close relationship with the provincial government but it seems that they treat us half-heartedly (*setengah hati*). The provincial government has a lot of financial resources, especially with the special fund (*dana keistimewaan*) that they are now entitled to. However, we have to beg (*mengemis-emis*) to obtain additional amounts from them. It is okay (*tidak apa-apa*); we do not mind (*ora patheken*)…" *(J-13)*

From a cultural point of view this open conflict showed an interesting situation. The Javanese, as the most culturally dominant in Indonesia, endorsed indirect conflict resolution with an emphasis on a calm appearance, respect for authority, and unity with leadership as described by Kuntjaraningrat[236]. However, open conflict between Kutai Kartanegara and the province of East Kalimantan demonstrated a different approach in communication between district and provincial government. It is possible that the difference in approach is influenced by this difference in cultural background between the two areas. While a large number of the local government elite in East Kalimantan

are Javanese or descendants of Javanese migrants, the two leaders in open conflict are not Javanese.

Both direct approach and indirect approach characterise the relationship between different levels of government in Indonesia. Indirect approach used to be more apparent but in recent years it has becoming less applicable as the process can take a longer time to comprehend and the relationship between different levels of government has become more straightforward. The differences between these two approaches in lobbying the central government for more funding could be observed in two respondents' statements below:

> "…I have network with prominent persons in the province and when the central government finally granted the special region law (*undang-undang keistimewaan*) to the province I congratulated them. I told them that the province must have more revenue as part of the new law. I've also told them about the achievements that we have reached in our district and the challenges that we are facing…" *(J-13)*

The respondent further added:

> "…the person from the province said that the provincial government has a lot of priorities that need to be considered. The newly allocated funds from the central government will be allocated to these priorities…" *(J-13)*

The above statement shows the indirect approach between district and provincial government regarding the provincial special fund (*dana keistimewaan*). Even though the district was interested on the fund, they did not explicitly request it. Respondent *J-13* said that it was '*saru*', a feeling of being indecent to overtly show intention, particularly regarding money. In this case, the response from the provincial person was also

culturally appropriate. The provincial government was obviously refusing to allocate any funds to the district but instead of directly saying no they mentioned the provincial priorities without referring to the district. This approach is no more effective than direct approach. The aim was to keep the relationship harmonious. Every potential rejection is anticipated. Therefore, no one will lose face (*kehilangan muka*), a very important aspect in maintaining good relationship. This way of approach is differs starkly from that described below:

> "…I have requested the provincial people that they should provide more funds to the district. They have a large fund without that much responsibility, unlike us…" *(K-14)*

A similar respondent statement, but this time addressed to central government, was:

> "…I have asked the central government to provide more general allocation funds for us. We have contributed a lot to central government revenue so we also deserve much better…" *(K-7)*

These statements are examples of the direct approach that is common nowadays. District government has become more confident and, even though respect to central authority as a fatherly figure is still paramount, the relationship has become more straightforward. However, the relationship between district and provincial government was rather ambivalent. The impression that the respondents gave was a mix of indifference as district government prefer to communicate directly with the central government, but at the same time district government has a high expectation that provincial government could contribute more in district affairs.

5.2.1.2. The Relationship between Poverty and Central-Local Coordination

Kutai Kartanegara was not particularly poor compared to the other districts in this study (see Table 5.2). However, the government of Kutai Kartanegara drew public attention as the district was often criticised as not doing enough to prevent inequality developing within the district, as stated by a local legislator. Ironically, some of the most underdeveloped regions in Kutai Kartanegara are situated closed to mining areas. The villages lack basic amenities such as access to clean water, electricity, healthcare and education. The problem could not simply be resolved with pouring more money in these underdeveloped regions. For example, in the case of electricity there are 36 villagers in Kutai Kartanegara that could not yet access electricity[237], when the district government decides to increase the electricity capacity by building a power plant it has to receive approval from the central government through the State Electricity Company, or *Perusahaan Listrik Negara*. Even though there is already a foreign investor that is interested in this project the plan could not be continued as the power plant is not part of central government policy, as described by a respondent below:

> "…the plan to build hydroelectric power has gone through detailed engineering design and feasibility study. There is also already an investor from China that is interested and has surveyed the area. They said it is feasible and they are ready. But for the moment it has to be postponed (*ditunda*) because of the bureaucracy. The power plant is not yet listed (*masuk*) in the State Electricity Company policy. Even after the *bupati* sent a letter of request they did not budge (*berubah pikiran*)…"

A paradox common to the four Javanese districts of Java, which with the addition of Bantul, form the Special Region of Yogyakarta, is that even though the special region is

one of the most impoverished provinces, in Indonesia, it is the fourth highest ranked province in terms of the Human Development Index (Indonesian Bureau of Statistics, 2010). The Special Region of Yogyakarta, or widely known by the Indonesia abbreviation DIY, has the highest life expectancy of 74.2 years and the highest concentration of elderly people (National Development Planning Board, 2014). According to Armida Alisjahbana from the National Development Planning Board, the residents of DIY live longer due to a higher level of health and more accessible health services[238]. This paradox confirms a study conducted by Chowdhury *et al*[239] in Bangladesh that revealed income poverty does not always translate to lower health outcomes. Income poverty could be moderated with education, equitable distribution of resources, women empowerment and participation and health innovations.

Table 5.2 Number of Poor per District

Districts	Year	Number of Poor People	Percentage of Poor People	Poverty Line (IDR/capita/month)
Kutai Kartanegara	2007	63,500	12.59	217,131
	2010	54,700	8.68	272,835
Bulungan	2007	24,000	22.31	179,744
	2010	16,600	14.57	248,653
Balikpapan	2007	18,300	3.74	226,599
	2010	22,900	4.07	313,485
Samarinda	2007	38,200	6.6	218,940
	2010	38,000	5.21	337,162
Kulon Progo	2007	103,800	28.61	173,738
	2010	90,100	23.15	225,059
Gunungkidul	2007	192,100	28.9	158,152
	2010	148,700	22.05	203,873
Sleman	2007	125,400	12.56	198,907
	2010	117,000	10.7	247,688
Yogyakarta	2007	42,900	9.78	249,318
	2010	37,800	9.75	290,286

Source: Bappenas, the National Development Planning Board.

The poverty lines differ in each district as the prices of basic needs such as food, clothing, housing and healthcare from which the poverty line derives is widely varied across districts.

5.2.1.3. The Problem with Availability of Reliable Data

One important factor in decision making is the availability of reliable data. Local decision making is also based on data, as described by a respondent below:

> "…nowadays we used data for many purposes, to develop a local program but also to convince (*meyakinkan*) local legislators and *bupati*. When we negotiate our program or budget with them they want us to show the data. They do not just want to hear what we said but they want us to provide data to support our arguments…"

However, it is quite clear that reliable data is not always obtainable. One respondent described the data collected by *puskesmas* as often misleading and thus adversely affecting local health performance:

> "…how can we increase our health performance if the data is not reliable? For example, in one *puskesmas* it was reported that there were twenty three malnourished infants under five. However, when we checked in the field *(di lapangan)* we could not find the twenty three. We only could find around fifteen and that is from one *puskesmas* only. How can we treat them if they do not exist? Moreover, we could not report that we have treated 100% of malnourished child in our area..." *(K-7)*

Unreliable data is not a problem specific to Kutai Kartanegara. Inaccuracy of health data has been acknowledged also by the central government. Inaccurate data is not only damaging to local prestige as implied in the quote above, but it has more serious

consequences. Unreliable data has hindered development of effective and efficient health programs. According to the Health Metric Network in cooperation with the Centre of Data and Information, the Ministry of Health Indonesia in 2007 pointed out inadequacy in resources (47%), indicators (61%), data sources (51%), use and dissemination (57%), and data management (35%). In addition, the study found that a quality assurance system was not yet in place and that monitoring of data quality relied on the willingness of each office. Local human resources were indeed one of the key factors in providing reliable health data, as *K-7* described:

> "I think it is the capacity of the staff in the *puskesmas* that needs to be improved. They do not understand that accurate data is very important…" *(K-7)*

The inaccuracy of local data was also reported by a respondent from another district:

> "…one of the most important things that the central government needs is reliable local data. But our data in the central government is just full of nonsense *(gojeg kabeh)*. For example, our revenue from income tax is supposed to be 1.2 but the central government data showed from the same item in the same year was 2.1. This difference cost us a lot. We should receive a larger revenue-sharing but because the data is not accurate we receive less than we are supposed to…" *(J-13)*

5.3. The Importance of Leadership in Local Interpretation

Local interpretation cannot be separated from local actors, particularly the *bupati* and the politicians in the local House of Representatives. As mentioned in Chapter 4, local decision making was dominated by *bupati* and the local legislators as the key actors. The introduction of direct elections for local government positions has opened opportunities for local leaders. It removes central government control and devolves

accountability to local communities, and at the same time strengthens the position of *bupati*. *Bupati* are strengthened as they are not appointed by the local House of Representatives anymore. However, the concept of local accountability seems theoretical because, as Lele[240] points out, even though *bupati* and governors were popularly elected, the public had little ability to demand government accountability. In addition, an unclear division of responsibility between central and local government makes it more difficult for voters to identify who is responsible for certain policies and programs. As pointed out by Keefer and Khemani[241], and Mani and Mukand[242], the situation is problematic, especially in the developing countries where people are less likely to be educated and information is less accessible. Public participation was mostly limited to casting votes every five years without effective control of the government.

Even so, for some, the prospect under local leaders was considered favourable to centrally appointed *bupati*. A specific reason for this was that local-grown leaders have the advantage of experiencing local conditions first-hand, as explained by a respondent below:

> "…locally elected leaders can act (*berbuat*) according to what they see (*lihat*), what really happens (*riil*) in our district. It is not the same when the province or central government appointed (*drop-dropan*) the *bupati*. They do not know the conditions in the field…" *(J-4)*

Another participant added that it would be better if they also have had experience in serving the area as public officials, as they are exposed to more specific local problems and are accustomed to local mechanisms of finding a suitable solution. Central government-appointed leaders could be potentially less attuned to local conditions, as expressed below:

> "…if a person never holds any office (*duduk*) in the local government, how can that person translate local needs (*menerjemahkan kebutuhan daerah*)? Those people from the central government do not necessarily (*belum tentu*) understand (*memahami*) local problems…" *(K-5)*

This view must be interpreted cautiously though as Côté pointed out, decentralisation, especially after the introduction of direct elections, has seen resurgence in preferring *putera daerah* or having locally born people as local leaders[243]. As mentioned in Chapter 4, people's choices were often influenced more by traditional solidarity than by the candidate's capacity. This phenomenon was particularly visible for political positions, such as *bupati* and governors, with candidates and incumbents deliberately associating themselves with particular local ethnicities. In Papua, the most eastern part of Indonesia, non-locals were even prevented from running for *bupati* or governor. However, this regulation for Papua was a special case. In the selected districts of this study there is no such regulation.

In the eight districts of this study, the lures of *putera daerah*, or other traditional allegiances, have become less relevant in local elections, as mentioned in Chapter 4. The attributes of ethnicity or other local-solidarity factors in a prospective leader have weakened and been replaced by ability of the candidate to provide tangible programs, such as the *jamkesda*. According to one respondent, the voters prefer a *bupati* with a well-planned program with a clear vision, reachable targets and reasonable timelines as their first attributes, rather than being *putera daerah* as explained below:

> "…a *bupati* must have well-defined (*jelas*) concept, well-defined objective, well-defined vision, and well-defined mission. But not only that, the objective and vision should be achievable (*bisa diraih tidak*) within the timeframe…" *(K-5)*

According to Tead[244], in modern management, every organisation such as a district has to have a clear vision and objectives that act as a reference for the local government apparatus in performing their duties. *Bupati's* leadership as top manager in the district has an important role in ensuring that the vision and objectives are understood and reflected in local programs and policies, particularly as the authority of the district encompasses a wide range of public services.

Besides having good prospective policies, as a second attribute, a *bupati* must also perform well as a decision maker and take risks. Siagian[245] pointed out that effective leadership depends on an ability to make a decision that is practical, realistic and applicable. Since the district is an autonomous unit, the *bupati* could no longer rely on central government, as expressed by another respondent below:

> "*Bupati* must be able to make the most reasonable decision amidst the limited resources. We have problems and challenges that need quick solutions. For example, the issue of shortages in health personnel we could only recommend the *bupati* to recruite more health personnel. But it is up to the *bupati* to make the decision..." *(J-3)*

Another respondent stated:

> "It was the head of the district health office that had the idea to contract health personnel. She discussed it with the *bupati* and the local legislators. It was a risky decision to make as the central government had imposed the moratorium. But our understanding was that the moratorium applied only to permanent staff and not temporary staff like the contracted doctor..." *(J-5)*

The respondent further added:

> "...the *bupati* has already given consent to go ahead and the *bupati* decree (*peraturan bupati*) will soon be issued..." *(J-5)*

As a third attribute, another respondent stated that a *bupati* should have a good relationship with the local House of Representatives. According to Kaloh[246], a *bupati* should have the ability to promote local cooperation and networking as this attribute is required in developing the district. The *bupati* needs the support of the local House to push through local programs, but strong collaboration with other stakeholders is also essential, such as the district planning board and the private sector.

> "…a *bupati* must have support from the local House of Representatives. Therefore, it is essential that the *bupati* can cooperate (*bekerjasama*) and have a good relationship with the legislators…" (K-11)

However, as one respondent put it, a *bupati* sometimes needs to be authoritative, the fourth attribute, particularly in the decision making process where forming a consensus often takes considerable time. According to Terry and Franklin[247] a good leader should possess the ability to persuade their other colleagues to aim for common objectives.

> "…for education and health, usually the process of negotiation with the local legislators went smoother as the *bupati* and the legislators often have the same interest. A more tough (*alot*) negotiation instead came from the local house office. For example the *bupati* decision to proceed with the *jamkesda* amid tight budget and the lack of a preliminary study of the program. It received strong disapproval from the local health district. The local health district views the program as populist and not necessary. However, with the backup of the local House of Representatives the program was implemented…" *(J-16)*

A fifth attribute that a *bupati* should have is strong commitment for local causes. For some respondents strong commitment was reflected in the larger share of the district budget that has direct impact on public welfare such as health and education, as expressed below:

> "We allocated a large amount of funds (*anggaran yang tidak sedikit*) for public health. Indeed, education has more but healthcare comes second. It is part of the *bupati's* commitment…" *(J-4)*

Another participant provided similar information:

> "…together with education and public works, public health receives a larger share of the district budget. It is part of the government policy…" *(K-1)*

A strong commitment to health seems widespread in all districts, even among districts with a low fiscal ability.

> "…the new *bupati* has made a number of policies to increase public access to health services. One such policy is that all residents' health needs would be covered by the local government. Not as comprehensive as the *jamkesmas* but every resident could show their ID card and they will receive free health services. The government has allocated 9 billion IDR last year and absorbed around 7 billion IDR…" *(J-6)*

Even though greater government spending can improve the human development index, and health and other health-related indicators such as those indicated by Widodo *et al* [248], it must be remembered that the effectiveness of the funds also depends on how the spending is allocated[249].

In relation of having a strong local commitment a respondent argued that *bupati* should also guard local interests where central government interpretation seems to interfere with the local interests and needs, as described by a respondent below:

> "…a *bupati* must defend local rights against excessive central government. The authority to issue mining permits that used to be the district's affair has been handed over to the provincial government as the representative of central authority. Health-related policy has also being 'centralised'. For example, the central government has regulated that all *puskesmas* must be accredited. The problem was that each district has a different situation and condition that is not accommodated by the central government. The central government do not acknowledge *puskesmas* ISO certification as part of the local initiative. Besides that, the need to recruit more health personnel is also hindered by the central regulation. We definitely need more health workers." *(K-7)*

The desirable attributes of *bupati* described above were qualities that the respondents envisioned such an official should possess. This shows a preference for more pragmatic qualities with two main features: first, building strong cooperation at the local level and developing programs and policies that sided with the public welfare; second, acting as a protector of local interests against encroachment of central power.

In general, the public sector in Indonesia trails the private sector and non-government organisations in a number of issues, such as global insight, ability to adopt technology, orientation to innovation and personal capacities. The private sector has the lead in quality of service. For instance, Dr Ch B Lumenta, an Indonesian professor of Neurological Surgery and chairman of Neurosurgery, Bogenhausen and Schwabing Academic Teaching Hospital, Technical University in Munich, Germany has stated that

the Indonesian private sector has become enomously wealthy and responsive to people's needs while public sector agencies such as public hospitals and *puskesmas* remain afflicted with problems such as a shortage of medicines and human resources, outdated facilities and a low standard of services[250]. This disparity between the quality of public and private health facilities is widely acknowledged by local stakeholders[251,252] and a number of efforts haves been made to boost public health facility performance. One widely advocated policy is to provide broader autonomy to public sector hospitals and *puskesmas* in managing their own affairs, with the expectation that they will eventually improve and become more professional (see the discussion about the BLUD policy on page 176). Another pertinent local policy is the regulation of the distance between health care facilities/providers, particularly between *puskesmas* and private clinics. While this regulation is said to improve access to all facilities, it appears more to do with governments' concern about the ability of public facilities to compete with private clinics[253].

There are obviously a number of public hospitals and *puskesmas* that, in terms of human resources and technology, could be considered efficient and effective[254]. For these facilities, the number of physicians and nurses, and the availability of pharmaceuticals and medical equipment may not be a major concern in most cases. Nevertheless, the quality and timeliness of care may be influenced by how most of the physicians employed in the public sector also work in the private sector, presumably paying more attention to their private practice[255,256]. Another important factor is interaction, communication and effective team work; essential aspects that seem to be ignored by public hospital management[257]. A survey conducted by Lingkar Survey Indonesia in Banyuwangi, East Java supports this claim of a lack of professionalism in the district

public hospital[258]. Members of the public found health services in the district hospital to be discriminatory and insensitive. Patients claimed to often receive care based on their socioeconomic background or physical appearance. The survey revealed that, due to this apparent lack of professionalism, it is mainly the low-middle income groups that access services at a puskesmas while those from high income groups opt for a private hospital.

The Global Competitiveness Index from the World Economic Forum shows that Indonesian competitiveness sits in 38th position, far below neighbouring countries like Malaysia or Singapore. Compared to other Southeast Asian countries, the public sector in Indonesia tends to have a reputation for lower quality. One way to increase public sector quality is to have a visionary, strong leadership in the bureaucracy that can transform the public sector in an effective way. In a paternalistic environment like Indonesia, leaders in the bureaucracy have a strategic role and, especially after decentralisation, the *bupati*'s capacity has a large effect on the quality of local government administration. Reflecting on the attributes that respondents envisioned above, *bupati* and other leaders in a local bureaucracy should have the willingness to take risks, good communication and negotiation skills and the ability to mobilise local resources.

5.3.1. Local Capacity, another Important Aspect of Local Interpretation

Local capacity is an important aspect of decentralisation as more authority – in various degrees – is transferred to sub-national or lower tier of government. The new authority to plan, budget, execute, and evaluate public program (instead of just implementing central government program) brought to fore some concerns such as local government capacity to implement decentralised programs. It was for this reason that some central governments in the past refused to give broader autonomy to the local governments as

local government were considered unprepared and whether the local government will be able to deliver the assigned responsibility efficiently and effectively. Nevertheless, the phase that the local government could be considered fully prepared is difficult to define and measure. In addition, there is growing evidence that the maturity of local capacity will follow the development of decentralisation[259].

The term capacity has various meanings and interpretations. In economics for instance, the term capacity is associated with the degree of input utilisation in order to achieve a certain target or output[260]. Capacity therefore encompasses the use of production factors such as labour, land and capital. A similar concept is used by Fiszbein who defines capacity as the means contributing to a functioning (local) government. In order to perform well, local government requires a combination of qualified staff (labour), access to capital (capital), and outward-looking organisation and management (technology). Qualified staff with required knowledge and skills is necessary for decision making. Nevertheless qualified staff could be ineffective if there is no access to capital, for instance when there is insufficient access to necessary equipment. Outward-looking organisation and management is a prerequisite in order for local government to be more responsive to local needs and condition.

Discussing local leadership cannot be separated from the capacity of local health workers who provide direct services to the public and the capacity of the decision makers from the local health district who initiate local programs. Both are interconnected and contribute to the realisation of *bupati* leadership, though they do so in slightly different ways. In terms of health personnel, a number of studies indicate that a discrepancy in health performance across districts was due to a disparity in health workers[261]. The situation was apparent since before the implementation of

decentralisation, as highlighted by the WHO[262]. For example in 1998 (two years before decentralisation) the gap was already large. In 1998, Jakarta had the lowest infant mortality rate in Indonesia, with 27 per thousand live births, while West Nusa Tenggara was highest at 90. This difference was due, among other reasons, to uneven access to trained birth attendants. More than a decade later, even though infant mortality figures have improved overall, the disparity in these rates has not significantly changed due to difficulty in ensuring steady supply of trained birth attendant services across the many islands of Indonesia[263].

Another type of local capacity is related to the ability of decision makers in local health offices. Their role is essential as local health programs are mostly developed and derived by their office. They also provided feedback to the *bupati* and participated in the development of the medium development plan. The lack of local expertise could hamper the performance of local government, as explained by a respondent below:

> "Our problem is in human resources. We can feel it (*merasakannya*). Right now, we are understaffed in the division of disease control and prevention. The division could not function effectively because we do not have sufficient funds and expertise to perform comprehensive epidemiology surveillance on potential diseases in the district. Our program on disease early warning system (*sistem kewaspadaan dini penyakit*) and the study of disease outbreaks (*penyelidikan kejadian luar biasa*) is not yet running effectively. We know it is important but it is still not possible right now" *(K-17)*

One respondent who used to work on another island also acknowledged the different work conditions that the respondent encountered:

> "…our staff have different capacities, you cannot rely on them. You need to be more patient as things get done in a much longer time (*lebih lama selesainya*). In my previous place everyone seemed to know what to do but here I have to explain everything in detail and even then they only work at what they have been told. There is no initiative. The situation is not the same with local staff in the other island (the respondent refers to an island that is known to have better capacity)…" *(K-8)*

Another respondent stated:

> "I am not sure (*belum melihat*) if in all this time (*selama ini*) our programs have been evaluated. We are focusing on the implementation (*sibuk melaksanakan*) of health programs. Our aim is to overcome health problems (*mengatasi masalah*) in this district. *(K-6)*

The opinion of respondent may be a reflection that the staff are poorly skilled and have a less than optimal knowledge about the link between planning, implementation, monitoring, and evaluation[264]. However, it may also reflect that the districts may not have the required knowledge and skillset amongst staff to actually plan, implement, monitor and evaluate programs effectively. The quote above indicates that not every staff member in local health office has the same skills and knowledge on the importance of evaluation and planning, and possibly on some more important aspects in developing a health program. This situation raises the question regarding how local planning is developed in local government and local health offices in particular.

The view of respondent *K-6* seems to contradict the overall finding as presented in Chapter 4 that described local health program development through evaluation. However, even though the respondent claimed there was a lack of evaluation this does not necessarily mean that evaluation was totally ignored in the district. Often the

activities of evaluation and planning intersect. Therefore, various stages are being claimed by planners and evaluators at the same time as part of their respective activities[265]. It is possible that this is why later on this respondent admitted that actually there are some evaluation-related activities, though low-key, due to the human resources issue. A thorough evaluation was not possible due to lack of expertise.

> "…in every local government office they should have (*harusnya*) a distinct section for an evaluation program usually as part of the division for planning. This division would be responsible for the realisation of local health planning as well as evaluation. However, I could say (*kalau saya bilang*) that we implement less than 10% of the total evaluation activities that we are supposed to perform (*kita laksanakan*). This is how it is done here (*di sini begitu*). It could be said that the evaluation we have here is not serious…" *(K-8)*

The situation above does not apply to all districts, as mentioned in Chapter 4 most respondents have taken evaluation seriously and they appear to know what they are doing.

> "Evaluation is very important (*penting sekali*) because it is necessary in order to examine our achievements (*pencapaian*). With evaluation we could discuss whether we need to alter (*merubah*) our strategy to achieve a certain target or whether our on-going strategy is appropriate (*menguntungkan*) in the face of a changing situation. The purpose is to increase (*meningkatkan*) our upcoming performance. Human resources are ready, the budget is ready, and what do we want next (*tinggal mau melakukan apa*)?" *(K-7)*

Another more specific example of an evaluation of a health program is described below.

> "We evaluate all our programs. As an example, for our health promotion program we use the clean and healthy living behaviour (*perilaku hidup bersih dan sehat*) indicators to assess the effectiveness of the program. In all, there are twenty indicators that encompass all family members' health-related behaviours such as whether any members are smoking, drinking alcohol, etc. We surveyed the community regularly…" *(J-9)*

Regarding local capacity, there were indications in this study that some local health offices have taken shortcuts in developing local health programs. One particular temptation was the practice of copying a program (popularly known as 'copy-paste program') from a previous year with only minor modifications[266,267]. Rather than painstakingly conducting evaluation, analysing local data and examining public recommendations, it was easier just copy what had been done in the previous years. The respondents did not openly admit this practice, but they tended to refer to practice somewhere else or sometimes in the past, as described by one respondent below:

> "…I have heard that the practice of copy-paste program is widespread in neighbouring districts. One that I have heard is that they procure tables and chairs every year while everyone knows that tables and chairs could be used for many years. Another common practice is not reporting the discount that they have received. They are supposed to report it to the local asset and financial board (*badan pengelola keuangan dan asset daerah*) but they don't…" *(J-5)*

Another respondent stated:

> "…in the past the practice of copy-paste program was more common. But in my view it is not merely copying what has been done in the

> previous years, but it is more as doing the same activities. For example, we always have programs on maternal and child heath, immunisation, malnutrition and so on. It is the intervention that is often copy-pasted from the previous years…" *(K-1)*

The practice was apparently rather common in some places, especially in areas where public control was relatively weak. In areas where this practice was widespread, all mechanisms and procedures are merely taken as a formality while the programs and activities are pre-determined.

5.3.2. Locally Responsive or Local Elite Responsive Program?

Bupati and local legislators have always claimed that their aim in the local decision making is betterment of the local public welfare. However, distinguishing whether they act in the public interest or out of self-interest or what they believe is the public interest is sometimes difficult to determine.

> "…planning (*perencanaan sederhana*) should be based (*berdasarkan*) on needs (*kebutuhan*) not wants (*keinginan*). However sometimes it is not easy to distinguish between needs and wants…" *(K-5)*

The distinction between what the local public want and what do the public actually need is often not fully understood by local decision makers. Motivation to 'make the public happy' was often more influential than the more objective considerations such as effectiveness, budget constraints or moral hazards. This was visible during the political process when health programs were negotiated between the *bupati* and the legislature. For example, on the typical issue of health promotion as opposed to curative care:

> "…healthcare issues such as health promotion are not yet fully understood (*belum dipahami*) amongst the health office circle (*kalangan*) let alone the mayor, *bupati* or the governor…" *(K-5)*

The prevalent impulse to support curative care rather than health promotion was clear. Even after numerous studies have suggested that health promotion is potentially more cost-effective and therefore should be more favoured over curative care[268], not many districts willingly supported health promotion. One reason may be the ignorance of some local stakeholders, especially some executive heads and local legislators, as suggested in the previous quote. Curative care seems more tangible to lay people, and also to these decision makers. It encapsulates what is considered to be a responsive health program that is often defined as being treated whenever they are sick. Consequently, more districts are favouring curative care over health promotion, as the latter lacks immediate impact. This inclination is evident in a tendency for the budget for curative care to be greater than that for health promotion.

> "…to be honest, our budget (*anggaran*) for curative care is still very dominant compared to health promotion. However, in my point of view health promotion is very important (*penting*)…" *(J-8)*

Unless there is strong political will from local stakeholders it would be difficult to support health promotion programs. The initiative could be come from the local health offices, but without support of the local House of Representatives and the *bupati*, no health promotion program can be sufficiently funded.

> "…actually health promotion is indispensable (*sangat diperlukan*) here. However, the budget (*anggaran*) often failed (*mental*) in receiving support…" *(J-8)*

The intangible nature of a health promotion program has made it difficult to attract the support of local stakeholders, particularly the *bupati* and the legislators. Even for local health officials with sufficient understanding of health promotion, it is sometimes difficult to convince local stakeholders to support health promotion programs.

Curative care strengthening in these districts is undoubtedly necessary, both in terms of access and quality improvement. Nevertheless, health promotion is equally or even more important because of the high burden of potentially-preventable disease, and the need to address risk factors at individual, social and organisational levels. One way that health promotion planning and implementation within the overall district health program could get the attention of local policy makers (particularly the politicians and senior administrators) is through the generation of reliable data. Several local government websites declare that access to relevant information plays an important role in the government's planning and programs[269,270,271], including in health promotion programs[272,273].

Such data could be made available through the information collection that is a regular aspect of health services provision and disease prevention activities, and could also be generated by commissioning needs assessment and root cause analysis. It is important that health promotion advocates have the support of good data when lobbying those in the district who make decisions about funding public health and health promotion. For example, in one of the districts, Kutai Kartanegara, while this research was being conducted, the local department of health initiated a root cause analysis of the high number of maternal deaths recently experienced. That activity and the information made available helped the local health care department gained the attention of local politicians, thereby improving the funding for maternal health programs. Getting the

local politicians to support the program publicly through the news media was helpful in achieving this outcome.

5.4. Conclusion

My analysis of the material provided by the respondents indicates that decentralisation is not implemented in the same way across the districts even though the central government tries to limit the variation through regulations and policies. Ironically, it is these regulations and policies that at times prompt different interpretations by local governments. This chapter highlighted the variety in interpretation and implementation of central policy and regulations due to local characteristics and constraints.

The most powerful influence seems to be the relative fiscal capacities of local governments. Stronger fiscal capacity has allowed some local districts to subtly challenge central authority. The different positions taken by local governments is in part determine changes in the relationship between local politicians – the local government and legislators –, local health personnel and local public. While prior to decentralisation local governments were given less opportunity to interpret central policies and programs, after decentralisation local politicians were given acquire more space to have more discretion. This situation has influenced local government practices in response to central policies, such as the moratorium on civil service recruitment. Local government initiative in contracting health personnel not as permanent employees but as casual temporary staff showed that local governments' understanding about local pressing needs acted as another influence in policy implementation process. If central policy does not work to accommodate local pressing needs, such as the shortage of health staff, the district would tend to find alternative mechanism by identifying area which the

policy is silent. This pathway is easy to adopt for districts that have the relative better fiscal capacity.

The combination of desire to fulfil local expectations, the inadequacy of fund receive from the centre and the policy interpretation space provided by the decentralisation have encouraged local government to experiment in finding alternative means of resource generation. For example, this phenomenon is reflected in the move towards using public hospitals and *puskesmas* for resource generation by escalating fees and/or privatising some of the services, but at the same time introducing local health insurance for deserving poor.

Within the increasing role of local actors, the centre tries to monitor and exert pressure when it sees locals deviating too much from what the centre considers as the intention of the policy. For this purpose the centre keep coming up with additional regulation as obvious from the introduction of Public Service Agency to limit the influence of local political structure on hospital finances. In some places the process has an impact on local initiative, causing local government inertia to return; particularly when local see that they might be penalised for taking initiative. The example of the new *bupati* feeling unable to take initiative is an example of this phenomenon.

There are some other important defining factors in implementation of decentralisation particularly local leadership, local capacity [technical, medical public health expertise] and the coordination within the local government in the region. The local considered learning from each other as important mechanism to strengthen the local system in decentralised government.

Chapter 6

Central Government Control through Regulations and Policies

Chapters 4 and 5 described and explored the implementation of decentralisation and factors that influence implementation of the policy in local contexts, from local fiscal capacity to local actors' interests, interpretations and interactions. Previous chapters provided an indication of strong central government influence in local affairs, including healthcare. Earlier, Chapter 3 provided an overview of the decentralisation policy legislative framework that shifted from a federalist separation of powers to a more unitary state power-sharing characterised by joint responsibility.

In this chapter, the role of central government is further explored; encompassing how central government influence has been made possible through local development planning, minimum standards of health service, data collection and human resources. Further, the central government has used central regulations and transferred funds through the local revenue or APBD as a means of control. The central government has transformed into the fatherly figure of Javanese culture, having responsibility to direct and supervise the implementation of decentralisation with emphasis on stability and cohesion rather than diversity. Despite the strong influence of central government, communication and negotiation is still an important part of developing local health programs that enable local government to convey their views and concerns.

6.1. A Javanese/Indonesian Perspective on the Nature of Central and Local Government Relationship

Indonesia's culture as mentioned in Chapter 5 is heavily influenced by Javanese culture due to their dominant role in politics and social life[274]. Therefore, it is appropriate to use Javanese-derived values to comprehend the broader Indonesian context of the central-local government relationship. These values emphasising social harmony and stability were extensively promoted by the New Order regime and played an important role in the way the state was governed at that time. Even though reformation brought many changes in how people view Javanese values which some had considered as irrelevant and relics from the past, they still have considerable influence among many Indonesians, including the majority of respondents. In terms of central and local governments, one respondent compared the relationship to that of a father and son, a concept known as *bapak*-ism:

> "…I considered central government as the father of both the district and provincial governments. We have the same father. There is no way that a father harms their children. However, at times a father needs to impose some restriction. But it is for our own good I guess…" *(J-13)*

The respondent added:

> "…if I have problem I could rely on the central government. For example, several years ago we had a financial problem that forced us to borrow around 13 billion IDR from a local bank. The interest was too high for us so I went (*menghadap*) to the Ministry of Finance and I wept (*menangis*). They wanted to listen and give the solution for my problem. The central government agreed to take over the debt and used our general allocation fund for the instalments. Each year our general allocation fund is deducted 1 billion IDR…" *(J-13)*

The Javanese uphold the values of *kekeluargaan* (family-ism) and *bapak-ism* (father-ism) as central tenets of their culture[275]. *Kekeluargaan* derives from the word *kula* (individual) and *warga* (community), a concept that harmonises microcosm and macrocosm. The three founding fathers of Indonesia, Soekarno, Hatta and Soepomo endorsed the concept of family-ism in the government system. However, each had their own interpretation. According to Sofian Effendi, the Rector of the University of Gadjah Mada, Soekarno emphasised the spirit of *kekeluargaan*, mutual help, or *gotong royong* while Hatta emphasised social interactions and collectivism. Soepomo on the other hand highlighted the comparison of Indonesian leaders with a father in a family[276]; leaders of a nation should unite with the people and maintain order in the state. This view supported the value of father-ism or *bapakisme*.

Bapak-ism is the relationship between leader and follower that imitates the relationship of father and son. This value has been perceived in many ways. For example, at a local commemoration ceremony, Lukman Hakim Saifuddin, the Minister of Religious Affairs, associated the value with authoritarianism. He encouraged local bureaucrats to abandon the culture of *bapak*-ism that tends to rely excessively on the leader without leaving space for staff to develop ideas and initiatives[277]. The value of *bapak*-ism in the *Kamus Besar Bahasa Indonesia*, the principal dictionary of Indonesia, is also associated with venerating leaders. However, Irawanto *et al*[278] argued that *bapak*-ism should be understood as personifying the ideal *bapak*, the one who demonstrates attributes such as prudence, sincerity and responsibility. Good leaders should have these qualities when dealing with colleagues. In addition, a popular Javanese motto summarises how a leader should act amongst followers: "*ing ngarsa sung tuladha, ing madya mangun karsa, tut*

wuri handayani" (The front should give a good example, the followers should give motivation and the back should give support).

Central to *bapak*-ism is the possession of authority. Central government, with the president as the supreme power of the state, has authority regarding how power should be distributed to local governments and which authorities must be limited; as implied by some respondents in Chapters 4 and 5. Respondents' views on this were follows:

> "…the central government devolved authority to provide healthcare and education to district governments. It was the most appropriate thing as we had better understanding (*lebih tahu kondisi di lapangan*) than central government…" *(J-1)*

Another respondent stated:

> "…Indonesia is a huge country. Each area has its own specific challenges. It would not be suitable if every policy is determined by the centre as it used to be. I guess people's expectations have also changed…" *(K- 4)*

As part of the value of *bapak*, the central government's role was to control and supervise local governments to avoid them abusing their power that may jeopardise provision of local public services. Unchecked use of local power could risk national and public interests alike, especially in a pluralistic country like Indonesia. It is the central government's role to assure that this does not happen, as expressed by one respondent below:

> "…the central government role is to make sure that local government prioritises their public health services. All district governments have to put the health sector as their main priority…" *(K-10)*

In the case of insufficient local resources, a respondent argued that it is the central government's responsibility:

> "…we could not cover all residents in the program as we have limited resources. We must make some priorities. Local residents should have the first priority. As for non-local residents (*bukan penduduk tetap*), I am sorry but we do not have the resources to include them. The central government or the provincial should be responsible for that, maybe through *jamkesmas* or other initiative…" *(K-9)*

It was also this local insufficiency that according to a respondent indicated that central government has doubts about the ability of local governments:

> "…I feel that central government only half-heartedly (*setengah-setengah*) devolved their authority to us as though they would not wean (*menyapih*) us. Maybe they are worried that we could not perform well…"

Doubts like this have motivated central government to supervise local programs and policy more closely. According to MacKinnon[279], to ensure the process of supervision is effective, the central government needs to regulate mechanisms, procedures and strategy. The central government has regulated in detail every sector that has been devolved. I am using three examples of central government regulation that must be followed by local governments: the national planning system through Law No 25/2004, minimum standards of services in the health sector through Ministry of Health decree No 828/2008 and the use of central government-sourced data through Presidential decree No 86/2007. With these regulations, central government tries to influence and direct local government health programs and policies. In addition, central government involvement in shaping local policies is also practiced through the transfer fund and the

requirement for local government APBD to be authorised by the central government. These regulations will be discussed in the following sections.

6.2. National Planning System: What does the Central Law Say?

Local planning is an integral part of the national planning system, *sistem perencanaan nasional*, that requires integration and synchronisation of local planning with central planning. According to Law No 25/2004 this planning system is aimed to assure that development can be carried out effectively, efficiently and on target from the central government's perspective. In short, local planning consists of three different terms:

1. The 20-year local development plan, or RPJPD;
2. The 5-year local development plan, or RPJMD; and
3. The annual local development plan, or RKPD.

The latter two documents refer to the higher level documents. As such, the local document must refer to the national document, and a shorter term document must refer to the longer term document. This means that district development plans must refer to the provincial and national development plans and the annual development plan must refer to the medium and eventually the long term development plans, as described by one respondent below:

> "Our health program passed through the process of local planning (*perencanaan daerah*) first through the long term local development plan (*Rencana Pembangunan Jangka Panjang Daerah*) then the local medium development plan (RPJMD) and from it every year we developed our annual work plan (*rencana kerja*). In each stage our development plan must also refer to the provincial and national work plans…" *(J-1)*

Local programs that were generated from this process are expected to be in line with central government interests and policies. Consequently, any program that was deemed not in accordance to central government policy could be dissolved.

> "...we used to allocate (*menganggarkan*) the 'health fund' (*dana kesehatan*). This was related with the effort to reduce (*menanggulangi*) poverty (kemiskinan) among local residents because often when they were healthy (*sehat*) they were not poor (*tidak miskin*), but once they became sick (*jatuh sakit*) they become poor (*miskin*) because of costly hospital bills (*biaya rumah sakit mahal*). We had the initiative to provide some assitance (*bantuan*) to alleviate this problem. We assigned some funds (*persiapkan sejumlah dana*) for them as they were not covered by the jamkesda because they do not hold a Kartu Keluarga Miskin or the low income family card, of course with the support of the local House of Representatives. With this program they received 50% of what they have to pay with a maximum of Rp 5 million. Nonetheless, with the Ministry of Internal Affairs decree (*permendagri*), by 2013 this program was not possible (*tidak bisa*) as it needed to be budgeted (*dianggarkan*) a year beforehand (*satu tahun sebelumnya*). The problem was that we could not predict (*direncanakan*) illness (*orang sakit*)..." *(J-4)*

6.2.1. National Planning System: How is it perceived at the Local Level?

The hierarchical process is part of the national planning system, According to Dadang Solihin, the National Director of Local Government Performance Evaluation, one of the aims of the system is to ensure that local government plans are integrated, synchronised, and synergised with those of the central government. When asked about the necessity of a hierarchical process in a decentralised system, the respondent added:

> "…we are part of the national government. Even though we have our own autonomy it does not mean that we should decide everything. We are supposed to support the central government and the central government should support us. What would happen if every local government initiated their own program without coordination with the central government? It would be total chaos (*tidak karuan*). Just like in a family, there should be order (*ketertiban*). Every child for certain (*pasti*) has their respective talent, characteristics and passion. However, they could not just pursue their own way. There must be ground rules (*aturan bersama*)…" *(J-1)*

The sentiment of *kekeluargaan* or family-ism seemed to influence the respondent's views. Local government sees the central government as the embodiment of the head of family and, as such, responsible for the stability of the whole nation. One of the ways to reach this is through central regulations and an integrated plan. Pragmatically however, another respondent argued that even though the central interest must be taken into account, the local interest should also be taken into consideration:

> "…we must address some aspect that is emphasised by the central government such as reducing child mortality, improving maternal health and combating contagious disease. However, in terms of implementation it depends on our resources…" *(J-9)*

The balance between central interest and local interest has always been one of the respondents' main foci during the study. Their views on this issue were ambivalent between the ideal concept of central and local government harmony in planning and programming and the feeling of unease at the central government becoming dominant, as described by one respondent:

> "…I felt that the central government has recently tried to make everything uniform recently…" *(K-7)*

This hierarchy shows that, despite decentralisation, local planning was directed by the central government. The structure and nature of the planning process was reminiscent of similar New Order five year development plans. During the regime, all public sectors were to support specified national interests with a five year focus. Both arrangements also had similar aims: local government policies should not deviate from those of central government. Local government planning is supposed to support national interests, as expressed by a respondent below:

> "…to be honest I have never thought about it. I thought that it was not an issue and it does not go against (*menyalahi*) the principle of regional autonomy. The centre just want to assure that every district is on the right track (*tidak melenceng*)…" *(J-4)*

The view that local programs, particularly the health program, are an indivisible part of the national program was implied by a number of respondents, as expressed below:

> "…our program was developed to accommodate local needs, but also to accommodate national interests. In a way we are just like politicians (laugh)…" *(K-5)*

Another respondent stated:

> "…we must fight (*memperjuangkan*) for local programs because the local program strengthens the national program…" *(J-3)*

As each local health program relies on local commitment and the local political process, central government seems to be concerned whether local government would be able to

perform public health services in accordance with central expectations. This concern has caused the central government Department of Health to closely control local health programs[280].

Law No 25/2004 stipulates that, as elements of the state, national, provincial and district governments must support the national objectives. Therefore, programs and policies developed by each government are supposed to complement each other. This supposedly well-ordered mechanism does not always work as planned. At times, this synchronisation of central, provincial and district government planning did not materialise during the implementation phase. Consequently, a central program could overlap with a local program or the latter program could not be sustained, as described by a respondent below:

> "…I have heard that central government has built several *puskesmas* near the border. Afterwards, these *puskesmas* were handed over to us just like that, without further central government support for *puskesmas* operational cost. The *puskesmas* were also not equipped with necessary infrastructure, especially health personnel such as doctors and nurses. Hence, some of the *puskesmas* lack doctors. The development of these *puskesmas* was a central government program using the central government budget and was not synchronised with our [local] program…" *(K-8)*

Instead of one common program, central, provincial and district programs have become three separate programs. This disharmony is the reflection of poor coordination and communication between the three governments. The development plans, rather than that of provincial government. It is what described by a respondent as the manifestation of *bupati's* promise to the constituents, as described by a respondent:

> "…even though the medium term development plan is supposed to refer to the central and provincial government plans, as a document that elaborates the *bupati's* vision and program in my view it reflects the *bupati's* promises during the election. I think this is reasonable as the *bupati* is responsible to the public and not to the provincial or central government…" *(J-2)*

The situation could become more complex if the *bupati* and governor came from different political parties that support different policies, as the respondent further stated:

> "…the situation could be more complicated if they (the *bupati* and governor) came from different political parties. Sentiments will run high, particularly during the election…" *(J-2)*

As the political process now takes place at central, provincial and district levels the synchronisation of development plans has become more difficult to achieve as politicians at various levels of government try to influence and shape government policies that suit their interests. This situation is very different from what had happened during the New Order regime where local governments merely functioned as local administrators that implemented national programs and policies as directed.

6.3. The Minimum Standard of Service

The Constitution of 1945 mandated that healthcare is a basic right of every Indonesian citizen. The central government interprets this as assuring that all citizens have equitable access to a basic health program. As health services are provided by local government, the central government regulates the minimum number of health services, known as the Minimum Standard of Health Services, through Ministry of Health decree No 1457/2003 that applied from 2003 to 2007 and Ministry of Health decree No 828/2008 that has applied from 2008 onward. Figure 6.1 shows the division of local

government affairs. Health was considered not only mandatory for local government, but also part of basic services, meaning that the health sector has to be a local priority and its implementation guided by a set of indicators, called the Minimum Standard of Service.

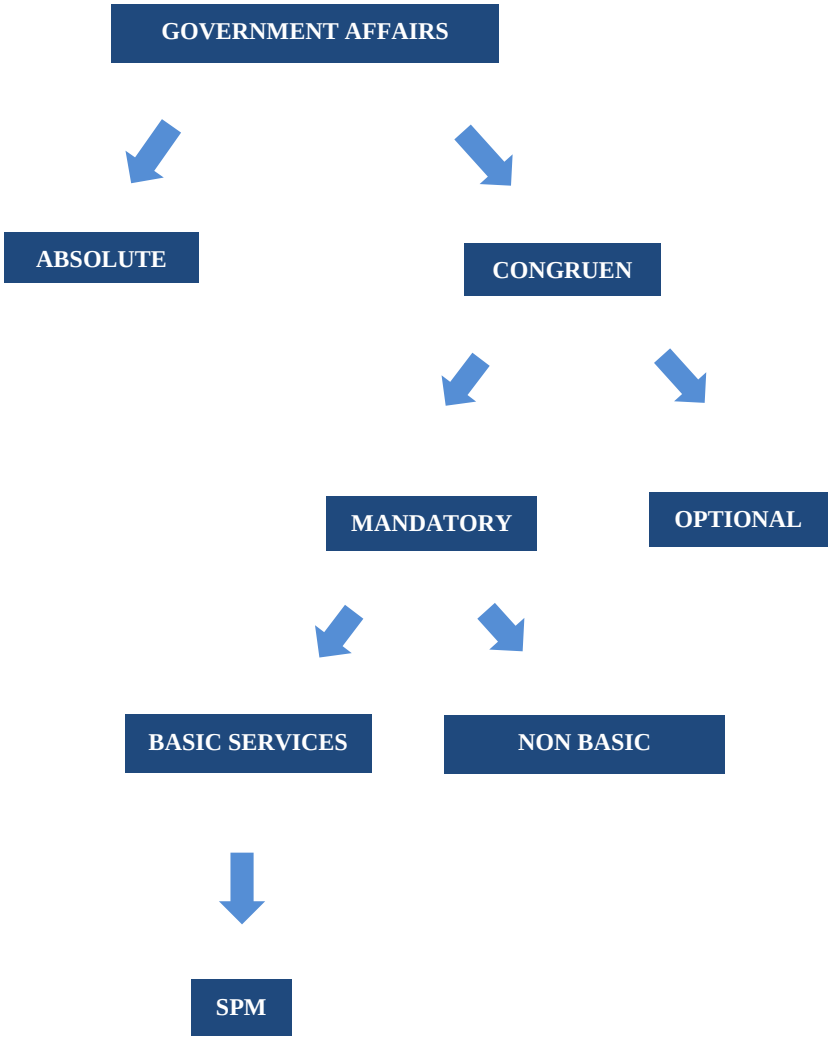


Figure 6.1 the Structure of Government Affairs[281]

The Minimum Standard of Service (SPM) is a set of measures that district governments are required to refer to for health programs in their respective areas. The most recent SPM, issued in 2008, described four main sectors: basic health services, referral health services, epidemiology and outbreak prevention, and health promotion and community empowerment. These were further broken down into twenty two activities, each with targets and performance. This version was much simplified compared to the 2003 version that consisted of twenty six measures that were further breakdown to fifty four activities, each with target and performance. This version was simplified as it was considered way too specific. It was alleged in the media, but perhaps exaggerated, that local health offices were too busy filling out the indicators to do what they were supposed to do.

6.3.1. SPM as a Guideline in Developing Local Health Programs

Respondents perceived the Minimum Standard of Service as having at least three roles. The first role is to guide local government in developing each health program. Chapter 4 explored how local health programs are developed through the activity of evaluation. The evaluation to which respondents referred was performance of Minimum Standards of Service, or SPM. A respondent described how they used the SPM in developing local health programs:

> "…we used SPM as our guide (*acuan*) in developing our health program. The first reason is it is measureable (*terukur*), and second, because it is accessible (*mudah didapat*). For instance, we have a priority program, but we did not implement it successfully. The target was not fulfilled. We evaluated the program to determine what the possible reasons…" *(K-1)*

The use of SPM as the reference in developing local health programs was enforced by the central government through Government Regulation No 65/2005 Article 9. Respondent *K-1* confirmed this regulation:

> "…the requirement to use SPM is enforced through the Ministry of Health Regulation, but I forget which number. It was not the case before, it was just enforced recently. But the requirement applies nationwide. It is demanded (*tuntutan*) by the central government…" (K-1)

Another respondent stated:

> "…the reference (*acuan*) for SPM is in a Ministry of Health decree (*SK Menkes*), it has eighteen indicators. Next it would be elaborated (*dituangkan*) into programs, technical programs…" *(K-4)*

While another respondent added:

> "…for the local health office the references (*acuannya*) were the SPM and MDGs in the form (*bentuk*) of indicators that would further be translated by each local health office into programs (*program*) and activities (*kegiatan*)…" *(K-7)*

The effective use of SPM in developing a local health program is supported by intensive communication with central government, in this case the Ministry of Health, as described by one respondent below:

> "…we have good communication access with the Ministry of Health. Change of the indicators, like what happened previously, was quickly communicated to us so that we could quickly adjust with the change. We use the ministry website for interactions such as consultation,

> raising concerns, or making inquiries. Other ministry's website maybe they have not reached this stage…" *(J-14)*

The internet served another purpose, providing quick responses to central government such as described by a respondent below:

> "…we are already familiar with the internet. Internet access is not that bad. We can quickly send our reports to the Ministry of Health…" (J-6)

The SPM was not too difficult for the local health office to adopt as the minimum number of services recommended in SPM were similar to those already being implemented by the locals (such as those related to maternal and infant health, malnutrition interventions, communicable disease prevention etc).

> "…we are familiar with the SPM indicators. They are more or less similar to what has been our job description so it is not too different. We know our target and performance. We do not have any problems…" *(J-8)*

However, some respondents pointed to problems in following SPM. For them, the SPM is not easy when it comes to reporting as one indicator could consist of several activities with each activity having its own weight. The situation is described by a respondent below:

> "…last year we did it by the end of 2012. We have done it for 2013 but with notes (*dengan catatan*) that it was disorganised (*amburadul*). We did not properly measure the indicators as we are not sure how to measure them. This time it was right, nevertheless far from perfect (*jauh dari sempurna*). Now we have to do it because it is required by the government. They need it as a reference (*acuan*)…" *(K-1)*

The statement above indicates two concerns with SPM. First, some local staff were not properly trained to report on SPM performance. Even with the simpler SPM indicators introduced early in 2008, some local staff seemed had trouble until very recently. The second issue is the validity of the SPM reports as data collected by the local governments can be flawed. This can potentially influence the effectiveness and efficiency of local health programs. It can also influence central government allocation of funds for the local governments.

6.3.2. SPM as Equal Entitlement to Basic Health Services

The second role of SPM was as an agent to ensure equal entitlement to basic health services across districts, as expressed by one respondent below:

> "SPM ensures that every district provides the same basic health services otherwise each district could provide different types of public services…" *(K-7)*

The above statement was supported by another respondent who stated:

> "…if not each district will have different (*berbeda-beda*) standards. It would be a pity as not all local leaders are concerned (*perhatian*) with the same issues. What if they do not care (*tidak peduli*)? Subsequently, the public health condition could be left behind (*tertinggal*). A minimum standard is necessary (*harus ada*). It is not a re-centralisation (*sentralisasi*) as the central government does not force (*mengharuskan*) us to achieve certain targets (*harus sekian*) but they provide (membuat) us with a number of directions (*rambu-rambu*) that is called the minimum standard of service and we must not provide services below (*di bawah*) that." *(K-1)*

Another respondent provided this statement:

> "Each district has their respective interest and capacity. If there is no standard of service one district might omit certain health services as it is not the priority of the local government even though it is essentially the basic needs of the people…" *(J-6)*

Respondents views show that the SPM guarantees equality of basic health services as described in Government Regulation No 65/2005 which stipulates that the SPM regulates the type and quality of basic services as local government tasks. Further, the regulation states that every citizen has the right to receive at least the minimum standard of service. However, with SPM there are at least four implications for local government that if not anticipated could widen the disparity between districts. First, with SPM it is necessary for each district to precisely plan the number and type of health personnel that will be needed and increase the capacity of their health personnel. Second, each district should strengthen the role of the district health office, hospital and *puskesmas*, but no less important is to have strong coordination between these three institutions. Third, the district must ensure equity of access for all citizens to *puskesmas* care and the need to improve local hospital facilities. Fourth, each district must support reliable information system for monitoring and evaluation purposes. All four implications will put pressure on the APBD. As mentioned earlier, on average around 60-70% of the district general allocation fund or DAU is allocated for government civil servant salaries. Therefore, only 30% of the funds can be allocated for the health sector and other public services, such as education, public work etc. Other local resources, such as shared revenue from natural resources could supplement this but only if the district is rich in natural resources. With a number of public sector activities that need to be supported and

prioritised, further disparity of district capacity to meet SPM indicators cannot be ruled out.

6.3.3. SPM as an Indicator of Local Health Performance

The third role of the SPM is as a local health performance indicator. The function of SPM as an indicator of local government health performance was stipulated by the Regulation of the Ministry of Health No 741/2008. This regulation encouraged local governments to focus health programs on achieving SPM indicators, as described by a respondent below:

> "…besides activities related to administrative and operational activities other health programs aim to achieve (*pencapaian*) the SPM and to accelerate (*percepatan*) the MDGs 2015." *(K-6)*

Another respondent added:

> "…our local health programs aim to support the SPM and MDGs. Our health program is basically (*pada dasarnya*) part of (*bagian*) a larger health program, the national health program…" *(K-4)*

However, respondents were ambiguous when asked whether there were any consequences if the targets were not fulfilled:

> "If I am not mistaken there is punishment, our budget will be reduced…" *(K-1)*

Another respondent supported the view that there are consequences but the respondent was not sure of the form:

> "There must be some consequences but I am still not sure. I have heard that the central government will adjust the deconcentration fund for the following year but this information needs to be confirmed with the right authority…" *(K-3)*

Another respondent stated that there are no consequences:

> "…no, there is no such thing as consequences. Why would the central government bother? It is all just rumours. The indicators were developed by the central government to assist local government so it would be easier for local government to measure their performance. The indicators are also used to develop our health program…" *(K-2)*

As described in Chapter 3, Law No 32/2004 clearly gave mandate to the central government to provide standardisation of local public services to safeguard public rights and interests across districts. The SPM has played a significant role in local health programs. It is not suggested that these indicators are irrelevant to the local situation, much the opposite. In fact, issues such as child mortality, maternal health and communicable diseases are still very much a local problem in many parts of Indonesia. However, SPM indicators do not accommodate the variability between districts. The central government meant SPM to ensure standard basic services provide standard basic services. The indicators do not reflect more local-specific conditions in the district, such as described by a respondent:

> "…environmental health (*kesehatan lingkungan*) was part of the older version of SPM indicators. Unfortunately it is not part of the new version of SPM. I do not know why but I think it is important. In other districts it would be difficult to obtain the government budget if the program does not support particular SPM indicators. Fortunately, in this district we have the commitment to support the programs. Many of

> the people here have problems with access to clean water (*air bersih*), latrines (*jamban*), and waste disposal (*pembuangan limbah*). These are our three focuses…" *(K-3)*

Another respondent added:

> "…we have a routine check of mosquitos' larvae in homes and schools each month, mostly focusing on the bath tub (*bak mandi*). Usually we recruit *posyandu*'s cadres to do this with small incentives and it was quite effective as these cadres from the neighbourhood they were usually welcome and could respond fast whenever there are larvae. But the program was discontinued as we could not obtain a sufficient budget. It is not a priority anymore…" *(J-9)*

6.3.4. The Local Component of Local Health Programs

Local initiatives, as described in Chapter 4, could be generated from the local people or local government, particularly district health offices. The local government task, through the health district office, is to synchronise with the SPM or other central government policies, such as MDGs, to develop local health programs. This process is called program harmonisation. However, in practice local initiatives, especially those that do not fit to specific SPM indicators are difficult to support, as described by a respondent below:

> "It was our job to sort out (*memfilter*) and rationalise the proposal particularly if it came from the public. If we looked at the budget they proposed it was relatively high, thus we needed to verify it. Later we would rationalise it. Does it fit and support (*mendukung*) the SPM target?" *(K-7)*

This view was supported by another respondent:

> "...all these propositions (*usulan*) would not be automatically developed into the annual work plan (*rencana kerja tahunan*). The one that must not be left out (*ditinggalkan*) is the SPM. We have mandatory (*wajib*) authority that needs to be implemented through the SPM..." *(J-8)*

The local initiative was a matter of choosing an option of programs or activities in order to achieve the targets of each SPM indicator, as described by a respondent below:

> "The SPM is there to guide us but we could decide what kind of activity that we considered to suit local conditions in achieving SPM targets…" *(K-7)*

The respondent added:

> "For example, to increase the coverage for treatment of labour with complications (*komplikasi kebidanan yang ditangani*) we decided to use simple technology, the cellular phone. Everyone here has one and it is very useful. We just need to give local staff the telephone (*pulsa*) to cover the cost. By using the cellular phone we can communicate and coordinate more easily. The *puskesmas* could also use the phone to communicate with patients so that if anything happens *puskesmas* could assist quickly. If the patient needs to be referred to the hospital it can be dealt with quickly…" *(K-7)*

Another respondent described a local initiative that emphasises local regulation:

> "…in order to reach our SPM target, particularly to reduce our maternal and infant mortality rate, we have started to implement the local regulation for maternal, new born and infant health (*peraturan daerah kesehatan ibu, bayi dan anak balita*). In this regulation all interventions necessary for maternal and infant health are included (*tercantum*). It is not genuinely our idea but it has been implemented in Sangata, one district in Aceh, Tangerang and Bandung. We have replicated our model from the one that was implemented in Bandung…" *(K-6)*

The regulation abbreviated as KIBBLA comprises a comprehensive arrangement of all local stakeholders' rights and obligations in terms of maternal and infant health. It mandates the maternal right to receive proper treatment during and after pregnancy and includes access to contraception. The law also stipulates the rights of new born babies and infants to basic health services, exclusive breastfeeding and colostrum, clean environments and access to healthy and unpolluted food. In addition, this law describes the obligation of local governments to support implementation through law enforcement and local funds, the obligation of local health facilities and health personnel to provide appropriate health services, and the obligation of the public and families to participate in the system. However, the law seems exclusively focussed on local residents.

The relevant article in the local regulations clearly stipulates that the program is intended only for local residents. Thereby, excluding citizens who happen to live there, but who are not considered to be locals administratively. A respondent explained:

> "…local residents are residents who have a local ID card. They can just show it to us and they will have the access to the local government program…" *(J-6)*

Focusing only on local residents, proven by showing an ID card, or *Kartu Tanda Penduduk*, seems to be a characteristic of post-decentralisation local health programs. The phenomenon was clearly shown through the local *jamkesda* as mentioned in Chapter 4. The idea apparently originated from the concept of the local fund being solely reserved for local public welfare. A respondent statement below implied the situation:

> "…we have increased our hospital capacity near the border as a large percentage of our population is concentrated in that region. We cannot force (*memaksa*) them to get health treatment (*mendapatkan pengobatan*) here in the capital. It would not be practical and too costly. But we have to give them an alternative so that we do not waste our funds by paying the cost of our residents by having health treatment in neighbouring districts, particularly if they could be treated in our hospital…" *(K-10)*

The phenomenon appeared to be a reaction, especially amongst natural resource-rich districts, to the central government. During the New Order regime the central government exploited local resources without returning equivalent compensation to local governments. With decentralisation, as a respondent put it, the opportunity presented itself to use local resources for local welfare:

> "…the central government has exploited our natural resources in the past. It only benefited people in Jakarta. The situation is much better now after ten years of decentralisation. But it was much worse back then. That is why our government has demanded (*menuntut*) the central government revise Law No 33/2004. We should have a larger share from our own natural resources. We need a lot to catch up (*mengejar ketertinggalan*). The allocation for us is too small…" *(K-5)*

In one particular district they used a local identity card issued by the local population office to curb migrants from other provinces looking for work in the district. A resident provided this statement below:

> "…there are a lot of migrant workers from other provinces that live temporarily here. Some are looking for work somewhere else [our province], but some others intend to find work here. Most of them end up jobless. We do not have the capacity to provide the same health services for them. It would absorb much of our budget. We use the local ID card to make sure that they are genuinely from this place. If we use the national ID card that can be forged (*asli tapi palsu*). Only those who have the local ID can get free health services…" *(K-12)*

It is not only the resource-rich districts that apply this exclusion. The less-affluent districts also have similar regulations where only residents with a local ID-card can access local health services. One respondent argued that the regulation is necessary to give priority to local residents as their budget is limited:

> "…local government provides free health services for everyone who can show their local ID-card. We would like to provide services to the wider public, but we have to set a priority as our budget is limited…" *(J-6)*

It was apparent that decentralisation of local government expenditure and policies in health programs, such as the *jamkesda*, has contributed to the rise of disparity, not only between districts but also between local residents and local non-residents. A similar situation has been described by Rodriguez-Pose and Ezcurra[282], who pointed out how a local social protection program excluding non-residents can increase the disparity

apparent between regions in low and medium-income countries after decentralisation has been implemented.

6.4. Data Collection

From an unduly restricted view of the central-local relationship, local governments are no more important for the central government than they were before decentralisation - when local governments were merely an extention of central government authority. This is because, after decentralisation, central government retains the overall responsibility for ensuring that effective and efficient public services are being implemented throughout Indonesia. Nevertheless, now that decentralisation has taken place, the central government influence can only be exercised indirectly, and for that reason effective communication and coordination have become even more important. One of the avenues for this coordination is the provision of data by the central government to the local governments for local planning, budgeting, and program development. It is still mainly the central government that is responsible for and generates and analyses nation-wide data sets necessary for planning. Without reliable data any planning would be useless, as any program target or aim that was based on these unreliable data could be misleading[283].

Generating reliable data would not be possible without the involvement of the two tiers of government, highlighing further the importance of coordination. Central government generally has a much larger budget, better expertise, and advanced technology; whereas local government has services and staff on the ground at the coal face from where information on specific local needs and characteristics could be generated[284]. The central government then supports data validity by providing local staff and establishing the necessary training for improved capacity to collect data in a timely manner[285].

Information used by local governments to develop health programs came from two main sources: internal and external. External refers to information collected by central government or other parties while internal refers to information collected by the district government technical office – the district health office and district hospital – and its *unit pelayanan teknis* or technical units, such as *puskesmas* and *jamkesda*, and through community-based health services, such as the *posyandu* with its cadres. Information gathered through these institutions was mostly on health-related indicators that support SPM and MDGs.

> "...we used SPM and MDGs as measurable (*terukur*) indicators and manageable (*mudah didapatkan*)..." *(K-1)*

6.4.1. Internal Data Collection through Posyandu

The broader indicators of SPM and MDGs were broken down into smaller supporting indicators through various programs. The data could be collected by the *puskesmas* or through health cadre networks across villages in rural areas and by neighbourhood associations in urban areas. The survey was described by a respondent:

> "…in the clean and healthy lifestyle program (*program perilaku hidup bersih dan sehat*) there were a number of indicators. If I am not mistaken there were twenty indicators related to family members' (*anggota keluarga*) health-related lifestyle (*perilaku kesehatan*). The data were collected through a survey conducted by the *posyandu* cadre…" *(J-9)*

The practice of utilising informal health workers was not entirely new; the practice existed long before decentralisation was implemented. In fact, the *posyandu* was a product of the New Order regime. Initiated by President Suharto in 1984, and decreed

nationwide in 1986, the program aimed to assist the Government with various basic health programs, such as maternity health, child health and family planning. With decentralisation there seemed to be a considerable setback to the *posyandu's* role in local health context. This was possibly caused by a combination of local government lack of interest and social-political changes in the community.

> "…why everything related to Suharto was deemed bad and abandoned, it was not always so. Like the *posyandu* for instance, it brought health services closer (*mendekatkan pelayanan*) to the community. But there was not much commitment (*komitmen*) left and no budget (*anggaran*) for it. Nowadays, community contributions (*sumbangan*) are also rarely seen, unlike in the past…" *(J-10)*

Nonetheless, not all districts lost faith in the *posyandu* and its health cadres. Some local health offices have made some adjustments to keep up with society's inevitably changing expectations. Higher living expenses since reformation and the swift flow of information appeared to have shifted community priorities, including the importance of incentives.

> "…we undertook a lot of coordination with the health cadres. We have a number of health cadres (*kader kesehatan*) as an extension (*perpanjangan tangan*) of the *puskesmas* service. For their assistance they receive some honorarium (*honor*) and pocket money (*uang saku*) for transportation…" *(J-9)*

But it was not always about money. It was also about appreciation of tireless efforts and to convey the importance of all local stakeholders' participation, as described below:

> "…to encourage them to participate depended on our appreciation (*apresiasi)*. The honorarium that we gave was not comparable to their

> actual expenditure (*tombok*). However, it was their enthusiasm (*semangat*) to have a role (*berperan serta*) in the community. We must tirelessly (*greteh*) engage with the cadres to actively participate. Therefore, it was not entirely due to the incentive." *(J-9)*

However, only simple types of data can be collected through *posyandu*. The main role of *posyandu* is not in data collection, but in providing basic health services such as immunisation, antenatal care and monitoring the weight of under-five rear olds.

6.4.2. Internal Data Collection through Puskesmas

In addition to community-based data collection, local health offices also developed internal coordination with *puskesmas* and external networking with hospitals to build a reliable surveillance system, particularly regarding specific mortality rates, such as infant mortality and maternal mortality, and other disease-related data.

> "...we have surveillance in place. We have a network (*kerjasama*) set up as well with local hospitals and some hospitals out of town to record our residents' death statistics." *(J-9)*

Surveillance is an integral part of the role of the local health office, which a reliable surveillance system is fully aware, as described by *J-9*:

> "It was our initiative; there was not any instruction from the central government for local health office to do so. We just wanted to strengthen (*memperkuat*) our surveillance system for our data collection (*pendataan*). We do not want to see infant mortality or maternal mortality unrecorded." *(J-9)*

Nevertheless, the effectiveness depends on the willingness of the local health authorities and on the availability of resources:

> "The main reason was the system. We have signed cooperation with various local stakeholders including private hospitals for surveillance data collection. Therefore, it is a multilayer (*berlapis-lapis*) surveillance system (*sistem surveilans*). If an incident was not recorded in *puskesmas* or *pustu* the hospital would report it. If not our surveillance staff in the area would definitely report it." *(J-9)*

The system was established to overcome the problem of delays in health information about morbidity and mortality that is quite common:

> "…the procedure for data entry is quite good but the reporting takes a longer time, possibly because they are still doing it manually and they also have other things to do. Sometimes the data are missing. In that case we have to follow-up…" *(J-9)*

A more comprehensive system is also necessary for obtaining the most reliable data.

> "…the data on infant mortality and maternal mortality in the district profile is an estimate because at that time we did not have the coordination with the local hospitals that we have now. In the village some incidents were not reported, it happened in homes…" *(J-9)*

However, the effectiveness of local surveillance also depends on the method used. It was reported that method was often inadequate and crude, one instance described by a respondent being the surveillance of dengue fever:

> "…our dengue fever eradication and prevention program until very recently has never been effective as we could not decide how to determine the type of intervention and the right time due to insufficient supporting data, such as risk factor type and which area has the potential for an outbreak. All this time our intervention is based on the number of free mosquito larvae (*angka bebas jentik*). Our intervention

> using *angka bebas jentik* was not accurate as we got the data from one specific time, including outside the transmission season (*masa penularan*) that would be misleading…" *(J-6)*

Another respondent stated that the irregular surveillance conducted by the local government also contributed to the ineffectiveness of local dengue fever eradication and prevention programs:

> "…our dengue fever eradication and prevention program is not effective because our supporting data on the area by using a stratification map is incomplete. Sometimes the map has gone missing (*hilang*) when we need it. Often the map is out of date as we could not yet manage it regularly…" *(J-18)*

The issue of consistency appeared to be one of the main problems in the local government surveillance system. The system may have been initiated soundly, but does not receive adequate funds and human resources regularly. The staffs responsible for surveillance also have other job descriptions as described by a respondent below:

> "…we do not yet have the staff to be in-charge full time with the surveillance system. It has to be overseen by other divisions (*rangkap tugas*)…" *(J-12)*

According to the Centre of Health Service Management, Gadjah Mada University, surveillance was seen by many local governments as a central government requirement. Therefore, local governments tend to have little enthusiasm for the activity. The Centre pointed out that local governments have become accustomed to relying on central government funds to support their local surveillance system[286]. However, the centralist nature of the surveillance system developed by the central government appears to

contribute to local government indifference about surveillance as implied by a respondent below:

> "…central government tried to develop an integrated database from all local health offices, public hospitals and the Ministry of Health. However, they never talked to us (*kita tidak pernah diajak bicara*). It is better that we develop our own system that suits our needs…"
>
> *(K-10)*

With poor communication and coordination, divergence in focus between central and local government could cause inefficiency as both local and central government could collect the same data in two separate activities rather than integrated the activities.

6.4.3. BPS, the Central Government Data Collection

External sources of information came from local officers of the central statistical agency, better known in Indonesia as BPS or *Badan Pusat Statistik*. As such, BPS was neither part of regional government, province and/or district, nor was it held accountable to the heads of regional governments. Nonetheless, the local officers of BPS were expected to support the local government health program by providing supporting data, usually demography-related data, as explained below:

> "We used BPS data for demography-related data such as the mortality (*kematian*) rate in the general population (*secara umum*), population size and education level (*tingkat pendidikan*)..." *(J-9)*

Nonetheless, as BPS did not conduct data collection on an annual basis, the data provided by BPS was often disputed by regional health offices as inaccurate.

> "The data from BPS sometimes seemed not right (*tidak sesuai*). In my view it was due to the nature of the data collected (*pendataan*) every ten years. Therefore, the data sometimes were less significant. It is only because it is mandatory (*harus menggunakan*) to use the data for our programs, such as community health education and eradication of communicable disease, that we used it all this time…" *(K-6)*

Local health offices chose to use an alternative local source, such as the local registrar, which was considered by local health officials to be more reliable as they collected records on births, deaths and marriages annually.

> "...for population-related data we also used the demography data from the registrar, it is more up to date than the data from BPS..." *(K-9)*

Nevertheless, in anticipation of potential discrepancies in local ability to collect data, the central government issued a regulation that obliged regional health offices and all regional technical offices to utilise data provided by the BPS:

> "…for statistical data it was inevitable (*mau tidak mau*) as the law (*peraturan*) ordered (*harus mengikuti*) us to follow…" *(K-4)*

Thus, if that meant that some targets were very difficult for the local health authority to achieve. A respondent discussed the situation:

> "...that was the problem as we must (*harus*) refer (*mengacu*) to BPS data as regulated by the law (*peraturan*), but often the target was way too high. That was why in the last couple of years our performance in immunisation coverage was always under (*di bawah*) target. The targeted babies (*sasaran bayinya*) based on BPS data were higher (*terlalu tinggi*) than what we could find in the field (*lapangan*). Our

> fellow friends in *puskesmas* said that it was too high. They have tried to check regularly in *posyandu*, sweeping door to door from house to house, but we could not find them..." *(K-7)*

Information for planning was the first step of the planning cycle after decentralisation that was explicitly assigned for regional governments to execute. Nevertheless, as in previous aspects of local health programs described in this chapter, the local health planning cycle was also balanced between local initiatives and central authority influence. The extent of this influence, however, was always dynamic. At times it appeared that local government could flex their authority without objection from the central government, but on other occasions the central government seemed to convey a message that there were limitations and that local governments must observe the rules assigned by the central government.

6.5. Balancing between Central and Local Power

Central regulations on the national planning system, the minimum standard of services and the use of central government-sourced data suggest that the central government has tried to balance their growing authority in directing and shaping local policies and at the same time acknowledge local governments essential role in responding to local-specific needs. The dynamic decision making process at the local level is necessary as it gives local actors roles in their respective districts. However, the central government message has become very clear regarding whose role is the father (*bapak*) and whose is the child (*anak*). The highest authority in the state and the main person in charge is the father (*bapak*), the central government, while the local governments are the children (*anak*). Even though local governments have their own discretion, these must be executed within central government regulations.

Having noted their diminishing role in implementation, central agencies have used their planning regulations to remain active in implementation as well. They do this by encouraging the local bureaucracy to align themselves with central vision. This centralising tendency is in line with the study of Rueschemeyer and Evans[287] on the implementation of centralised bureaucracy in achieving national agenda.

Along with effective monitoring, the central government implemented repressive monitoring. The cancelation of a number of local regulations, or *peraturan daerah*, by the central government has shown that the central authority oversees decentralisation to prevent local government from misusing their authority. Until 2008, the central government cancelled at least 2,665 *peraturan daerah* that were considered as disturbing the investment climate and violating national regulations[288]. According to the central government, if these regulations were allowed they would threaten the accomplishments of decentralisation. However, even though respondents generally agreed to the idea that central government has the responsibility to guarantee the cohesiveness of central and local regulations, there are concerns that central government has become too dominant as implied by the statement of a respondent below:

> "…central government commitment to implement decentralization should come with common understanding from both central and local governments. Each has its own task and authority. It is problematic (*yang menjadi masalah*) if the implementation of decentralization is linked (*dikaitkan*) with central government control. It is just like centralization…" *(J-4)*

The strengthening of the central government grip on local authority spending is also shown through how the local APBD is supervised. The central government uses the APBD, particularly the general allocation fund, to support national goals through local

government programs. Herbst's[289] opinion provided the reason for this. He argued that centralised fiscal resources have greater ability to support national goals. Local governments are required to inform the central government ministries about their APBD and seek central government authorisation of their proposed use of their APBD, even though the final authorisation remains the responsibility of local government and the local House of Representatives. A respondent described the procedure as follows:

> "…we have to deliver (*menyerahkan*) our APBD to the central government through the Ministry of Finance by the end of January otherwise we will not receive our general allocation fund. The central government will deduct (*memotong*) 25% every month until we report our APBD to them…" *(K-10)*

Nevertheless, this requirement was not fully accepted by the respondents, especially since some component of the APBD (such as the general allocation funds, shared-revenue and local own-source revenue) should be allocated according to local priorities without central government involvement. Few would openly object:

> "…unlike the specific allocation fund which is based on a specific grant, the concept is that the general allocation fund is to be granted (*sudah diberikan*) to local government for local priorities. Therefore, central government should not control the general allocation fund. The fund is granted to local government so that it can be used to increase the efficiency and effectiveness of public services…" *(K-14)*

Table 6.1 shows the four-fold increase over ten years in the payment of the general allocation fund to the local governments. This allows more resources for local health programs, but also enables the central government to wield more power in local program implementation.

Table 6.1 Central Government Expenditure for Local Governments

Transfer Funds (in trillion IDR)			
Year	Shared-Fund (Dana Bagi Hasil)	General Allocation Fund (DAU)	Specific Allocation Fund (DAK)
2003	31.4	77.0	2.7
2004	37.8	82.1	4.2
2005	49.8	88.7	4.7
2006	65.1	145.6	11.6
2007	68.5	164.8	17.1
2008	65.6	178.2	22.5
2010	77.7	193.2	21.4
2011	81.6	273.2	26.2
2012	91.0	310.9	31.4

Missing data for 2009
Source: Ministry of Finance

Both central and local government share the view that the APBD could support the betterment of public services. However, central government is concerned about how the APBD is planned and developed through political process. On the other hand, for some respondents it is the political process and particularly the role of local House of Representative, not the central government, should be driven more to control and monitor the development and implementation of APBD. A respondent argued:

> "…as local governments we have a similar structure to central government. We have the legislative body whose role is to control the executive. Allocating (*peruntukan*), controlling and monitoring the implementation of the APBD should be under local authority (*kewenangan daerah sepenuhnya*), the local House of Representatives and the local external auditor, not the central government…" *(J-2)*

According to an evaluation conducted by the Ministry of Finance[290], the main problem with the APBD has been inefficient use of the budgetary funds. There was a strong indication that the funds were not used maximally. Some factors were poor planning

and different interests between local governments and local legislators. However, some factors were due to central government failure to provide transferred funds, such as general allocation funds or specific allocation funds, in time. As a result, local governments could only start planning and using the funds, the specific allocation fund in particular, around September, far too late to implement effective programs. A respondent described the problem:

> "…for the specific allocation fund often we have to wait for the related technical department to develop the guidelines first. Therefore, we have to wait until it is ready, and as always (*seperti biasalah*) we have to wait for weeks and even months…" *(K-12)*

Local government proposed that central government improve the procedure and bureaucracy in order for local government to receive transferred funds much earlier so as to achieve effective public programs.

> "…we already gave feedback to the central government concerning the late disbursement but they always said that they will improve it. However, nothing really improved…" *(K-12)*

The central government interest in local APBD was also an attempt to prevent corruption at the local level. After decentralisation, corruption cases in local governments have increased considerably[291]. According to data from the Indonesian Corruption Watch in 2010 there were 448 cases with 1157 convicted; by 2013 the number of cases increased to 560 with 1271 convicted[292]. One of the most scandalous was corruption of the head of the district education office in East Kalimantan who stole more than 500 trillion IDR. A respondent commented on this issue:

> "…you could find corruption everywhere (*merata*). There is an anecdote that to regional autonomy [the term that often used in Indonesia to refer decentralisation] has become auto-money. Everyone, especially those in the government could easily abuse their power and treat the government budget as their auto-debit card…" *(K-5)*

The increase in corruption, according to Rinaldi[293], was likely caused by the considerable power that has been devolved to local governments, particularly in cases of corruption involving local legislators. Implementation of Laws No 22/1999 and 32/2004 means that the local House of Representatives has become one of the authoritative institutions at the local level, including in allocating local budgets. From my observation, many corruption cases were caused by undisciplined local legislators who did not refer to government regulations when developing local budgets. However, this situation was complicated as a number of central government regulations were vague and could be interpreted in different ways.

6.6. Space for Communication and Negotiation

Despite more central control, communication and negotiations between central and local governments seems to be an important part of decentralisation. As a respondent stated, communication and negotiations with the central government are the manifestation of the relationship between father (*bapak*) and child (*anak*) and that consensus (*musyawarah*) should be central to this activity:

> "…we have a philosophy '*ana rembug dirembug*' (if we have a problem or concern let us discuss it), therefore communication between central and local government has become more open. If we have a concern we could directly consult with the central government…" *(J-13)*

Another respondent stated:

> "…we often consulted with the central government. It was merely to consult on certain central policies, cross checking it, making sure that our understanding is in line with that of the central government, but sometimes it was also our way to enquire if there are possibilities to obtain additional grants or programs. Even though the value might not be much, but for our district it could be useful..." *(J-15)*

The respondent added:

> "…we need to expand our network. If we are just doing our routine work in the district we might miss other opportunities. The central government has programs and grants that we could obtain to supplement our own programs…" *(J-15)*

However, it seems that the central government occasionally fell short of meeting the need for good communication and coordination with the local governments:

> "…the central government sometimes unexpectedly (*ujug-ujug*) implements their own program without consulting us, like giving a grant of medical equipment to the *puskesmas* very recently. They cannot do that because we could be in trouble. We have to keep a record of all our assets. Where we got it from, how much does it cost, the depreciation etc. If the national audit board found out they could accuse us of money laundering (*pencucian uang*). I have met (*menghadap*) with the person from the Department of Health and expressed my concern. They seem to understand our position…" (J-12)

6.6.1. The Class-less Hospital

One case that illustrates how negotiations were conducted between central and local governments was the plan of one particular district to develop a class-less hospital. A respondent described how the idea came about:

> "…it was the idea of the district health office. We wanted to have a hospital where patients, whoever they might be (*siapapun mereka*), whatever social class they are from (*dari golongan sosial apapun*), could receive decent and appropriate treatment without feeling discriminated because of their ability to pay (*kemampuan untuk membayar*)…" *(K-7)*

The respondent added:

> "…it is a common public perception that the quality of treatment a patient receives will be determined by their ability to pay. To some extent it is true, but the situation is more complicated. When we talk about *jamkesmas* for example, the program is clearly based on third class service. Therefore, the ward, the medicine used are third class standard. The doctor's service should be the same standard for all classes, but in practice it is not always the case. It is not because the doctor is unprofessional, but maybe because when they treat the *jamkesmas* patient they received lower incentive. In our district hospital normal delivery costs 1.8 million IDR, but *jamkesmas* only reimburses 600 thousand IDR and that is to cover the whole cost including for the doctor fee…" *(K-7)*

The concept of a class-less hospital received full support from the local government and the local House of Representatives, as described below:

> "…we have presented our concept and plan to the *bupati* and the district House of Representatives. They supported the idea and promised to back it up with the local regulation (*peraturan daerah*)…" *(K-7)*

However, the central government disapproved of the idea as it would have violated central regulations. The central government used these central regulations as a means of control to ensure that the local government conformed to central regulations, as described by a respondent:

> "…the central government rejected the idea as it will violate (*berbenturan*) the national regulation that requires hospitals to provide four types of classes to assure that all social classes can access appropriate health services…" *(K-7)*

The use of central funds as a means of control seemed relatively unsuccessful, as described by the respondent:

> "…we proposed the hospital to be co-funded with the central government using the APBN, but if they disagree we could arrange an agreement with a third party…" *(K-7)*

There were different points of views on the concept of class-less hospital. While the central government wanted low cost services, the local government wanted good quality services for all constituents, as described by a respondent:

> "…actually, the concept of a class-less hospital is already regulated by the central government, but it is based on third class. We do not want this type of classless hospital. We want the hospital to have a good quality of services (*pelayanan yang bagus*) where a ward is for one or at least two patients not six or ten. The staff and doctors will also be professionally evaluated based on their performance…" *(K-7)*

The real reason for central government's strong refusal was that the class-less hospital concept, as proposed by this particular district, could have disrupted the national health coverage program, be it the *jamkesmas* or the national social security program that was modelled on classed hospitals. The respondent stated:

> "…the central government emphasised that the local health system is inseparable (*tak terpisahkan*) to the national health system. The *jamkesmas* and the national security system must be supported by the local government…" *(K-7)*

Reimbursement would be particularly difficult with a class-less hospital, as described by the respondent:

> "...I guess it is problematic particularly for reimbursement as both the *jamkesmas* and the national social security program are based on a third class standard. The unit cost is all in third class standard. There need to be lots of adjustment…" *(K-7)*

After months of negotiations a consensus was not reached. The central government offered to allow the local government to have an all-third class hospital with higher standards of service subsidised by the local government. However, the local government still could not decide whether or not to accept the arrangement. The different stances taken by central and local governments showed different interests and points of view.

The central government seemed to be more concerned with uniformity of the health system at the national level by applying uniform regulations, while the local government was also concerned with uniformity, but at the local level by providing the same access to the better hospital services. The diversity of access across the district that the class-less hospital might address was not a concern of central government. Rather, the diversity of reimbursement systems for the national health coverage program seemed to be their main concern. One of the respondents described central government attempts at homogeneous regulations as *meng-Indonesia raya-kan*, referring to the Indonesian national anthem that places emphasis on unity:

> "…there are indications that the central government want everything to be uniform *(meng-Indonesia raya-kan)* *(K-5)*

Based on the values of *bapak*-ism, when the interests of the two parties collided and consensus could not be reached it was the central government view that took precedence because the central government in this value system was considered to be in charge, the father with responsibility to ensure national interests were served: stability and an even distribution (*pemerataan*).

6.7. Conclusion

This chapter reveals that, after decentralisation, the relationship between central and local governments is not as straightforward as might appear in the simple organisational chart for as reflected in Figure 3.1 and 3.2. The emerging complexity of hierarchy and relationship in the decentralisation context can be understood from the Javanese cultural perspective. While local governments still consider the central government to be the fatherly figure in the family and as such to have the responsibility for providing direction and guidelines, local governments' perspective has evolved with a preference

for an extended family structure that provides space for local initiatives. Consequently, local governments are asking for more authorities and trust from the central government in order for the local governments to be able to provide healthcare to their local constituencies at their discretion and in line with local needs.

Local government demand for more space for local discretion does not mean that they do not support the idea of central government involvement in local health affairs. Indeed, local governments still view the central government as the guardian of national cohesion and stability. They realise that undirected decentralisation would inevitably cause regional disparity, and thus could lead to national instability and fragmentation. However, local governments would like to see central government involvement to be limited to providing regulations and funds with a clearer division of responsibility between central and local governments. The idea of joint responsibility that is promoted by the central government might be ideal in theory, but complicated in practice – as reflected in the raising and allocating of funds for health provision.

From the legal framework described in Chapter 3 and the pronouncements of the founding fathers of the republic, the central government stance is clear that Indonesia is a unitary state. There is no separation of powers between central and local governments, but rather power-sharing or joint responsibility. Public services, such as education and healthcare are considered to be the responsibility of both central and local governments. However, as decentralisation has stipulated that public health services be implemented by local governments, the central government can now influence the implementation only indirectly through increases funding, the use of national planning regulations and the standardisation of quantity of health services by issuing protocols such as SPM (Minimum Standard of Services).

The trade-offs between central government requirements and local governments' needs are a major feature of decentralisation. The importance of good coordination and communication between central and local governments is always raised by local governments. However, in practice it is not always achieved. One example that reflected the differences in emphasises between central and local government is that of data collection. The differing emphasise was not clearly communicated. While central government wanted quantifiable information for national statistics and to meet international obligations, at the same time local governments needed more in-depth information for the purpose of local planning. At times subsequently, local governments have had to collect two sets of data, thereby leading to inefficiency in times and resources. Less than optimum communication and clarity between central and local government was also highlighted by the attempt of a local government to open a class-less hospital and the initial strong dispproval by the centre. The central government saw potential complications if such a policy were to be extended across many districts, impacting on resource generation and allocation. Even after lengthy negotiation, the compromise agreed upon is more in line with the central government's desire to maintain national uniformity and cohesion.

Chapter 7

Conclusion

7.1. Conclusion

This research set out to find answers to questions about the process of implementation of decentralisation with reference to health and health care, how the central government policies are interpreted, what are the implications of decentralisation for local decision making, and the nature of centre-local relationships after the decentralisation. This research complements our knowledge on health decentralisation in Indonesia through the use of a political perspective. This approach has enabled the study to explore the phenomenon of decentralisation more deeply, understanding how and why the policy is interpreted as it is today and understanding the roles of the many types of stakeholder involved and the incremental process of the policy.

The discussion and conclusions in Chapters 4, 5 and 6 referred specifically to and provided answers to the above listed research questions. The following few pages are to sum up my overall impression about how the decentralisation unfolded and its impact on health services development plans in the local settings. The previous three chapters examined concepts such as how fiscal capacity broadened the flexibility of local options, and how it influenced choice regarding the intensity of health programs. However, while locally constituted insurance programs, such as *jamkesda*, depended to some extent on local fiscal capacity the local decision making was influenced by other factors as well, including, among others, the local government commitment and

negotiations amongst local actors, the importance of negotiations, and the centre's attempts to re-take some of the power.

One other factor that played an important role in decision making was central government bureaucracy engaging with the local government bureaucracy to push through the regulations and policies that promote uniformed structures and programs across Indonesia, while the local governments trying to find space to plan locally responsive programs. The local fiscal capacity did come out as an important factor on local government discretion as it gives some flexibility in developing local health programs and interpreting central government's policies. However, this should be taken cautiously as there is no guarantee that stronger local fiscal capacity would automatically lead to strengthened health system and better health outcomes. This is due to two factors: First, the local political process between the *bupati (heads of the government)* and local legislators may be influenced more by the political interests of these players rather than by the public services interests; second, other local factors such as poor coordination between local technical offices (department of health) and the local staff technical capacity have significant influence on development of local health programs.

Decentralisation in Indonesia is characterised by dynamism and has evolved to its current status over time, and is still evolving. One of the earlier features of Indonesian decentralisation was the strong political objective, as the main reason that this policy was initiated back in 1990s was the economic crisis followed by the political upheaval. At that time, central government was subjected to strong pressure to devolve much of its power to local governments as some regions threatened to break away from the Indonesian nation. Therefore, at the initial stage, the enactment of decentralisation was

more about decreasing tensions between the centre and the regions with the desire to sustain unity and was little to do with improvement in healthcare. However, later the efforts of the local actors in the districts brought public service, particularly health, to the centre stage of the decentralisation play. Decentralisation enabled local political actors to be more proactive than beforehand. In order to meet public expectations, local government and legislators have taken the initiative to focus on, adapt, and develop health programs that appeal to the public. The local actors are using their newly-acquired power to make health program-related decisions such as recruiting staff, building hospitals and transforming puskesmas into 24-hour service providers. Decentralisation has influenced health outcomes through the policy's ability to encourage district initiativse, supported by local commitment and resources. These local initiatives have brought health into the main focus of decentralisation, despite the original motive of the central government being mainly about the centre-regional political relationships.

Some of the programs and policies initiated by local governments such as *jamkesda*, class-less hospital and local response on central moratorium on government civil servants show the evolution of decentralisation as these initiatives become pressure points between central and local governments. Despite central government's attempt to synchronise local interpretation and implementation with central policies, these pressure points brought to fore the inherently different motivations of the centre and local in developing health system. The overarching national context and national need such as unity, cohesion, and avoidance of disparity amongst regions lead the central government to view the local initiative in a particular light. On the other hand, after decentralisation the local actors see themselves as accountable to their constituencies with a reference to

service availability, adequacy of health resources and addressing of locally-specific needs. These pressure points and tensions played out differently in different localities within the context of local factors that have been highlighted in this thesis. To a person interested in health and in managing healthcare system all this points to the need for staying informed about the political processes, empowerment, stakeholders and their motives, and the local-central interaction. On one hand it could be suggested that there is the need for local and centre to sit down together at the outset and delineate the objectives, authority and responsibility of the respective actors in order for smooth implementation of changes and for rapid development of health system. On the other, it also alerts to the complexity and difficulty of predicting how the change will unfold. Hence, there is a need to plan ahead but also working together and staying alert about any twists in the tail.

One important feature of decentralisation is centre's attempt to take back its role in local health affairs where centre sees that the local initiatives may erode their authority to an extent beyond what was envisaged at the inception of decentralisation. The centre's attempt for such taking back of the devolved power includes them stressing the need for joint responsibility toward health care planning and implementation. Healthcare, as a public good, becomes an objective of power contested by the central and local governments. In such contest, local government may be allowed by the centre to take initiatives but with a condition that initiatives get pre-approved by the centre; hence, providing the centre an opportunity to assert their authority. Locals on the other hand try to avoid heavy central interference in their local planning by referring to local needs, generating alternate resources, and utilising ambiguities and/or gaps in policies and regulations.

Decentralisation has not only influenced the pattern of relationship between central and local governments, but has also considerably shaped the nature of relationship between local actors. The seemingly unity shown among local actors when dealing with central government conceals the dynamic processes that occur at the local level. The tensions arise between those who support and those who contest a particular policy or a program - between *bupati* (district mayor) and legislators (local district parliamentarians), between district health office and local politicians, and within the district health office itself. Different motivations drive these differences. The programs such as the local insurance systems have the potential to cause tensions amongst the local actors The health office tend to concern with the long term sustainability and the mechanics of how to reach the target communities, whereas the local politicians' focus is mainly coverage i.e. reaching out to as many people in the constituencies as possible.

Decentralisation is a policy that should not be regarded as the final answer of the problems within public health services in Indonesia. Decentralisation is a 'living policy' that is constantly evolving within the context of a multitude of expectations of various stakeholders. Undeniably, the decentralised system provides more opportunity compared to a centralised system to define local public welfare. However, its success is determined by the combination of factors beyond mere introduction of some policies.

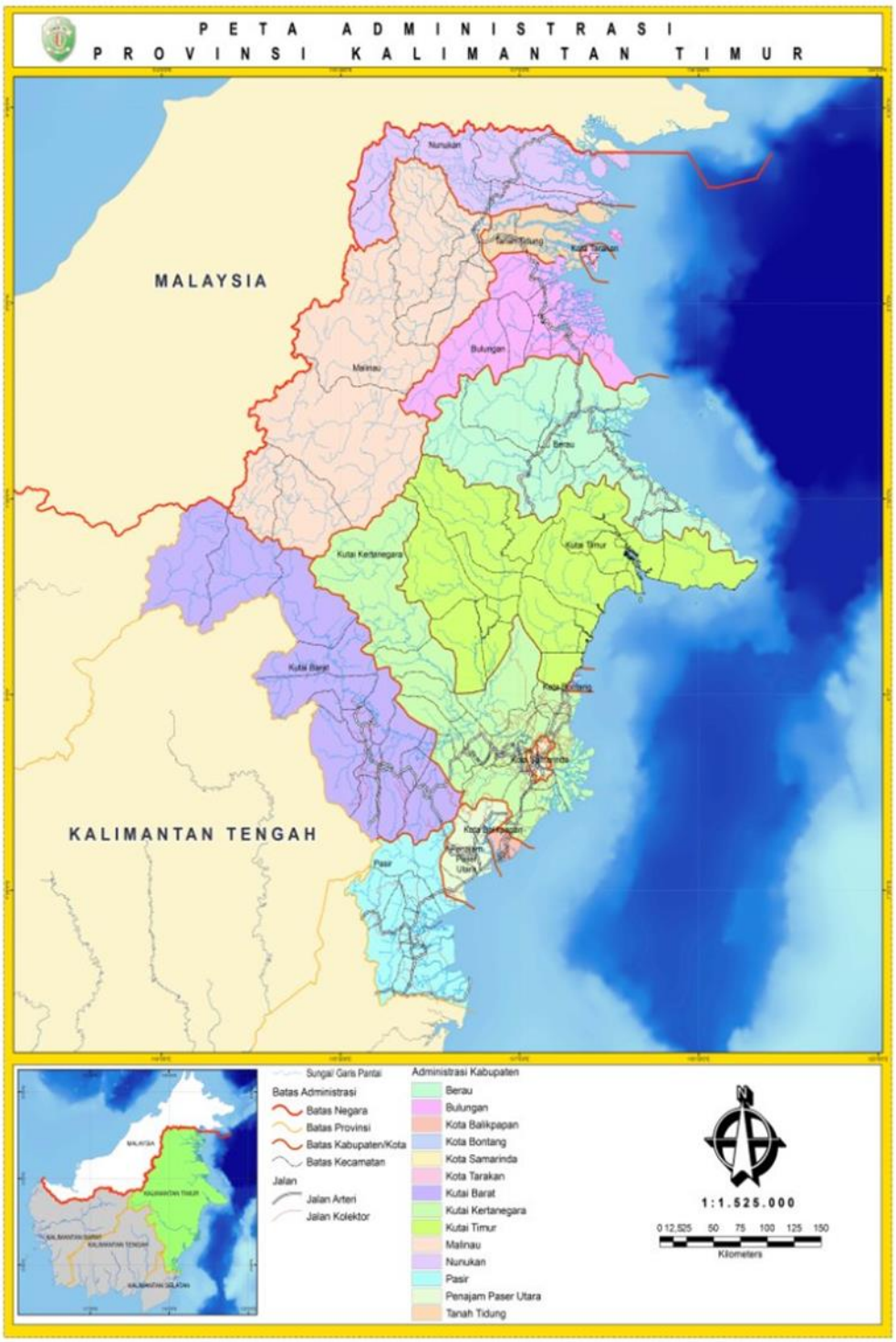
The qualitative method employed in this research has helped in providing this rich information and understanding about the nature and the process of decentralisation, the perceptions and roles of various policies and program actors, and how these interactions, processes, and perceptions influence the local developments. While a quantitative survey was not suitable to find this in-depth understanding about the dynamics of decentralisation and the mechanisms that play role in health services

development, a quantitative follow up research could now help find the relative health outcomes across various districts and their associations with the phenomena (e.g. local fiscal capacity, proactivism of local actors) highlighted by this research.

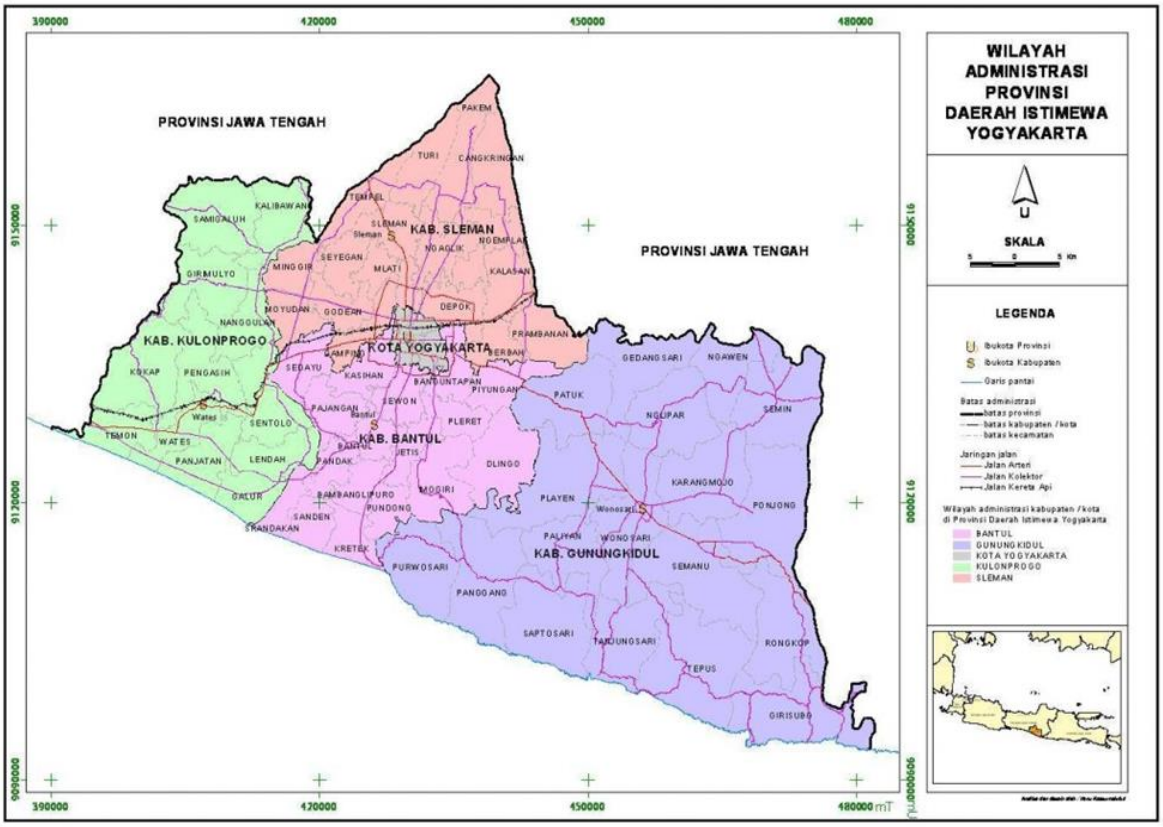
In summing up, I would like to refer again to the Indonesian values of *kekeluargaan* and *bapak*-ism. The centre has been a personification of a father in the family of Indonesian archipelago. During this evolution of decentralisation, while the centre did devolve some of its power to the other members of the family, it tended to hold on and/or take back the core decision making authority perceived to be associated with the role of a parent. There has been a reluctance to admit that the younger members of the family are now grown up and who now perceive that they could take locally relevant decisions on public service matters such as education and health. The inadequate communication amongst the members of the family may cause inertia, ineffectiveness and inefficiencies in provision of health care. Communication and working together is the key; the dinner time conversations keep a family united, effective and efficient.

Appendix

Location of East Kalimantan and Special Region of Yogyakarta among Other Indonesia's Provinces (http://www.istanbul-city-guide.com/map/country/Indonesia-Map.asp)



East Kalimantan and its Administrative Units
(http://www.kaltimprov.go.id/profil-7-peta-administrasi-kaltim.html)



Special Region of Yogyakarta and its Administrative Units
(http://www.infojogja-infojogja.blogspot.com)

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