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Decentralisation in Indonesia: The Impact on Local Health Programs

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Abstract

Background: After more than a decade of implementation, the outcomes of decentralisation in Indonesia, particularly for the health sector are still obscure. Government health expenditure in a number of districts has increased considerably, but despite this health system performance to a large extent seems unaffected, calling into question how health stakeholders actually interpret local needs and how this interpretation can influence the consequent process for developing health programs. The main objective is to reveal the impact of decentralisation on health programs. **Methods:** In order to explore the complexity of the process, thirty-six stakeholders from eight different districts were interviewed, individually. These stakeholders consisted of representatives of the executive and legislative bodies, and the head of the district health office. Using purposive sampling, districts as the unit of analysis were selected on the basis of different degrees of fiscal strength and of urbanisation. The data were explored using framework approach. **Results:** One feature of decentralisation was the transfer of central government-that includes the discretion to develop and financing local initiative health programs to the local governments. However, the extent of health programs in each local government depends on factors such as local fiscal capacity, regulations, and the political process. In the case of *Jamkesda*, local fiscal capacity will determine the coverage and benefit of the health scheme that usually was supported by local regulations. However, the amount of local budget allocated for *Jamkesda*, relied greatly on the political process. The role of *Jamkesda* as a vote-getter for local politicians is significance, both in term of local commitment (budget allocation and regulation) and the sustainability of the program. **Conclusion:** Decentralisation has changed the development of local health program, nevertheless, the scope of local initiative health programs is determined by local fiscal capacity and the political process.

Keywords: decentralisation; fiscal capacity; *jamkesda*

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1. Introduction

Today, around 80% of developing countries worldwide, including Indonesia, have decentralized public services in various forms.(1) 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.(2) Studies carried out on the impact of decentralisation on health care 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(3); 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.(4) 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, was more likely due to private sector utilisation rather than public service provision.

One of the main problems that some local governments in Indonesia face after decentralisation is limited access to funding, as indicated by Kristiansen and Santoso.[5] 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 the disparity in revenue allocations.

Kristiansen and Santoso revealed 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,[6] further jeopardizing health status amongst the lower income group. The practice of ‘privatizing' *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.[7] 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 categorized as near-poor[8] 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.

A possible reason for local governments allocating insufficient funding to health budgets may be poor judgment on the part of local decision makers. Even though health expenditure could lead to better service provision and health outcomes[9], it depends on how the decision makers allocate the resources. A larger share of health expenditure is not always directly proportional to improved health services.[10] Health office (in the region) capacity on local condition as well as public active involvement would be a prerequisite for achieving this. A localized 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 the 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.

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 article focuses on the process and practice of decentralisation as implemented by local government, particularly in regard to local government discretion in health. This article aims to discuss how decentralisation is practised at the local level, particularly in terms of the implications for local government interpretation of central government health policy.

2. Method

The aim of this study was 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 was utilized. In all, forty-seven stakeholders were contacted, and thirty-six agreed to be interviewed, twenty-three male and thirteen female (Figure 1). They were selected due to their position in the government or local House of Representatives with an assumption that holder of certain public positions such as the district secretary and the head of district health office have in-depth knowledge on the local decision-making process. However, as this study needs to explore the changes caused by decentralisation on the decision-making process, only those who were already in office for at least three years were finally chosen to participate. 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

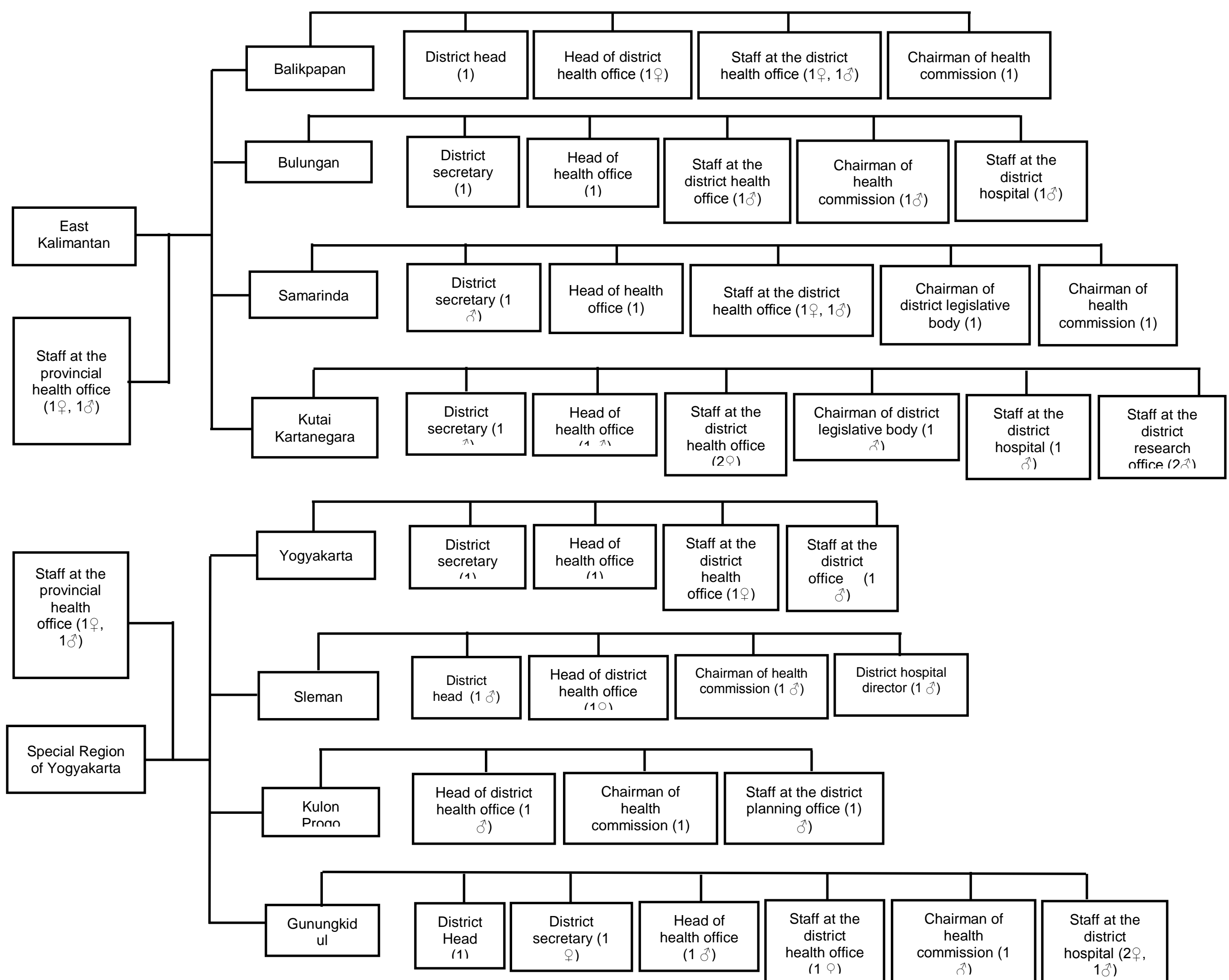

Figure 1. Respondents of Study

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. 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 were urban, four were rural, and one was an urbanized rural district. In general, each district has its own specific characteristics in terms of demography, geography and economic capacity.

In order to assure that this study upholds all participants dignity, rights, safety and well-being, we registered and received ethical clearance from the Human Research Ethics University of Adelaide.

2.1. The Framework Approach

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 analyzing the data, from initial data management to the development of descriptive and explanatory accounts, as pointed out by Smith.(11) In addition, as emphasized by Ritchie and Lewis, the approach also provides a transparent track of the researcher's interpretation(12), 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* issue and inductive reasoning through respondent-generated themes to develop the research framework.(13) In general, the method consists of two sequential activities: data management, where data is synthesized 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 synthesizing 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(14) 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.

3. Results and Discussion

Decentralisation in Indonesia brought considerable changes to the role of local government in regard to public services. 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 synchronizing locally-derived proposals and at the same time taking into account central regulation and policies as part of the top-down process.

3.1. Public Policy: the Local Initiative

In general, public policy is defined as the actions that a governmental entity undertakes.(15) Public policy is often associated with the government as only the government has the authority and power to govern the people with the purpose of developing public justice, involvement, and prosperity.(16) 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, local government has the power to develop health policy within the designated corridor. The power to plan

under decentralisation brings a responsibility to benefit the public. However, it is not a boundless freedom. The local power is still bounded by central regulations and policies.

3.1.1. The Relationship between Responsibility to Plan and Empowerment

The power to plan a local health program can empower local government. This sense of local empowerment was the result of the 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.[17] 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.[18] 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 were confined to having authority to plan and execute local programs. This has less to do with the improvement of local ‘ability' and more to do with expanding local ‘authority'.

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[16] view empowerment as developing subordinate skills in management along with devolution of authority, or as Kanter[17] 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 the 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.[18] 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.

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.[19] 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 the 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 utilized 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.

3.1.2. 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 or local commitment, referring to active support from the *bupati* and local House of Representatives that has the defining role in authorizing local programs.[20] Local government commitment can materialize 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.

3.1.3. 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 the higher regulation, support local policy, promote local diversity and improve public welfare,(21) 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 the legality of policy and, therefore, sustainability of the local health program. Also, local regulations also serve to increase public awareness and participation. In some cases, the local regulation also regulates sanctions in order to encourage public participation even though the sanction is rarely applied. Local health programs supported by *peraturan daerah* tend to receive special attention, particularly in the form of financial support.

3.1.4. 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 the local government in specific sectors, such as healthcare, education and other public services. The APBD may also indicate the 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.(22) 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.(23) 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(24) or districts with a stronger fiscal ability may misuse funds to increase salaries of the local elite.(25) Nonetheless, local fiscal capacity has a considerable influence on local health programs. In local districts with a relatively strong fiscal ability, budget allocation is relatively flexible.

The lack of fiscal capacity means that local government often has to prioritize and make difficult decisions by supporting some activities and rejecting others. However, this does not mean that the cheapest program is automatically prioritized. The local health program priority setting is not all based on unsound judgment. The situation in districts is complicated as some districts 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 Torgerson.(26)

3.2. Jamkesda, the Local Health Coverage Program: a Local Health Program

After decentralisation, local health programs and policy are determined by local government commitment and local financial resources. Local health policy and programs

are more the results of the interaction between policy content, local actors, context, and processes, as identified by Walt and Gilson,[27] rather than clear-cut sequential stages of agenda setting, formulation, implementation, and evaluation as suggested by Brewer and deLeon.[28]

The localized 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.[29] 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 localized 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.[30] 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[31] and Hasanudin.[32]

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 and Buehler.[33];[34] 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 the local dress or religious symbols to emphasize shared ethnicity or religion with most voters in the area.

3.3. Developing the Jamkesda

Local identification by emphasizing factor, in particular, ethnicity, was not always relevant and workable. Aspinall[35] 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 the local power structure.[36] 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.

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.[37] 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 schemes with different coverage and benefits, depending on local fiscal capacity.

There seemed to be different roles of *jamkesda* 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 jamkesda as a vote buying strategy by providing generous benefits and coverage, the district office acts as a controller and is more cautious with local capacity in terms of human resources and fiscal capacity. However, as pointed out by Fatmawati, some local governments did realize what they have promised during the campaign and a number of them were fairly successful.[38] 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.[39] However, health schemes, including central government schemes, have so far have not reinforced the quality of health care, as pointed out by Aspinall.[40]

The study shows that decentralisation has put the district government in the spotlight. However, due to resource differences and local political process across the districts, central government role is still crucial in assuring that the disparity in outcome, be it in health and education, is not widening. Further, the study is necessary to explore the influence of decentralisation in other districts as this study only covers eight out of more than five hundred districts in Indonesia.

4. Conclusion

The development of local health programs was 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.

The second factor was a 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.

Jamkesda is one of the few local health programs that was less associated with the central government and as such it has contributed to two local impacts: public preference in electing the *bupati* and the strengthening of the 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.

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Conflict of Interest

The founding sponsors have no role in the design of this study, in data collection, analysis or interpretation of data, in the writing of the manuscript, and in the decision to publish the result.

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