



THE UNIVERSITY
of ADELAIDE

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

Muhammad Syamsu Hidayat

Thesis submitted to The University of Adelaide
School of Public Health

In fulfilment of the requirements
For the degree of Doctor of Philosophy

May, 2016

Table of Contents

TABLE OF CONTENTS	2
LIST OF TABLES	5
LIST OF FIGURES	5
ABSTRACT.....	6
THESIS DECLARATION STATEMENT	10
ACKNOWLEDGEMENTS.....	11
CHAPTER 1 : INTRODUCTION	13
1.1. HEALTH AND DECENTRALISATION: CONCEPTS AND PURPOSES	13
1.2. DECENTRALISATION IN INDONESIA: A HISTORICAL PERSPECTIVE	17
1.3.IMPACT OF DECENTRALISATION IN HEALTHCARE: THE EXPERIENCE IN INDONESIA AND OTHER NATIONS	21
1.4. RESEARCH QUESTIONS	29
1.5. STRUCTURE OF THE THESIS	32
CHAPTER 2 : METHODS.....	34
2.1. THE INITIAL STAGE: DEVELOPING THE ANALYSIS	34
2.1.1. <i>The Characteristic of Local Discretion that Prevented Consistent Measurement</i>	37
2.1.2. <i>The Problematic Correlation between Degree of Discretion and Health Indicators</i>	38
2.1.3. <i>The Solution</i>	39
2.2. QUALITATIVE ANALYSIS: THE ADVANTAGE	40
2.3. LOCATION OF STUDY	42
2.3.1. <i>Gunungkidul</i>	43
2.3.2. <i>Kulon Progo</i>	44
2.3.3. <i>Sleman</i>	44
2.3.4. <i>Yogyakarta</i>	45
2.3.5. <i>Kutai Kartanegara</i>	45
2.3.6. <i>Bulungan</i>	46
2.3.7. <i>Balikpapan</i>	47
2.3.8. <i>Samarinda</i>	47
2.4. SAMPLING AND DATA COLLECTION	48
2.5. TRANSCRIPTION AND DATA ANALYSIS	57
2.6. THE FRAMEWORK APPROACH	58

CHAPTER 3 : LAWS, GOVERNMENT STRUCTURE AND DISTRIBUTION OF POWER.....	66
3.1. BRIEF DESCRIPTION OF LAW 5/1974, THE LAW PRIOR TO DECENTRALISATION	67
3.2. LAW NO 22/1999, THE FIRST LAW ON DECENTRALISATION AND ITS IMPACT ON GOVERNMENT STRUCTURE AND POWER DIVISION.....	69
3.3. THE NEW LAW NO 32/2004 AND ITS IMPACT ON GOVERNMENT STRUCTURE AND POWER DIVISION	74
3.4. LOCAL GOVERNMENT SOURCES OF FINANCE: LAW NO 25/1999 AND LAW NO 33/2004	78
3.5. RESPONDENTS PERCEPTION ON LAW NO 32/2004 AND LAW NO 33/2004	86
3.5.1. <i>Shared Responsibility</i>	87
3.5.2. <i>Division of Financial Resources</i>	90
3.6. FROM LAW NO 22/1999 TO LAW NO 32/2004: A REFLECTION OF CONSTANT CHANGE.....	94
CHAPTER 4: DEVELOPING LOCAL HEALTH PROGRAMS.....	96
4.1. THE ACTORS IN THE LOCAL GOVERNMENT.....	97
4.1.1. <i>Head of District (Bupati)</i>	97
4.1.2. <i>District House of Representatives</i>	98
4.1.3. <i>District Health Office and District Public Hospital</i>	101
4.1.4. <i>Head of Province or Governor</i>	105
4.1.5. <i>Provincial House of Representatives</i>	108
4.1.6. <i>Provincial Health Office</i>	108
4.2. PUBLIC POLICY: THE LOCAL INITIATIVE	110
4.2.1. <i>The Relationship between Responsibility to Plan and Empowerment</i>	111
4.2.2. <i>Developing Local Health Program</i>	114
4.2.2.1. The Role of Local Government Commitment in Supporting Health Program	118
4.2.2.2. Local Government Commitment: Local Regulation.....	119
4.2.2.3. Local Government Commitment: Fiscal Support and Fiscal Utilisation.....	120
4.2.2.4. Cross-sectoral Cooperation: Support and Challenges	128
4.2.3. <i>Public Participation: Promoting Public Involvement in Government Program</i>	130
4.2.3.1. Musyawarah Perencanaan Pembangunan or the Development Planning Meeting	132
4.2.3.2. Gathering Public Aspirations	134
4.3. JAMKESDA, THE LOCAL HEALTH COVERAGE PROGRAM: A LOCAL INITIATIVE	137
4.3.1. <i>Developing the Jamkesda</i>	138
4.3.2. <i>Potential Conflict with Central Government: Jamkesda as a Local Distinctive Feature</i>	145
4.4. CONCLUSION	148
CHAPTER 5 : LOCAL HEALTH POLICY AND PROGRAMS – FACTORS INFLUENCING LOCAL INTERPRETATION	151
5.1. MORE THAN LOCAL INITIATIVE: LOCAL HEALTH POLICY DECISION REFLECTING VARYING INTERPRETATION	151
5.1.1. <i>The Moratorium on Local Government Civil Servants</i>	161
5.1.2. <i>The More Assertive Process: the Case of East Kalimantan</i>	163
5.1.3. <i>The More Cautious Process: the Case of Java</i>	170
5.2. THE DEFINING ROLE OF FISCAL CAPACITY IN LOCAL INTERPRETATION.....	175
5.2.1. <i>Does Fiscal Capacity Really Matter?</i>	186
5.2.1.1. Inter-district and District-Province Coordination	187
5.2.1.2. The Relationship between Poverty and Central-Local Coordination.....	193
5.2.1.3. The Problem with Availability of Reliable Data	195
5.3. THE IMPORTANCE OF LEADERSHIP IN LOCAL INTERPRETATION	196
5.3.1. <i>Local Capacity, another Important Aspect of Local Interpretation</i>	204
5.3.2. <i>Locally Responsive or Local Elite Responsive Program?</i>	210
5.4. CONCLUSION	213

CHAPTER 6 : CENTRAL GOVERNMENT CONTROL THROUGH REGULATIONS AND POLICIES	215
6.1. A JAVANESE/INDONESIAN PERSPECTIVE ON THE NATURE OF CENTRAL AND LOCAL GOVERNMENT RELATIONSHIP ..	216
6.2. NATIONAL PLANNING SYSTEM: WHAT DOES THE CENTRAL LAW SAY?.....	220
6.2.1. <i>National Planning System: How is it perceived at the Local Level?</i>	221
6.3. THE MINIMUM STANDARD OF SERVICE.....	225
6.3.1. <i>SPM as a Guideline in Developing Local Health Programs</i>	227
6.3.2. <i>SPM as Equal Entitlement to Basic Health Services</i>	230
6.3.3. <i>SPM as an Indicator of Local Health Performance</i>	232
6.3.4. <i>The Local Component of Local Health Programs</i>	234
6.4. DATA COLLECTION.....	239
6.4.1. <i>Internal Data Collection through Posyandu</i>	240
6.4.2. <i>Internal Data Collection through Puskesmas</i>	242
6.4.3. <i>BPS, the Central Government Data Collection</i>	245
6.5. BALANCING BETWEEN CENTRAL AND LOCAL POWER.....	247
6.6. SPACE FOR COMMUNICATION AND NEGOTIATION	252
6.6.1. <i>The Class-less Hospital</i>	254
6.7. CONCLUSION	257
CHAPTER 7 : CONCLUSION	260
7.1. CONCLUSION	260
APPENDIX.....	266
REFERENCES	271

List of Tables

Table 2.1 Selected Health Indicators in the Four Districts in Yogyakarta	43
Table 2.2 Selected Health Human Resources in the four Districts in Yogyakarta	45
Table 2.3 Selected Health Indicators in the Four Districts in East Kalimantan	46
Table 2.4 Selected Health Human Resources in the Four Districts in East Kalimantan	47
Table 2.5 Commonalities and Differences in Basic Indicators between Districts	48
Table 3.1 Differences between Law No 22/1999 and Law No 32/2004	80
Table 5.1 Shared-revenue and APBD in 2011	177
Table 5.2 Number of Poor per District.....	194
Table 6.1 Central Government Expenditure for Local Governments	250

List of figures

Figure 2.1 Sampling Process and Response	52
Figure 2.2 Illustration of Charting Diagram.....	62
Figure 3.1 Prior to Decentralisation: Indonesia's Three Tier Government Structure	69
Figure 3.2 Post decentralisation: Indonesia's two tiers government structure with province and district at the same level.....	71
Figure 3.3 District Sources of Financing.....	83
Figure 6.1 the Structure of Government Affairs ²⁸¹	226

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 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

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying, subject to the provisions of the Copyright Act 1968.

I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

Muhammad Syamsu Hidayat

Acknowledgements

Firstly, I would like to express my deepest gratitude to my supervisors, Dr. Afzal Mahmood and Assoc. Prof. John Moss, for their supervision, support and encouragement over the course of my PhD candidature. I would particularly like to thank Dr. Afzal Mahmood for his continual enthusiasm, vision, and determination for my research to succeed. I am also grateful to Assoc. Prof. John Moss for his help and motivation during the time of my candidature.

I would like to acknowledge the financial support from the Government of the Commonwealth of Australia through their Australia Development Scholarships (ADS) for sponsoring my study at the University of Adelaide. In addition, I would also like to acknowledge the academic and administrative staff from the School of Public Health for their throughout assistance and the International Office, particularly Niranjala Seimon and Augustine Bhaskarraaj for their constant support since the first time I arrived in Adelaide.

I would like to thank the district government, the district health office and House of Representatives of Bulungan, Balikpapan, Kutai Kartanegara and Samarinda in East Kalimantan and Gunungkidul, Kulon Progo, Sleman and Yogyakarta in the Special

Region of Yogyakarta for the opportunity that has made this study possible. Special thank for Ibu Masitah, Ibu Ismi, Ibu Aniek and Ibu Hesti for helping me accessing these offices.

I am very grateful to my fellow Indonesian students for their friendship, encouragement, and help. Many thanks also to other PhD students in the School of Public Health: Siau, Gizachew, Habib and Ting who have helped me throughout my study, reading my chapters and at times giving constructive feedback for improving my thesis.

Last but not least and most importantly I thank my family, my wife and two children, my parents and parents-in-law, my sister and brothers and their families who always pray for me and help me in this journey.