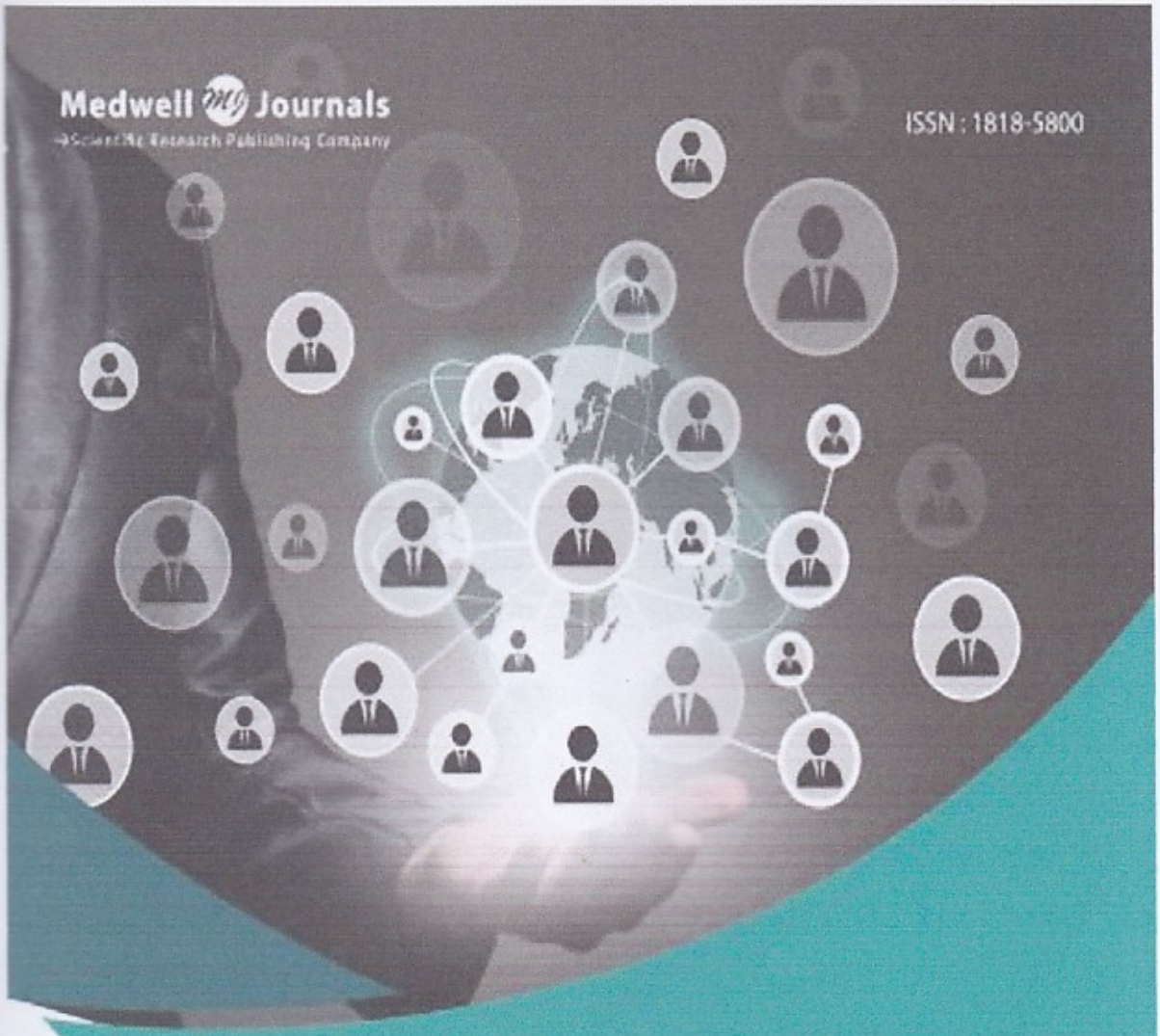

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The Effect of Decentralization on Health Services: The Experience of Pesawaran District, Lampung Province, Indonesia

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Abstract: The goals of this study are to explain the effects of decentralization on health services. We conducted empirical research based on qualitative approach. Data is collecting by interviewing some key informant who holds power to formulating and implementing public service in the health sector at Pesawaran District. Data is analyzing with an interactive model. We find that Pesawaran District does not meet minimum service standards health as stipulated by the central government. Lack of infrastructure, health workforce and public funding for health sector are a major factor that weakens the ability of Pesawaran government to make their people healthier. Also, several key informants revealed that the Indonesia Health Card Program (health insurance for poor people) and national health insurance program had not fulfilled a sense of justice. Although, each who became a member of national health insurance pays the same cost, their received different healthcare due to different quality of infrastructure and health services between Java and outside Java. Governance issues became the first step to improving the performance of health decentralization in Pesawaran District because of local government has power, resources and legitimate to perform a variety of treatments as part of health reform at the local level. We also suggest recommendation for the next research on this theme.

Key words: Decentralization, health service, Pesawaran, Lampung, Indonesia, reform

INTRODUCTION

Historically, health decentralization in Indonesia is not a new phenomenon. The Netherlands East Indies public health service supplanted the former civil medical service in 1925 and was a full-time central public health service with headquarters at Batavia (now Djakarta). Its program was a centralized one until 1934 when province health services organized in Java, Sumatra and the East Archipelago, under central supervision. By 1937, local health departments had charge of soil sanitation, water supply, sewerage, hospital care and dispensaries. Decentralization was completed by 1938 and public health work was also transferred to local authorities and municipalities an organizational structure which now continues under the central authority of the Ministry of Health. A large proportion of medical personnel is now employed by the Ministry of Health and the provincial health organizations. In 1937, 651 of 1,135 practicing physicians were employed by the government and in 1938, 527 of 1,247 physicians.

Under new order (1966-1998) regime, Indonesia's has practicing centralization to controlling health sector. Health reform in this country was begun when new order collapse in 1998. Financial crisis (Krisis Moneter) in 1998 has trigger central government to change health policy totally. According to Hotchkiss and Jacobalis (1999), despite the negative impacts of financial crisis, government policymaker view current economic crisis environment as an opportunity to accelerate health care reform efforts. In this manner, reform is a process of change involving the what, who and how of health sector action (Berman, 1995). In 1999, central government has passed on Law 22/1999 on regional government. In this law, central government gives more authority, responsibility, resources to local (province/district/ municipality) government including health sector. Under this process, 2.4 million civil servants were reassigned from central government to local government. No other decentralizing country has undertaken such a massive transfer of staff (Kolehmainen, 2004).

Previous research on health decentralization in Indonesia shows multiple issues. Kristiansen and Santoso (2006), for example was generating three conclusions from their research. First, the local administration of health care services is without transparency and accountability. Second, health centers are turned into profit centers. Third, the increasing roles of private actors tend to reduce concerns over preventive health care and the conditions for poor people (Halabi, 2009). Triratnawati (2010) said

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that the main problems related to under-utilization of community health centers are mostly on administration (fewer quality services, un-efficient, a long hour waiting), a high bureaucratic system (physician has a dominant power, overlapping programs, poor coordination and integration with other divisions).

Another researcher shows that despite the promise of decentralization to increase sectoral "decision space" at the district level, the central government now has control over essentially all public sector health staff at the region, marking a return to the situation of 20 years ago (Heywood and Harahap, 2009). There has been little improvement in the performance of the health system since decentralization occurred in 2001 even though there has also been a significant increase in public funding for health (Heywood and Choi, 2010). Fastly implementation of decentralization reforms may have contributed to a slowdown in mortality rate reduction (Hodge *et al*., 2014). However, it also makes less integrated malaria control between districts (Herdiana *et al*., 2013), low complete immunization coverage and limited use of evidence-based financing and budgeting (Kurniawan *et al*., 2012).

On the different side, Kruse *et al*. (2012) suggests that increased public health spending improves targeting to the poor as behavioral changes in public health care utilization are pro-poor. Herdiana *et al*. (2013) also show that intervention carried out by the government of Sabang, during 2005-2010 have dramatically reduced the burden of malaria over the past 7 years. Finally, Sparrow *et al*. (2013) find that social health insurance improves access to health care in that it increases utilization of outpatient among the poor while out-of-pocket spending seems to have grown for Askeskin insured in urban areas.

This study is designing to follow the debate on health decentralization in Indonesia, especially in the new autonomous region which is given little attention by the researchers as the object of study. Based on empirical research in Pesawaran District, Lampung Province, this study would like to explain what and how the effect of decentralization on health service delivery. To analyze this effect, we modified framework proposed by Campbell *et al*. (2013) and adopting several indicators, namely: health infrastructure, health workforce, health financing and performance of health service.

MATERIALS AND METHODS

We use qualitative approach to conduct this research. Data was collected from key informants (bureaucrats and local politicians) who have authority to make and implement health programs in Pesawaran District. Key informant determined by snowball technique. Secondary data was collected from official publications issued by Pesawaran government on health sector. Analysis will be focused on health infrastructure, health workforce, health financing and the performance of health services. Data were analyzed with interactive models (data reduction, data display, verification and conclusion) developed (Miles and Huberman, 1984). We believe that this method can reveal the effects perceived by key actors in the decentralization of health policy at research sites.

RESULTS AND DISCUSSION

Pesawaran District is a new autonomous regions that splitted from South Lampung District by Law No. 33/2007 on the establishment of Pesawaran District. In 2013, Pesawaran District has an area of 1173.77 km^2, inhabited by 416.372 and consists of 9 (nine) sub-districts that is: Gedong Settings, Negeri Katon, Tegineneng, Way Lima, Padang Mirror, Punduh Pedada, Kedondong, Way Khilau and Marga Punduh (Table 1). Agricultural sector has contribute 50% for Pesawaran GDRP (gross regional domestic product) that reach Rp. 1.994,969 in 2013.

Health infrastructure in Pesawaran District is poor. There is only 1 hospital, 12 main public health center, 39 sub-public health center, 6 dispensaries, 17 clinics, 422 Posyandu (integrative health center) and 99 Poskesdes (village health post). According to Ministry of Health, Posyandu and Poskesdes is spearheading of health service in the village. It is managing by midwife, village government and villagers. Posyandu is one of the Poskesdes program for mother, child and elderly people. Government of Pesawaran District usually put a midwife to manage Poskesdes functions (promotion, preventive and curative) in providing primary health care for villagers. The employment status of the village midwife could be permanent civil servants or temporary civil servants. Government of Pesawaran District gives buildings, medical equipment and fund to Poskesdes. However, midwife, village government and others stakeholder in village level have greater room to collecting resources from another source (for example: fund raising,

Table 1: Number of household and population of Pesawaran District by sex and sex ratio, 2013

Sub-districts	Household	Male	Female	Total	Sex ratio
Punduh Pidada	3.467	6.808	6.118	12.926	111.28
Marga Punduh	3.365	6.864	6.178	13.042	111.10
Padang Cermin	22.480	48.553	44.398	92.951	109.36
Kedondong	8.489	17.041	15.961	33.002	106.77
Way Khilau	6.080	13.738	12.464	26.202	110.22
Way Lima	7.664	15.500	14.449	29.949	107.27
Gedung Tataan*	21.717	46.921	45.712	92.633	102.64
Negeri Katon	16.870	32.764	31.105	63.869	105.33
Tegineneng	13.499	26.525	25.273	51.798	104.95
Total	103.631	214.714	201.658	416.372	106.47

*Capital city; http://pesawarankab.bps.go.id/linkTabelStatis/view/id/36, accessed in 10/07/2014

Table 2: Number of village and health facilities by sub-district in Pesawaran District, 2013

Districts	Hospital	Maternity Hospital	Health center at sub-district level (Puskesmas)	Community Health Sub-Center (Pustu)	Dispensary	Clinic	Posyandu	Poskesdes	No. of village
Punduh Pidada	0	0	1	3	0	0	40	6	11
Marga Punduh	0	0	0	2	0	0	0	5	10
Padang Cermin	0	0	3	6	2	3	77	19	31
Kedondong	0	0	1	4	1	0	54	9	12
Way Khilau	0	0	0	3	0	0	0	7	10
Way Lima	0	0	1	5	0	1	34	11	16
Gedung Tataan*	1	0	2	6	3	9	93	15	19
Negeri Katon	0	0	2	5	0	4	70	16	19
Tegineneng	0	0	2	5	0	0	54	11	16
Total	1	0	12	39	6	17	422	99	144

*Capital city; http://pesawarankab.bps.go.id/linkTabelStatis/view/id/38, accessed in 04/08/2014

charity fund, donation, etc). In Pesawaran District, each Poskesdes must serve 4,206 people (Table 2). The number of health workforce in Pesawaran District is still low. As shown in Table 3, the number of doctors is only 30 people and spread unevenly among sub-districts. With this number, 1 doctor must serve 13.879 people. This condition does not an international standard on the doctor-population ratio. In fact, Indonesia is one of doctor exporter countries in Southeast Asia (Kanchanachitra *et al*., 2011). The dentist, nurse and midwife have similar conditions. This situation indicates a high demand for health workers in Pesawaran District. Although, the supply side of health workers has been quite good but the capacity of local government to absortive health workers is still dependent on central government who hold full authority to determine the amount of local civil servant formasi (job vacancy). Prioritizing health services thorugh government bureaucracy is actually contrary to the contemporary thinking on public service which required greater role for private sector and civil society. Accelerated development of health sector should be encouraging both sectors to provide modern health services in this region in accordance with the character of each institution.

Table 3: Health workforce in Pesawaran District

Sub district	Type of health workforce			
	Doctor	Dentist	Nurse	Midwife
Gedong Tataan*	5	2	44	57
Negeri Katon	3	0	18	32
Tegineneng	4	0	19	35
Way Lima	3	0	11	26
Padang Cermin	10	2	25	42
Punduh Pedada	2	1	8	16
Kedondong	3	1	12	16
Marga Punduh	0	0	0	0
Way Khilau	0	0	0	0
Jumlah	30	6	137	224

*Capital city; Health Service Agency of Pesawaran District in 2013

Table 4: Source of health financing in Pesawaran District, 2013

Source of finance	Health fund	
	Rupiah (Rp.)	%
District government budget	927.583,00	22.22
Province government budget	586.792,367	14.06
State budget		
Askeskin (health insurance for poor household) program	2.408.420,000	57.70
Others	79.163,735	1.90
Foreign state grants/loans	24.725,000	0.59
Others	47.286,000	3.53
Total health fund	4.173.970,102	100.00
District government budget	62.324.076,993	
Health fund in district government budget (%)		1.49

Health Service Agency of Pesawaran District in 2013

On the financing side as show in Table 4, health sector in Pesawaran District still rely on Askekin program (health insurance for poor household) which is controlled entirely by central government. Contributions of district government budget on health financing is only 22.22%. While total health funds in Pesawaran budget in 2013 is only 1.49%. This situation support Heywood and Harahap (2009) finding who show that at least 40% of the district level of public expenditure on health is for personnel. Although, since the direct election of district heads (pilkada) in 2005, health issues have always exploited by candidate as a strategy to attract voters to the polls but the movement of health fund in local government budget has not increased significantly. Health issues is still sexy in the eyes of the politicians. Political campaign in pilkada on health issues could be increase the degree of candidate alignments to the public interest. However, it is not easy to intervene health problem in local level because it is requires modern technology, political commitment, funds, institutional capacity and good governance (Ciccone *et al*., 2014). Health sector in local level requires more than just a political commitment, rhetoric, political popularity and electability.

Lack of infrastructure, health personnel and funds causes Pesawaran District have not been able to meet minimum service standards on health sector outlined by central government (Government Regulation No. 65/2005 on guide for Formulating and Implementing Minimum Service Standard in Public Service) and Ministry of Health (Regulation of Ministry of Health

Table 5: Achievement of minimum standard service for primary health service in pesawaran district

Indicator of minimum standard service	Result	Target	Achievement (%)
Primary health service			
Percentage of antenatal care for pregnant mother	8.550	10.466	81.690
Percentage of pregnancy complication which has been treated	313.000	1.878	16.670
Percentage of births attended by skilled health personnel	8.078	8.962	90.140
Percentage of puerperium service	8.066	17.070	47.250
Percentage of neonatus complication which has been treated	244.000	1.202	20.300
Percentage of newborn babies visiting health care (Puskesmas. Poskesdes. or Posyandu)	6.229	8.535	72.980
Percentage of village which has reached Universal Child Immunization (UCI) targeted	119.000	133.000	89.470
Percentage for children under five care at health center (Puskesmas. Poskesdes, Posyandu)	17.796	38.369	46.380
Percentage of babies (2-14 years old) within poor household receive complement food	2.379	2.677	88.870
Percentage of malnutrition children receive treatment	11.000	11.000	100.000
Percentage of primary education student receiving health screening	-	-	-
Percentage of active participant in family planning program	56.354	81.021	69.550
Finding and medical treatment for desease			
Acute Flaccid Paralysis (AFP) rate (population under <15 years old)	1.000	119.947	0.830
Finding pnemonia suspected	159.000	4.691	3.390
Finding new tuberculosis suspected	187.000	686.000	27.260
Treatment for dengue suspected	52.000	52.000	100.000
Finding diare suspected	11.601	16.871	68.760
Percentage of primary health care for poor people (Askekin program)	209.471	209.471	100.000
Healthcare refferal			
Percentage of healthcare refferal for poor people			
Percentage of ICU service level 1 in district hospital	-	-	-
Epidemiologi investigation and treatment for extra-ordinary event			
Number of village with extra-ordinary event on epidemiologi <24 h	9.000	9.000	100.000
Health promotion and people empowering			
Number of the Alert Village (Desa Siaga Aktif)	39.000	133.000	29.320

Health Service Agency of Pesawaran District in 2013

No. 741/MENKES/PER/VII/2008 on Minimum Service Standards in District Level Juncto Decree of Health Ministry No. 828/MENKES/SK/IX/ 2008 on the Guide for Implementing Minimum Service Standard in District Level). Government of Pesawaran District able to reach 100% in some indicators because of the target was set out in low value (for example: malnutrition children receive treatment, treatment for suspected dengue, primary health care for poor people and number of village with extra ordinary event on the epidemiology of <24 h) (Table 5).

The central government's efforts to strengthen health decentralization policies tend to be contradicted with several health program launched by Jokowi-JK administration for example Indonesia Health Card (Kartu Indonesia) for poor people as part of health insurance program. Indonesia Health Card *is purely managing by centralization mechanism. This* program does not considered variation of people need, availability, accessability and acceptability of health service in local level. Some key informant argues that the principle of risk and cost sharing in this program has not meet the principle of justice. Although, every citizen who participated in this program pays the same cost but they will receive different health care due to different health infrastructure and health services quality between regions (Java versus outside Java). In addition, the majority of poor people live in rural areas where health center does not have doctor and full health facilities. Despite the government's efforts to improve the health of the poor, the rich-poor gap in health status and service access still continues until today (Utomo *et al*., 2011).

CONCLUSION

Health decentralization in Indonesia has been practiced since the Netherlands East Indies era. This policy continues today. In Pesawaran District, decentralization has not been giving significantly effect on public health improvement. The lack of facilities, health workers and public funds led to the achievement of minimum standards services on health sector has not been maximized. Although, Jokowi-JK administration is very serious with the Indonesian Health Card Program, but this program do not meet the principles of justice. The different of infrastructure, human resources, institutional and health sector governance in each region is the basis of differentiation health care received by people who are the members of national health insurance.

The success of Indonesia's great experiment in decentralization, said Booth (2011) will rest on the ability of province and districts to supply the services people need. In health sector, local governments must pay attention to the dynamic of social constructs shaped by changing political and social conditions that influence health system (Grundy *et al*., 2014). Since, government holds the mandate, resources and power to control health sector governance, then improvement of governance becomes the first step to addressing a variety of health problems so that health development in line with public interest including poor people. For the next research, we need to give a special attention to the influence of political processes to health care at local level. Governance issues in local politics are very dynamics due

to change in local political power after 2014 general elections and perhaps pilkada in 2015. In the context of Pesawaran District, we can use primary data from Demographic and Health Survey (DHS), developed by USAID and Department of Health of the Republic of Indonesia or Indonesia Family Life Survey (IFLS), developed by Rand Corporation to explain more deepening on the effects of decentralization to health care at district level.

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