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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 article is to explain the effects of decentralization on health services. We are conducted empirical research based on qualitative approach. Data were collected by interviewing some key informant who holds the power to formulating and implementing public service in health sector at Pesawaran District. Data were analyzed with interactive model. We find that Pesawaran District does not meet minimum service standards in health sector as stipulated by 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 theirs people healthier. In addition, several key informant revealed that the Indonesia Health Card program (health insurance for poor people) and national health insurance program has not fulfilled a sense of justice. Although each person who became a member of national health insurance pay the same cost, but 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 improve 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 local level. We also suggest recommendation for the next research on this theme.

Keywords: decentralization; health service; Pesawaran; Lampung; Indonesia.

1. 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 provincial health services were 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 general 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 are 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 (Jenney, 1953).

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 & 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, almost 2.4 million civil servants in total were reassigned from central government to local government. No other decentralizing country has undertaken such a massive transfer of staff (Kolehmainen-Aitken, 2004).

Previous research on health decentralization in Indonesia shows multiple issues. Kristiansen & Santoso (2006), for example, was generating three conclusions from their research, that is: the local administration of health care services is without transparency and accountability, health centers are turned into profit centers, and the increasing roles of private actors tend to reduce concerns over preventive health care and the conditions for poor people (see also Halabi, 2009). Triratnawati, (2006) said that the main problems related to under-utilization of community health centers are mostly on administration (less quality services, un-efficient, long hour waiting), strong bureaucratic system (physician has a dominant power, overlapping programs, poor coordination and integration with other divisions).

Another researcher show 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 district level, marking a return to the situation of 20 year ago (Heywood & Harahap, 2009). There has been little improvement in the performance of the health system since decentralization occurred in 2001 even though there have also been significant increase in public funding for health (Heywood & Choi, 2010). Hasty implementation of decentralization reforms may have contributed to a slowdown in mortality rate reduction (Hodge, Firth, Marthias, & Jimenez-Soto, 2014), less integrated malaria control between districts (Mandarwati et al., 2014), and low complete immunization coverage (Kosen, 2013), and limited use of evidence-based financing and budgeting (Kurniawan, Harbianto, Purwaningrum, & Marthias, 2012).

On the different side, Kruse, Pradhan, & Sparrow (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 seven years. Finally, Sparrow, Suryahadi, & Widyanti (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 increased for *Askeskin* insured in urban areas.

This article is designed to following debate on health decentralization in Indonesia, especially in the new autonomous region that is rarely seen by the researchers as the object of study. Based on empirical research in Pesawaran District, Lampung Province, this article would like to explain what and how the effect of decentralization on health service delivery. To explain 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.

2. Research 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 &

Huberman (1984). We believe that this methods can reveal the effects perceived by key actors in the decentralization of health policy at research sites.

3. Finding 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 (see Table 1). Agricultural sector has contribute 50 percent for Pesawaran GDRP (gross regional domestic product) that reach Rp1.994.969 in 2013.

Table 1 Number of Household and Population of Pesawaran District by Sex and Sex Ratio, 2013

No.	Sub district	Household	Male	Female	Total	Sex Ratio
1.	Punduh Pidada	3.467	6.808	6.118	12.926	111,28
2.	Marga Punduh	3.365	6.864	6.178	13.042	111,10
3.	Padang Cermin	22.480	48.553	44.398	92.951	109,36
4.	Kedondong	8.489	17.041	15.961	33.002	106,77
5.	Way Khilau	6.080	13.738	12.464	26.202	110,22
6.	Way Lima	7.664	15.500	14.449	29.949	107,27
7.	Gedung Tataan*)	21.717	46.921	45.712	92.633	102,64
8.	Negeri Katon	16.870	32.764	31.105	63.869	105,33
9.	Tegineneng	13.499	26.525	25.273	51.798	104,95
Total		**103.631**	**214.714**	**201.658**	**416.372**	**106,47**

*) capital city

Source: http://pesawarankab.bps.go.id/linkTabelStatis/view/id/36, accessed in 10/07/2014

Health infrastructure in Pesawaran District is poor. There is only 1 hospital, 12 main public health center, 39 sub public health center, 6 dispensary, 17 clinic, 422 *Posyandu* (integrative health center), and 99 *Poskesdes* (village health post). According to Ministry of Health (2006), *Posyandu* and *Poskesdes* is spearheading of health service in the village. It is managed 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 sources (for example: fund raising, charity fund, donation, etc.). In Pesawaran District, each *Poskesdes* must serve 4,206 people.

Table 2 Number of Village and Health Facilities by Sub-district in Pesawaran District, 2013

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

*) capital city

Source: http://pesawarankab.bps.go.id/linkTabelStatis/view/id/38, accessed in 04/08/2014

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 13.8[18] 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

No	Sub district	Type of health workforce			
		Doctor	Dentist	Nurse	Midwife
1.	Gedong Tataan*)	5	2	44	57
2.	Negeri Katon	3	0	18	32
3.	Tegineneng	4	0	19	35
4.	Way Lima	3	0	11	26
5.	Padang Cermin	10	2	25	42
6.	Punduh Pedada	2	1	8	16
7.	[17]dondong	3	1	12	16
8.	Marga Punduh	0	0	0	0
9.	Way Khilau	0	0	0	0
Jumlah		**30**	**6**	**137**	**224**

*) capital city

Source: Health Service Agency of Pesawaran District (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 percent. While total health funds in Pesawaran budget in 20[15] is only 1.49 percent. This situation support Heywood & Harahap (2009) finding who show that at least 40 percent 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, Vian, Maurer, & Bradley, 2014). Health sector in local level requires more than just a political commitment, rhetoric, political popularity, and electability.

Table 4 Source of health financing in Pesawaran District, 2013

No.	Source of finance	Health fund	
		Rupiah (Rp)	%
1.	District government budget	927.583.000	22,22
2.	Province government budget	586.792.367	14,06
3.	State budget		
	- Askeskin (health insurance for poor household) program	2.408.420.000	57,70
	- Others	79.163.735	1,90
4.	Foreign state grants/loans	24.725.000	0,59
5.	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**

Source: Health Service Agency of Pesawaran District (2013)

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 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 percent 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 hours) (see 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 Sehat Indonesia*) for poor people as part of national 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, Sucahya, & Utami, 2011).

Table 5 Achievement of minimum standard service for primary health service in Pesawaran District

No	Indicator of minimum standard service	Result	Target	Achievement
A	**Primary health service**			
1.	Percentage of antenatal care for pregnant mother	8.550	10.466	81,69%
2.	Percentage of pregnancy complication which has been treated	313	1.878	16,67%
3.	Percentage of births attended by skilled health personnel	8.078	8.962	90,14%
4.	Percentage of puerperium service	8.066	17.070	47,25%
5.	Percentage of neonatus complication which has been treated	244	1.202	20,30%
6.	Percentage of newborn babies visiting health care (Puskesmas, Poskesdes, or Posyandu)	6.229	8.535	72,98%
7.	Percentage of village which has been done Universal Child Immunization (UCI) targeted	119	133	89,47%
8.	Percentage for children under five care at health center (Puskesmas, Poskesdes, Posyandu)	17.796	38.369	46,38%
9.	Percentage of babies (2-14 years old) within poor household receive complement food.	2.379	2.677	88,87%
10.	Percentage of malnutrition children receive treatment	11	11	100%
11.	Percentage of primary education student receiving health screening	-	-	-
12.	Percentage of active participant in family planning program	56.354	81.021	69,55%
13.	Finding and medical treatment for desease			
	a. Acute flaccid paralysis (AFP) rate (population under < 15 years old)	1	119.947	0,83%
	b. Finding pnemonia suspected	159	4.691	3,39%
	c. Finding new tuberculosis suspected	187	686	27,26%
	d. Treatment for dengue suspected	52	52	100%
	e. Finding diare suspected	11.601	16.871	68,76%
14.	Percentage of primary health care for poor people (Askekin program)	209.471	209.471	100,00%
B.	**Healthcare refferal**			
	a. Percentage of healthcare refferal for poor people b. Percentage of ICU service level 1 in district hospital	-	-	-
C.	**Epidemiologi investigation and treatment for extra-ordinary event**			
	a. Number of village with extra-ordinary event on epidemiologi <24 jam	9	9	100,00%
D.	**Health promotion and people empowering**			
	a. Number of the Alert Village (Desa Siaga Aktif)	39	133	29,32%

Source: Health Service Agency of Pesawaran District (2013)

4. Conclusion

Health decentralization in Indonesia has been practiced since the Netherlands East Indies era. This policy still 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 programs 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, Hoban, Allender, & Annear, 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 be given a special attention to the influence of political processes at local level to health care. Governance issues in local politics are very dynamics due to change in local political power after 2014 general election 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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