Health Decentralization in Indonesia: Some Obstacles

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Introduction

The implementation of decentralization policy in Indonesia has created huge differences in managing public sector. After experiencing centralization on its entire political history, Indonesia has changed the local government system radically and had become one of the most decentralized countries in the world. Decentralization had only surrendered five authorities to be managed by the central government namely: international affairs, defence, monetary policy, religion and judiciary (Pratikno 2005). Despite the facts that Indonesian “big bang decentralization” has faced many problems related to the emergence of corruption decentralization, communal conflict and disputes in allocation of natural resources (Bunte 2008 p.103), decentralization has brought hopes related to the opportunity for district to manage some basic public services such as health and education.

There are three principles of managing local government in Indonesia, decentralization, deconsentration and madebewind (tugas pembantuan). Decentralization disperses the authorities (kewenangan) from central government to local governments through bypasses the province and strengthening district. Deconse is the central holds the authorities but implement it at the centre but implement it at the province level. In madebewind, the central holds the authorities but implement it at districts and provinces. These three local government management systems exist in post-Soeharto Indonesia.

This paper is an attempt to discuss the impact of decentralization in health sector in Indonesia. I argue that although central and district government has given a significant financial allocation to health sector, the improvement has not been as high as predicted due to three reasons: the formation of health system that create reluctantly of health

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providers to give an appropriate service poor people, the revenue gain strategy by local
government and the increasing role of the central government through deconcentration
principle. This paper will structured by examining health providers in Indonesia, the
policy of health care and the impact of decentralization in health care.

The Structures of Health Providers

Health providers in Indonesia are combination between public and private providers. This condition can be traced to the period of Dutch colonial rule which did not put health for “pribumi” into their concern. In 1950, five years after Indonesian independence, 72 million people only served by 1,200 medical doctors. Moreover one out of five babies was died in their first year (Kristiansen and Santoso 2006). To improve health care condition, private providers has flourished and has boosted by religious organization as a mean to gain followers. In almost all of districts in Indonesia established health care providers which can be easily associated with particular religious organizations. For instance, Muhammadiyah, the second largest Muslim organization in Indonesia, establishes health care facilities before opening their new branch in particular area. The detail can be seen below.

Figure 1
Hospitals based on ownership

![Hospital Ownership Chart](https://example.com/hospital-chart.png)
Another prominent feature of health system in Indonesia is the existence of *Puskesmas* (Pusat Kesehatan Masyarakat/ community health centre) established in 1968. It is designed to be available in every sub-district (*kecamatan*) in Indonesia with a referral hospital at the district level and an addition sub health centre at the village level. At the provincial level, a further referral hospital also established. However, most of health centers only open at the most busiest time for mother between 9 am-12 pm (Dov and Astra 1986). After decentralization, many local governments try to increase *Puskesmas’s* open time to 27/4 and upgrade it with laboratory and bedrooms facilities (Kristiansen and Santoso 2006).

**The Policy on Health Care**

When the economic crisis hit Indonesia in 1997-1999, the expenditure for health care is decline significantly. Real per capita of health expenditure had fallen by 7% in 1997-1998 and 13% in 1998-1999 respectively. Moreover, the gap between budgetary allocation and the actual spending rose between those years from 10 % in 1994-1995, climbed to 23% in 1997-1998 and rocketed to 30% in 1998-1999 (World Bank 1999). Poor people, which defined as those who earned less than $1/ day (or Rp. 152.847/capita) and are the most beneficiaries of *Puskesmas*, rose from 17.47% (34.1 million) in 1996 to 24.23% (49.5 million) in 1999 ([Berita Resmi Statistik/ Statistical report, 2006](http://www.yparmedik-depkes.net/statistik_rs_2007/daftar_rs/menuRS.htm)). With this condition, health budget allocation reduced and the number of poor people increased, government’s ability to maintain health provision in check, as a bargaining power during the Soeharto period, collapsed.

Habibie, who was in power to replace Soeharto, realized the important issue of health sector and established the first health provision in Indonesia, called Health Card program (*Kartu Sehat*) by gathering foreign donors, especially ADB and World Bank. Foreign donor was doubled from $58 million in 1997-1999 to $109 million in 1998-1999 (World Bank 1999). Health Card program gave poor people to obtain medical services, family planning and childbirth (Surhayadi 2002). As it was predicted, the classification of “poor people” created disputes between central government’s bodies, giving opportunities for free riders that eventually collapsed the program in 2003. Health Card
then replaced with Poor Card program (*Kartu Miskin*) during the end of Megawati presidency. Unlike its predecessor, Poor Card only applied in some areas as pilot projects in Indonesia.

In November 2004, the new program has established, called Askeskin (*Asuransi Kesehatan untuk Masyarakat Miskin*/*health insurance for the poor*) soon after Yudhoyono was inaugurated. In Askeskin, the local government set up the poor people list and not the central government. Askeskin holders can go to *Puskesmas* and hospitals for medical treatment and the hospitals then claimed it services to PT Askes, the government’s insurance company which receive Askeskin funds from the Ministry of Health of deconsentration budget. In 2007, Askeskin has changed to *Jamkesmas* (*Jaminan Kesehatan Masyarakat*/*health social security*) without any major improvement, after the Ministry of Health failed to pay PT Askes’s claims on time.

Decentralization policy, which effective in 2001, has created a major shift in term of managing health care. Since 2001, the administration of Health Card is managed by local government using district’s by-laws while central government supports financially through deconsentration. The financial allocation for health sector has also improved five times in eight years from Rp. 2.8 trillion in 2000 to Rp 16 trillion in 2008 (Sby.info 2009).

In addition to government health provision, local government also established their health insurance scheme for citizens living in their particular area. The best known examples are JKJ Program (*Jaminan Kesehatan Jembrana*) in Jembrana District, Bali (Jembrana Government 2009) and Jamkesda (*Jaminan Kesehatan Daerah*) in Yogyakarta city. For those who are not poor and are not covered by local health insurance have to finance their health service out of pocket.

**The Obstacle of Decentralizing Health Care**

This part is discussing the impact of decentralization in Indonesia, especially with the relation to deconsentration principle. Although health decentralization in Indonesia should be analyzed case by case at a district level, some broader pictures can be drawn. I argue that there are three reasons why the improvement of health services is not as high as expected in regard to a big money that has already invested. They are, first, reluctantly of health providers to treat poor people, second, the strategy used by local
government to increase local revenue through hospitals and third, the central government strategy to hold health care in their control.

The problem related to how to give appropriate health service to poor people has never been resolved. With almost 40 million people live under poverty line, health providers tend to prioritize those who funding their health out of pocket or through private health insurance. During 2007, the Ministry of Health had failed to pay PT Askes’s claims of Rp.1.145 trillion (US$ 110 million), and was paid in June 2008 (Kompas, 2008). This condition has collapsed many government’s hospital at local and province level, because they could not funded their normal activities during this “debt” period. Since then, there has been no choice rather than treating poor people who holds Askeskin and Jamkesmas as a second class. In private health providers poor people are often explicitly rejected before they enter the hospital because no agreement has been made between the hospital and the central government.

Hospitals at the district and province level are parts of local government revenue unit called Lembaga Teknis Daerah/LTD (Government’s Technical Unit) based on local government’s by-laws. In this condition, local government set up a yearly standard that hospital should earn based on their own interests. Some local governments that concern with people’s health care are using the issue as a political strategy to gain popular support, while other using it to maximize local revenue (Pendapatan Asli Daerah/PAD). In Kabupaten Bulungan, a district hospital gave Rp. 1,6 billion out of Rp. 3,3 billion as it 2008 target. Every year, local government and local legislative decide how much money should be spent for health care (Bulungan Gov 2008, Sinar Harapan 2007).

It is interesting to acknowledge that although local governments spend more on health sector, there is no such major improvement in health services. Most of the money is used to build new facilities for middle-high income patients as exit strategy to balance between giving appropriate health services and demand to increase PAD. Public hospital physical development is a new trend in Indonesia today. By establishing special unit with special services, the public hospital can attract out of pocket and middle-high income “customers” which normally go to private hospitals. The hospital’s special unit is also attracting the best resource of medical staffs to join, created a semi private and an independent unit within public hospital. This makes poor people as second class patients and treated by second class medical staffs.
On the other hand, central government is reluctant to give authority in health services to districts because health issue is an important for political purposes (sby.info 2009). Using decentralization, deconsentration and madebewind, the central government tries to hold health sector in their control. It controls health sector using budget and regulation as mechanism.

In decentralization, the central government has power to determine the financial allocation of each district through DAU (Dana Alokasi Umum/General Allocation Fund) using some complicated financial formula. Each year, more than 400 districts are “struggling” for better allocations. Besides, central government also has other mechanism to fund health sector projects such as Kompensasi BBM (fuel subsidy compensation), DAK (Dana Alokasi Khusus) and ABT (Anggaran Belanja Tambahan) (Trisnantoro 2004). In deconsentration and madebewind, the central government’s money is also expanding. In the first time after Soeharto, since July 2008, the ministry of health can fund an hour weekly broadcast on national coverage MetroTV and Trans7 every Sunday called B4M (Bincang-Bincang Bareng Bu Menkes/ Dialog with Mrs. Health Minister) (Tempo 2009). In 2003, the central government budget was exceeding the budget of local government as shown below.

Figure 2
Comparing Districts and Central Government Budget on Health
The central government has also an authority to regulate many important issues in health services. In Government decree number 25/2000, the central government through provinces is controlling the price of service, the price of medicine and it distribution, health providers’ accreditation and social health security. This condition created the burden for districts to implement such health policies and turn to implementing central government’s policies.

**Conclusion**

The decentralization has no doubt created a major improvement in many sectors in Indonesia. However, if we look the lenses deeper, there are huge problems still unresolved. The power struggle between central and local government can easily be seen in health sector. The central government tries to hold health sector in their control because it is important to gain popular support. On the other hand, the local government has treated decentralization to maximize local benefits by placing health providers as revenue gain unit.
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