

Decentralization in the Provision of Health Care Services: Study on the Provision of Regional Health Insurance (Jamkesda) In Malang Regency East Java Province

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Abstract

This study holds two objectives. Firstly, to describe decentralization process in the provision of health care services through the Jamkesda or Regional Health Insurance System. Secondly, to describe driving and constraining factors in such decentralized provision of health care. This study used the qualitative approach. The focus of study is more on the execution of Jamkesda system within the context of the implementation of the delegation of government affairs in the health sector by the central government to regency administration pursuant to Government Regulation (PP) Number 38/2007. Data and information were acquired through in-depth interview to study informants using the snow-ball technique, field observation, and documentation. The study's source of information referred to three health services public service elements, namely service consumer, service provider, and service arranger/regulator. The data processing and analysis referred to steps formulated by Creswell. Results of study showed that the implementation of Jamkesda system in Malang Regency is not purely initiated by Malang Regency Local Government, but more on the response toward regulation launched by the East Java Province Government. Therefore, the commitment and consistency of the Malang Regency Local Government in implementing Jamkesda is very weak. This commitment and inconsistency are actually the main constraints in the implementation of Jamkesda in Malang Regency.

Key Words: health services, regional health insurance, decentralization, local government.

1. Background

Health is part of human rights and at the same time as investment for the success of nation building (Mukti dan Moertjahjo, 2010:1). In the event that health is the basic right of the community, the state as sets forth under Article 28 H (1) of the 1945 Constitution of the Republic of Indonesia imperatively is obligated to fulfill and assure the provision of proper health services (see also Mun'im, 2006:126-128). Under Law of the Republic of Indonesia (RI) Number 40 Year 2004 on National Social Insurance System (SJSN) and Law RI 36 Year 2009 on Health, it is stated that the State is responsible for the fulfillment of the right for healthy life of the community especially the less fortunate and underprivileged. Even the Ministry of Health of the Republic of Indonesia, for example, through Minister of Health Decree Number 686/Menkes/SK/VI/2010 has elaborated the issue in the form of health insurance services for the very poor, poor, and underprivileged communities under the Community health Insurance Program (Jamkesmas) and later extended its membership to pregnant mothers, mothers in labor and peurperal mothers, and newly born babies under the Labor Insurance Program further on known as Jampersal (Ministry of Health RI, 2011).

In the regional autonomy era through Law RI Number 32 Year 2004 on Local Government, the State's obligation to provide community basic health right is also decentralized to provincial and regency governments. Furthermore, through Government Regulation Number 38 Year 2007 on the Division of Government Affairs, Provincial and Regency/Municipal Government, it is described as how and what obligatory health affairs are divided among the above government levels. Therefore, in a number of regions, both province and even regency/municipality responses emerged in the provision of such Regional Health Insurance Services System (Jamkesda). In addition to such stipulation, the Jamkesda system also serves as an alternative to basic health services for the poor and under privileged communities outside the Jamkesmas quota-underprivileged community health care organized by ministry of health (Department of Health East Java Administration, 2011:1).

As investment for successful nation building, the efforts exerted by the State in the provision of basic health services both by the central government and regional/local government is expected to improve the access and quality of community health care (Suharto, 2009:60). The success of health development is expected to improve the quality of human resources to achieve Millenium Development Goals (MDGs) in the year 2015 (Kompas, 23 Mei 2013), which among others is measured through Human Development Index (HDI) (Stalker, 2008:18-27). In measuring HDI, health is one major component in addition to education and income generation (UNDP,

2011:167). Health is also an investment to support economic development and has a significant role in the effort to eradicate poverty (Usman dkk., 2010:326; Buse et al., 2005:6).

However in its further progress, through the review of decentralization perspective, several inconsistency phenomena were discovered. Normatively, not only a gap between regulatory norms and their implementation were discovered, but also a number of contradictory regulations on health services. Empirically there were also policies and programs that were not consistent between one region and another. And conceptually, particularly associated with Jamkesda inconsistencies were discovered in the tug between centralized and decentralized government.

The implementation of Jamkesda in Malang Regency is different compared to other regencies in East Java. While other regencies already have strong legal basis in the form of Regional Regulation (Perda) and Regent/Mayor Regulation (Perbup/Perwali) along with other generic technical requirements for the implementation of Jamkesda, Malang Regency has none of the aforementioned. The implementation of Jamkesda directly referred to Cooperation Agreement between the East Java Provincial Government and Malang Regency Government, which for the 2011 implementation was based on Cooperation Agreement: 120.1/1133/012/2011 and Number: 120.1/07/421.022/2011 on Community Health Services Funding Guaranteed by East Java Provincial Government and Malang Regency Government.

The absence of Perda and Perbup along with other generic technical guidelines could be interpreted that the Malang Regency Government has not seriously given the attention and community health services. The Regency Government also has not intensively engaged legislative party, in this case the Malang Regency Regional People's Representative Assembly (DPRD) in the implementation of Jamkesda. One of the consequences is that there is not a special post allocated for Jamkesda under the Regionally Generated Revenue (APBD). The budget for Jamkesda is merely stated as "Underprivileged Community Health Services Additional Financial Aid), which is a sub-sub-sub- section under "Additional Social Assistance Expenses for Community Members", sub-sub-section under Social Aid Expenses for Community", and is a sub-section of "Social Assistance Expenses" post. Meanwhile, the budget allocated for Jamkesda based on Cooperation Agreement 2011 was Rp 2.000.000.000,- (two billion Rupiah). For 2012, based on Malang Regent Decree Number: 180/196/KEP/421.013/2012 on Donation Budget Technical Verification, Social Budget, Production Sharing Budget and Miscellaneous Expenses 2012 was set Rp 3.900.000.000,- (three billion nine hundred million Rupiah).

Meanwhile, the demographic development of Malang Regency through mid 2011 showed that there were 155.000 underprivileged households (RTM) or around 568.591 community members from the total population of 2.8 million people (<http://bappekab.malangkab.go.id/index.php?kode=26>). There is actually quite a number of underprivileged households living in uninhabitable houses. From 608.890 house units spread in 33 districts, approximately 25% or 152 thousand houses are considered as uninhabitable (<http://perumahan.malangkab.go.id/newsdetail.php?id=129>). If viewed from the total aspects of HDI, between 2009, 2010 and 2011 there were improvements, but the number is only a fraction, from 70,09 in 2009 to 70,55 in 2010, and increased again to 70,80 in 2011 (Badan Perencanaan Pembangunan Daerah Kabupaten Malang, 2012:70).

Observing the demographic data of Malang Regency and confronts it with budget allocation for Jamkesda—both allocated by the Provincial and Regency Government—which is relatively minimal is something to be concerned about. The fact above shows that the care of Malang Regency Local Government toward the provision public services in the health sector is still very minimal. It is even more ironic if the above fact is confronted against the 7 (seven) Development Priorities and Focus in the Malang Regency Development Program, which places the provision of affordable health services for the community at the first priority. Furthermore, based on the matter elaborated above, the specific objective of this study encompasses: first, to describe the decentralization process of the implementation of regional health insurance services system (Jamkesda) in Malang Regency. Secondly, to describe the driving and constraining factors against the decentralization process of the implementation of regional health insurance services system (Jamkesda) in Malang Regency.

2. Literature Review

2.1 Decentralization

In reference to Cheema and Rondinelli (2007), the development of decentralization concept can be grouped into 3 phases. Firstly, during the era of 1970-1980s, decentralization was still focused on the decentralization of government and bureaucray structural hierarchy. Decentralization was interpreted "the transfer of authority, responsibility, and resources—through deconcentration, delegation, or devolution—from the center to lower level of administration" (see also Smith 1985; Muttalib and Khan, 1982; Rondinelli, 1983). Secondly, starting in mid 1980s, the concept of decentralization was no longer the transfer of power, authority, and responsibility in the government, but also encompassed "the sharing authorities and resources for shaping public policy within society". The categories for decentralization became at least four shapes: administrative decentralizaion, political decentralization, fiscal decentralization, and economic decentralization (see also Work, 2002; Seller and Lidstörn, 2007). Thirdly, is when decentralization was viewed as a way to open up the government with the

participation of a wider public through civil society organizations, that also required the assistance and partnership with other state governments and international organizations. And so emerged the concept of decentralized governance, which was defined as "...attempt to enhance the limited public management capacity of weak governments through partnerships with other governance institutions or create alternative arrangements for providing social services through parallel organizations in the private sector and organizations of civil society". (see also Shah, 2006; Schaap, 2007; Dwiyanto, 2007).

2.2 Conceptual Prolem and Empirical Decentralization – Centralization of the Provision of Health Services

The policy for health does not follow free market strategy, but health sector has various markets, all vulnerable to failure. Health policies require the combination of regulation and competition, funding from the public and private sector, and institutional framework that facilitates all (Nallari, 2011:231). Therefore, according to Buse et.al (2005:6) policies in health can cover public and private policies on health, where health policies is assumed to embrace all course of actions (and implemented) that influences institutional, organization, services governance, and funding regulation in the health system. This policy encompasses the public sector (government) and the private sector at the same time. Under this context, according to Mills (1990:5) decentralization structure and health management system are key to health services, especially in achieving "health for all" and primary health care development in various countries.

Decentralization in general as also elaborated above is defined as the transfer of authority, or power sharing in planning, management, dan governmental decision making from the national to the regional level. In practice, the decentralization of health system has many forms and is not dependent upon governmental political and administrative structure, but also upon health system organizational pattern existing in respective countries. As such, decentralization is not only an important concept in health management, but also a difficult one to understand (Mills, 1990:11). Apparently, Bankauskaite and Saltman (2007:9) agree with Milss, by stating that evidences considered as decentralization capabilities in achieving the objective is very complex and confusing.

In his study on government and governance decentralization in Latin America, Latin, Cabrero (2007:158-159) found out that in general countries where the government decentralized their administrative and operational functions to sub-national administrations rejected to delegate control through policy formulation and regulations and through various aspects of funding. All countries, except for Chile, have facilities coordinating health services—such as through the Federal Health Council in Argentina, the intermanagement commissions in Brazil, and the National Health Council in Mexico—among the level of governments involved. In the health sector, intergovernmental coordination in Latin America has become very effective, although there are still rooms for improvement.

Meanwhile, in his research on The Decentralization of Health Care in a number of Latin America countries, Burki et al. (1999:75) discovered the fact that reformation in the provision of health care occurred in various ways. Several countries had tried to decentralized the provision of health care, transferred the responsibility for the threatment of primary health care and the lower level of accute treatment (hospitalization) to sub-national government units. The others had intorduced competition in health care, by forcing state hospitals to compete against private hospitals for the government's health care funds. Other facts discovered was, although five of six countrieswere tested with various forms of purchaser-provider splits, the continuity of health care was dominated by the public sector, both in financing and production. Decentralization in the health sector according Buse et.al (2005:53) is a popular reformation, aiming at transferring balance of state power. In the study in Ghana and Zambia, they discovered decentralization practice in two forms. The first form, pointed out to the functions held by health departments being transferred to newly-established executive agents taking managerial responsibilities at the national level. Here the Minister of Health is expected to focus on policies and control. The other form, authority is delegated to regencies or regional level. Decentralization includes the delegating of autonomy to hospitals by providing them with control against their own budget. Decentralization channels power or authority of the Department of Health to other organization.

Byrkjeflot and Neby (2008:331-349) apparently saw a different phenomena. They were seuccessful in mapping changes and made a comparison along the the axis of health centralization/decentralization from time to time accross the Scandinavian countries. The explanation for development was found in the incermental dynamics, which created institutional changes mostly dependent upon national context. The mapping indicated three differing periods under different characteristics:

(1) The making of decentralization model (before 1970). Political decentralization colored the three countries. In Sweden, county/district is the main public institution, in Norwegian and Denmark it was municipality. Incrementally, the state and county had an involvement with hospital, and gradual funding became an issue in the public economy sector. Administratively, decentralization became the mark of every country.

(2) Golden era of decentralization model (1970 – early 2000). Significant reformation intitutive that indicated the number of sectors being politicized and established hospital as public responsibility. Apart from similarities,

the sequence of time and reformation was different. Funding, political decisions and administration were put in the hands of counties/districts.

(3) Challenging decentralization model (after 2000). The three countries were disparate due to the introduction of new reformation – they did not follow each other’s steps. The latest development devitalized decentralized institutions. Norwegian and Denmark can be said as becoming more and more centralized.

In the study in Nepal on decentralization and health care through an approach based on "principal-agent" relationship, Regmi et al. (2010: 361-382) said that the central government acted as principal, which voluntarily transferred formal authorities to agents in order to promote the objectives of health policies. One of the findings was, although the level of transfer was not the same case by case, the approach gave the frame to measure the three most important elements from health decentralization, namely:

- a. nature and extent of options transferred to regional health system;
- b. elected local officials caused an increased discretion being applied;
- c. these options had affected the performance of health system

In the decentralization of health care Burki et al (1999:82) by basing the results of studies in six Latin America countries formularized health care as follows:

“Decentralization has largely been limited to the transfer of parts of the public sector system from the central government to subnational governments. Central governments have tended to retain responsibility for policymaking, overall financing, and operation of highly specialized medical care centers (cancer, for example), while the states or provinces have often been given responsibility for provision of secondary and tertiary hospital care, and municipalities responsibility for primary health care”.

Meanwhile, the decentralization process or mechanism experienced in Nepal based on the study of Regmi et al. (2010:365), is outlined as seen on Figure1.

Among the different objectives of decentralization, good governance is perhaps the most targetted subject, especially in developing countries. Regmi et al. (2010:370) mentioned that decentralization increases governance and public service in four ways:

- (1) by improving allocation efficiency based on local needs and interests;
- (2) by improving efficiency through accountability enhancement of regional administrations;
- (3) by having less bureaucracy layers, and
- (4) by providing fair opportunities for the citizens.

Although in several countries the role of the state is lessen by the reformation of governance, according to Buse et.al (2005:53) almost all agreed that the state should maintain their various functions. On one side, the government needs to manage the health sector, where such management includes maintaining the health of the community by developing policies, stipulate and implement standards, measure and set priorities for allocation of resources, prepare regulation framework, and control the behaviour of service providers. On the other hand, the government needs to empower the private sector or ensure fair funding pursuant to terms of services through tax or government insurance in high income countries and target government spending to the underprivilege communities in poor countries. Nallari (2011:232) also confirmed that there had been serious market failures both in the implementation of health care by the private sector both in developed and developing countries. Nevertheless, according to Nallari (2011:234), although on one side he stated that the government still has to play a strong role in funding healths care to maintain equity, and increase efficiency and quality of health care by introducing competition and incentive efficiently through the application of two-or three-tier system), by utilizing health sector budget by taking inflation into consideration. On the other side, since governments of developing countries do not have the capacity or resources to fund health care, to provide medical services to satisfy the masses, to regulate and manage hospital multi-tier health system, community health centers, and rural clinics serving the well to do, middle class, and underprivilege communities, the government should put the effort to involve the private sector in insurance and provision of health care. The same phenomena happened also in Sweden. In the early 1990s, according to Anderson (2008:169-176) there was a significant rate of unemployment at the local level, and it coincidentally occurred with the decrease in government aid to 15% for health care at the local level. Driven by the New Public Management (NPM) ideal movement, many local government in Sweden started to experiment with a model organization that segregates the function of purchaser and provider and opened the opportunity for privatization and competition on the provider side. This reformation was made possible by amendments in national laws which eliminated several existing constraints in the provision of completely independent health care at the local level, and started by contracting the provision of health care to private health care providers, introduced the segregation of purchase/provider and private contract practice, including profit-seeking actors.

In regard to cases in Indonesia, the context of this regulation apparently became a crucial problem as to who the regulator and operator is in the health sector. Governance process always requires the analysis of the involvement of stakeholders to see which party is supportive and which is not supportive, and even rejects the development of regulations in health. The following criteria according to Utarini et al. (2009:220) can be used to

analyze support by looking at the extent of power of every stakeholders. The determination on the extent of power is determined by the criteria whether each stakeholder for access to highest rank decision maker, access to media, possession of equipment and skills.

Although the justifications that brings a country to decentralization are usually political (Mills, 1990:141-142), the benefits gained from the decentralization of health are as follows:

- It is possible to organize a more rational and integrated health care based on geographical and administrative areas such as regency, especially for primary health.
- Decentralization to the direction of local communities yields higher participation in the management of their own health sector, which ultimately can be directed to a more appropriate health planning in relation to the requirements of local health and their problems.
- Decentralization can cut cost and avoid duplication of services, especially secondary and tertiary health care, by connecting the responsibility to the community within the work area.
- The inter-region and inter-city and village unequal health status and provision of health care can be reduced through a more selective reallocation of central resources.
- Government, non-government and private health cares can be more integrated.
- Planning duties and policies implemented by the ministry of health can be enhanced by releasing senior staffs from administrative duties.
- Implementation of health programs can be improved by lessening the central government's control against administrative issues.
- Decentralization can increase funding from the regions and control on health care facilities and staff members..
- Intersector-coordination between health and other sectors can be improved, particularly within regional administration and in rural development activities.
- Decentralization can help overcome various issues and delay due to a variety of reasons, such as distance, inadequate communications, and insufficient land and air transportation.

However, in regard to decentralization of health system, Mills (1990:20) warned that there are two major issues that needs to be considered if a country decides to include health care under regional administration. First, the health sector yields high demand in the budget, while in most cases regional administration has limited tax resources. Therefore, developed countries have the tendency to transfer or release the burden of funding from regional administration. This is due to the fact that health care becomes very hard to handle by regional administration. But if funding is provided by the central government, there will be a dependency in part of the regional administration to the central government which ultimately would alleviate autonomy. It is worth to note here the study by Suharto (2011), Eko (2008), and Riyarto et al. (2009) which indicated that there are a number of countries and regions with low GDP and PDRB but capable of spending high social cost, also for health expenses. Secondly, decentralization (devolution) could complicate the efforts to formulate the hierarchy of a reasonable health care and establish regional structure. But these can be surmounted by, for instance, primary health care as the responsibility of the community, secondary health care as the responsibility of the district/county, regional specialist services to be established through cooperation between districts at the regional level with specialist services provided by the central government.

In equal terms with Mills' warning, it should also be put into consideration the framework expressed by Vrangbaek (2007:54) which pointed out the differences of decentralization levels for differences in functions. Simple frameworks for specific functions encompasses the functions of health system regarding arranging, financing, and delivery of services, which detail can be seen on Table 1. Such framework can enhance the understanding on what aspects should be decentralized in the health system.

In association with the decentralization of health care governance through Jamkesda scheme, the delegation of health care from the central government to regional administration was based on Government Regulation No. 38 Year 2007. Under Article 2 (4) item (b), it is stated that health sector is a government affair equally distributed among levels or government hierarchies. And more specifically on obligatory affairs, meaning government affairs to be compulsorily implemented by provincial and regency/municipal government, in terms of basic services. One of the obligatory affairs as referred to under article 7 item (b) is the health sector, which according to Government Regulation No. 38 Year 2007 covers the sectors of: health efforts, health funding, human resources in health, medicine and health counseling/briefing, community empowerment, health management.

2.3 Decentralization Motivating and Constraining Factors in the Provision of Health Care

In the study on decentralization of development programs in Asia, Rondinelli (1983:198-204) brought forward various factors influencing the implementation of decentralized programs. The most important among which is (1) the strength of political support and central government's administration, (2) behavioral influence, (3) organizational factor, (4) adequacy and feasibility of regional funding, human and physical resources. In the health decentralization practice in Uganda, the constraints emerging are among others cultural differences and the gap/inequality between regions (geographically), where one region is better than the (Trisnantoro dan Chusniati,

2009:381). In the study on the creation of health care services in Gunung Kidul Regency (Usman and friends (2010:349), one of the conclusion also confirmed that spatial inequality has significant implications against the accessibility level of health care services. Health care services could be delivered optimally if policies implemented disregard such spatial inequality issues. While in a case in Vietnam, there are several supporting factors in the implementation of the decentralization of health, first, strong commitment at the entire level where decentralization is considered as the overall part of public reformation. Secondly, support from other sectors, where devolution process gradually applied is followed by various supporting facilities, such as regulation changes in legislation, administration and finance (Trisnantoro dan Chusniati, 2009:394-395).

3. Materials and Methods

This study using qualitative approach is more focused on the implementation and tasks/authority distribution process in the health sector by the central government to regency government pursuant to Government Regulation No. 38 Year 2007. The study was conducted in Malang Regency region from August to December 2013. Data or information were acquired through indepth-interview with informants using snow-ball technique, field observation, and documentation. Study informants referred to the three health care public service elements, namely service consumer (Jamkesda participants), service provider (hospitals and community health centers); and service arranger/regulator (bureaucrats and DPRD members). Data processing and analysis referred to steps organized compiled by Creswell (2010).

4. Results and Discussion

4.1. Context of the relationship between the central government and regency local government in the provision of health care services.

In line with the demand of decentralized governance, the relationship between the central government–local government (regency/municipality) in the provision of health care services should be parallel (egaliter) and democratic. However in practice, such relationship is not entirely established. Administration decentralization aspect (deconcentration) encompasses structural deconcentration and bureaucracy of the central government, authority delegation and responsibility of the central government to semi-autonomous institution, and cooperation decentralization of government institutions running the same functions under common regulations (Cheema and Rondinelli, 2007:6-7). Administration decentralization according to Work (2002:4) has two basic types, namely deconcentration, which is the transfer of authority and responsibility from one central government level to the other with a local unit reporting to central ministry or a decentralized body. And delegation, namely redistribution of authority and responsibility from the government or institution not necessarily required, branch or local office delegating authority, with most of the part still reporting vertically to a central unit delegating such. In reference to Achmadi (2013:189-190) opinion on the principles and policies of decentralization, some of the health program responsibilities implemented in the region are still within the responsibility of the Ministry of Health. Funding at the provincial level is coordinated by the Provincial Department of Health. In regard to health program delegation principles and policies in the region it is executed by the respective region (Provincial and Regency/Municipal Department of Health) but the cost and personnel are still under the responsibility of the Ministry of Health.

Based on acquired data, the relationship between the Central Government (Ministry of Health) and Provincial Government (Provincial Department of Health) and Regency/Municipal Government (Regency/Municipal Department of Health) still places the Ministry of Health as the ordinate and Provincial/Regency/Municipal Department of Health as subordinate, although Head of the Department of Health Malang Regency was reluctant in admitting such relationship by stating:

“The connection of the Central Government (Ministry of Health) and Regency Government (Department of Health) is difficult to tell on whether who is stronger and who is weaker. They all run side by side and try to synchronize.” (interview on October 8, 2013).

But in reality the policies or various programs organized by the Central Government or Ministry of Health has been top-down, and does not give the room for the local government and institution to participate. The development of organizational structure of Provincial/Regency/Municipal Department of Health does not provide the room to actualize local interest and needs which may be specific in nature. The Ministry of Health has formulated Technical Guidelines that must be followed by Provincial/Regency/Municipal governments in developing the department of health’s organizational structure. Such Technical Guidelines is in the form of Minister of Health Decree No. 267/Menkes/SK/III/2008 of Technical Guidelines for the Organization of Regional Department of Health. The technical guidelines was formulated with the objective to build common perception at every governmental level in the structuring of organisation institutionalization and work procedures within the Regional Department of Health environment. Therefore, what was discovered empirically in the field was that the organization structure of Provincial/regency/Municipal Department of Health in the whole state has relatively the same structure with the organization structure of the Ministry of Health. With more or less the

same objectives, in exercising authorities attached there to the Malang Regency Department of Health, Head of the Department of Health said:

“In carrying out its duties and functions the Department of Health provides health care services based on Minister of Health Regulation (Permenkes) No. 741/MENKES/PER/VII/2008 on Health Sector Minimal Services Standard (SPM) in Regency/Municipal” (Interview on October 8, 2013).

Such is the same with national health programs. In the Jamkesmas program, for instance, the criteria for underprivilege and quota of participant, are entirely decided by the Ministry of Health. The regions, in this case The Regency/Municipal Department of Health and Health Care Providers (RSUD/Regional Public Hospitals and Community Health Centers) only execute the program. This resulted in the unregistered underprivilege communities as Jamkesmas participants, and even Jamkesmas membership which are not effective. The experience and observation of Head of Kepanjen Community Health Center confirmed this phenomena, and revealed as follows:

“Not only are there a number of underprivilege communities not covered under the Jamkesmas membership, let’s say that the quota from the Ministry of Health is 5.000, while the number of the underprivilege community is 10.000. In addition, there are Jamkesmas membership that are not effective. The people who are really poor are not registered, while those who are financially capable are registered as Jamkesmas participants” (interview on November 11, 2013).

There was also a problem related to the plan for the implementation of National Health Insurance (JKN) by Health Insurance Executive Body (BPJS) for the manifestation of Law No. 24 Year 2012 on BPJS. This JKN program or later known as Health BPJS Program is a national scale program. It cannot be denied that JKN in later days will intersect or even collide with regional health care services programs in their various respective schemes available in almost all regency/municipality. Since its planning, regions felt that they were not given the opportunity to participate in JKN. However, in its implementation stage, regions were obligated to implement the program. In Malang Regency, the implementation of JKN will surely collide with Jamkesda. The anticipated problem is whether JKN as a national program would eliminate the Jamkesda program, or whether Jamkesda would continue to exist parallel with JKN, Jamkesda to be integrated into JKN, or how? In regard to the possible collision of JKN and Jamkesda associated with the relations between the central government and local government, Chairman of D Commission DPRD Malang Regency with a protesting tone said:

“For us at DPRD, the Jamkesda program is very important. The problem is, there will be JKN and BPJS. We still do not know it will turn out. If Jamkesda should be integrated with JKN and BPJS, we will fully support. Nevertheless, this is a program for the interest of the people. However, actually, we in the region should be involved in the outset, so that we would know how it would be. For instance, on the amount of premium (PBI) that has to be paid by the government, it is still not clear. And it is still hearsay. Officially we still do not know. Then about the funding, will it be fully covered by the government, or sharing between the central government and regency, and how much is the share, or between the central, province and us. It is still not clear. The central government only mentioned about the gradual transfer from Jamkesda to JKN. But how gradual remains unclear to us.” (interview on September 12, 2013).

As for the political decentralization aspect (devolution) basically is the transfer of power and authority to sub-national level (Work, 2002:3); the strengthening of procedures or organisation to increase the citizen’s participation in the public policy making process, changes of government structure through devolution to a smaller government unit, institutionalization of power-sharing through federalism, provision of beneficial social services, and mobilization of financial and social resources to influence the establishment of political policies (Cheema and Rondinelli, 2007:7). In line with this political decentralization policy, according Achmadi (2013:189) part of the responsibility of health program is delegated to the Department of Internal Affairs. Program implementation on the provincial, regency, and district level (management, supervision, and funding) is delegated by Minister of Internal Affairs to respective Governors and Regents/Mayors.

The connection between central – local governments in this devolution context does not happen entirely in the provision of social security services and health insurance in the regions, particularly in Malang Regency. Constitutional authority has been transformed to the regions in a practice often not implemented, and even denied by the central government. The East Java DPRD’s claim to Constitutional Court of the Republic of Indonesia (MKRI) against article 5 section (2), (3) and (4) under Law Number 40 Year 2004 on SJSN is a good example. The article was contested as it is considered as closing the opportunity of local government to participate in developing a social insurance sub-system within the frame of national social security pursuant to authority derived from article 18 section (2) and (5), and article 3 of the 1945 Constitution, which was later further regulated under article 22 letter h and article 167 Law Number 32 Year 2004 on Regional (Mukti dan Moertjahjo, 2010:6-8). As sets forth above, the contest was later accepted by MKRI and became one of the basis urging the East Java Provincial government to set up a Jamkesda system. The tugging political decentralization implementation phenomena (devolution) was admitted by the Malang Regency DPRD. This is based on experience and knowledge set forth by Chairman of Demokrat Faction to the researcher as follows:

“In this local autonomy era, pursuant to applicable regulations, all obligatory affairs of the region should be entirely executed by the region. But fact in the field is not like that Sectors which should purely be the authority of the region, are still constrained by central government regulations that must be followed by local government. It should not be that way. If it is under the authority of the region, it should be given entirely to the region, to be adjusted by taking into account requirements in the region” (interview on October 8, 2013).

On the other hand, the regions, in this case Malang Regency, does not look very serious and lacks the grip in assuming its authority in this obligatory health sector. This can be seen, for instance, that the management of Jamkesda so far has not been based on permanent legal umbrella which specifically regulate the management of Jamkesda in Malang Regency. Legal umbrella only refers to the East Java Jamkesda system and East Java Governor Regulation 62 Year 2012 which is the second amendment of Governor Regulation Number 4 Year 2009 on Technical Guidelines on East Java Jamkesda System. For more technical matters the management of Jamkesda is based on Cooperation Agreement between Malang Regency Local Government and East Java Provincial Government which is yearly updated. In regard to this Jamkesda regulation, Head of Malang Regency Department of Health in an interview on October 8, 2013 clearly reiterated:

“There is no specific regulation to to regulate Jamkesda in Malang Regency. Regulations only refer to East Java Regional Regulation and East Java Governor Regulation, and MoU between Malang Regent and East Java Governor.”

The DPRD circle also did not consider it important with the existence of specific regulations regulating the management of Jamkesda. Chairman of Commission B of DPRD in an interview on September 12, 2013 stated that both DPRD and the Regent believed that specific regulations on Jamkesda was not significant. He said that there were various regional regulations regulating the provision of health care in Malang Regency that can be used to support the implementation of Jamkesda.

The impression of being not too serious in executing obligatory affairs in health provision through the Jamkesda system is also coupled with the absence of autonomous institution given the authority and responsibility to handle Jamkesda, as in other regions. The management designed to implement the Jamkesda system in Malang regency is limited in the shape of cross-sectoral work team which is more coordinative in nature. In his explanation during the interview on October 8, 2013 Head of the Department of Health mentioned that although the management of Jamkesda is attached to tupoxy of Empowerment Section of the Department of Health Malang Regency, there are two teams responsible for managing the Jamkesda program, namely:

- a. Coordinating team appointed based on Regent Decree where the Regent is the patron, Regional Secretary as the Chairman, Head of the Department of Health as Secretary, and with cross-sectoral members (Bapekab, Assistant to Community Welfare, Head of DPPKA, Director of Kanjuruhan Hospital, Family Planning (KB) Body, etc.).
- b. Jamkesda and Jamkesmas managing team appointed based on Head of Department of Health Decree Malang Regency, where head of the Department of Health is the Patron, Secretary to Health Department as Chairman, and three members from sections within the department of health based on applicable regulations in Malang Regency.

The unclear autonomous executive institution/agency according to the researcher is the basic issue faced by the Malang Regency Local Government in developing the Jamkesda system.

Fiscal decentralization aspect according to Cheema and Rondinelli (2007:7) covers the development of fiscal cooperation mechanism for sharing community's income among government institutions at all levels, fiscal delegation to increase community's income and expenses allocation, and fiscal autonomy for regional government, and local government. And according to Work (2002:4) it is the level of reallocation of resources executed to enable local government to function well, through the regulation of resources allocation commonly negotiated between the regional and central governments. Briefly Trisnantoro (2009:17) mentioned, fiscal decentralization is the transfer of power to collect and manage financial and fiscal resources. Fiscal decentralization is one of the major components in decentralization. If the local government carries out its function effectively and given the liberty in making decisions on the provision of services in the public sector, they have to be supported by adequate financial resources originating from regionally generated revenue (PAD) including surcharge of taxes, tax and non-tax sharing, loans, and even subsidy/aid from the central government. Fiscal decentralization is implemented simultaneously with authority decentralization. Therefore, Law No. 32/2004 is followed by Law No. 33/2004. Health decentralization basically aims at making the health sector a regional household affairs. In order to achieve such objective requires the establishment of ownership and elevation of APBD for health (Trisnantoro, 2009:25). The problem, is authority decentralization in the provision of health care services in Malang Regency also followed by or simultaneous with fiscal decentralization? In connection with the aforesaid Head of the Department of Health Malang Regency in an interview on October 8, 2013 explained as follows:

“In the Jamkesda context, the budget provided is very small, not comparable with the number of underprivileged communities. The extent of health budget is also not in accordance with the mandate under Law No. 36/2009,

which obligates health budget an amount of 10% from APBD outside salary. This is due to the limited APBD of Malang Regency”.

The health budget allocation data showing that the percentage of health budget from APBD (including salary) in 2011 was 7,82%, 9,08% in 2012, 8,61% in 2013 underlined the statement made by Head of the Department of Health. On the other hand, for 2012 based on the Attachment under Minister of Finance Regulation No. 245/PMK.07/2010 on Regional Fiscal Capacity Mapping, Malang Regency is included as a regency with low fiscal capacity index (0,1885) and in 2011 based on the Attachment under Minister of Finance Regulation No. 244/PMK.07/2011 is still low (0,1309). But it should be understood that the the provision of funding always has its constraints, because basically the budget is always limited. Law Number 33 Year 2004 regulates such limited funding resources that can be utilized by the regions, namely through the utilization of resources in the regions themselves or through transfer to the regions. Often, efforts to use local resources are not optimally carried out by local governments. Under the pretext of fiscal decentralization, regions actually rely on transfer from the central government. What Chairman of Commission B DPRD Malang Regency said as follows at least proved such phenomena:

“In the decentralization context, including the decentralization of health, regional autonomy is like given the head, but the legs restrained. Obligatory affairs are delegated, but the budget is limited. Duties yes, decentralization. But financially, we are still begging to the central government.” (interview on September 12, 2013).

Indeed in the implementation of fiscal decentralization the main instrument used is the delegation of authority to local government to collect tax (taxing power) and transfer to regions. Although the execution against the authority of Malang regency to delve regional resources is still limited, but from year to year there has been an increase in regional generated revenue (PAD) financial sharing (DBH) against Regional Budget (APBD). Within the period of 2010-2013 the percentage of PAD against APBD was 7,27% and DBH 5,64%.

These facts according to the researcher actually show that on one side the Malang Regency Local Government does not have the attention and desire for the provision of health care services in line with Law No. 36/2009, and on the other side the Malang Regency Local Government does not have the desire to increase regional generated revenue (PAD). The problem of health budget in the perspective of decentralized governance particularly experienced by the Malang Regency Local Government actually has been anticipated since two decades ago Mills (1990:20). Mills suggested that there are two things to be considered by a state in including the duties of providing health care services to local governments. First, the health sector is highly demanding in terms of budget, while the local government has limited tax resources. Therefore, according to Mills, in a number of developed countries there is the trend of transferring or releasing the burden of funding from the local governments. This is due to the fact that health services become too demanding to be handled by local governments. However, if all funding is provided by the central government, there will be dependency in part of the local government to the central government which ultimately would weaken regional autonomy.

The second suggestion from Mills, which more or less is similar to what is suggested by Cheema and Rondinelli (2007:7), is that decentralization (devolution) can complicate the effort to develop a reasonable health care hierarchy and establish regional structure. But that can be solved for instance, by that primary health services is the responsibility of the community, secondary health service as the responsibility of the district/county, and regional level specialist services be established through inter-county cooperation in the regional level with super special services by the central government. Mills' second suggestion according to the researcher, whether it was realized or not by the policy makers, although not completely similar can be observed of its application in the Jamkesda system. The similarity is in the health care services that uses structured tiered mechanism along with shared funding between the Malang Regency and East Java Provincial Government. Referring to the framework developed Vrangbaek (2007:55) which covered arranging function, financing, and delivery of services as illustrated on Table 1 it can be said, that the implementation of Jamkesda system in Malang regency has not been completely decentralized. This is caused by either from arranging, financing, and provision of services which partly is still dependent upon the cooperation with the East Java Provincial Government and the central government.

4.2. Motivating and Constraining Factors in the Impelementation of Jamkesda System nin Malang Regency

The most crucial issue related to this motivating and constraining factors is how the commitment and consistency of – which actually is a reflection of political will – the leadership of Malang Regency in implementing the Jamkesda system. Strong commitment and consistency from the leadership of Malang Regency will serve as strong motivation in the implementation of Jamkeda system, on the contrary if the commitment and consistency is weak, it will serve as constraining factor to the implementation of Jamkesda system. Based on the dicussion on the data acquired, it was clear that the health sector is mentioned in the vision, mission, priority and development program of the Malang Regency Government and the Department of Health

Malang Regency. Surely this is the commitment that is the motivating factor in the implementation of Jamkesda system. It is just that such commitment is not accompanied by concrete actions that is the strong impetus in succeeding the implementation of Jamkesda system. Therefore it can be said that basically the leadership of Malang Regency Government has a weak commitment and consistency in the implementation of Jamkesda system. The weak commitment and consistency are based on at least three things:

- (1) The implementation of Jamkesda system in Malang Regency is not entirely the initiative of the leadership of Malang Regency—although the vision, mission, and health development program are placed as the main priorities—but mostly a response to Jamkesda system implemented by the East Java provincial Government based on East Java Regional Regulation 4/2008 on Health Insurance System in East Java and Governor Regulation Number 4/2009 which was first amended to Governor Regulation Number 55/2010 and second amendment to Governor Regulation Number 62/2012 on Guidelines for the Implementation of East Java Province Regional Regulation 4/2008 on Health Insurance System in East Java. This further resulted in the opinion that the Malang Regency Local Government was not required to draft its own regulation either in the form of Regional Regulation or Regent Regulation which specifically regulate the implementation of Jamkesda system in Malang Regency.
- (2) The Malang Regency Local Government does not have a special agency whether in the form of Executive Body (Bapel) or technical executive unit (UPT) given the mandate as organizer of Jamkesda system. The importance of the existence of legal body—which specifically handles this Jamkesda system—quoting Rondinelli (2007:14) opinion is to:

“provide rules for structuring and organizing corporations, identifying the activities in which they can engage, defining the nature and characteristics of legitimate business practices, and clarifying corporations’ rights and obligations”.

But what exist are just a cross-sectoral coordinating and Jamkesda and Jamkesmas managing team. In fact, their intensity the coordinating and Jamkesda and Jamkesmas managing team in Malang Regency are not capable to perform optimally. The consequence is that there are crystalization of problems, not only matters related to participation but also on funding/financing. It is true that under Jamkesda there is BPJKD. But BPJKD “is owned” by East Java Province and has no authority and function whatsoever as a legal body in the implementation of Jamkesda in Malang Regency.

- (3) The budget allocated under APBD for the financing of Jamkesda system is very limited, not comparable with the number of underprivilege communities not covered by Jamkesmas program. Even under such allocated budget, the budget item is somehow inserted under the Social Assistance Expenditure for the Community post entitled Poor Community Health Care Additional Funding Assistance.

Outside the crucial factor related to political will of the Malang Regency leadership, there are also a number of structural factors that could become motivating and constraining factors against the process of the implementation of health decentralization. The motivating factors for health decentralization are among others: that in the decentralization process there is the money follow function concept (Ahmad, 2007:6). It means that in its implementation of decentralization—particularly health decentralization—state functions (central government) transferred to Malang Regency Government are followed by the flow of APBN fund allocation in the form of parity/leverage fund consisting of production sharing fund (DBH), block grant (DAU) and special grant (DAK) (Darise, 2009:38-39). The utilization of parity/leverage fund is customized to regional needs; regional policy customized to the condition of respective regions, *musrenbang* or development planning conference at the village, district/county, regency and all the way to the central government level. While the constraining factor, especially in Malang Regency, is that regional budget is limited and continuously dependent upon APBN. Chairman of B Commisiion DPRD, related to the dependency of APBD to APBN affirmed:

“If full decentralization is to be implemented, including the provision of health care, in terms of budget, regions may have problems. Medical equipment, such as dialysis equipment, CT scan, and others are very costly. The procurement depends on the (central) government. We are short of doctors, we are short of functional staffs. There are so many shortages.....” (interveiw on September 12, 2013).

The dependency of APBD toward APBN can also be seen from the fact that within the period of 2010–2013 the average percentage of PAD (regional generated revenue) of Malang Regency was only 7,27% from APBD, while during the same period the average percentage of DBH (peroduction sharing fund) was 5,60%, DAK (special grant) 4,9%, and DAU (block grant) reached 53,75% from Malang Regency APBD. More ironic, is that the health sector for Malang Regency Government has dual significances. First, it places health sector as non-profit oriented sector, which is the sector that provised basic services and the obligation of local government in providing services. Second, health sector as revenue center or income center (see Retna S dan Ardhyanti, 2011:3) generated form health retribution, and RSUD revenue/income. During the 2010-2013 period, the average percentage of health retribution was 12,30% from PAD, and RSUD revenue reached 23,31% from PAD. Such contradiction or dilemma is actually a challenge faced by all governments in this 21 century, governments are forced to create a system that is capable of enhancing and supporting efficient economic interaction, and at

the same time advancing the health, safety, welfare, and security of their citizens. Such as stated Rondinelli (2007:17):

“The challenge facing all governments in the 21st century is to create a system of governance that promotes and supports efficient economic interaction and that, at the same time, advances the health, safety, welfare, and security of their citizens. All states face continuing challenges in renewing political institutions, finding new modalities of governance, and expanding political capacities to guide national economic activities without undue intervention and control”.

Other structural constraining factor is the absence of institution dedicated to handle the implementation of Jamkesda. This results in the lack of trans-sectoral coordination.

In addition to the factors mentioned above, based on information gathered from the field, there are still a number of motivating and constraining factors in the process for the provision of Jamkesda services. The factors meant are community culture and geographical (spatial) factors. Community culture which serves as motivating factor in the implementation of Jamkesda as referred to on the Attachment under Regent Regulation 18 Year 2013, Chapter II-26, is the increasing awareness of the community on the significance of self-sufficient health, and hygienic and healthy way of life (PHBS). Head of Community Health Center study informants also admitted the increase in PHBS, although it was revealed that in other locations it was found otherwise. PHBS, as described under Malang Regency Department of Health (2012:92-93) is a 12 composite from 16 indicators (assisted labor, breastfed toddlers, house density, access to clean water, latrines/toilets, watertight floors, health insurance, non-smoking, regular exercise, and balanced diet). While community culture acting as constraining factor in the implementation of Jamkesda is associated with low self-esteem. Study informants revealed that in order to gain access to Jamkesda system part of community members have lost their self-esteem. Those who are actually capable financially to gain health services for themselves and families, allowed to group themselves and families under the underprivilege criteria, just to enjoy free health care services through the Jamkesda system. This practice is actually a violation of other citizen's rights, namely the true underprivilege community members who are more entitled to free health care services through Jamkesda. On the other hand, cultural and bureaucratic behaviours, particularly from institutions associated with the implementation of Jamkesda system have not demonstrated themselves as servants as demanded by the new public service (NPS) paradigm (Denhardt and Denhardt, 2000:553-557; Denhardt and Denhardt, 2007:28-29). Inside this bureaucratic body there are still quite a number of bureaucrats having sectoral way of thinking. The lack of information on Jamkesda system for underprivilege communities, is not solely caused by the inadequate socialization of Jamkesda system to the underprivilege communities. More than that, the Department of Health itself has not done enough socialization and coordination with other relevant sectoral institutions. The consequence, as revealed by informants, besides the lack of information in the part of village apparatus and underprivilege communities, the participation under the Jamkesda system are mostly not effective.

Other constraining factor is geographical condition. Geographical constraint is particularly felt by community members which settlement location is far from the capital of Malang Regency, namely Kepanjen, where RSUD Kanjuruhan is located. This long distance is one important reason why Jamkesda the participation number in Kasembon District/County is very small. Although Jamkesda provides free health care services, in reality family members watching over and visiting patients require significant cost for meals, transportation and others. The issue on distance according to Head of Kasembon Community Health Center (Puskemas), often implicates an inharmonious relations between Puskemas executive staff and part of the community and village apparatus. The root cause is that each party has not fully comprehend and stick to their respective codes. Very often there are community members and village apparatus demanding for SPM to Puskemas staff to be used to gain referrals outside the region, such as to RSUD Kediri in Pare which in term of distance is closer than having to go to RSUD Kanjuruhan, Kepanjen.

In executing its controlling function the Malang Regency DPRD also captured the phenomena as revealed by Head of Puskemas Kasembon above. Chairman of Demokrat Faction also found out that in the boundary and remote regions community members have to take a long trip when going to hospital. It is even closer going to a neighbor's hospital. Therefore, the Demokrat Faction continues to urge the utilization of funds generated from excise for the development of puskesmas in the boundary regions, and even more so existing puskesmas in remote areas far from hospitals be developed into type D hospitals. The Department of Health also realized the geographical and spatial gaps among regions in Malang Regency. Solution steps have also been taken. However, unlike what was discovered and revealed by the DPRD circle, steps taken by the Department of Health gave the impression of insensitivity. Evident shows that the Department of Health stresses more on encouraging the involvement of the community in community health development instead of building an APBD-based community health program initiative and not putting the effort to utilize financing resources from other stakeholders.

5. Concluding Remarks

The implementation of Jamkesda system as manifestation of the provision of a pro-poor community health care services in Malang Regency is not a genuine initiative from the Malang Regency Government. The application of Jamkesda system in Malang Regency is only a response to the East Java Province Regional Regulation Number 4 Year 2008 on Regional Health Insurance System (SJKD) in East Java, and East Java Province Governor Regulation Number 4 Year 2009 which was twice amended into East Java Province Governor Regulation 62 Year 2012 on Implementation Guidelines for the Implementation of East Java Province Regulation on Regional Health System in East Java. Therefore, the Malang Regency Government does not feel it necessary to draft specific regulation that specifically address the implementation of Jamkesda system. Regulation –more technical in nature–applied is only a Cooperation Agreement between East Java governor and Malang Regent on Funding of Regional Health Insurance Program. This agreement is renewed yearly, and therefore the lack of assurance in the intensity and continuity of the implementation of Jamkesda in Malang Regency can be understood.

The process for the provision of health services through Jamkesda did not involve stakeholders outside the local government, be it professional organizations, private hospitals, consumer protection agency, or the community. The roles of regulator or service arranger, service purchaser, and service provider are fully executed by local government–in this case the East Java Province Government/East Java department of Health, and Malang Regency Local Government/Malang regency Department of Health, and Malang Regency RSUD and Provincial RSU (provincial public hospital).

The provision of health care services in Malang Regency–encompassing facilities, infrastructure and human resources–for Jamkesda participants is no different with what is provided for general patients. The only difference is in access to services. Jamkesda participant patients are entitled for free services (paid for by Malang Regency Government), while general patients through out-of-pocket expenses or through insurance premium for participants of commercial insurance plans.

The commitment and consistency of Malang Regency Government in the implementation of Jamkesda system is weak. Although the vision, mission, and development priority program of Malang Regency places the provision of affordable health care services as the first priority, the provision of Jamkesda system services is nowhere to be found under the regional development work plan, medium term or long term development plans. The low commitment and consistency can be seen from the absence of regulations and dedicated institution to arrange and manage the implementation of Jamkesda system, and the feeble effort in overcoming limited budget allocation, infrastructure, and human resources in the implementation of Jamkesda system.

Stimulating factors for the implementation of Jamkesda system in Malang Regency are various legislated regulations on governance decentralization or on health decentralization, Constitutional Court's verdict that provides room for regions to implement health care services autonomously, and East Java Province regulation on regional health insurance/security. In addition, the vision, mission and development priority program of Malang Regency which places affordable health care services for underprivilege communities as the first priority is also a stimulating factor. Such is the extensive authority possessed by the Malang Regency Department of Health, and the increasing awareness for hygienic and healthy life style which is not less significant to say the least as stimulating factor in the implementation of Jamkesda system.

The main constraining factor for the implementation of Jamkesda system in Malang regency is the weak political will of the local government in the imeplementation of Jamkesda system as a pro-poor social policy. Other not less important factors are: unavailability of specific legal umbrellaa (regulations) regulating the implementation of Jamkesda system; absence of dedicated or autonomous institution (like a governance body) as Jamkesda implementer; low fiscal capacity leading to the limited budget allocation for Jamkesda implementation; the diminishing self-esteem in part of the community; culture and bureaucratic behaviour not characterized as having “serving” attitude; geographycal gaps (spatial) among regions especially in remote and boundary areas; and the implementation of JKN (Health BPJS) per Januray 1, 2014; and the absence of stakeholder's participation.

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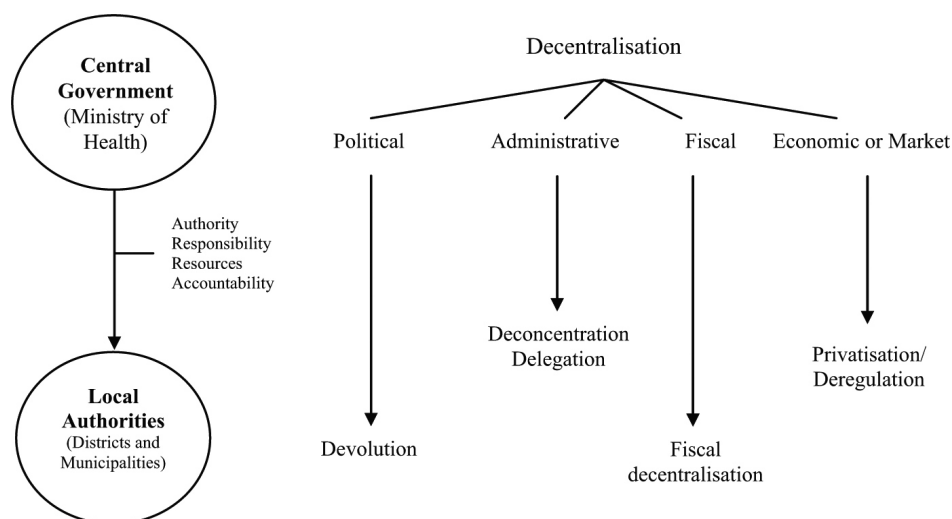
RI Law No. 36 Year 2009 on Health

RI Law No. 24 Year 2011 on Social Security Executive Body

Government Regulation No. 38 Year 2007 on Division of Government Affairs between the Central Government, Provincial Administration and Regency/Municipal Administration

Kompas, 23 May, 2013

Figure 1 Types of decentralisation and the level of power and authority



Source: Regmi et al. (2010:365)

Table 1 Governance structures: examples of institutional forms for different health service functions

	<i>Arranging/planning/ facilitating</i>	<i>Financing (revenue collection)</i>	<i>Delivery (ownership, distribution of risk and profit, "decision room" regarding organization, technology and processes)</i>
Central	National planning system Formal national assignment of rights and obligations Centralized agreements Regional planning and networking Local/municipal planning and networking	National taxation (general or healthspecific) Mandatory contribution to national sickness fund Regional taxation Mandatory contribution to regional level sickness fund Local/municipal taxation	National health system State ownership and control Regional ownership and control Local/municipal ownership and control Private organizations having contracts with public authorities or sickness funds (the internal structure of such organizations/networks may be more or less centralized) Private independent service delivery
Decentralized	Market interaction Individual choice of insurance or treatment facility	Mandatory contribution to local sickness fund Voluntary contribution to sickness fund/ insurance company Out-of-pocket payment to providers	

Source: Vrangbaek (2007:55)

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