
Health Sector Reform

A Case Study on Decentralization of Health Care Management in the East Java Province

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ABSTRACT

The objective of the study is to identify appropriate commitment among Ministry of Health and Provincial Health Office, the local health authorities (Municipal/District Health Office), and Community (NGO, Health Professionals, and Local Legislative Board-DPRD) concerning the coming decentralized health care services management in the East Java Province.

Design of this study is a case study utilizing both qualitative and quantitative approaches. The qualitative approach uses In-depth Interview, Focus Group Discussion (FGD) and workshop. The quantitative approach uses survey and study documents. Respondents for the qualitative approach are key officials at Kanwil Kesehatan (Provincial Health Office) and Kandep Kesehatan and its implementing units, and key officials from Dinkes Tk.I (Provincial Health Office), Dinkes Kabupaten (Municipal/District Health Office) and their implementing Units (City Hospitals, Health Centers, Nursing School, etc.). Respondents for survey are those responsibility for data management in each administrative levels Kanwil Kesehatan and Kandep Kesehatan and its Implementing Units and key of ficials from District Health Office , Dinkes Kabupaten (Municipal/District Health Office) and their implementing Units (City Hospitals, Health Centers, Nursing School, etc).

The result revealed that : 1. Decentralization on Health in Indonesia is a right policy and a must to be done in the year 2001, unless the development of Indonesia will be left behind among other countries in the world.; 2. There are still a couple Health Programs should be handled by Ministry of Health (MOH) namely : Public goods (Immunization, Chronic diseases, Hospital). The health programs should be decentralized are primarily private goods; 3. .Community participation in health will be increased gradually in accordance with Local capability (Resources: man, money, material, industry, technology, information etc).; 4. The implementation of decentralization in health, in each District or Municipal Health Office should be different and varied. It should be due to their authority, and the local competencies, i.e. economic competence, health facility availability and so on.; 5. The Health organization Structure is sub-system or Sub-ordinate of Government Home Affair. It needs to create a new Sub-ordinate below the Chief of DHO or MHO, to anticipate the decentralized authority.

Key words: health reform, decentralization, authority of health municipal/district

INTRODUCTION

In April 1999 the Legislative Board of Indonesia (DPR-RI) published two laws to decentralize all Central Government activities to the Local Government, Law No. 22/1999 on Local Government and Law No. 25/1999 on Financial Distribution between Central Government and Local Government. Central Government activities will be limited to five areas, i.e.: Monetary affairs, Security, Foreign affairs, Law and Justice and Religious Affairs. The local Government will be responsible for at least eleven activities, including health care services.

The implementation of the Law should be in effect by April 2001 and by April 2000 all the supported regulations such as some Presidential Decree and preparation should be in order to make the decentralization effective on time. The period from April 2000 to April 2001 will be used as a trial period before the Law becomes full in effect on April 2001.

Self-reliance in health care services in the district is one of the objectives of autonomic and decentralization police. Implementation of it should be in line with: Law RI No. 5/1974 on Essential Procedures of Local Government, Law RI No. 22/1999 on Local Government and Law RI

No. 25/1999 on Financial Distribution between Central and Local Government, Law RI No. 23/1992 on Health and Presidential Decree No 7/1987 on Decentralization of Health Care Services to the Local Government.

Concept of real autonomy, dynamic, and responsibility in Law RI No. 5/1974 means that delegation of authority from Central to Local Government in the Province and District levels, should consider the real local capacity of resources. It should be applied steps by steps (dynamic) and should be managed effectively and efficiently (responsibility).

The decentralization program of health care services should also be in line with the New Paradigm of health in which is targeted by Healthy Indonesia 2010. According to new paradigm, community should be encouraged to participate actively and be empowered to manage their own health. Consequently, this kinds of changes both in health paradigm and management need some extra attention from the health personnel themselves, the related sectors and especially the decision makers and staff of the Local Government. That is why these sudden changes in the health care organization in the provincial and district level should be carefully considered and implemented gradually.

Accordingly, there will be four stakeholders in decentralized health development program, i.e. community (NGO, Health Professionals, Local Legislative Board-DPRD), health care service providers, local government and other related sectors. All of them ought to discuss and solve any problems concerning with health together. They should decide on what is the priority of health care program that beneficial for the community at large.

Based on that reason a careful study on decentralization process of health care services in the East Java Province is really needed. It is supposed as a case study that enable to reformulate a health sector reform which covers new structure, system, funds raising and budgeting mechanism, appropriate policy or maybe some regulations needed.

STUDY OBJECTIVES

The objective of the study is to identify appropriate commitment among Ministry of Health and Provincial Health Office, the local health authorities (Municipal/District Health Office), and Community (NGO, Health Professionals, and Local Legislative Board-DPRD) concerning the coming decentralized health care services management in the East Java Province.

LITERATURE STUDY

Health Care Paradigm

Health care as a system. Health care as subsystem of the government and social systems. Health Reform (HCR) is a process that seeks major changes in national, district policies, programs and practices through changes in health care priorities. Laws, regulations organizational structure and financing arrangements. The central goals are most often to improve access, equity, quality, efficiency and/or sustainability.

Decentralization is a sharing or transferred authority on social business from political Officials to relative autonomous institutions (Vaughan P, 1991). Decentralization means responsibility and authority more on district or municipal Government, institutions and the local community.

Decentralization due to Law No. 22 /1999

The district and municipal autonomy is a real autonomy with the following principles:

1. Decentralization and autonomy are implemented through democracy principal and local specific consideration. (Based on community ideas and aspirations in conformity with laws & regulations of the Republic of Indonesia (Ps 1)
2. The implementation of autonomy focusing more on district, so there are no special administrative areas or special geographical areas in the district or municipality.

3. The implementation of district autonomy should increase the roles and functions of parliament, As well as channel of people's aspiration and controlling institution to local government. Ps 16, Ayat 2. The District 's parliament has equity position and work collaboratively with the local Government.
4. In the development processes, the local government needs to encouraged participation of the local community and private sectors (community empowerment) Ps 92.

Rondinelli and Cheema define decentralization as the transfer of planning, decision making, or administrative authority from the central government to its organizations, local administrative units, semi-autonomous and parastatal organizations

So decentralization means decentralization of functions and geographical areas. Decentralization in Indonesia seems to be mixed type (function and geographical area). Decentralization on health sector, stressing more on decentralization of Authority function and Subsystem of district government system.

Type of Decentralization

1. **Deconcentration:** 1) Transferring administrative authority function (not political) to Subordinate, 2) Implemented with vertical or integrated pattern
2. **Devolution:** 1) District authority as a local 'autonomy', 2) Some functions should be implemented have clear geographical border and judicial status, having authority to generate its own income and management.
3. **Delegation:** Delegation of managerial responsibility of certain tasks to organizations outs of the central government and is controlled indirectly by the central government (University hospitals, Leprosy hospital). Delegation is on administrative autonomy.
4. **Privatization:** Delegation of managerial tasks to voluntary organizations or private sector profit or non-profits ones with related government regulations.

Issues on Health Sector Decentralization

1. Authority on Health Care Activities
How many authority (power) functions owned and implemented by district health unit? Number of authority based on a) District capacity b) Mechanism of community participation, c) Controlling and supervision of the higher institution, d) Approaches of planning, attitude of government official on decentralization political culture. Hierarchy or level of authority. Does it reach to district or villages?
How is the composition or structure of local health authority?
2. Financial System
How is the coordination of multi financial resources for health? Does the central or local government determine budget allocation? The allocation is based

on (number of population, “local income” (PAD), last year Expenditures → “Equity”? How is the supervision and controlling for efficiency?

3. Human Resources and Facilities

Need identification, recruitment, supervision & controlling, especially for specialists and new skill. Distribution of alumni? Accessibility and equal distribution provider - community ratio?

The implementation of decentralization is not only as formally demand (Law No. 22/1999), but also as real needs Indonesian people as a developing country that facing global competition and demanded to increase government efficiency. The health sector decentralization is not only a trend, but also a need

THE REQUIREMENT OF A DECENTRALIZATION

The main component of decentralization is the local participation. Decentralization will be succeeding if there are some factor that should be taken into accounts, such as.

1. Political requirement

Decentralization should be a willing of the Central Government to release a part of the government business to the authorized local government (Law No. 5/1954 and No. 22 and 25/1999). The next step is developing technical regulation as the back up and then proceeds to the giving of authorization to the local government.

Political will is a guarantee and absolutely important for the process of decentralization. This could be a Law, Central regulation or local government regulation but still in the context of the unity of the country.

Decentralization is a transformation from central authorization to the local authorization

In the beginning there would be a conflict of interest between the Central and Local Government but at the end of the process it would be a beaurocracy section

Decentralization could increase efficiency and equity but at the other side it could be a potency for disintegration. So, it is very important to make a same perception of paradigm (mind set) or mental attitude in

the context of developing the country in the unity as the basic operational of the transformation.

The Clean Government is also the important requirement for the decentralization. Problem exist when determination of who, how far the role, and proportion of each government level in making policy, standardization and operation.

2. Economical requirement

There are two factors that should be developed that is empowering human resource through improving capacity building and developing the potential and management of other resources (income generating, efficiency). Principal of empowering community is: Priority to the most vulnerable.

Provision of capability building to similar level playing field, Covering all the developing population especially those who vulnerable.

3. Management requirement

Once the authorization of central and local government is decided it should be followed by Reorientation. Restructure, and making Alliance.

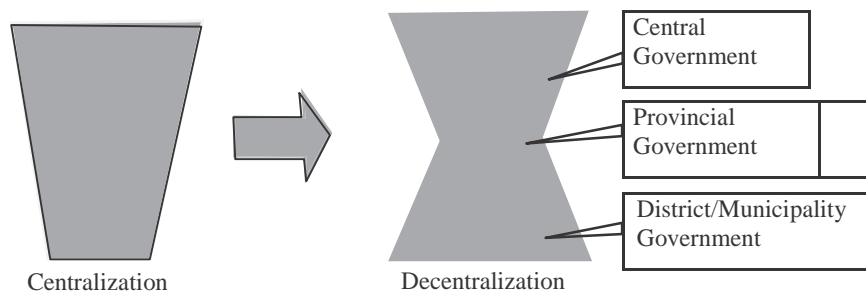
a. Reorientation

Decentralization not only the need of formal jurisdiction of political elite (Law No. 22/ 1999) but also the real demand of the Indonesian people to face the globalization. The changes of the external environment need the new vision, mission, and strategies of local development, including culture of management local potency to meet the external environment development (political, and socioeconomic)

The essential of Re-orientation or self finding means the organization is in transformation (changing process) in the central, Province, district or municipality has to know where their position in this changing condition, is the direction remain the same, the role and functional authorization is changing gradually or even totally changed.

b. Re-structure

Decentralization is not merely to give authorization and other function of management to lower hierarchical level, but also sharing of management competence.



There is a motto:

A good organizational structure is a structure of organization with least structural positions, but rich in functions.

There are 7 points to be the foci to develop simultaneously: Vision, Mission, and Strategy, Structure, System, Style (leadership) and Staff.

c. Alliance

Alliance is a concept how two or more things to be combined and give a synergy or multiplies in result but not addition.

RESEARCH METHOD

Design of this study is a case study utilizing both qualitative and quantitative approaches. The qualitative approach uses In-depth Interview, Focus Group Discussion (FGD) and workshop. The quantitative approach uses survey and study documents.

East Java Province consists of 37 districts/*kabupaten/kotamadya*. This study will use stratified proportional random sampling. Sample of this study is regencies and municipalities with criteria based on its local product domestic brute (income) and cultural specific. According to the above mentioned criteria and cultural specificity three districts are chosen, i.e.: Malang Municipal (*Kotamadya* Malang), as high category of APBD and “*arek*” culture. Probolinggo District (*Kabupaten* Probolinggo), as medium category of APBD and “*Madura*” culture. Nganjuk District (*Kabupaten* Nganjuk), as low category of APBD and “*Mataraman*” culture

Respondents for the qualitative approach are key officials at *Kanwil Kesehatan* (Provincial Health Office) and *Kandep Kesehatan* and its implementing units, and

key officials from *Dinkes Tk.I* (Provincial Health Office), *Dinkes Kabupaten* (Municipal/District Health Office) and their implementing Units (City Hospitals, Health Centers, Nursing School, etc.).

Respondents for survey are those responsibility for data management in each administrative levels *Kanwil Kesehatan* and *Kandep Kesehatan* and its Implementing Units and key officials from District Health Office, *Dinkes Kabupaten* (Municipal/District Health Office) and their implementing Units (City Hospitals, Health Centers, Nursing School, etc).

Data from the qualitative approach was analyzed by using content analysis method. Data from survey and study documents was collated and analyzed by using SPSS PC for data cleaning and logical check for consistencies.

RESULT AND DISSCUSION

Focus group Discussion is held on November 13, 2000, in the School of Public Health, Airlangga University. There are three groups of 8 to 10 persons. They consist of representative of the Health providers (DHO, MHO, PHO), Government representatives, Researchers and Counterparts, Local Legislative Boards Representative Board.

The objectives are as follows: to communicate the result of research that has been done, to negotiate the role, functions on policy, implementation and evaluation of the DHO or MHO, PHO, MOH, Government Home Affair and community (NGO’s, Health Professionals, local Legislative Board) on decentralization of health care services to identify authority between government and community related to health program decentralized in term of public and private goods.

Matrix 1. Authorization based on programs considered as **Private Goods** and **Public Goods** in accordance with the above mentioned respondents perspective.

	GOVERNMENT	COMMUNITY
Public Goods	3, 6, 7, 17, 24, 25	4, 5, 10, 11, 12, 18, 19, 20, 21, 22, 23, 26
Private Goods	9	1, 2, 8, 13, 14, 15

Program considered as Public Goods or Private Goods

- | | |
|------------------------------------|---|
| 1. Child and Mother Health Care | 14. Basic Medical Service |
| 2. Family Planning | 15. Medical Rehabilitation |
| 3. Nutritional Improvement | 16. Health Referral |
| 4. Hygiene and Sanitation | 17. Specific Health Development |
| 5. Environmental Health | 18. Basic Laboratory |
| 6. Prevention and Disease Control | 19. Provision of Health Equipment |
| 7. Disease Surveillance | 20. Sub Health Center |
| 8. Dental and Oral Health | 21. Midwives services in the villages |
| 9. Mental Health | 22. Essential Drugs |
| 10. School Health | 23. Health Insurance (JPKM) |
| 11. Public Health Nursing | 24. Immunization |
| 12. Public Health Information | 25. Chronic Infectious Diseases Control |
| 13. Accident and Curative services | 26. Community Health Education |

DISCUSSION

The term decentralization should be changed to be devolution. In doing devolution, it should be carried out together with delegation and community participation (private roles).

Authority

The Provincial Health Office and the Ministry of Health will be considered in determining the policy, goal, target, standard and technical manual on decentralization of health care services management. In the implementation and evaluation of the program, the District or Municipal Health Office have a big responsibility.

Authority Allocation of community participation in Health Program by order

1. Community health education
2. Hygiene and Sanitation
3. Community Health Managed Care (JPKM), Health Insurance
4. Nutrition Improvement Program
5. Simple or Basic Laboratory
6. Accident and Curative Services
7. Dental Health Program
8. Control of Communicable Diseases Program (Prevention, Control, and Surveillance)
9. Surveillance

Program with less community participation (In Policy making but not in implementation)

1. Essential drugs
2. Medical Rehabilitation Program
3. Basic Health service Program
4. Subordinate Health Center

Centralization focused program

1. Hospital Services
2. Essential drugs (procurement)
3. Mental Health Program
4. Health Program of Dimensionality (Program *Matra*)
5. Health equipment and Drugs
6. Midwife Program in the Villages

Decentralization focused program

1. Managed Care (JPKM)
2. Immunization
3. Environmental Health

Public and Private Goods

The Public goods should be responsibility of the government, but in reality it is also responsibility of the community.

- a. Public goods that become responsibility of the government (DHO, MHO, PHO and MOH)

1. Nutritional improvement program
 2. Diseases Prevention & Control program
 3. Diseases surveillance program
 4. Specific Health Development program
 5. Immunization program
 6. Chronic infectious Diseases program
- All of the above mentioned programs are related to promotion and preventive actions.

- b. Public goods due to the community
 1. Environmental Health program
 2. Diseases Prevention & Control program
 3. School Health program
 4. Public Health Nursing program
 5. Public Health Information services
 6. Basic laboratory services
 7. Provision of health equipments
 8. Sub Health Centers
 9. Midwife services in the villages program
 10. Essential drugs management
 11. Managed Health Care or Health Insurance (JPKM)
 12. Public Health Education and Health Promotion

All the above mentioned programs are related to community health services which the community can afford it and do on decentralization on health services.

Private Goods: All private goods become authority of the community except Mental Health Program.

Structure

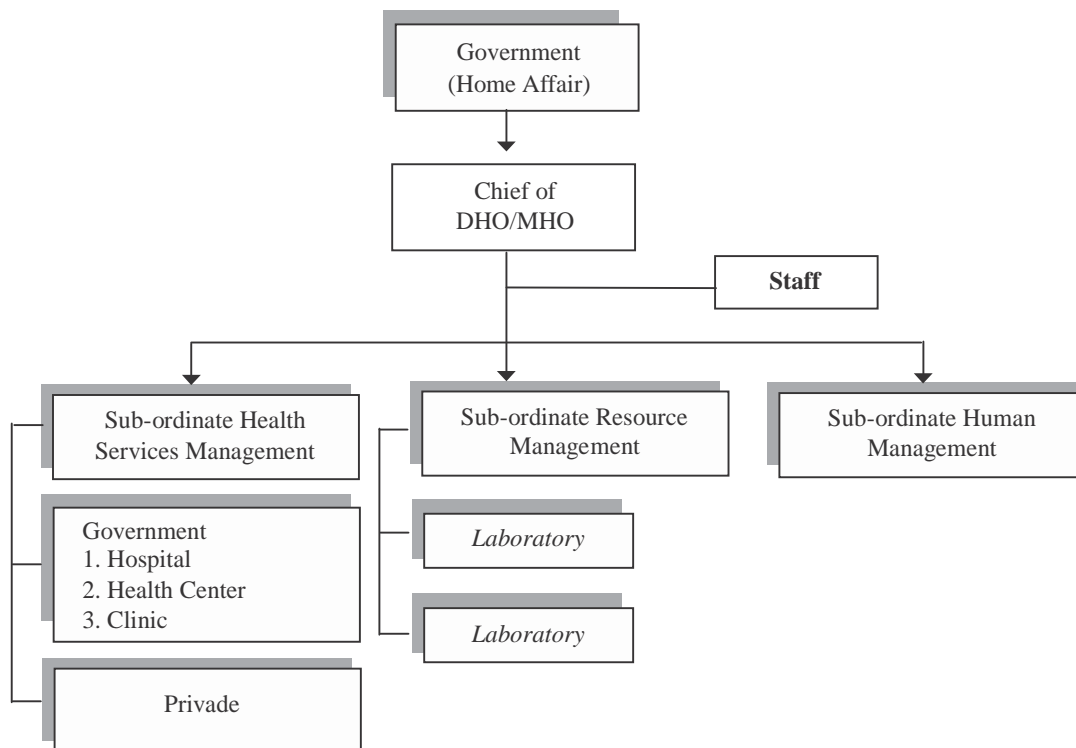
Based on the authority of the services of the Government and the community 1) in policy making, implementation and evaluation, 2) Private and Public Goods, 3) variation in term quantity and quality of authority, the decentralization of health service management must not be the same between the DHOs and the MHOs. Consequently the organization structure will follow the distribution of authority on health care management among the related health institutions and the community.

Guidance in Structure development:

1. Design: should be minimum in structure, but rich in function
2. Structure follows functions. Function should be based on the local needs, and decentralized authority, Law of The Republic of Indonesia No. 22, 1999.
3. Health Organization becomes sub-ordinate of Local Government of Home Affair

Function will be categorized into:

1. Health service (Hospital, Health Center, Health Clinic either Government or Private)
2. Human management
3. Resources management (Non Human: supporting system like laboratory, licensing)



CONCLUSION AND SUGGESTION

Based on the results and discussion in chapter V, the conclusions are as follows:

1. Decentralization on Health in Indonesia is a right policy and a must to be done in the year 2001, unless the development of Indonesia will be left behind among other countries in the world
2. There are still a couple Health Programs should be handled by Ministry of Health (MOH) namely : Public goods (Immunization, Chronic diseases, Hospital). The health programs should be decentralized are primarily private goods.
3. Community participation in health will be increased gradually in accordance with Local capability (Resources: man, money, material, industry, technology, information etc).
4. The implementation of decentralization in health, in each District or Municipal Health Office should be different and varied. It should be due to their authority, and the local competencies, i.e. economic competence, health facility availability and so on.

5. The Health organization Structure is sub-system or Sub-ordinate of Government Home Affairs. It needs to create a new Sub-ordinate below the Chief of DHO or MHO, to anticipate the decentralized authority.

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