Social Sector Decentralization: The Case of Indonesia

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Chapter 1

Introduction

Decentralization: A TwoEdged Sword

The concept of decentralization is commonly associated with the process of democratization in terms of economic, social, and political affairs. It is a process that attempts to improve the general welfare and well-being of people. However, experiences from other countries indicate otherwise, i.e., promotion of people's welfare was realized through a highly centralized system of governance.

The cases of the Asian Tigers, popularly known as the New Industrializing Countries (NICs) - Taiwan, South Korea, Singapore, and Hongkong - have proven that economic power and amelioration of the plight of the masses can be attained not through the dispersion of power but concentration of power in the hands of government. In fact, the initial phase of economic development in the said countries can be characterized as a period of extreme political repression and centralization of power.

On the other hand, experiences of Latin American countries reveal another dimension. It is perceived that economic bankruptcy was a result of centralization of policies though neatly veiled under the avowed decentralization policy statements of the government. Mawhood (1993:1) presents a succinct description of the problem:

Most of us and most governments like the idea of decentralization. It suggests the hope of cracking open the blockage of an inert central bureaucracy, curing managerial constipation, giving more direct access for the people to the government and the government to the people, stimulating the whole nation to participate in nation development plans. But what do we often see in practice? Experiments with local government (autonomy) lead to chaos in the bureaucracy; decentralized structures of administration serve only as a more effective tool for centralizing power; decisions are solely made by government officials of regional and district committees while local representatives are silent; village councils as mechanisms of peoples participation in decisionmaking, do not have the power to decide on the allocation of resources. Too often, the word (decentralization) seems to convey only what the public relations departments want it to mean.

Decentralization is related to the transfer or bestowal of national governments power and authority to lower level units with the goal of improving the latter's functions, duties, and responsibilities. Implicitly, the scheme mandates the national government to create local institutions relatively autonomous from the central government with enhanced capacity to mobilize local resources that can be utilized at their own discretion for local development.

Moreover, the concept is associated with devolution or political decentralization (Allan 1995:25) which refers to the central governments power to create or strengthen local governmental units (LGUs) whose activities are organized beyond the power and authority of the national government. These local units are relatively autonomous and independent. The power and authority of the central government are often exercised indirectly. In devolution, the national government is concerned with organizations that provide public services.

Apart from devolution, decentralization is also related to the concept of decentralization. This pertains to the central governments delegation of administrative duties, responsibilities, and authority to the local governmental level. Nevertheless, the delegation of authority does not include the powers of decision-

making. It is more concerned with the attempt to develop a sense of propinquity between the national and local governments.

Recently, decentralization has gained popularity among developing countries as a scheme and an alternative mechanism in delivering public services and public goods as well as in carrying out governmental functions and duties. Likewise, decentralization has been heralded by many social planners as a multifaceted panacea to overextended and deteriorating delivery systems of social goods and services. Some of the advantages of decentralization can be mentioned herewith.

Decentralizing the delivery of social services is thought by some as a means to improve its efficiency and effectiveness as well as make such services available to people who need them most, thus, it promotes equity. Likewise, it mobilizes and augments existing resources - human, technical, and financial. This is done by shifting decision making, management, and responsibility in the administration of resources closer to the local level, i.e., to a certain extent, the private sector. Notably, the public services provided by the private sector such as irrigation, water supply, and other similar services, are mainly cost recoverable.

Therefore, the privatization of services should be supported by economic sectors engaged in developing the potential of the area such as tapping resources for tourism, agroindustry, or indigenous industry. To realize this, the regional government must enact laws that will precipitate and facilitate a bigger role of the private sectors and cooperatives. Decentralization policy can also solve some problems brought about by the lack of transportation and communication facilities as well as simplify the procedures in decision making. Furthermore, decentralization may bring about policy decisions that reflect local conditions. Thus, local customs and traditions must be taken into account in policy making, a valid concern not understood by national officials. Finally, decentralization can cut down red tape practices which commonly beset developing countries.

However, decentralization may also bring about disadvantages to the system. Among these are: lack of control over the local institutions leading to inefficiency in managing government's budget; widening of the gap between and among regions whereby wealthy and progressive regions could develop their economy better and faster while poorer regions are left behind; and intensifying regionalcentered sentiments at the expense of endangering national unity.

In order to minimize its negative effects and maximize positive outcomes, decentralization must be operationalized in various sectors. A comprehensive approach in the execution of decentralization and a deep sense of commitment among implementers across sectors are needed if success is hoped for.

The Rationale of Decentralization in Indonesia

A study of government and politics of Indonesia cannot be divorced from the physical and sociocultural factors that define the character of Indonesian society. Indonesia has 17,000 islands (five [5] of which are the biggest) spread over an area of 1,948 sq. km. Its population of 180 million people are ethnically and linguistically diverse with more than 300 ethnic groups that speak more than 250 dialects. The largest part of the population live in the island of Java - the smallest of the five major islands. Under such situation, a unitary state was considered as the best form of government to maintain national unity and national integration. However, this does not mean that the centralization of power at the national government is the only logical structural arrangement. In fact, the central government carries out its national responsibility in a decentralized manner by delegating its authority and duties to the regions. Through this effort, management of national affairs is made more efficient. Hence, the administrative structure in Indonesia follows a combined approach of centralization and decentralization.

The legal basis of the aforementioned principle is found in various laws. Since independence, five laws have been consecutively issued for the purpose of dispersing powers of the government, namely: Law No. 1/1945; Law No. 22/1945; Law No. 1/1957; Law No. 18/1965; and Law No. 5/1974. Based on these laws, 317 autonomous regions have been established, namely: 27 first level autonomous regions, 290 second level autonomous regions and 49 municipalities.

Decentralization involves the formation of autonomous regions at two levels, namely: *daerah tingkat I* (first level autonomous regions) and *daerah tingkat II* (second level autonomous regions). First level regions form the largest units of autonomous government. The second level comprises *kotamadya* (urban municipalities) and *kabupaten* (regencies). These autonomous regions have elected representative councils (*Dewan Perwakilan Rakyat Daerah*, DPRD).

Within a regency, a *kota administratip* (administrative city) may be constituted sans a city council. It is devoid of any autonomous powers unlike urban municipalities. Nonetheless, an administrative city can become an autonomous unit and be considered as an urban municipality at a later stage of its development.

In line with the States philosophy which stipulates that the Republic of Indonesia is a unitary state, not a federation, office holders or heads of the first two levels of government exercise dual roles. They are responsible for the administration of the local government and supervise the general work of the central government through its field offices at the provincial, regency, and *kotamadya* levels. They act as chief executives of the region (*kepala daerah*) as well as representatives of the national government (*kepala wilayah*). They provide the necessary leadership in managing regional affairs especially in initiating and implementing regional policies and activities.

Moreover, they provide the leadership in local governmental institutions such as the DPRD (*Dewan Perwakilan Rakyat Daerah* or Regional Peoples Representative Council), Regional Planning Board (*Bappeda*), and the Regional Government Secretariat. As representatives of the central government, they maintain law and order, and coordinate the activities of the national government's field staff in the region such as the Regional Inspectorate Office and Regional Capital Investment Coordinating Board, as well as their line (vertical) agencies (*dinas vertical*) at the local levels. These efforts signify the recognition of the central authorities to adopt policies based on the diverse needs and demands of the local condition rather than simply impose national policies in total disregard of local communities idiosyncrasies. In summary, there is an administrative framework for decentralization. However, there is still much debate on how extensive delegation of responsibility and decision making should be in regencies. The two- tier system (Malo & Nas 1991:175) has even complicated the matter, in the sense that, alongside with autonomous local government structures, central government bodies are also present in the form of local branches which carry out various functions and activities.

The complexity of local autonomy is also due to the legal institutional arrangements and formal structures; existing interaction and relationship between higher and lower units at the national and regional government; required managerial skills of administrators in enhancing inter and intra-governmental relationships at various levels; nature and character of linkages; and mobilization of available financial resources. In the final analysis, the actual autonomy is largely dependent on the quantity and quality of existing and potential resources which managers can tap and mobilize.

In recent years, the debates have become more heated with the trend moving towards the empowerment of the regencies as against that of the provinces. In a general sense, some changes are likely to occur as manifested by the recent deregulation measures which gave more responsibilities to the regencies. Nevertheless, it is generally understood that not much has yet taken place. The key factor seems to be that there has not been enough political will on the part of the elites to get rid of or at least to simplify

the aforesaid two-tier system of government. Nonetheless, the growing aspiration of the people for equality and democratization will eventually serve as a push factor towards decentralization It is in this context that one of the aims of the study is to determine the extent of lower governmental level's movement to assert greater independence.

The Historical Account

The dual system of government in Indonesia evolved since the time of the Dutch East Indies Trading Company (VOC). As the supreme authority, the VOC provided governmental and judicial institutions for its own people separate from the indigenous people prescribed by local government institutions. This phenomenon was explicitly visible in the city of Batavia. The VOC had its own territory with a castle, court of justice, and jail.

For the city, it appointed a bailiff (*baljuw*), who represented the citizens. Both bailiff and alderman, however, were strongly dependent on the VOC who received their remuneration from the latter. The VOC, as a central government, was very dominant. It collected the most important tax such as the abinese head tax and importexport duties. While the city government retained smaller sources of income such as the socalled "mudmoney" (*moddergeld*).

After the end of the VOC in 1798, the authority of the alderman was restricted by Daendels and Raffles. Powers of local government institutions were further reduced with the installation of a centralized government in the Dutch East Indies. As a result of the Indies Constitution of 1854, the administrative system became highly centralized under the socalled "onhead government" of the Governor General. There were no autonomous regions and the entire territory was divided into administrative areas of jurisdiction, namely: region or residency (*Gewest or Resindentie*); division (*afdeling*); underdivision (*ounderafdeling*); district; subdistrict and *desa* in rural areas; and ward (*wijk*) in urban areas.

In 1903, the system of government was changed through the introduction of a decentralization measure. The main purpose of the law was to enable administrative units to allocate and disburse funds (*afgezonderd bedrag*) coming from the central budget through their respective municipal boards to meet the specific needs of the territories under their jurisdiction. The funds could be augmented by revenues from local taxes.

From the beginning, the process of decentralization was viewed by the central colonial administration with some distrust. Apparently, they do not want to loose any powers and tried to keep a firm grip on them. However, the local central government dominated boards developed rapidly into representative bodies with collegial executive councils headed by a mayor for the city. This change occurred as a result of pressures from local leaders and officials who were concerned that local issues should be dealt with at local levels instead of being subjected to the stultifying powers of the central authority which was incognizant of the diverse needs of local conditions.

Methodology

The study has three major methodologies. First, a review of documents and literature on decentralization programs and policies covering the period from Independence in 1945 to 1994 was made. A summary of the literature and studies is presented in Chapter III. From the survey, basic issues and themes underlying the current decentralization programs conceived and implemented by policy makers and program planners were extricated. Second, key informants responsible for planning and implementation of decentralized programs in the social sectors at all levels (ministerial, provincial, municipal, and village) were interviewed to elicit their perceptions on the: programs and the effectiveness in their implementation; adequacy of roles performed by key actors and stakeholders; linkages established and

created in pursuit of program goals and objectives; manner of resource mobilization; and capability of administrators to fulfill the ends of decentralization. Likewise, program beneficiaries were interviewed covering the same areas of concern. Third, case studies were done to portray, as vividly as possible, the processes utilized by local government units (LGUs) in forging a partnership between themselves on one hand and, nongovernmental organizations (NGOs) and the community on the other hand, both in terms of planning and delivery of social services.

The case studies were done in rural and urban areas. These covered two (2) provinces West Java and Bali. Each province has two (2) regencies/municipalities: Bandung and Gianyar regencies representing the rural area, and Bandung municipality and Badung regency representing the urban area.

The province of West Java was chosen on the assumption that policies and programs of decentralization would be readily adopted considering its proximity to the nation's capital city (where the seat of power rests). On the other hand, the province of Bali was selected due to the uniqueness of the Balinese culture. Badung regency has the biggest ratio of PAD over APBD (regional income over total income) at 78% while the regency of Gianyar is one of the pilot projects in decentralization.

Eighty (80) respondents were interviewed from abovementioned areas which include key informants from the ministerial, covering three (3) social sectors, to the LGU levels, i.e., Governor and the head of each social sector at the provincial level, head of the regency, city mayor, and heads of municipality and village. Interviews were also conducted with leaders of NGOs and program beneficiaries at the village level.

As outlined in the study, the research instrument has two (2) parts. The first one is addressed to the social service sector staff while the second is to the beneficiaries of the program. For the first group of respondents, questions relate to the variables involved in the process of decision making, local power linkages, programs clarity and consistency, allocation of functions, formulation and implementation of decentralization procedures, involvement of line or vertical agencies, and appraisal of perceived and actual support to decentralization efforts.

On the other hand, the second group was queried on the same variables focusing on the aspects of technical and managerial capability, coordination, mobilization of resources and support complement, internal communication, involvement of and with other organizations, control of and access to fund sources, roles and functions fulfilled, and performance indicators.

Chapter 2

Decentralization Concept and the National Policy

Decentralization in the social sector is one of the provisions explicated in Law no. 5, 1974. The Law stipulates the principle of decentralization in local governance. It defines decentralization as: "the delegation of government matters from the central or higher level administration to the lower level in order that the latter could manage their own affairs".

Given such definition, decentralization becomes a form of relational activity among levels of government administration. The scope of this activity is geared towards the realization of regional autonomy. As provided by Law no. 5, 1975, regional autonomy has the following features:

- a. the institutionalization of units with specific boundaries that possess the legal right, authority and responsibility to manage their own affairs within the context of national unity and in accordance with the prevailing rules and regulations;

  b. the operational transfer of autonomy to the regions that support the people's struggle and aspiration to strengthen the unity of the nation and improve the general welfare of the people;

  c. the transfer of autonomy should be carried out in a substantial, genuine, and responsible manner (as substitution of the principle of unlimited real autonomy adopted before Law No. 5, 1974 was enacted);

  d. the principle of decentralization should be applied along with the principles of decentralization and coownership/copartnership;

  e. the transfer of autonomy should give priority in promoting national harmony along with the enhancement of democratization powers; and

  f. the goal of the transfer of autonomy is to improve the effectiveness and the efficiency of regional government's operation.

In short, the above mentioned six principles basically contain the idea of improving the general welfare and promoting social justice; defining the scope and limitations of authority; promoting people's participation; enhancing the mobilization of resources; and strengthening of structural linkages. In a simpler framework, the transfer of autonomy includes the dimensions of regional economy, management of government, delivery of services, and people's participation.

Decentralization is not the only mechanism used by government. Decentralization and coownership/co-partnership are the two other mechanisms. The differences are as follows:

a. Decentralization

The functions of government which have been transferred to the regions become the responsibility of the regions. In this case, initiatives emanate completely from the regions including policy making, planning, execution and funding. Likewise, the operating apparatuses are managed by the regions, especially the regional offices (*dinas-dinas daerah*)

b. Decentralization

The functions transferred by the central government to the regions continue to be the responsibility of the central government including planning, execution and funding. These functions are carried out by vertical institutions in coordination with the regional head offices (*kepala wilayah*), considered as appendages of the central government. The policy remains that the execution of functions pertinent to deconcentration is decided by the central government. This principle is based on the assumption that not all central government functions in the regions can be transferred to the regions.

c. Coownership (partnership)

This refers to functions of the central government implemented by the regional apparatuses. In this case, the central government retains the right to make policy decisions, plans, and provide funds. This principle is carried out based on the consideration that certain central government functions must be undertaken by regions to alleviate the former from performing burdensome functions.

Comparing the abovestated principles, it is apparent that the concept of decentralization is dependent on the perception of the central government authorities whose functions can or cannot be transferred. In otherwords, realizing the objectives of decentralization is a matter of political will on the part of the central authorities. For instance, in examining the concrete practice of decentralization, a difference of perception is noted among officials occupying different levels of administration and even those belonging in the same level, i.e., between the Ministry of Interior and other Ministries, on the powers and functions that must be transferred to the regions and maintained by the national government. The differences in viewpoint illustrate the magnitude and intensity of political support and character of bureaucratic culture prevailing among authorities engaged in the implementation of decentralization.

Based on the aforementioned scope, the concept of decentralization in the social sector and mechanisms of application are linked with the procedures involved in the transfer of functions as well as with the various economic, political, social, cultural, and policy variables. Therefore, as presented in the theoretical framework, an evaluation of the application of the decentralization program in the social sector is based on the balance struck between the desired and feasible scope of decentralization. At the same time, such balance serves as an indicator in appraising the accomplishment of decentralization.

The process of decentralization in the social sector starts at the level of the ministry (Ministry of Interior) and flows downward to the province and regency. The process begins at the time when regions are created and basic social service functions are transferred: education, health, and social welfare. Decentralization is manifested through the formation of regional offices (*dinasdinas*) which constitute the operational apparatus of the social service sector. Moreover, regional offices through their respective regional heads coordinate and collaborate with their counterpart regional social sector ministerial offices. Such process is in line with the principles of decentralization as stipulated in Law no. 5, 1974.

Results from the field study in Java and Bali reveal that there are a number of variations in the application of decentralization in the social sector services. These variations occur due to the simultaneous implementation of the principles of decentralization and deconcentration. The functions of the vertical offices (Ministry) and the regional offices (*dinas*) can vary from one region to the other. In some instances, the two (2) offices may not be supporting each other on the operational level, such as in the arrangement of primary school teachers.

However, findings show that the above inconsistency became the general pattern of implementation of decentralization in Indonesia. Within this pattern, decentralization is exemplified in the vertical line of responsibility as well as horizontal line. This situation exhibits that the regional government is not in full

control of several services in as much as some functions remain to be coordinated with other ministerial offices. The problem of sectoral egoism emerges in the process.

The concurrent implementation of decentralization and deconcentration is attested by several staff members. There is a general perception that ministerial offices in the region dominate the role of policy making and planning while regional offices have been limited to execution of decisions and plans. The practice is not only contrary with existing regulations which mandate that regional offices should exercise policymaking and programplanning functions but also obscures the delineation of functions between vertical and horizontal lines of responsibility. In some areas, such as Bandung regency in West Java, the problem is solved simply by a leadership mechanism--one person is appointed to direct and perform the functions of two offices.

One of the missions of the decentralization pilot project in 26 regencies is based on the Ministerial Decree No. 105/1994 which is meant to institutionalize the pattern of decentralization consistent with Law no. 5, 1974. In this pattern, Dinas (regional office) exercises authority and responsibility over regional affairs in coordination with the local government. Ministerial offices that were set up and operated outside the jurisdiction of the local government were abolished but maintained only one non-operational office at the provincial office. In otherwords, all operational functions in the region are carried out by the dinas under the control and leadership of the regional head.

However, there are still several ministries which cannot and do not operate under this scheme, such as the Ministry of Education and Culture. In the implementation of the pilot project, some technical problems arise related to the basic issue of sectoral egoism. Evidently, technical questions are easier to resolve compared to the psychological problem of recognition of some sectors including the social sector.

Appendix

1. Menteri Dalam Negeri	Minister of Home Affairs
2. Gubernur	Head of Province
3. Bupati	Head of Regency
4. Walikota	Head of Municipality (Mayor)
5. Camat	Head of a District
6. Kepala Desa	Head of a Village
7. Lurah	Head of a Subdistrict
8. Setwilda	Secretary, Office of Governor
9. Setwil	Secretary, Office of Regency
10. Department	Related Ministry
11. Kanwil	Related Ministry Government Office in the Region
12. Kandep	Related Ministry Office in the Regency
13. Dinas	Functional Unit of Local Government in Relation with Implementation of Program of Related Ministry
14. DPR	Parliament for Central Government Affairs
15. DPRD	Parliament for Local Government Affairs
16. Bappenas	National Planning Bureau
17. Bappeda	Local Planning Bureau
18. Puskesmas	Public Health Center
19. Inpress	Presidential Instruction
20. SD	Elementary School
21. SMP	Junior High School
22. SMA	Senior High School
23. Itjen	Monitoring Office of Central Government Project
24. Itwilprop	Monitoring Office for Provincial Project
23. BPKP	Monitoring Bureau of Government Finance
24. Bapeka	Bureau of Financial Monitoring
25. LPND	Nondepartmental Government Office
26. Depdikbud	Department of Cultural and Education

Chapter 3

The Development of Local Government System in Indonesia

Decentralization and Regional Autonomy During the Colonial Period

The form of government in Indonesia was shaped in accordance with the political experience of the country. During the colonial era, a centralized form of government was dominant. Centralization in Indonesia was first introduced by the United EastIndian Company (V.O.C.) which ruled Indonesia in the 17th century. The top administrator of the VOC was the Governor General, who resided in the capital city of Batavia. To safeguard its trading interests, the VOC began to expand its political power by placing a number of territories under its rule, either directly or indirectly.

It appointed Dutch officials as regional authorities with the rank of resident. To control the company's monopoly on trade, the residents gradually interfered in the administration of the native rulers. The agricultural, trading, and political systems of the natives were redirected toward the cultivation of products demanded by the headquarters of the Company. Furthermore, residents interfered in the appointment of native rulers. In the island of Java, for instance, each newly appointed native ruler had to sign a contract with the Company stating that the recognition of the latter's authority over the former.

In West Java, native rulers were given the authority to levy taxes on behalf of the Company. The colonizers also forced native farmers to plant and cultivate designated crops to be sold to the Company at predetermined prices. Through the introduction of various systems of subjugation, the VOC was able to control the strategic trading networks, thus, protect and enhance its economic and political interests.

At the end of the 18th century, the Company ceased its colonial rule only to be replaced by the NetherlandsIndies Government, hence, Indonesia became a Dutch colony. During the reign of Governor General W.H. Daendels, the native rulers--regents (*bupati*)--were bestowed with powers and authority to rule. Eventually, they became officials of the colonial government whose seat of power was placed in Batavia. The power of the Dutch and native authorities to levy taxes and impose forced labor were reduced. For better administration, areas of Java outside of the Javanese kingdoms were divided into nine (9) administrative regions under the direct rule of the Dutch government.

During the British interregnum, Lieutenant Governor Thomas Stamford Raffles converted the administrative regions in Java and Madura, (outside the Javanese kingdoms in Yogkarta and Surakarta) into sixteen prefectures (which later, under Dutch rule, became the recidencies) whereby the bupatis were merely salaried employees of the colonial administration. These bupatis were responsible in supervising the cultivation of agricultural products and its subsequent sale to the colonial administration. To curb the authority of the *bupatis*, Raffles created the position of assistant resident and limited the rights of the *bupatis* on land and compulsory labor.

Residencies were subdivided into administrative areas called *afdeling*, headed by *bupatis* who were placed under the authority of the assistant residents. Each *afdeling* was divided further into districts, and each district into subdistricts (*onderdistrict*). Within each sub-district there were a number of villages, each headed by a village headman.

When British rule ended (1816), the Dutch authorities made legal arrangements with the native rulers detailing their functions in governance. According to the regulation introduced in 1820, the areas of authority of the *bupatis* were in the fields of agriculture, farming, security, irrigation, public health, road maintenance, taxes, and law enforcement. The legal arrangement became the basis for the establishment

of seventy *kabupatens* or *afdelings* in Java and Madura (outside the kingdoms in Yogyakarta and Surakarta).

Over time new policies were introduced, among other things, the adoption of a new constitution in 1855. A significant shift in policy was the introduction of a law on decentralization in 1906.

Decentralization

The introduction of the Decentralization Law (Decentralizatiewef) in 1903 opened new possibilities for the development of local government. The new law, nonetheless, was tied in with the principles of the 1854 constitution which, among other things, drew a distinction in administration between the Island of Java and the Outer Islands. In a number of *gewest* and parts in Java and Madura, decentralization was introduced, but centralization remained prevalent in the Outer Islands.

The development of a system of local government, though on a limited scale, brought about changes in relatively developed *kabupate*n and municipal governments in Java. In the beginning, the membership of the local councils (*local raad*), included members of the civil service. Furthermore, local administrators in charge of decentralization were usually European members of the Civil Service (*Europesche bestuursambtenaar*). This type of dualism was seen as an obstacle to the right of local administrators to exercise their authority in advancing their territory's interests.

To overcome the problem of dualism, the government introduced new policies with regard to the appointment of local administrators. Since 1916, for instance, the dualism in municipal government in Java was solved after municipal administrators were no longer recruited from the ranks of the civil service.

An ordinance adopted in 1918 (*ontvoogdingsordonnantie*) enabled European or native government authorities to hand over authority to local administrators. This policy later become the basis for the decentralization of regencies *kabupatens* in Java and Madura. Moreover, a law on governmental reform (*Wet op de Bestuurshervorrning*) enabled local municipal governments to exercise authority without interference from the colonial government. Based on this law, a number of s *gewests* were merged and later became the basis for the formation of provinces based on the principles of decentralization.

The application of the principles of decentralization was made possible by the ordinance on the formation of provinces (*Instellingsordonnantie*). This ordinance set forth the distribution of responsibilities between central and regional governments, whereby regional governments were granted the authority to manage their own internal affairs.

The provinces established under the new policy were managed by a provincial council (*provinciale raad*). The members of the council were partly elected and appointed by the Governor General. For operational purposes, the council had the authority to appoint a council of deputies (*college vangedeputeerden*). In charge of supervising the provincial council and council of deputies was a governor appointed by the Governor General. The governor acted as the chairperson of both councils apart from the authority he possessed to perform duties and responsibilities for and in behalf of the Governor General. Hence, the governor was a local official whose authority and power were derived from the central government.

This arrangement showed that the type of decentralization in the provinces was limited in nature and subject to the supervision and control of the governor who represented the central authority. Conceivably, the extant constitutional arrangement stifled the full operation of decentralization in the Outer Islands. It is to be noted that in the early period, a number of native kingdoms occupying large

areas in the outskirts of Java had governed in accordance with the principles of deconcentration. In this type of governance, officials were given the power and authority to rule over a specific area of the territory.

In such areas, the government appointed European residents. Under the residents were either the heads of *onderafdelings*, controleur B.B. or native assistant residents. While areas beyond the range of power of traditional leaders were ruled by district head or subdistrict head. Likewise, native deputies of district heads (*bestuurssassistenten*) were also given the authority to rule certain areas. On the other hand, areas where majority of the population have Arab or Chinese descent, authority to rule was granted to Chinese or Arab officers or heads (Chinese/Arabishe officieren, hoofden).

The political arrangements during the colonial period had shown that in same areas both European and native authorities ruled regional governments with some degree of selfrule or political autonomy. Nevertheless, selfrule of local governments existed alongside with local governments with administrative powers rather than political. This dualism in the system of governance led to the bifurcation of administrative arrangement between the central and regional governments. Moreover, the dualism was rooted in the inability of the central government as well as its vertical or line departments to finance the operations of regional governments. Consequently, this provided local governments the opportunity to manage, administer, and finance their own affairs.

The gradual decentralization which developed over time led local governments to improve their social service delivery system. Data culled from reports submitted by a number of residents and governors in Java between 1921 and 1940 (when their term of office ceased) appear to support this conclusion.

Decentralization in Social Services

Health Services

In the late 1940s, the provision of health services was entirely in the hands of the central government. The decentralization in the field of health services began in 1952 with the partial transfer of responsibilities to the regions.

Responsibilities transferred to the regional government include, among others: (1) authority to establish and administer general or special hospitals and clinics; (2) supervision of hospitals owned by other branches of government or by the private sector; (3) provision of health services to areas outside the reach of central hospitals; (4) procurement of medical equipments and supplies; (5) protection of public health and prevention of the spread of communicable diseases; (5) provision of immunizations; (6) training of lower and middle level paramedics; (7) establishment of regional health offices; (8) assistance to the ministry of health whenever necessary; (9) provision of health facilities; (10) recruitment, employment, training, deployment and transfer of provincial health workers and absorbed health workers from the Ministry of Health; and (11) administration of government funding for the provision of regional health services. Apparently, the decentralization in the field of health was however limited; certain functions, such as budgeting, personnel and health policy, were still performed by the Ministry of Health.

To promote equity, regional hospitals and clinics gave priority service to underprivileged patients. The regional governments saw this as a heavy burden in the light that most underprivileged patients reside in regional areas.

Legislation in the field of health during the period began with the enactment of Government Regulation No. 4, 1984. This was concerned with the control of communicable diseases. By encouraging social

participation in financing campaigns for the eradication of communicable diseases, the government appeared to be gradually moving away from the centralization of health care. The desire to mobilize social participation in health care was also expressed in Law No. 23, 1994. This was the first law on health care since Independence. It contained general principles on the decentralization of health services.

Support for decentralization of health services was also found in other legislative acts issued during the period. Through Government Regulation No. 7, 1987, for instance, the central government transferred certain health functions to first and second level regional governments throughout Indonesia. This was far more progressive compared to previous regulations which transferred health funding to specified regional governments only. The regulation also identified the form, organization, and responsibilities of first and second level regional health services (*dinas kesehatan*) as well as their relation with higher level government health agencies. The linkages between central and regional governments were explicit: health services provided in the region were managed by a health professional who was responsible to the regional government, but part of the medicaltechnical staff of the regional health service were employees of the Ministry of Health and derived their authority from the central government.

Despite a wide variety of functions transferred, the regional government was still seen as the administrator of policies formulated at the center. The relationship between the center and region was still characterized by the dominant role of the central government.

Education

The idea of decentralization in the field of education could be found in Law 32,1947 which allowed regional governments to establish public schools. The law, however, specifically ruled that the authority to establish and administer secondary schools continued to be in the hands of the central government.

In the early 1950s, Law No. 4, 1950 further expanded decentralization in the field of education. Apart from the power granted to regional governments to administer and establish public schools, private organizations were accorded with the right to establish private schools. Although the supervision of public schools was placed under the regional governments, teachers and curricula were subject to the authority of the Ministry of Education, Teaching, and Culture (METC). In 1951, a number of government regulations were issued which transferred certain functions of the METC to regional governments.

Law No. 2, 1989 (National System of Education) set forth the principle of equality of educational opportunity. This was followed by a number of governmental and ministerial regulations and decisions designed to implement the law. Nonetheless, certain policies like the administration of centralized entrance examination for public institutions, placed more emphasis on efficiency rather than equality. Moreover, another principle embodied in the law was the mobilization of social participation in raising funds for education.

Although decentralization has been expressed to be a desirable goal, its operationalization in the field of education has been far from reality. Various functions such as curricula development, entrance examinations for public institutions of higher education, and accreditation of private institutions for higher education persist to be centralized. Furthermore, functions transferred to regional governments have been limited to the implementation of policies formulated by the central government.

Social Welfare

The Constitution of 1945 contained a number of basic principles concerning the provision of services in the field of social welfare. The establishment of the Ministry of Social Affairs in the first cabinet (1945)

enabled the government to implement these principles. The commitment to realize these principles could be seen from the large number of legislations issued since 1946.

In the early 1950s, the government began decentralizing social welfare functions as mandated by Law No. 2, 1950. This was the same law that initialed the decentralization efforts of the government in the fields of education and health. Since 1952, provinces have assumed social welfare functions. Responsibility to perform these functions were transferred either fully or partially.

On one hand, provinces were given complete autonomy in taking care of the welfare of the poor, orphans, and abandoned citizens. On the other hand, responsibility in the performance of the following areas was limited to mere execution with the central government retaining its power of control and supervision: social education; social guidance; organizations of social welfare; homes for children who had undergone detention; care of juvenile delinquents; control and eradication of social deviants; and support for the homeless. Evidently, the policy of decentralization had not been complete with the central government maintaining a tight grip over the provision of major social welfare services.

Beside the transfer of authority to provincial governments, a number of functions were transferred to governments of *kabupatens*, municipalities and cities. These functions included activities related to social guidance and information, improvement of social conditions, and social support.

Social guidance and information was concerned with education for beggars and vagabonds, abandoned children and juvenile delinquents, and social deviants such as prostitutes (sex workers), drug users, and gamblers. While the improvement of social conditions covered the investigation of social problems, improvement of housing and rural settlements, and prevention and eradication of deviant behavior. Social assistance, on the other hand, pertains to services provided to beggars, vagabonds, orphans, abandoned persons, juvenile delinquents, ex convicts, victims of disasters, refugees, persons dislocated by armed conflict, and private charity organizations.

Despite the transfer of a wide variety of responsibilities to regional governments, the capability of the regions to exercise them was circumscribed due to limited financial resources at their disposal. The control of funds persisted to be in the hands of the central government. In a similar manner, the national government through the Minister for Social Welfare held the ultimate power in the allocation, deployment, and transfer of regional employees in spite of the authority given to regional governments to select and place employees at regional offices. Likewise, the final endorsement and approval of the Minister for Social Welfare was mandatory before regional governments can devolve its political power and transfer its authority to provincial, *kabupatens*, and municipal governments.

The restrictions imposed by the central government on its subnational units had consequently led to the inability of the government to effectively and directly respond to social welfare needs and demands of the nation. Moreover, the political instability and turbulence which characterized the period and failure of the government to mobilize adequate funds for social welfare narrowed down the scope of social services to a small. segment of the societyùretired persons, war victims, widows, and orphans of civil servants. Ironically, it was the private sector through nongovernmental organizations (NGOs) which responded, although in a limited scale. to the welfare needs and problems of the people.

As in other social services, social welfare services demand the mobilization of financial support from other sectors of the society. This is in view of the fact that the magnitude of problems to be solved cannot be matched by available resources. One way of eliciting societal participation is the encouragement of nongovernmental organization to take an active role in the formulation and implementation of social welfare programs. It has been evident that various policies made in the field of

social welfare have only strengthened the norm of centralism. Regional governments. in most cases, have been limited to implement policies made by the central government.

Decentralization and Regional Autonomy, 19451955

Early Independence

The spirit of decentralization or regional autonomy during the early independence period was based on article 18 of the 1945 Constitution. In November 1945, Law No. 1, 1945 was issued to realize the principles of decentralization.

The law classified Indonesian autonomous territories into kabupatens, municipalities, and regions. Furthermore, the law classified selfrule provinces into three types: residencies, *kabupatens*, and municipalities. In reality it was the politicoqurisdical units which defined their own territories. The province of Sumatra, for instance, divided itself into three sub-provinces (North, Central, and South Sumatera). The division was later affirmed by the central government.

In 1948, Law No. 22 was issued which defined the territory of the Republic of Indonesia into three (3) selfrule areas, namely: (1) provinces; (2) kabupatens and municipalities; and (3) cities, villages, and communities. The law also designed the structure and functions of regional governments.

Period of Dutch reoccupation (19451949)

During this period, the territory of Indonesia was divided into two: areas controlled by Indonesians in Sumatera and Yogyakarta known as the Provisional Government of the Republic of Indonesia (*Pemerintah Darurat Republik Indonesia* or PDRI) and the Republic of Indonesia in Yogyakarta; and areas under the rule of the Netherlandslndies Civil Administration.

While both Indonesian governments continued to develop regional autonomy on the basis of previous legal arrangements forged between native rulers and colonizers in 1820, the Dutch government adopted a law based on a prewar colonial system of decentralization.

Period of the United Republic of Indonesia (19491950)

During this period, the Indonesian state system was changed from a unitary state into a federal. The principal rule governing decentralization was article 47 of the constitution of the United Republic of Indonesia (the RIS), which proclaimed that each state within the federation had the authority to promulgate laws, policies, and rules for and in behalf of its own autonomous regions. Eventually, the concept of selfruling regions Swapradja was introduced and authority of residents was handed over to regional government's boards (*Dewan Pemerintah Daerah*) or governors in their capacity as the provincial head. In East Indonesia, three levels of autonomous regions were introduced.

Period of the Provisional Constitution of 1950 (19501959)

This period saw the reintroduction of Law No. 48, 1948 and enactment of a number of laws on decentralization. The first was the formation of seven (7) autonomous provinces in Java and Sumatera and transfer of a number of functions from the central government to the provinces. In addition, eighty one (81) *kabupatens*, eleven (11) municipalities and eight (8) administrative units were formed within the provinces together with the delegation of research to these new autonomous regions. Besides, the law also recognized twenty (20) other types of regions with selfrule rights. Furthermore, a law that laid

down the procedures for the election of members of the Regional People's Reprecentative Council (Dewan Perwakilan Rakyat Daerah) was legislated.

In terms of regional finance, the law adopted the principles of equity and uniformity. This meant the provision of financial support and subsidy to regions, with due priority to the poor ones. Furthermore, measures were taken to prevent interregional tax disparity. As shown, decentralization and autonomy was a combination of full and partial transfer of autonomous rights but still under the close supervision of the central government.

Apart from these, the concept of togetherness or collegiality (the principle of sharing equal authority among colleagues) in governance was introduced in regional governments. This made it possible for regional government to bring together two councils, namely, the Regional People's Representative Council (DPRD) and House of Representative Government Council (DPR), within its politico-administrative structure to assist in managing affairs relative to regional concerns, problems, and issues.

Another development in this period was the enactment of Government Regulation (*Peraturan Pemerintah*) No. 20, 1952. This was concerned with the placement of representative offices of various branches of the national government (*jawatan*) in the regions. Although located in the regions, the *jawatans* were responsible and accountable to the ministers of the cabinet and not to the head of the regions. The idea of creating vertical *jawatans* from the national level down to the regions stemmed from the need to aid the tasks and functions of the cabinet ministers in the regions.

Decentralization and Regional Autonomy (19561965)

Two important legal documents were enacted in this period. These were: Law No.1 (1957) concerning the principles of regional government based on the Provisional Constitution of 1950; and Law No.18 (1965) based on the 1945 Constitution.

Law No. 1, 1957

The law contained the following principles: (1) real autonomy, (2) two to three strata of regional government; and (3) elected head of the region (*Kepala Daerah*) who represents the regional government and chairs of the regional government board (*Dewan Pemerintahan Daerah*).

The principle of real autonomy, as stated in the law, refers to a decentralized system of governance which takes into consideration the conditions, needs and capabilities of both regional and central governments relative to their specific as well as collective responsibilities in carrying out the development goals and objectives of the nation. According to lawmakers, a clear and distinct line delineating the functions, duties, and responsibilities of national visavis regional governments cannot be drawn.

The only possible distinction, in their view, was for the central government to assume the tasks that pertain and relevant to national interests. Outside of these would be considered as local concerns, thus, must be undertaken by subnational or regional governments. The effects of such simple distinction are enormous and at times alarming that can substantially reduce the power of regional governments.

In as much as any regional problems can have or may potentially have a national implication, or perhaps be viewed by central authorities to affect or have affected national interests, the central government can conveniently interfere into regional or local affairs. Moreover, powers bestowed and delegated upon regional governments can be easily withdrawn.

The law also made a distinction between selfgoverning regions (*daerah swatantra*) and special regions (*daerah istimewa*) on one hand, and between three (3) strata of regional governments on the other hand. Each stratum was regarded as a tier of local government with the first level regional government as the highest among local governments and the third level as the lowest.

The first level region or province (*Daerah Tingkat I*) included the capital city of Jakarta Raya, the second level or regency (*Kabupaten*) included municipalities and autonomous cities (*kotamadya*), and the third comprised other cities and towns. The important factors considered in the creation of autonomous regions were the capability to mobilize financial resources and recommendation of the upper level Regional Peoples Council (*DPRD*). As provided in the law, every region was granted the right to manage and administer their own internal affairs as it deems fit. It further stipulated that any creations of autonomous regions must be accompanied with specific types of duty, function, and responsibility which the region concerned believes must be transferred to them by the central government in pursuit of its goals.

Nevertheless, the types of responsibility can be expanded or limited either by the central or higher level regional government after due consultation with the region concerned. Besides, regional governments may be assigned to perform the administration of national or higher level regional government programs, projects, and policies in their area of jurisdiction.

The law also expressed that functions, duties, and responsibilities as well as programs and policies already undertaken or being done by the central or higher level regional government cannot be assumed by the regional government. In a similar vein, governmental and administrative activities performed by a regional government are regarded invalid, void, and inoperative if these are currently being taken cared of by the central or higher level regional government.

In addition, the central government and upper level regional governments exercised certain degree of power and political prerogatives over lower regional governments. These are the powers of supervision, inquiry and investigation (*enquete*), sanction, and judicial. Supervisory power refers to the authority of the central government to regulate and control the operation and function of regional governments and/or the authority of the upper level over lower level regional governments.

Such control can be discharged proactively or reactively. A proactive control is manifested when a regional or lower level government is prevented by the central government to perform activities and functions contrary to national rules, regulations, or policies. While reactive control is done when a higher tier of government represses, annuls, or invalidates a lower tier's action or actions found to be illegitimate or regarded as unauthorized and disadvantageous in the pursuit of national or supraregional goals, objectives, and general welfare.

Moreover, the power of inquiry is exercised by the central government over subnational governmental units or higher level regional governments over lower levels to determine the appropriateness, effectiveness, and efficiency of the latter in the performance of its assigned or devolved functions. This power ensures that lower tiers of government meet the expectations of the higher levels of government and assures that activities are done within a predetermined framework as well as set forth objectives. Finally, judicial right or power is discharged by central authorities to adjudicate conflicts among and between upper and lower levels of regional government arising from the interpretation of laws, policies, rules, and decisions made.

Organization of Regional Government

The regional government is composed of the Regional Government Council (DPD *Dewan Pemerintahan Daerah*) and the Regional Peoples' Representative Council (DPRD). The members of the regional legislative body were elected for a period of four (4) years. The head of the region (*Kepala Daerah*) is also the chair and at the same time a member of the DPD. Although the law mandated that the regional head must be directly elected by its own constituents, in reality he/she was elected by the regional legislative body. An important figure in the regional government was the secretary (*Sekretaris Daerah*) who is responsible in managing the affairs of the DPD and DPRD. He/she is chosen through the recommendation of the DPD and formally appointed by the DPRD.

Autonomous Region and Taxing Power

The government formed eight (8) first level and 94 second level regional governments between 1956 and 1965. The autonomy of the two levels of government was enhanced by granting them the power to mobilize financial resources specifically the power to tax and right to receive tax proceeds. Several policies and rules were enacted by the government to strengthen the financial autonomy of regional governments.

Towards this direction, states taxes were collected the proceeds of which accrued to regional governments. For instance, revenues from states taxes like motorized vehicles tax and household tax went to first level regional governments while second levels received the proceeds from road tax, copra tax, and development tax. Further, regional governments were given the right to share certain portions from states taxes such as income tax, property tax, and wage tax.

Apart from these, regional governments were given the authority to impose regional taxes on persons, properties, and practice of profession not taxed by the state. This includes the power to issue and levy tax on fishing permits in public waters as well as impose school tax. First level regional governments, for example, were allowed to tax public performances and festivities, advertisements displayed outside of national mass media, dog tax, producers of firecrackers and fireworks, and retailers of alcoholic beverages. Revenues collected from these taxes accrue to the coffers of the regions.

The Regional Government Under Law No. 18, 1965

The law divided the entire territory of the Republic of Indonesia into three (3) levels of selfgoverning regions, these are: the province and major city as the first level (*daerah tingkat I*); *kabupaten* and middle level municipality (*kotamadya*) as the second level region (*daerah tingkat II*); and *kecamatan* and lower level municipality (*kotapraja*) as the third level.

Regional governments were composed of a regional head (*kepala daerah*) and members of the Regional Peoples' Representative Council (*Dewan Perwakilan Rakyat Daerah*). Unlike in the previous law, the regional head was no longer the Chair of the Council but a representative of the central government. This arrangement was done to promote a harmonious relationship between the central and regional government.

Although regional governments were given full powers to manage their own internal affairs, the central government had not relinquished its reign over them. The latter continued to exercise supervisory and control (preventive and repressive) powers over the former. The authority, functions, duties, and responsibilities which the law devolved and delegated to regional governments are therefore not absolute. These can either be limited or expanded depending on the national and local needs and demands as perceived by the central authorities.

Decentralization and Regional Autonomy (19661994)

The period is characterized as a stage of transition from the "Old Order" to the "New Order" government. Similar to other periods, the principles of decentralization under this stage was based on the provisions of the 1945 Constitution. However, the enactment of Law No. 5, 1974 which replaced the 1965 Law No. 18 on regional governance made the difference. It provided substantial autonomy to regional governments.

The decision of the Peoples' Consultative Assembly (*Majelis Permusyawaratan Rakyat*) in 1966 to grant meaningful autonomy, referred to as territorial decentralization and deconcentration, to regional governments was a watershed in the history of decentralization. This was reiterated by the 1973 Peoples' Consultative Assembly and gave birth to a landmark decentralization policy otherwise known as Law No. 5, 1974.

The law on decentralization and deconcentration was operationalized by dividing the country into autonomous regions (*daerah otonom*) and administrative territories (*wilayah administratif*) respectively. In line with territorial decentralization, two (2) regional levels of government were created (*daerah tingkat I* and *daerah tingkat II*). On the other hand, deconcentration was pursued by creating provinces which are composed of regencies (*kabupaten*) and municipalities which are divided into subdistricts (*kecamatan*). The possibility of conceiving administrative cities (*kota administratif*) within *kabupaten* in the future was also considered by the law.

Under this framework, autonomy was anchored on the principles of popular participation and equity. Further, the law placed due importance on the role of second level regional government (*Daerah Tingkat II*) compared to other levels. Lawmakers perceived that at this level the people are closer if not directly linked with the government. Nevertheless, the central government maintained its right to limit the powers of autonomous regions if not totally withdraw them in case regional governments fail to perform their mandated functions and responsibilities. On another plane, the central government can also cease its support to the regions if found to be effective, competent, and responsible in managing their affairs.

Considering that all regional governments draw their financial sustenance from the national coffer, a self-reliant regional government receives less financial support from the central government in exchange for more freedom from political and administrative interventions of the state. Thus, the transformation of regional governments into self-reliant political units is most desired by the central government. This objective led to the formulation of various policies, rules, and regulations in order to increase the capacities of regional governments to tap and mobilize revenuegenerating resources.

Enhancing the capabilities of regional governments had been coupled with institutional arrangement on the coordination of programs and projects implemented by the central and regional governments at the administrative territories with the enactment of Government Regulation No. 6, 1988. It mandated the head of the territory (*kepala wilayah*) to be the chief Coordinator of all activities of both central and regional offices.

Despite the legal mandate and scheme to promote interinstitutional coordination, problems in coordination emerged. The difficulty arose in as much as field offices of the central government were functionally accountable to their respective mother ministries, departments, and institutes whereas those of the regions are to their regional heads and not to the head of the territory. Apparently, the law was unsuccessful in establishing the nexus between administrative deconcentration and territorial decentralization.

Apart from the weakness on deconcentration, territorial or political decentralization has also taken a back seat due to some pressures exerted by forces seeking for greater autonomy. For instance, the problem of separatism and regionalism in the country led the national government to merge the positions of the head an administrative territory (*Kepala Wilayah*) and head of an autonomous region (*Kepala Daerah*) into one with the function of the former given more weight by the central government than the latter. Hence, decentralization during the period tilted more towards deconcentration than territorial devolution. Albeit the powers transferred from the center to the regions consisted of political, administrative, and financial, the policy of decentralization continuously swung back and forth between granting more power and retrieving granted power to autonomous regions. This was dependent not only on the issue of resolving separatism but also on the perceived priorities of whosoever heads the Ministry of Internal Affairs. The constant shift in policy between autonomy and centralization was therefore a function of the objective demands of the situation and subjective biases of political leaders.

Nonetheless, autonomy of regions remained to be pursued. It was expressed in terms of legislation. For instance, the Regional Peoples' Representative Council (*Dewan Perwakilan Rakyat Daerah* or DPRD) was given relative freedom to formulate and implement laws and policies imperative to regional development. The DPRD together with the regional head collectively designed the regional budget, administered taxrelated functions delegated by the upperlevel regional government, and promoted social welfare on the basis of national development programs.

In the performance of these tasks, the DPRD divided itself into sectorbased commissions responsible for drawing up legislative agenda and proposals for the Councils consideration, namely: Commission A (government, security and order; B (finance and regional firms); C (economy); D (development); and F (social welfare). All commissions were authorized to exercise the following rights: budgeting, inquiry, information, initiation, and investigation.

Fiscal autonomy of regional governments was also strengthened by providing them access to four sources of revenues: regional income (*pendapatan asli daerah*) based on various regional taxes; shares from general taxes, subsidies, and grants from the central government (aids for the construction of markets, schools, and roads); and incomes from regional enterprises (*perusahaan daerah*). In addition, the government increased the opportunities for regions to increase their income by allowing them to engage in different incomegenerating endeavors like owning or managing profitoriented enterprises apart from those concerned with the delivery of social services.

However, fiscal autonomy was not fully exercised by regional governments in spite of avowed pronouncements. Factors, both structural and material, impeded the process of achieving fiscal self-reliance. Among these are the: dearth of available natural and human resources in the region; stiff restrictions and control of the higher level governments on the disbursement and utilization of central and regional funds; and limited access to grants.

On the other hand, autonomy of villages was also considered. Law no. 5, 1974 recognized the right of the village (*desa*) the smallest autonomous territorial community to manage its own internal affairs. This right was, however, not given to the urban ward (*kelurahan*). The *desa* is headed by an official elected periodically (*kepala desa*) while the *kelurahan* by a centrallyappointed official (*lurah*). Both *kepala desa* and *lurah* are responsible to the subdistrict head (*camat*).

Although a *desa* is supposed to be politically autonomous, its function is no different from *kelurahan* which is limited to the administration of centrallyplanned policies of the national and upperlevel regional governments. To support the finances of the village, the government has authorized it to receive part of the land and building tax (PBB) as well as generate and utilize its own sources of revenues. However, over time the village lost some of its sources of income when its control and usufructuary

rights over the following resources ceased: traditional communal lands; village forests; sand and gravel from river beds and lakes; and village markets.

Political responsibilities are more expressed and shouldered by second level regional governments as stipulated in Government Regulation No. 45, 1992. Under this ruling, governmental matters outside of security and defense, judiciary, foreign affairs, currency and monetary, and other functions not affecting national interests are within the scope of accountability of second level regional governments. Towards the effective administration of assigned functions and responsibilities, the regional government were authorized to set up administrative offices (*dinas daerah*) in their own respective political jurisdictions.

Chapter 4

Issues in the Implementation of Decentralization: Case Study of Java and Bali

The Implementation of Decentralization Models in Java and Bali

The case study was done in the provinces of West Java and Bali. Two areas, one urban and another rural, were taken in order to appraise the activities of people, local authorities, and other parties concerned relative to their participation in planning and implementation of the decentralization program in social sectors.

The case explored and identifies various problems in the implementation of the program, solutions designed to solve them, outcomes of solutions made as well as benefits derived by the social sectors from the program. Moreover, it examined the perceptions of the elite on the program, their expectations and apprehensions, mechanisms of implementation, manner of execution, inputs utilized, organizations involved, activities performed, and tools of supervision and monitoring.

Finally, the case assessed the nature and character of relationship and interaction established between the government, social organizations, and the people in the course of managing the program. In other words, the study described, documented, and analyzed the decentralization program--covering the stages of planning, implementation, and evaluation; issues which emerged in the decentralization process; and participation of no-governmental organizations in the social sectors relative to the program.

In the main, the study identified the aspects of the decentralization program in the social sector which can be carried out by the local government. Apart from this, the following concerns were also addressed: (1) initiatives taken by the local government in line with the decentralization policy of the state; (2) manner of deciding and criteria used in setting the priorities of the program , and (3) steps taken to solve the problem of resource allocation. On a more specific plane, the study answered the following questions: (1) What are the socio-economic and cultural factors that affect the effective implementation of the decentralization program in the social sector?; and (2) What are the necessary processes involved in implementing the program and how do these affect the operationalization of decentralization?

West Java and Socio-Economic Condition.

The province of West Java occupies a strategic location, surrounding the city of Java. It is bounded on the north by the Java Sea, south by the Indian Ocean, Sunda Strait on the west, and central province of Java on the east. The province covers approximately 43,117 sq. Kms. And consists of 24 regencies. In 1992, total population was estimated at 8,259,000 with an annual growth rate of 2.57%. Out of the total, 5,375,238 are in the agricultural sector; 137,420 in mining; 1,914,194 in manufacturing; 33,061 in electricity, gas, and water; 549,858 in construction; 2,553,234 in trading; 603,944 in transportation; 89,267 in finance; 1,924,574 in social service; and 34,376 in other occupations.

The Educational Sector

The educational sector in West Java covers all types and levels: elementary; secondary; and tertiary education, including vocational education. The facility and human resources are shown as follows:

Education Facilities in West Java, 1990/1991
Numbers

Education	Schools	Teachers	Students
Level	Total	Total	Total
Elementary	24,624	174,329	4,874,876
Junior High	2,321	52,793	788,020
ST (Yunior High Technical School)	37	865	11,536
SKKP (Yunior High Home Economics)	14	265	3,296
Senior High	974	34,372	354,122
STM (Senior High Technical School)	151	5,753	74,979
SKKA (Senior High Home Economics)	17	515	6,105
SPG (Senior High Education for Teacher)	72	1,767	7,938
SGO (Senior High Physical Education)	14	451	1,978
SMEA (Senior High Economics)	183	5,278	84,781
State University	5	5,424	46,774
Private University	82	9,724	118,503

Besides the formal education, there is also the Moslem boarding school type. In 1990, it reached a total of 2,782, with 10,867 teachers and 408,316 pupils.

Health Sector

The health facilities in West Java consist of 146 hospitals, 796 Community Health Centres (CHC), 1,316 auxiliary CHC, 458 mobile clinics and 1,774 Family Planning Clinics. These facilities are supported by 18,023 health personnel composed of 1,641 medics, 9,705 paramedics, 2,738 health workers, and 3,939 nonmedical personnel.

The improvement in health care is shown by the decrease in mortality rate to 5.8 per 1,000 from 18.9 per 1,000 between the years 1980 and 1985 and increase in life expectancy from 42.2 years for men and 45 years for women in 1971 to an average of 69.9 years in 1985. On the other hand, an analysis of nutritional status of people between the years 1986 and 1987 showed that 51% were considered good, 37% moderately good, 11.1% fair, and 0.95% bad.

Social Welfare Sector

In the social welfare sector there are 515 welfare organizations which maintain 121 orphanages with a total number of 7,666 orphans. There are also 7,065 youth clubs and 43,476 community workers engaged in local welfare development. In 1990, it was recorded that there were 280,000 poor families, 134,247 neglected children, 10,518 juvenile delinquents, and 1,155 drug abuse victims.

Case Study in Decentralization : The Municipality of Bandung

The municipality of Bandung is the capital city of West Java province. The city is 500 meters above sea level and surrounded by mountains. Its temperature ranges between 18 to 22 degree Celsius. The municipality has a population of 1,819,336 with 35.59% working in the trade sector; 25.88% in industry, and transportation with 10.22%.

Administratively, it is divided into six (6) districts, 28 subdistricts, and 135 urban wards. The total number of officials is placed at 73,502 with 59,648 (81.15%) and 13,854 (18.85%) of which are central and regional government officials respectively. In terms of learning institutions, 75 are of higher learning located in West Java - 19 universities, 36 institutes, and 17 academies. Out of the total, 33 are in Bandung including one of the best universities in Indonesia, the Bandung Institute of Technology.

In Bandung City, there are 974 state elementary schools with 222,437 students and 1,931 teachers while there are 182 private elementary schools with 47,180 students and 1,931 teachers. At the junior high school level, there are 44 state schools with 41,180 students and 587 teachers and 191 private schools with 64,399 students and 655 teachers. The number of senior high school registered are 25 state schools with 27,290 students and 1,563 teachers. In addition, there are 140 private schools with 47,299 students and 4,749 teachers.

Data on health indicated that health facilities between 1990 and 1991 comprised 20 hospitals, 153 drugstores, 54 community health Centres, 5 auxiliary community health Centres, a mobile clinics, 20 pharmaceutical industries, 87 by pharmaceutical traders and 10 small pharmaceutical industries. Records also show that there are 3,713 neglected children, 6,183 aged people and 515 victims of drug abuse.

The Regency of Bandung

Bandung regency is one of the 25 regencies in West Java. It has a strategic location serving as a link between the municipality (Bandung) and the rest of West Java as well as buffer of urbanization in the municipality. Hence, it benefits directly from the urban development of Bandung municipality.

Similar to the municipality, the regency is generally a mountainous area with an altitude of approximately 500 meters above sea level. This gives the general area a cool weather throughout the year with some areas having a temperature range of 1518 degree Celsius (for districts with an elevation of 700 meters above sea level). Majority of the population are engaged in farming with 308,323 has. considered as agricultural lands. In 1992, total number of farmers were estimated to be at 500,097.

The regency has 41 districts and 451 subdistricts, including three (3) districts in the administrative city of Cimahi and 11 autonomous areas and eight (8) branches of primary. Moreover, it has 10 office departments with seven (7) representatives of LPND and three (3) BUMP owned by the city county.

Bandung regency has a population of 3,117,280 with a density ratio of 1.113: 1 km.. Among the districts, central Cimahi has the highest density ratio placed at 11.390:1 km.

In the field of education, Bandung has numerous facilities. Below is a brief description of these facilities:

Education	Student	Teacher	School
Level	Total	Total	Total
State Elementary	431,703	18,636	2,573
Private Elementary	7,158	385	31
State Junior High	50,091	2,564	66
Private Junior High	43,967	3,626	184
State Senior High	18,872	1,258	26
Private Senior High	27,845	1,896	109

In health, Bandung regency has six (6) general hospitals, 10 polyclinics with nursing facilities, 64 comprehensive Community Health Centres (CHCs), 107 auxiliary CHCs, and 34 mobile clinics. These are staffed by medical professionals and workers consisting of 41 dentists, 15 specialists, 156 general physicians, 322 midwives, 375 nurses, eight (8) pharmacists and 42 assistant pharmacists. In 1993, a total of 1,255,526 patients were served.

In social welfare service, the regency has been active in helping natural disaster victims, (in 1992, it was recorded that 80 incidents of natural disasters occurred such as 16 floods, 46 fires, 67 hurricanes, and 11 others) orphans, and the elderly through its 1,038 community workers, 451 youth clubs, 22 orphanages, and six (6) homes for the elderly.

Bali Province and SocioEconomic Condition

Bali province is one of the provinces of Indonesia. It consists of eight (8) regencies and one (1) municipality covering a total land area of 563,286.08 has. Topographically, the province has a mountainous terrain stretching from the far west to far east of the island dividing it into two areas with different geographical characteristics. The northern portion is generally lowland with some mountains while the eastern part of north Bali has a drier climate compared to the western portion. On the other hand, the southern part has a large land area suitable for agriculture. The entire coast of Bali, from west to east, is considered a tourist attraction.

Population records of 1992 showed that Bali has a population of 2,736,090 with an annual growth rate of 1.5%. Population density is estimated at 486 persons per km. with Denpasar city as the most dense having the highest ratio at 2,704: 1 km.

Education Sector

The sector has 348,302 elementary school pupils, 119,451 high school students, 10,366 junior high school teachers, 22,394 elementary school teachers. Data showed that a good proportion of elementary pupil graduates proceed to junior high school. There are 2,925 state and private elementary schools, 394 junior high schools, and 251 senior high schools.

Health Sector

Health services are provided by 13 government hospitals with a total bedcapacity of 2,125; and 13 private hospitals with 466 bedcapacity. Apart from these, there are community health centres at the district and village levels. These consist of 109 clinics, 405 polyclinics, 106 mobile polyclinics, and 4,330 community service posts. Furthermore, health facilities are maintained by 213 physicians, 40 dentists, and 1,535 paramedic personnel.

Social Welfare Sector

Social welfare services are provided to 811 handicaps, 187 beggars and homeless, and 128 prostitutes. The number of social welfare clients have decreased remarkably considering the figures the sector served in 1986 - 1,364 handicaps, 323 beggars and homeless, and 842 prostitutes. Notably, Bali has provided assistance to 2,324 orphans housed in 39 orphanages.

A Case of an Urban Area: The Bandung Regency

Bandung regency has a total land area of 54,250 has. divided into 15,971 has. of rice fields; 23,099 has. barren lands; 1,979 has. forest land; and 6,250 has. of plantations. The land classification indicates the predominantly agriculturebased economy of Badung.

Bandung is also a tourist attraction with many scenic spots and beaches (among the most popular are Kuta, Sanur, and Nusa Dua beaches) it can be proud of. Facilities which serve foreign and local tourists are 63 hotels with a total of 1,536 rooms and 3,074 beds. In addition, its airport, seaport, and harbors offer internationally competitive facilities. Records show that a total of 110,921 tourists have flocked the area and generated substantial income for the regency.

In the field of education, Bandung has 298 elementary schools, 50 junior high schools, and 27 senior high schools with a total of 33,542 elementary pupils and 14,365 junior high school students. On health facilities, it has four (4) government hospitals with a total of 367 bedcapacity, 19 clinics, 56 polyclinics,

14 mobile polyclinics, and 931 health service posts. Total medical personnel is divided into 33 physicians, 24 specialists, 10 dentists, and 237 paramedics.

A Case of a Rural Area: The Gianyar Regency

Gianyar regency occupies a land area of 36,800 has. and a population of 330,481. Compared with Badung, it has limited hotel facilities having only four (4) hotels with a total of 96 rooms and 198 beds. However, it is able to attract a number of foreign tourists (recorded at 10,694) due to its native dances, paintings, and carvings.

Its educational facilities include 321 elementary schools, 52 junior high schools, and 26 senior high schools. There are 39,339 elementary pupils and 16,622 junior high students. In terms of health facilities, Gianyar has only one (1) public hospital with 107 bedcapacity, 13 polyclinics, 47 supporting polyclinics, 13 mobile clinics, and 523 health service posts. Its medical staff is comprised of 22 doctors, five (5) dentists, 182 paramedics and a number of specialists.

On social welfare service, Gianyar has only two (2) private orphanages with 73 orphaned children. Nonetheless, its proximity to Denpasar city makes it possible for Gianyar to avail of the social services in the city which the regency cannot provide. For example, patients from Gianyar can receive medical attention and care in Denpasar. This is one of the success indicators in social sectors as it shows the initiative of people in improving their health condition through efforts other than the government.

Local Leadership

As per the provision of Law no. 5, 1974, the municipality of Bandung is headed by a mayor while Badung regency by the regency head. Both of them are elected by the Regional Legislative Body whose members in turn are directly elected in a general election held every five (5) years. Similarly, the mayor and regency head have a term of five (5) years and do executive functions. They are primarily responsible in managing and administering local affairs in their respective political jurisdictions.

In the process of carrying out their functions, reliance is placed on informal leaders. The involvement of traditional, informal, and indigenous leaders in regency and municipality ensures the participation of the grassroots in the formulation of local plans as well as monitoring and supervision of development programs. Hence, the process assures that programs emanate from the bottom and policy decisions are products of mutual agreement between the formal and informal leaders.

Social Participation

Programs in decentralization are usually carried out in consonance with the programs initiated by the local government. Apparently, the role of local government in coordinating such programs is crucial not only in avoiding duplication and overlapping of tasks, functions, and responsibilities between private and public sectors but also in the proper and equitable allocation of available resources.

Coordination, as a mechanism in effecting decentralization, is imperative relative to program implementation in all social sectors. Besides, the participation of people in the decentralization process is basic. Below is an illustration of people participation in social sector programs in West Java and Bali.

Social Welfare Sector

Social participation in decentralization program in the social sector is realized in many forms. In a more formal way, this is done through various activities during the Social Solidarity Day. Another activity is the mobilization of relieffund which is needed for social programs.

In Bandung, social participation is realized through a continuous fund raising movement known as *Rareongan Sarumpi*. The governor organizes the activity in its initial phase and followed by local leaders at the regency and municipal levels and finally by the members of the society. The funds collected are used for various social activities including the construction of buildings to facilitate the provision of social services. The total funds collected thus far is 1 billion rupiah. The traditional organizations have played an active role in this activity.

Arisan movement is another form of fund raising familiar to the people who lived in the early years. Funds collected from this movement is used to take care of social needs such as relief and rehabilitation operations, donations to orphanages, etc. This phenomenon shows that social participation can be elicited in solving many of the social problems. It also exhibits that traditional and modern private organizations can actively work together, through their social and public foundations, in building orphanages, homes for the aged, and others.

In Badung, social participation in the social sector is demonstrated through the assistance delivered by various groups for the homeless, handicaps, prostitutes, orphans, and the elderly. Assistance is made in two ways: One, by equipping and enhancing their skills that will prepare them to gain productive employment or will make them successful entrepreneurs, like making and selling of ornaments used in traditional ceremonies and celebrations; and two, by educational programs which augment formal, informal, applied, and religious learnings of the target clientele. The types of assistance enlarge the capacities and tap the potential of the least privileged sector to become productive members of the community.

Social participation in Bandung and Bali is rooted in conventional institutions namely, Banjar and traditional village. These institutions have proven their capabilities to mobilize the social energy of their populace in implementing government programs.

Education Sector

Social participation in education is shown through the establishment of private schools, from primary to tertiary levels. The data show there is a good number of private schools at all levels of education in Indonesia. Apparently, the government cannot manage to take care of the education of all children. Thus, private schools perform a very important role in answering the people's desire for education.

Operational funds of private schools come from various sources, usually in the form of donation and subsidy. It is important to note, however, that there exists a tendency among the business community to treat education as a profitable venture rather than a social service. Cognizant of this tendency, the government has taken various steps to curb this view.

The role of the central government in education is vital in as much as it decides solely on the content of the curricula while initiatives of private and local schools are limited to curricula implementation. Substantive social participation is expressed in combating illiteracy through local governments' self-organized educational programs oriented toward Working and Learning.

The program has two levels designed to approximate formal education in the elementary and junior high school. The first level, known as Program A, is equivalent to elementary formal education. It caters to the illiterates who are taught to read and write Indonesian language. This is done by combining formal classroom education and field study.

Program B corresponds to junior high school education. It is operationalized with the local government doing the essential functions of determining the venue of study, recruiting qualified tutors, and mobilizing other necessary resources. Both programs are largely financed by the central government.

The program intends to attract the most number of illiterates in the locality by making it accessible and convenient to them. Thus, the success of the program lies in the patronage and participation of the people which in turn is dependent on the sustained financial support of the government and creative implementation of the local government.

Health Sector

Social participation in the health sector is manifested in the establishment of private hospitals, adequacy of private clinics, availability of private physicians, and presence of pharmaceutical firms. As in the case of other countries, the role of the private sector in health care in Indonesia is significant.

Social participation, in general, has been encouraged for several reasons such as the promotion of religious, ethnic, and profit interests. Nevertheless, peoples' participation in health care is shown in family planning programs. *POSYANDU* is one such program organized by the people whose activities include the dissemination of information relative to family care, weighing of babies, immunization, and others.

As an outcome of the program, Bali was able to achieve a zero population growth in its area. Moreover, the people in both areas also maintain a health fund, the proceeds of which are communally used to address health problems. In addition, the presence of health cadres, trained by the Health Department as motivators and resource persons on health concerns, issues, and problems, cannot be underrated in the success of the program. In other words, the level of autonomy and exhibited initiative of the people in program implementation are necessary components in improving the health condition of the people.

Issues in Implementation

It has been stated that the administrative system of the government of Indonesia is operationalized through a decentralized manner. Under the provisions of the 1945 Constitution, the country has been divided into varying administrative areas with differentiated structures, forms and functions.

The spirit behind such mode of administrative arrangement was to create a conducive environment whereby regions can exercise and be guaranteed of their right to autonomy. Hence, the idea to democratize participation in decision making and provide greater opportunities for local governments to manage their own affairs are the underlying reasons for decentralization.

A general political will to realize the autonomy of regions was exhibited by the central government in the 1950s with the creation of a special committee, led by Mr. Wongsonegoro, tasked to examine the functions which the national government can transfer to local government units. This was in consonance with the provisions of Law no. 1, 1945, Law no. 2, 1948, and the Provisionary Constitution of 1950. One of the more important results of this endeavor was the transfer of educational and cultural functions to local units as explicated in Government Regulation no. 65, 1965.

During the "New Order" era, this political will was further strengthened with the issuance of Law No. 1, 1967 and later improved by Law No. 5,1974 concerning the basic tenets of local government. The law was made applicable with the issuance of Government Regulation No. 45,1992 which specifically placed the locus of regional autonomy at the Regency and Municipality level. This suggests that it took 18 years, after Law No. 5,1974, for the central government to decide on the real locus of regional autonomy.

Seemingly, the main factor that slowed down the realization of autonomy was the central government's perception on decentralization and regional autonomy. This was manifested by the reluctance of various ministerial offices to transfer rights and responsibilities to the local government.

One of the dominant views was that regional autonomy would mainly benefit the Ministry of Interior since the transfer of authority will only widen the spectrum of power of the ministry while control of the other ministries will be lessened. This perception was generally evident among the central government staff as well as the local government officials. The situation became more tenuous when the central government decided to pilot project the process of decentralization in 26 regencies and municipalities out of 303 in 27 provinces of Indonesia. The pilot project was meant to operationalize the autonomy concept based on Minister of Interior Decree No. 105,1994 and Government Regulation No. 8, 1995.

The regencies involved in the project were the following: North Aceh; Simalungun; Tanah Datar; Muara Enim; Central Lampung; Kampur; Batanghari; South Bengkulu; Bandung; Banyumas; Sleman; Sidoardjo; Kutai; Sambas; East Kotawaringin; Tanah Laut; Central Lombok; South Central Timor; Gowa; Minahasa; Donggala; Kendari; Bandung; Aleu; Central Maluku; and Sorong. The problem worsened when the central office of the Department of Education and Culture decided to withdraw the functions already transferred to the regional governments. Likewise, several other ministries were still very reluctant to devolve more powers to the local government. Among those which registered vehement reaction was the Ministry of Information and the Ministry of Religion.

In the attempt to unravel the why and wherefore of decentralization, one of the leading newspapers in Indonesia, KOMPAS, initiated a discussion on this matter. The forum revealed that the reluctance and apprehensions of central offices were related to the lack of full understanding and appreciation of autonomy. Concretely, the fear of central government officials was anchored on the issue of budget.

It was believed that with decentralization, local governments will divide among themselves the national financial resources apart from their own local sources of revenues which are solely utilized by them; thereby, depriving the national government of its main revenue source aside from the power and privilege that accrue from the exercise of centralized power.

In the following section, the different perceptions of three (3) social sector ministries relative to decentralization are illustrated further.

Difference in Perceptions

At the Department of Health, delegation of health affairs has been responded with different perceptions. These are related either to decentralization issue itself or the consequences of delegating authority within the organizational structure.

There is a viewpoint in Bali that if decentralization is implemented in the health sector, all health services will be done by the department at the provincial office (*dinas*) or level 2. Moreover, decentralization is perceived to give authority and opportunity to the regional office to develop and gain

independence in the delivery of health services in its own region and leave the central government inactive.

Nevertheless, decentralization must be seen in the context that regional offices are still part of the central government, therefore, not all health affairs can be delegated to the regional office. There are some health concerns that will remain to be under central jurisdiction while others will be assumed by the regional office. For instance, cure and prevention of diseases with national implications will continue to be under central control. And the regional office will be involved with basic and referral services.

This zoning has its consequences on the duties of territorial representative office (*kanwil*) and regional office. Matters that have been delegated to regional office will be taken by the provincial health office *(Dinas Kesehatan Daerah)*, while those which the health regency (*kanwil kesehatan*) can do will be its responsibility. The effective and efficient conduct of health affairs are highly dependent on how the head of provincial health office *(dinas kesehatan)* plays its role in the mobilization of staff members to address health questions.

The availability of financial resources is also an important factor in the effective delivery of health services. An informant stated that the major source of fund should come from its own income if the region intends to be autonomous. In the delegation of functions, due consideration should be taken on the capabilities of the region. Based on its capabilities, a regional office may decide which direction to take. In Bali, the provincial health office *dinas kesehatan* maximizes its responsibility. That is the reason why the problem which it faces is not related to its delegated responsibility but the necessary fund that must be generated to perform its task.

Furthermore, an informant believed that even if there is a perception that decentralization has a clear mandate in accordance with Law No. 5, 1974 and Government Regulation No. 45,1992, problems will still occur when it is implemented. It seems that when autonomy was designed, there was uncertainty about its impact on the limited fund and authority.

In West Java, difference in perception is caused by the terms being used in the provincial health office (*Dinas Kesehatan*) and territorial representative health office (*kanwil kesehatan*). For instance, terms such as PYMT *pejabat Yang Menjalankan Tugas* (acting officer on duty) and PGS *Pegawai Sementara* (temporary officer) raises questions about the difference in definitions. There are different perceptions about the consequences which might arise when autonomy is to be implemented. These perceptions especially relate to tasks that are to be transferred by the Ministry and those which shall remain under the jurisdiction of the Ministry. There is also a perception that placement and empowerment should be delegated to the regency because in the future, it will be the regency that is going to be the operational office of the central government.

These matters will have to be organized by regency health office (*dinas kesehatan*). This necessitates a sufficient number of health personnel in the regency to achieve its objectives. A concern is also expressed regarding assets that belong to the ministry after decentralization. A valid inquiry is made as to where ministerial offices assets can be transferred after their abolition.

Another perception concerns the position in the new organizational structure. If the department is to be integrated with the provincial office (*Dinas*), the question is which of the two will be maintained. Will it be the department officer or the provincial officer, since the dissolution of the department office will result in one office head. It is hoped that there will be a new layer of position in the provincial office.

In some cases, the head of department office and provincial office is the same person such as in Gianyar. In Bandung, the department has the same perception concerning its work as an implementor of policies

decided by regional office, considering that it is the representative of the Ministry. Department heads have doubts on what they would be in the future if decentralization is to be implemented.

They have a common perception about their provincial role as executives in the health sector. They perceive that if decentralization is to be implemented, they will gain wider authority either in planning or execution of tasks in the health sector. Delegation of functions has been perceived as a form of devolution of authority to manage financial affairs, infrastructure, personnel, and others. In Gianyar, there is a perception that department heads should be given a higher rank as a consequence of integrating departments and provincial offices.

In the Ministry of Education and Culture, there are still a number of different perceptions concerning decentralization at the regional as well as the central levels in spite of the fact that decentralization has been in effect for the past 24 years.

For instance, the Minister of Education and Culture, tried to take back powers delegated to the regional government on the argument that the low quality of elementary education was due to the inability of the regional government to administer it effectively. On the other hand, the regional government countered that the low quality of elementary school graduates has nothing to do with the regional governments ineffective management of the program but by the content of the curriculum which is the central government's sole responsibility.

Obviously , the underlying reason for the difference in perceptions can be attributed to conflicting and dialectically opposing interests between levels of government. Given that decentralization involves the transfer of funds and authority from one party to another, it is apparent that such transfer will consequently have an inimical effect on one party and benefit the other. The process is thus erroneously viewed as a zerosum game - the gain of one is a loss of the other.

In the Ministry of Social Affairs, the mechanisms of decentralization and autonomy are new, resulting in the difference of perception on the role to be performed by the key actors themselves.

In West Java, there is a perception that in order to implement decentralization optimally, the role of the governor, as the appointed official by the central government to direct the region, has to be differentiated from the role of the local leader elected by its constituents. The differentiation and separation of roles will henceforth lead towards the bifurcation of activities between those which have a national and local coverage.

There is another perception among regional officers about the execution of decentralization itself. It is viewed that decentralization as delegation between central and local governments is more of an instrument of regulation rather than a process of realizing the will of the regional government. Further, the existing perception of the community that programs of the Ministry of Social Welfare which take care of social problems are activities that waste money, has to be changed. This belief only weakens the position of Ministry and its office before the eyes of the community.

In Bali, perception on the implementation of decentralization focused on social welfare. This was related to the role of the head of the regency visàvis functions of the provincial and central governments in realizing the objectives of decentralization.

Attaining the goals of decentralization lies in the presence of qualified personnel, infrastructure support, and sufficiency of funding. Evidently, the absence of these three factors would make decentralization in the social welfare sector difficult.

The perennial problem of funding in the social welfare sector continues to stall the provision of essential welfare services in the community. In as much as an improved well-being of the people can only manifest after a sustained delivery of social welfare services, the inadequacy of funds to the program has made the sector ineffective. Thus, it has been a common perception that social welfare activities do not have a clear and concrete output. The effective sourcing of funds for the sector is observed to be a continuing quest.

Although there is evidence of different perceptions about effective and optimum implementation of decentralization and regional autonomy, there is no principal difference concerning the programs, except about those projects that often are not feasible under field conditions. This is shown by looking at the three of the indicators examined in this study, namely: equity, priority setting, and success indicator.

Priority Setting

Program priority setting in the Health Ministry is conducted by the local government at regency level, i.e., the provincial health office (*dinas kesehatan*). This is done based on urgent problems that need to be addressed immediately such as contagious diseases which would have an instantaneous impact on the community. Handling contagious diseases remains as top priority of the Ministry.

The immunization program for pregnant mothers or children below 5 years old is another priority program. During the National Immunization Week (*Pekan Imunisasi Nasional PIN*) in September and October 1995, 22,000,000 children below 5 years have been immunized. The program has been conducted to prevent children from being affected with communicable diseases.

These wo programs are national health priorities. Their implementation involve the participation of various institutions, both national and international. The programs are also integrated with other programs such as family planning (*keluarga berencana*). Aside from these, priority also is given to programs such as environmental health. The setting of priority is also based on the availability of funds and presence of infrastructure support. These are imperative to secure their successful implementation.

At the Ministry of Education and Culture, efforts have been geared towards the promotion of educational infrastructures, apart from the continuous dissemination of information on the importance of higher education. Nonetheless, emphasis has been placed on the provision of elementary education otherwise known as compulsory education (*wajib belajar*) at the elementary level for children aged 9. Today, priority has been expanded to include the junior high school (SLTP). These have been decided by the central government.

Although the regional government does not have the full knowledge on how priorities are decided and plans formulated, it is adept in executing practically every national program designed by the central authorities especially in solving unforeseen problems that occur in the process of implementation.

The priority given to elementary education also includes package programs for elementary school dropouts and those who failed to pursue their studies in junior high school (SMP). This is done by regular home visits of teachers and tutors to students in the evening, as most dropouts work in day time assisting their parents, and bring education closer to them. Most beneficiaries of the program are sons and daughters of the rural folk.

In West Java, the provincial government has instructed all second level local governments to locate and investigate the reasons of elementary dropouts, elementary graduates who failed to continue their education at the junior high school, and junior high school dropouts who withdrew from school. This

was in line with the government's open junior high school program designed to provide poor students with greater access to education.

Priority setting in the Social Service Ministry (*Department Social*) is regarded as an important aspect in the process of social welfare development. Among the priorities include proper program financing. This intends to achieve welfare goals optimally at the least cost.

In West Java, decentralization of social welfare entails due attention to the following priority concerns: enhancing the competence of human resource; decreasing the number of personnel in regency offices; increasing opportunities for career advancement of staff; and providing advanced education for officers in the regency's social service office.

In Bali, priorities include the urgency to reach out poor families living outside of identified poverty areas under the IDT program, and attend to the welfare of disadvantaged people specifically the homeless, beggars, and prostitutes. Unless their problems are addressed, they cannot be prevented from doing mischievous acts detrimental to the society. As a tourism area, the malfeasance of these people must be prohibited.

Mechanism and Implementation of Plan

The implementation of decentralized program in the health sector requires cross sectoral coordination, e.g., Regency Office of Department of Health (*Kandep Kesehatan*), the Provincial Office of Health (*Dinas Kesehatan*), Department of Public Works (*Department Pekerjaan Umum*), Department of Social Affairs (*Department Sosial*). In West Java, coordination is done by the Regional Regulation Office (Regional Regulation). On the other hand, the Regional Profiles Representative Council Level II (*DPRD Tk. II*) has authorized *Peraturan Daerah* , through a legislative act, to coordinate the implementation of various programs of government institutions.

Besides, the most important area that should be given attention is the coordination between Provincial Office of Health (*Dinas Kesehatan*) and Territorial Office of the Department of Health (*Kanwil Departemen Kesehatan*). The governor, as Head of Provincial Territory and Representative of the Central Government is responsible in coordinating the activities of these two (2) institutions.

In line with the implementation of decentralization that results in a change of organizational structures, a closer definition of the scope of authority between echelons of government institutions must be made. Currently, the authority and powers of the various echelons are yet to be stipulated.

Under the law, the head of the Territorial Office (*Kanwil*) and head of the Provincial Office (*Dinas*) correspond to Echelon II A and Echelon II B respectively. *Kanwil* is responsible in providing guidance and control to the provincial office while the *Dinas* is tasked to perform operational activities relative to the needs of the province.

In the health sector, financing of decentralized programs, consisting of 19 activities is coordinated with the Board of the Regional Development Planning (*BAPPEDA*). All project proposals which require funding support have to be consulted and approved by *BAPPEDA*.

With regard to the education sector, coordination and planning are highly centralized and the mechanism of decentralization follows a topdown approach. The decentralization of education to the local government (*Pemda*) is done only once the central government is convinced that *Pemda* can effectively accomplish the assigned jobs. In the event that *Pemda* is unable to fulfill its responsibilities, the powers entrusted to it is automatically revoked.

Implementation of decentralized activities and projects in the health sector is currently being undertaken by the Local Government II. This includes the Integrated Project which provides health and nutrition services to mothers and children as well as services to *Puskesmas*. Projects under financial support of the *APBD Tk.I* (Provincial Budget) are handled by regencies or municipalities. However, supervision remains to be the responsibility of the Provincial Government, especially infrastructure projects like construction of local hospitals.

Depressed areas in regencies or municipalities which do not have the capability to mobilize financial resources or have no access to sources of funds are assisted to respond to their health problems. Projects financed by the central government, i.e., *Inpres of Medicines*, managed by the regency or municipality are placed in least developed areas. A bigger portion of the *APBD Tk.I* is likewise allocated to these areas.

In the educational sector, resources are categorized into two: financial and material, and human. Human resources are mobilized in all levels of education especially educational personnel (teachers). In elementary schools (primary level of education), teachers are tapped to undertake activities required under Program Package A.

In junior high schools, public school teachers render additional services in private schools usually beyond the normal working hours. This is more frequently done in senior high schools as the needs are greater compared to junior high schools. This indicates that teachers, as human resources, are maximally utilized. The mushrooming of private schools, further signifies the existence of an ample supply of human resources.

On financial and material resources, elementary schools remain to be highly dependent on the subsidy given by the central government. For instance, Program Packages A and B are substantially financed by the central government through the Regional Office of Education and Culture Department.

Secondary schools, on the other hand, have other sources of finances apart from the contribution of the central government. The community and parents, through the contribution for educational program (SPP) and Participation of Students Parents (BP3) respectively, assist in shouldering the costs of education. In private secondary schools, government financial aids constitute less than the major source of funds. In fact, costs incurred in the administration of final examinations (*Ebtanas*) and accreditation are drawn from schools own coffer.

Although the principle of deconcentration has dominated the educational sector, the mobilization and participation of the community in defraying of the costs involved, especially at the higher level, indicates the value placed on the education of children.

In the social welfare sector, the mobilization of resources - both human and financial - is a significant factor in ensuring the success of social welfare programs, projects, and activities at the community level. In West Java, social welfare programs are carried out with the financial support from the central government and resources from cooperating local government agencies and private institutions.

Human resources are mobilized through staff and personnel development specifically dealing with methodologies in solving social welfare problems under the context of decentralization and autonomy. Enhancing their capabilities and tapping their potential to render social welfare services are measures that will prepare them to assume greater tasks in the event that social welfare functions are fully decentralized to the local units.

In Bali, mobilization of resources takes into account, among other things, the following:

- a. Central and local officials should possess high managerial quality and integrity in performing their duties;

  b. Performance of activities must be within the allocated budget which must be well accounted for, while funds procured from the community must be able to sustain development;

  c. Ability of community to play important role in planning and implementation of development programs; and

  d. Bureaucracy and administration of development programs should be simple and practical so that the bureaucratic and administrative impediments could be reduced to its minimum.

In addition, the presence of foreign aid for social welfare should be best utilized without precluding aids coming from community, private sectors, and other parties.

Structural Relations

The decentralization of the health sector to the Local Government Level II (regency or municipality) will consequently affect the existing organizational structure of the local government. The deconcentration of the health sector will result in the abolition of the *Kandep Kesehatan* (Regency Office of the Health Department) and restructuring of the *Dinas Kesehatan* (Health Office under the Regent or Mayor) in accordance with its new functions and duties.

Insofar as the status of deconcentration in the health sector is concerned, there is a difference between West Java and Bali. In West Java, all regencies and municipalities fully absorb the functions of the health sector. While in Bali, full deconcentration is only operationalized in some regencies and municipalities such as Denpasar, Badung, and Gianyar.

Following the policy of deconcentration, the new structure *Dinas* has long been legitimized through *Perda* (Local Regulation). Nonetheless, the application of the structure at the local government level can either follow the designed maximum or minimum utilization pattern. For research, the maximum utilization grid has been applied to determine all possible problems that might arise in the course of implementing the concept of deconcentration.

However, the application of the maximum pattern of organizational structure at the local government must be approved by the Regional Peoples' Representatives Council (DPRD). It is to be noted that a structural change of the *Dinas Kesehatan* is coupled with administrative problems in relation to echelon, structural position, and rank. For instance, employees of PB1 and PB2 (employees from the central government assigned in *Dinas Kesehatan*) are at a loss what will happen to them under the policy of decentralization. The restructuring of the *Dinas Kesehatan*, nevertheless, has not altered the structural relationship between and among other *Dinas*. The same relationship exists among *Dinas Kesehatan Tk. II* (in regency territory), *Dinas Kesehatan Tk. I* (in provincial territory), and Territorial Office of Health Department and so does the relation between *Dinas Kesehatan Tk. II* and other *Dinas Tk. II* in the territory. In terms of implementation, decentralization is still coordinated with the same parties in regency territory.

In education, decentralization strongly influences the vertical and horizontal structural relation. Decentralized activities are intricately linked with the function of the responsible department, e.g. provision of elementary school teachers. Required school teachers are initially proposed by *Dinas*

Pendidikan Dasar Tk. II (Office of Primary Education in Regency or Municipality Territory) to *Dinas Tk. I* (Provincial Office of Education). *Dinas Tk. I* in turn passes the proposal to the Regional Office of Education Department which endorses it to the Minister of Education and Culture. In the event that the proposal is approved on the strength of its justification and on the basis of available funds, the decision is communicated with *Dinas Tk. I.* Finally, the number of approved teachers will be posted and assigned by the Head of *Dinas Tk. II* on behalf of the Governor or Regent.

Although the structural relation often creates some points of coordination, it is also susceptible to problems. For instance, the concern of the community in West Java and Bali on the inadequacy of teachers is sometimes contested by the Head of the Regional Office of Education and Culture who points out that there are enough teachers in the area simply because *Dinas Pendidikan* reports that there are sufficient numbers. The fact remains that there are less than enough teachers given the demands of the people. According to the Head of Territorial Office of Education and Culture Department, the lack of teachers is caused by their unequal distribution.

However, in terms of educational infrastructures, the relationship between horizontal and vertical institutions is more congruous rather than contentious. As a result of a more amiable relationship, significant contribution is made in planning, implementing, and evaluating infrastructurebased projects (e.g. school building). This is manifested in a relatively fair distribution of schools to the level of *kelurahan* or *desa* (village).

Decentralization in the social welfare sector is done by the different tiers of local government in an integrative and collaborative fashion. Implementation is carried out at the provincial, regency, and municipal levels in an orchestrated manner with the local chief executives at each tier - Governor, Regent, and Mayor - directing and managing the actual social welfare operation in their respective political jurisdiction. Although the local chief executive is directly responsible in implementing social welfare activities in his locality, this does not preclude one from collaborating and complementing with other chief executives in order to engender a more comprehensive and holistic approach in social development.

In West Java, as per information gathered, structural linkage is intricately intertwined with the authorities in several levels of local government. Moreover, decentralized activities are integrated and coordinated at the central or regional office of Social Service Department (*Kawil Sosial*) and vertically linked with the local office or Provincial Social Office (*Dinas Sosial Propinsi*).

Meanwhile, in Bali, structural linkage among authorities is integrated and interconnected. Thus, activities in social welfare concerning planning, implementation, reporting, monitoring, and evaluating follow a common framework and attuned towards a single direction. It is hoped that through this closely knitted structural relation, any possible misinformation and miscommunication between and among authorities would be reduced to the minimum.

Bureaucratic Culture

Bureaucratic culture affects and influences the implementation of the decentralization program. In West Java, it is exhibited through paternalism. Paternalism in bureaucracy is demonstrated through uncritical if not blind obedience to the desires of a superior. It places undue importance on the superior's status and carries the notion that a superior is all-knowing and infallible. This belief practically made superiors little kings in their own organization.

Paternalism has also affected the subordinates in the performance of their job. They become highly dependent on superiors orders, lose initiative, and independence of mind, work only whenever a superior

is around, and make reports to satisfy the superior or say something which the superior wants to hear. This behavior has its roots from an Indonesian tradition which views that higher authorities have the sole power to make decisions. Hence, the relationship between a subordinate and a superior is similar to that of a lord and a vassal.

Apparently, paternalism has obstructed the acceleration of service delivery in the community. In Bali, an attempt has been made to check the prevailing bureaucratic culture of paternalism. An alternative working culture has been put into test in order to invigorate the health service environment. The list of a new belief system is herewith stated:

- 1. Not to underestimate no matter how small the problem is;
  2. Not to blame other people;
  3. Serve the people well especially those in need;
  4. Respect other people;
  5. Speak with fact and responsibility;
  6. Start with important things;
  7. Use working custom controlling system in any line of duty;
  8. A better working quality could be achieved by togetherness, openness, mutual cooperation and harmony;
  9. The weight of each member to hold is equal; and
  10. Positive and creative behavior motivate satisfying and exciting working environment.

Besides, health service has a customary vision expected to be valuable in the health service environment in an effort to provide better community service. The vision is: With the group spirit working, better human resources/working process/working results will be achieved.

While the bureaucratic system often influences either positively or negatively the social service system, it is also influenced by the existing sociocultural system which in turn affects the behavior of a social service officer. Therefore, the relationship between the bureaucratic system and sociocultural system is dialectical.

Concretely, a negative or positive effect on the bureaucratic system or sociocultural system has an impact on the performance of the individual bureaucrat. An improper or negative bureaucratic culture could decrease the efficiency and effectiveness of the social service officer and a positive or proper bureaucratic cultural system could enhance one's performance.

The presence of a strong paternalistic behavior decreases work motivation and performance. This is shown whenever there is new policy. The policy will not be carried out without a guidance of a higher authority. As a consequence of such bureaucratic culture, officers often do their routine jobs without trying to seek new ways of doing things. Likewise, officers with strong paternalistic culture, expect to be served by the community.

The above mentioned situation strongly occurs in West Java in the course of the study. For instance, an interview with the Head of the Territorial Education Office at the regency level had been scheduled after all the necessary requisites have been complied with. However, the interview cannot proceed unless the Head of the Provincial Office of Education is interviewed first.

Another instance is when the interviewer asked about education policy and decentralization process. The informant stated that all policies were to be made by the higher ranking official, and all that they could do was accept what had been decided by their superior. In contrast, in Bali, bureaucracy tends to support decentralization. Community's daily activities tend to have greater autonomy in terms of solving

problems, starting from planning, execution, funding and evaluation. All these are done at the lowest rank community (Banjar).

This was made possible through the initiative of social service officers to innovate when solving problems. The culture of independence, creativity, and initiative have become the working guideposts among officers in Bali, which makes it the only region in Indonesia a showcase of authority at provincial level.

In Bali, community's sociocultural system, with its custom and religion, influences bureaucratic culture. It influences the performance of social welfare decentralization . Bali's sociocultural system ostensibly is responsible in bringing about a strong and stable social structure.

Equity

In the health sector, equity is promoted by making its services and facilities more accessible to the people. This is done not only by increasing the number of health services and facilities but also having them available in a fairly extensive area. The Department of Health advances the goal of equity in two ways: one, by increasing its facilities such as *Puskesmas* (Community Health Centers, Auxiliary *Puskesmas*, Mobile Hospitals, and others) and medical personnel, and two, by bringing them closer to the communities which need them most.

It was found out that local governments have performed their job well in promoting equity in health. Although there are still problems regarding the distribution of health facilities, it is safe to conclude that medical facilities and infrastructures as well as health personnel are nearly adequate to attend to the health needs of the people.

The health situation is depicted by the following data:

In Bandung regency, in 1993, the ratio between the number of *Puskesmas* and subdistricts was 2.43 which means that for every subdistrict, there are almost two and a half *Puskesmas*. Meanwhile, the ratio of the number of *Puskesmas* for every 100,000 citizens in the same year was 33,644 (Bandung Regency Health Profile, 1994), which means that for every 33,644 citizens, there is one (1) *Puskesmas* available. The number almost met the national standard that for every 30,000 citizens, one (1) *Puskesmas* should be available. The same condition can be found in other regions of the research area.

It was also found that the ratio between the number of *Puskesmas* and auxiliary *Puskesmas* at the regency level in Bandung in 1993 was 1 : 0.89, this means that there was almost one to one correspondence between *Puskesmas* and Auxiliary *Puskesmas*. An interview with an informant disclosed that there is a tendency that the number of Auxiliary *Puskesmas* are being reduced since Auxiliary *Puskesmas* are gradually upgraded to Puskesmas.

Also in the same year, Bandung Regency which has eight (8) hospitals had a ratio of 29.93 hospital beds for every 100,000 citizens (Bandung Regency Health Profile, 1994) or an average of 42 beds in each hospital.

At the village level, a new approach was developed to promote the distribution of the health services. This was known as *Pos Pelayanan Terpadu* or *Posyandu* (Post for integrated services) *Posyandu* is also viewed as a forum where the community identifies its role in the health sector. The establishment of *Posyandu* has been done by *Puskesmas* in the *Posyandu* territory. In 1993, Bandung Regency had about 4,686 *Posyandu* which means that one *Puskesmas* was able to establish 47 *Posyandu*. Other *Posyandu* were also found in other regions of the research area.

In an interview with an informant, it was found out that other forms of health facilities and services were made available. There were initiatives by the private sector. In 1993, the regency of Bandung had 156 private health services, 279 private practicing doctors and 56 drug stores (see Bandung Regency Health Profile 1994). The emergence of private medical initiatives show that community participation in the health sector has been relatively high.

In terms of medical personnel, e.g., paramedics, nurses and auxiliary workers, Bandung regency has 2,423 in 1993. Out of the total, 49.23% are in *Puskesmas*, 33.43% in hospitals, and 17.33% in other health units. Their distribution in *Puskesmas* has the ratio of 1.74 for medical personnel, 5.83 for non-medical personnel, and 11.92 for paramedics personnel (Bandung Regency Health Profile 1994).

Furthermore, the ratio of medical doctors to 100,000 citizen in Bandung regency was 7.84; paramedics to 100,000 citizen was 2,423; non medical staff to 100,000 citizen was 41,49 (Bandung Regency Health Profile 1994). The data indicate that there is an average of 1 to 2 medical personnel for each *Puskesmas*; 2 paramedic personnel; and 5 to 6 non-medical personnel. In other words, there are 17 to 18 health personnel in every *Puskesmas*.

In the field of education, more educational facilities were provided in terms of elementary schools especially after the President Instruction (Inpres) was issued in 1969. On the average, there are about 2 to 3 elementary schools in every village.

Apart from elementary schools, junior high schools (SLP) also increased. In West Java, there is one junior high school for every two subdistricts. In Bali, there is one in every subdistrict level. On the other hand, there are roughly two Senior high schools at the district (*Kecamatan*) level.

In tertiary education, there is at least one university in every province but there is not enough state universities accessible to the people. In the attempt to equalize educational opportunities at the tertiary level, the government enforced two major policies. The first one widens the opportunity for students, especially those coming from poor families, to avail of college education through the merit system. This means that a student qualifies to enter a State College or University only upon passing a nationwide entrance examination (*Ujian Masuk Perguruan Tinggi* UMPTN) administered by the government.

The second policy was the establishment of governmentsponsored Open Universities. The intention behind the OpenUniversity concept is to accommodate students, regardless of family income and intellectual capacity, interested in pursuing higher education after receiving their secondary education.

Moreover, other educational programs that cater to the needs of people who are physically handicapped and materially deprived were created. Their sorry state does not disqualify them of educational opportunities and live at par with those who are more fortunate in life.

For the physically disabled and handicapped, extraordinary schools were established (*Sekolah Luar Biasa* or SLB). Similarly, students who dropped out from school due to economic and financial reasons and the elderly who cannot cope up with the demands and rigors of regular education due to their age can still benefit from the following programs: illiteracy (*buta huruf*); basic knowledge (*buta pengetahuan umum*); and Indonesian language (*buta hahasa Indonesia*).

These programs are divided into three levels or packages which correspond to the levels of school in formal education package A, elementary level; package B, junior high school; and package C, senior high school. Target age group bracket for the said programs is 1344 years.

In West Java, equity in social development is promoted by the Social Service Department by enhancing community participation. The strategy is embodied in its background village concept promulgated under President Instruction on Background Village Program (*Impres Desa Tertinggal* IDT). IDT is designed to stimulate the participation of the people in community development and enjoined their contribution in eliminating poverty. It is contended that poverty must be addressed where it begins and people are the major instruments in curbing its spread.

In Bali, equal distribution of social welfare services has long been conducted by the Social Service Department through its various programs. Oftentimes it is done in cooperation, collaboration, and complementation with the community especially in relief and rehabilitation operations during and after natural disasters and catastrophes.

Community participation is also realized through the involvement of the people in development meetings (*Rapat Koordinassi Pembangunan or Rakorbang)*. Meetings at the subdistrict level are conducted by the Regency Social Officer (*Petugas Kecamatan Sosial* or PKS) and Community Social Officer (*Petugas Social Masyarakat* or PSM). Apparently, a bottomup approach in social development has been proven effective in advancing the goal of equity.

Participation

Community participation has been one of the important aspects in the decentralization of the health sector, without which the program objectives of the sector could not have been realized.

Community participation manifests itself in different forms. In Bali, participation is evidenced by the presence of peoplebased organizations raising funds out of voluntary contributions from affluent members of the community: an example is the Health Fund Foundation for All People of Banjar. It was first established in Tabanan in 1978 and spread in other regions of Bali. The organization sprung out of the need to help poor families defray the cost of medical expenses.

Another is the movement of PKK encouraging the people to use indigenous medicines rather than commercial ones. This was done by setting up a drug store which dispenses herbal medicines. The operation of the drug store was sustained by encouraging the people to raise medicinal plants in their backyards. This does not only reduce the cost of medical expenditures but also developed self-reliance among the people in the use of traditional medicines.

Furthermore, in Bali, there is a strong tendency among the people to seek medical advice and assistance from nongovernmental organizations' health personnel and facilities apart from the confidence they entrust to private medical specialists concerning their problems on health. It was also observed that people in Banjar and Seke are actively and deeply engaged in activities that are directly and indirectly related to health care issues.

Community participation likewise manifests in the form of involvement of *Posyandu* (Point of Integrated Health Services) cadres in health activities in West Java. *Posyandu* active cadres increased from 16,941 in 1992 to 21,725 in 1993, yielding a ratio of 2.7 per 100 families in 1992 and 4.7 in 1993 (West Java Health Profile, 1993). This ratio indicates the level of people's involvement in health service. This means that as the ratio between cadre and family increases, the higher the level of people's participation.

Community participation can also be appraised by the number of visits the people made to *Posyandu*. In 1991, there have been 38,745 visits to *Posyandu* on a daily basis in West Java. In 1992, the number increased to 47,852 (West Java Health Profile 1993). As an informant stated, the increase in the number

of visits by community members has to do with the influence of religious and community leaders who act as role models for the community. In West Java, community participation in art activities such as *Rareongan Sarumpi* is used to raise funds to finance *Posyandu* activities. Each family contributes Rp. 1,000 out of which 10% were used to defray the cost included in collection; 15% as contribution when someone dies; another 15% for general common health; and 65% for RW savings.

In the field of education, the government allows wider participation of the community. Both informal or nonformal education offer not only skill and language courses to the community but also religious (*pesantren*). As per 1990 records, West Java has 2,782 Muslim education centers (*Pondok Pesantren*) with 10,887 teachers and spiritual leaders serving 408,316 students.

Muslim Education Center (*Pesantren*) differs from Muslim schools Madrasah. Madrasah is a formal school with 3 levels of education, *itidaiyah* (elementary), *tsanawiyah* (Junior high), and *Aliyah* (Senior high). There are also stateowned Madrasah under the department of Religion Affairs apart from private institutions. Community participation is also evident in kindergarten schools. In 1990/91, West Java had 5 state kindergarten schools with 29 teachers and 589 children and a large number of private kindergarten institutions at 2,946 having 8,970 teachers and 124,201 children.

In the formal education sector, stateowned schools at the elementary level dominate compared to junior and senior high school levels. This is shown by the table below:

Comparison between State schools and Private schools.

Indonesia, 1995

Level	State	Private
Elementary	24,146	478
Junior High	827	1,494
Senior High	233	741

At the university level, West Java has four (4) universities managed jointly by the Department of Education and Culture and the Department of Religious Affairs. There are also several other universities and academies that are administered by other departments such as the Department of Industry, Department of Health, Department of Public Works (DPU), and the Department of Tourism, Post and Telecommunication. In addition to these state institutions, there are 75 private schools consisting of 19 universities, 17 academies, 3 institutes, and 36 colleges.

In the social welfare sector, community participation is imperative. In West Java, decentralization of social welfare is manifested in the activity called *Rereong Sarumpi* where the community is encouraged to finance community programs of social welfare. *Rereong Sarumpi* is a scheme which generates funds from households to support a project intended for the poor. The fund is managed and utilized by the people themselves for socioeconomic programs directly assisting the lot of the least privileged members of the community. To date, the program which was carried out for several months involves *Kampung* Improvement, environmental improvement, and financial assistance for the health and education of children from poor families.

In Bali, community participation in development projects is operationalized in its traditional institutions called *Banjar dan Desa Adat*. The institution is conventionally a religious activity but is effectively used to mobilize the participation of the entire community to promote social justice.

In the celebration of National Solidarity Day (*Hari Kkesetiakawanan Sosial Nasional*), the territorial office of Social Affairs in the province of Bali rallied the people to financially assist the government in its housing improvement program for the slum areas. This stimulated the community to raise funds through private sector contributions and resulted in the completion of six (6) social welfare projects.

The experience discloses that with active community participation, financial problems can be overcome. The experience further reveals that community problems relative to social welfare can be resolved by mobilizing not only financial resources but human resources. In fact, funds can easily come in once the initiatives of the people are set free. Apparently, the model of people's participation in Bali can be replicated in other regions.

Assessment Indicator

Department of Health. According to the Department of Health, achievement indicators on the implementation of decentralization programs can vary. An informant says that one of the indicators is the proper provision of health infrastructures and facilities. The presence and accessibility of these to the people would precipitate the success of health service in the community.

Another is financial self-sufficiency. This means that the success of decentralization rests also in the ability of the community to bear the costs of health service without or minimal central government subsidy or financial assistance. Thus, the Municipal or Regency Office of Health must provide sufficient fund to finance the implementation of activities in the health sector.

Moreover, the commitment of local government officers to eradicate prevalent, especially contagious diseases in the community will also determine the success of the decentralization program. Further, close coordination between the officers and community members to address problems in local health constitutes a significant factor in achieving positive results. The combat of contagious disease in the community through preventive or curative action relies on health committed and dedicated officials.

Finally, the decrease of birth rate, mortality rate of mothers and babies, and increase of life expectancy indicate that the success in decentralization program has been achieved.

Department of Culture and Education. The achievement indicator on the implementation of the educational program is related to two (2) aspects, namely: process and output. Process refers to the manner in which programs are implemented to provide better educational service. Hence, it concerns the system of human resource improvement. On the other hand, output refers to the quality of the educational system's end product the students. A student is appraised not only on the basis of one's theoretical knowledge but also on the relevance of knowledge and skills in understanding society and solving its problems.

Regarding the process, development and improvement of the education system do not constitute an achievement indicator in decentralization in as much as the system is designed by the central government. This can also be applied to the quality of human resources. In contrast, the provision of education at the primary level (elementary school) is made through the local government. Therefore, assessing the delivery of service in education under decentralization necessitates an appraisal of the achievement of local officials (or employees) in providing services in the primary education sector.

Taking this into account, the central government's preparation of local government officials to implement the nineyear compulsory education program in West Java has indicated positive effects.

Regarding the output, the results are encouraging. This refers to the achievement of government officials in bringing dropout back to school, and inspiring them to continue their education at the higher level Junior High School of *Kejar Paket* B (Package B Program). The efforts have positive effects to date.

Department of Social Welfare. Assessment indicators in social welfare remain to be developed. These must be relevant to the achievement of program in the areas of planning, implementation, utilization of fund, manpower mobilization, and most important is the gains achieved by target clientele. Achievement indicators among other things, can be identified with the assistance and collaboration of program beneficiaries as well as funding institutions.

In West Java, achievement indicators may be determined by three (3) factors involved in implementing social welfare programs, namely: human resources; mechanisms and support system, and finance. In Bali, an achievement indicator may be related to the nature and character of community participation in implementing social welfare activities. It must be noted that the success of programmes initiated by the Provincial Office of Social Affairs in Bali was a result of continuous community support. This was done because of the active participation of the community in various stages of program development planning, implementation, and evaluation.

Thus, the achievement indicators of social welfare activities cannot be viewed only from the planning perspective of implementation. Evaluating the success of the program emanates from two (2) sides before decentralization and local autonomy can be effectively assessed.

Chapter 5

Conclusions

Perception about decentralization in the social sector

Within the three sectors encompassing education, health, and social affairs, equity of the services rendered by the authorities is quite adequate. Although there is a difference in perception, specifically about the task and obligations of the two different institutions, namely, the Regional Office of the Department and the Provincial Office of each sector, their efforts to ensure equity of services and coordinate the implementation of programs are clearly considered.

In the educational sector, the need to equitably distribute services is procured through the provision of educational facilities, financial support and development of human resources. With regard to the field of coordination, especially between the Regional and Provincial Office, overlapping and duplication of functions have been minimized. However, the integration of local culture within the national curriculum must be considered.

In the health sector, the provision of community health facilities is a clear indication that equitable distribution of health services is being advanced. This includes the establishment of *Puskesmas* (Community Health Centers) in each district, village, and other remote areas. Likewise, the continued increase of qualified medical personnel and their deployment in various depressed areas reinforce the political will of the government to seriously address the health problems of the poor.

There are differences in perceptions among authorities between the roles and functions of the regional office and Provincial Health Office. This has not affected the delivery of health services. Nonetheless, the differences in viewpoint are being ironed out through a series of meetings by both offices. The purpose of the meeting is to see that health planning is undertaken by the Regional Office in conformity with local problems and policy implementation is effectively and efficiently done by the Provincial Office.

In the social welfare sector, services being provided by the Regional and Provincial Offices are perceived differently. The provision of services, mandated by the national policy, implemented by the Regional Office are generally felt not very useful in responding to community problems in the provinces. Meanwhile, provincial programs carried out by Provincial Office run too slow as they are beset with administrative problems in as much as implementation has to be cleared with the central authorities and feasibility of projects approved to ensure their uniformity with the national program and policy.

Moreover, there exists a deep concern among officials in the region about the possible dissolution of the Regional Office and Kandep which may affect programs currently being undertaken.

Priorities of Program Implementation

There exists a difference between the provincial and central government in terms of priorities in the educational sector. Evidently, both levels of government consider different factors in identifying priority concerns. However, the fact that provinces are authorized to determine their priorities indicates that they are considered to be capable of conducting several programs by themselves in their own areas, as well as capable of securing funds for educational purposes.

Equity in education is expressed through the establishment of a large number of SD *Inpres* (Primary School by Presidential Instruction) throughout the country, especially in remote villages. This resulted in the increase of number of literate and reduction of illiterates.

This was followed by the Nine Year Compulsory Education program a rationally conceived program implemented by qualified provinces. Qualification is evaluated based on the technical and financial capability. Another is a program known as *Paket Bekerja Sambil Belajar* A & B (Learning while Working Packages A & B) or *Kejar Paket* A and *Kejar Paket* B. The program is intended to combat illiteracy among adults. For those who dropped out from the school but still within the maximum allowable school age, an educational program matched to the level of primary and junior high school is provided. The programs called *Pendi Dikan Kelas Jauh* (Distant Classroom Education) and *SD Pamong* (Rural Primary Education, are meant to cope up with the primary education problem.

Despite the existence of a national planning body tasked to carry out uniform and regular programs throughout the country, the pressing problems and concerns in local communities compelled provincial and regency authorities to divert from national health issues and set their own priorities.

For instance, priority programs such as Family Planning, Polio Immunization, Tuberculosis Combat and Family Nutrition Improvement have been determined nationally. Yet, local condition requires other priorities such as combating contagious diseases, coping with diarrhea, health service in areas vulnerable to natural disaster, enhancement of mother and child health, etc. Meanwhile, efforts to engage community participation in developing health services reflective of the local condition is considered a priority in the provincial or local area.

The research findings indicate that the development of selfhelp in the field of health such as *Posyandu* (Integrated Health Service Station), *Usaha Peningkatan Gizi Keluarga* (Improvement of Family Nutrition Service), *Pos KB Desa* (Village Family Planning Station) and *Posbankes* have positive outcomes regarding the improvement of health of families and village community.

Program priorities implemented in the social welfare sector involve financial and social assistance to special groups such as poor families, the aged, homeless, and beggars. For the special groups, priorities have been placed on the development of models and techniques of problem solving.

For example, the Banjar and Desa Adat institution in Bali was utilized to improve role performance. In West Java, the attitude towards mutual help and cooperation was enhanced through the establishment of the *Rariungan Sarumpi* institution. The activities of these indigenous and traditional institutions are directed to realize autonomy in the implementation of the government's program.

Planning and Implementation Mechanism

The planning of education is carried out nationally and its character is centralized, specifically in the area of curriculum development and system of instruction. However, modification and choices of priorities regarding some programs are allowed in the provinces provided that these are within the framework of the national education system. Therefore, the Regional Office plans the educational development program based on the regional conditions and the national needs, while the provincial office implements it based on the conditions, needs, interests, and the preparedness of the region.

In the field of health, cross sectoral coordination between the Regency's authorities and Regional House of Representatives (DPRD *Tingkat II*) facilitates the creation of *Peraturan Daerah* (Regional Regulations). This is in anticipation of the coordination that may be needed between *Kandep Kesehatan Kabupaten* (Regency Office of the Department of Health) and *Dinas Kesehatan Kabupaten* (Regency

Office of Health of the Province) to effectively implement program priorities in the field. The existence of this cross sectoral coordination indicates that there is an effort to bridge the relational gap between the planning stage at the central level and the implementation stage at the regional level.

In the social welfare sector, the mechanism of planning and implementation starts from the bottom. The Regency Office of Social Welfare makes plans on social services for the regency and proposes it to the Provincial Office for approval and appropriate funding. Meanwhile, the Regional Office of the Department of Social Welfare proposes a national plan in social services which is to be implemented in the region. The existence of these two models of program panning and implementation shows that there is a tendency that both plans can be implemented simultaneously. However, funding for each plan is considered differentially. The mechanism, in effect, clarifies the implementation of program priorities.

Mobilization of Resources

Decentralization in the sector of education regarding mobilization of human as well as physical resources signifies that nongovernmental organizations play an important role in the implementation of the national educational plan.

As far as provision of physical educational facilities is concerned, the role of nongovernment organization is recognized. Nonetheless, this is not the case in curriculum development as the design and content of curricula are decided by the national government. Efforts to improve the quality and quantity of human resources are being done by both government as well as nongovernmental institutions. The establishment of the Open University which provides opportunity for school teachers and public servants to improve their craft and enlarge their capacity is an example of the government's role in the education sector.

Finally, decentralization in education promotes a responsive and relevant program based on the needs of each region, specifically enhancing technical skills of people.

In the health sector, an increase of physical facilities as well as human resources is shown. The provision of medical doctors at the district level, employment of medical specialists for the *Puskesmas*, and modernization of facilities are a few examples. The improvement of the quality of the 'dukun' (traditional medicine man) and utilization of traditional herbs for treating illnesses and diseases are consequences of better medical education and skills as well as advancement of science and technology.

Some forms of deregulation in the health sector and realization of decentralization, can be mentioned: (1) the increase in number of private hospitals; and (2) improvement of the quality of health services offered in government hospitals known as *Puman Sakit Swadana* (Selfsufficient Hospitals).

The Social Welfare sector exerts efforts to increase the involvement of community or nongovernmental institutions in various social services activities. The existence of several private foundations supporting orphans, elderly, handicapped, homeless and vagrants, juvenile delinquents and prostitutes are some examples of services provided by communitybased agencies. Meanwhile, treatment of victims of natural disasters, settlements of refugees, and other forms of services continue to be the concern of the government measures.

Structural Linkages

At the beginning of decentralization, it is felt that there is dualism in the structure of programs in the field of education, health and social welfare. The fact that the Regional Office of the Department in the Province and the *Kandep* in the Regency remain in place together with the Provincial Section in the

Province and its offices in the Regencies and Districts, with respective functions, indicates the existence of a structural dualism. Despite the fact that Regional Offices are exclusively concerned with program planning and policy formulation while provincial or Regency Office are engaged solely in implementation, Provincial Offices still carry out both functions: program planning and implementation leading to sectoral egocentrism. This weakens the ability of the government to provide basic services to the public, because each sector feels that each existing structure is operating effectively.

In several regions, the existence of structural linkage and structural dualism has created a crosssectoral coordination. Coordination between the executive office and the legislative body in areas of program evaluation may smoothen its implementation through the issuance of a number of *Perdas* (Regional regulations) about education, health and social welfare.

Bureaucratic Culture

The bureaucratic culture illustrates the relationship between upper echelon and its subordinates. This bureaucratic model has manifested itself in the entire program operations, i.e., daytoday communication, interpersonal relation, language usage and problem solving techniques. This paternalistic bureaucratic culture can be seen as the form of vertical relationship between the upper and lower echelon.

Decentralization in the social sector has not been able to reduce the paternalistic attitude and relationship. This, in turn, has affected the problemsolving attitudes and actions taken by the central office as well as those in the regions. This, of course, weakens the coordination and implementation of the program, since entities will always feel dependent on their superiors or dependent on the power structure in their work environment.

One can observe the attitude of civil servants at the district level who are dependent on their superiors at the regency level, and further the bureaucrats of the regency who will wait for instructions and decisions from the Regional Office. On the other hand, the Regional Office can only express its mandate based on the limitation of policies of the Minister. In effect, the culture discourages initiative, and dampens creativity as well as disheartens one to make quick and responsive decisions which are oftentimes necessary to public interest.

Equity

Decentralization in the social sector is based on the concept of equity. Therefore, issues concerning this are important. The concept is part of the principles of development throughout the phases of *Pelita* (FiveYear Plan). Evidently, equity and distribution of development are two concepts which are inseparable in every phase of development planning and implementation.

The policy on the distribution of *SD Inpres* in remote villages, induction of 9year compulsory education, provision of *SD Pamong* and *SD Kelas Jauh*, utilization of special educational program for the adult population, and improvement on the quality of teachers through higher education and enhancement of programs are all parts of the equity concept.

In the sector of health, equity is operationalized through the distribution of health facilities and infrastructures to the level of districts and villages, i.e. establishment of *Puskesmas*, *Puskesmas Pembantu* and *Mobile Puskesmas*; establishment and promotion of *Posyandu*, *Posbankes* and *Pos KB Desa*; upgrading of the quality of hospitals and their medical equipments; and provision of education to medical workers. Equity is also being advanced in the community participation through the mobilization of resources in community institutions, traditional institutions, *adat* leaders and others.

In the social welfare sector, the equity issue is prominent since the implementation of decentralization is the *Pengentasan Kemiskinan* (Poverty Elevation) and *Inpres Desa Tertinggal* (Presidential Decree on Under Developed Villages). Both are positive measures of equity aimed at improving the standard of living of remote village communities. Other measures involve the distribution of manpower and *Pekerja Sosial Masyarakat* (Community Social Assistant) down to the level of villages, establishment of social settlements and residencies for orphans, the aged and the handicapped.

Participation

Since the inception of development, the concept of participation has been in the minds of planners and administrators of development. The implementation of decentralization in the framework of development has naturally taken into consideration the issue of participation being an inseparable part of national development program.

Participation of nongovernmental organizations and the general public by way of establishing schools and other educational institutions, and the government's new endeavors to setup various training institutions are just a few examples in anticipation of increased demands for skilled manpower and other employment opportunities. Based on field observations, the level of public participation in the sector of education at the village level is lower than in the cities. This is due to the fact that employment opportunities for skilled manpower are higher in the cities than in villages. Therefore, emphasis is given to programs designed to increase public participation at the city level, while on the village level, the emphasis is on the equity of education.

Public participation in the sector of health has been manifested through the involvement of the people in programs such as: combating diseases, environmental health, immunization, family nutrition, family planning *Banjar System*, *Dana Sehat* (Health Funds) as health insurance at the village level, referral services to medical doctors and *Bidan Swasta* (DSB). This public participation can become one of the indicators for the implementation of decentralization in the health sector, not only at the village but also at the city level.

Public participation in social welfare is shown in programs related to income disparity and poverty, specifically in the villages. The provision of social services in the villages encourages the utilization of existing traditional mechanisms to tap and mobilize manpower, institutions, and other resources. The level of participation of the community still has to be enhanced by a variety of programs such as the induction of HKSN, fund raising for victims of natural disasters, foster children program, adoption, *Rriungan Sarumpi* program, Charity Bazar, Humanity Funding Week, and other social activities. The active involvement of civil servants, administrators and high officials in government must be enjoined.

Achievement Indicators

Not much can be mentioned about the achievements of the decentralization program at the beginning stage of evaluation. However, based on the planning and its implementation which has been carried out for some time, a number of indicators is proposed to measure the extent of progress achieved. The indicators are:

- a. the numbers of tasks which has been turned over by the first level authority to the second level;

  b. the number of regional regulations issued by the first and second levels of authority concerning the operationalization of a number of tasks relative to regional autonomy;

c. the rate of growth and distribution of resources and infrastructure in social services (education, health and social welfare) to the villages and the scope of the programs;

d. the level of participation and self-determination of the public involved in the delivery of the social services as in the provision of human and material resources and other kinds of services;

e. the achievement of each program implemented according to the input/output, consistency and the dynamics of the programs;

f. the level of coordination, inter as well as intrainstitutional, exercised according to each program.

More specifically, achievements in the educational sector are noted in literacy rate, the number of pupils in schools, and number of graduates employed. In the health sector, the achievements would be the health condition of the people, increased life expectancy, decreased rates of infant mortality, increased involvement in community efforts and improved provision of health facilities and infrastructure. The achievements in the social welfare sector is reflected in the improvement in the quality of manpower for social services, the distribution of manpower to the level of villages, increased community participation, high degree of community self-sufficiency, creativity in solving social problems, decrease in the number of poor population; decreased number of underdeveloped villages, as well as higher degree of community solidarity.

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