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## **Perceptions of Indonesia's Decentralization – The Role of Performance Based Grants and Participatory Planning in Public Health Service Delivery**

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Abstract

This paper analyses the perception of different stakeholders with respect to performance based transfer schemes and participatory planning in Indonesia. The paper presents theories of fiscal decentralization and participatory governance from an interdisciplinary perspective and illustrates a gap between the ideal, conceptualized by the academic discourse, and the actual implementation.

With regard to Indonesia's Intergovernmental transfer design, the stakeholders refer to: the imbalanced and incomplete devolution of fiscal revenue authority and expenditure responsibilities, the high degree of uncertainty in transfers, the inadequate deployment of incentive schemes, and the low quality of spending, as the major shortcomings of Indonesia's intergovernmental transfer system. Regarding participatory governance, a lack of bureaucrats' capacity, resulting unsatisfactory guidance of participatory meetings, a bias towards the investment in infrastructure, lacking inclusion of marginalized groups and women as well as an inadequate implementation of participatory planning results, are frequently referred to as the major shortcomings.

We present further insights into performance-based transfers schemes and participation designs and how they can induce organizational changes at the health service provider level, improve the quality of planning and spending, and lead to positive behavioral changes at the level of health service users.

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## Introduction

Finding the balance between the central government and local authorities, on the one hand, and an effective ruling of the respective governments and citizen participation, on the other, is a classical topic that has long fascinated scholars and practitioners alike. Indonesia's “big bang” of decentralization (Hofmann & Kaiser 2004), which followed the end of Suharto's rule in 1998 and which was crucial to the country's *reformasi*, ranks among the most rapid and extensive decentralization programs in the world aimed at finding this exact balance. After a decade of reform implementation, however, the state of fiscal, administrative, and political decentralization still suffers from significant shortcomings. Deficiencies often associated with Indonesia's fiscal decentralization are an imbalanced and incomplete devolution of fiscal revenue authority/expenditure responsibilities to the regions, a high degree of uncertainty in transfers (Shah 2012a), an inadequate deployment of incentive schemes (Harjowiryo 2012), and a low quality of spending (Hofman et al 2006). Shortcomings related to political decentralization are a declining performance in democracy indices, poor enforcement of reform laws, the role of “money politics” in elections, and the limited space for civil society actors to influence the legislative process (Buehler 2012: n.p.).

These shortcomings affect the ability of the state to deliver basic services to its citizens, such as adequate standards of health and education, and thereby jeopardize the achievement of the Millennium Development Goals (MDGs) by 2015. In 2004, for example, it was stated that the maternal health goals, targeting at a reduction of the maternal mortality ratio by three-quarters and at universal access to reproductive health care, were “unlikely to be achieved unless extra efforts are made” (UNDP 2004), and in 2011, the maternal mortality rate of 228 per 100,000 still was one of the highest in Southeast Asia (UN 2013; UNDP 2013a). In 2012, Indonesia's human development index (HDI<sup>1</sup>) of 0.629 was below the average of 0.64 for countries in the medium human development group and also below the average of 0.683 for countries in East Asia and the Pacific (UNDP 2013). Ministries and government agencies at all levels of the state as well as international development agencies are striving to improve the health performance in the country.

This paper analyzes the potential of two specific pathways of fiscal and political decentralization, performance-based transfers and participatory governance, to improve the current state of Indonesia's health service delivery. Performance-based transfers, a dimension of fiscal decentralization, require the achievement of certain results in public service delivery in the health sector before further transfers to the local government level are made. Participatory governance, an aspect of political decentralization, is based on the assumption that certain forms of participation can lead towards more sustainable, effective, and innovative politics (Benz et al. 2007: 17; Hill 2005: 220). In this understanding, the political decision-making process should be guided by direct citizen participation (Heinelt 2002: 25).

Our focus lies on the potential that international development experts in Indonesia as well as Indonesian academia and local government officials see in these measures. Looking at two specific aspects of decentralization can improve the understanding of this broad topic with regards to public service delivery. Our analysis includes a gender aspect in order to take account of gender based differences in the components analyzed – especially participatory governance – and of differing needs regarding health services.

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<sup>1</sup> The HDI consists of life expectancy at birth, adult literacy, mean years of schooling and per capita GDP.

The paper is organized as follows. In the second chapter, we will review the state of the art of the current theoretic discussion on decentralization, participatory governance, and performance-based transfers and the putative benefits of these pathways to improve public service delivery. In the chapter on methodology, we will give an outline of the methodology used, and in the chapter on the perception of Indonesia's decentralization reform, we will present our findings on the potential of these pathways for improving public service delivery in Indonesia. Relying on field research in Jakarta and Mataram, we will discuss current developments, a best practice example, and its perceived impact on health performance. The results of these findings and implications for future developments will be discussed and then concluded upon.

## **Theory of Decentralization**

Decentralization as “a process and a condition in which decision-making powers, functional competences and resources are devolved from the center to lower levels of government, consistent with the principle of subsidiarity” (Rüland 2012: 5), is a prominent and enduring, but also ambiguous concept in development policy and theory debate. It continues to provoke a controversial debate on the theoretical appropriateness of the term and the empirical efficacy of the concept. More recently, it has been associated with the concept of good governance within a neo-institutionalist approach, which is challenged by approaches that highlight the highly competitive system of power relations influencing the outcome of decentralization (Hadiz 2004: 703). The intricate connection between decentralization and democratization has been accepted as common knowledge among development experts and scholars (see for example Carnegie 2008). Ideally, decentralization contributes to the “input” as well as to the “output legitimacy” of a political system and strengthens local governance (Rüland 2012: 6; Scharpf 2004). Seen from the angle of the good governance discourse, which is mainly driven by development organizations, decentralization is supposed to enhance the political responsiveness, accountability, and transparency of a country and to thereby contribute to better service delivery, alleviate poverty, promote economic growth, and augment and equalize local government revenues (ibid: 6). The connection between fiscal decentralization and participatory governance as a part of political decentralization on the one hand and public service delivery on the other will be presented in more detail in the following.

### ***Fiscal Decentralization***

Fiscal decentralization can be defined as the devolution of fiscal authority to lower levels of government. Its degree can be determined by the division of spending responsibilities between different levels of government, the amount of discretion given to local governments, and their ability to determine expenditure and revenue. Decentralization can move the government closer to the people and thereby ideally increases the accountability and responsiveness of service providers (Wetterberg & Brinkerhoff 2012: 6). Theoretically, it matches services to users' needs and preferences, increases allocative and technical efficiency of service delivery, and creates positive incentives for performance (ibid: 44). By decentralizing authority to the local government level, local governments can use their informational advantage for local needs, which increases allocation efficiency (Hayek 1948). The increased competition between sub-national governments should theoretically result in a higher responsiveness to local needs (Tiebout 1956). Looking at the potential of decentralization in the health sector, Jiménez-Rubio et al. (2010) argue that local decision-makers might have more opportunities to reduce costs compared to central managers, have

more freedom to experiment with alternative ways of treatment, and can train staff and procedures according to the local context.

Bahl identified the following criteria for a successful implementation of a fiscal decentralization reform: The reform has to take place at all levels of the system; just focusing on one element (e.g. revenue sharing) is most likely to hamper its positive effects (Bahl 1999). It needs political autonomy, a significant amount of taxing power, budget autonomy, transparency, and hard budget constraints.<sup>2</sup> The reform process has to take place in a correct order (“finance follows function”): expenditure assignments should be decentralized before revenue responsibility is determined since the knowledge about expenditure assignments has to be in place in order to devolve revenue assignments efficiently. *“Governments must settle on the assignment of expenditure responsibilities to local governments, at least an assignment that will hold for the near term future, before it can choose an efficient mix of taxing”* (ibid.: 7). Significant local government taxing power is required. *“Voters will hold their elected officials more accountable if local public services are financed to a significant extent from locally imposed taxes, as opposed to the case where financing is primarily by central government transfers”* (ibid.: 10). Central governments must comply with the fiscal decentralization rules they make. They should, for example, not underfund transfer programs or reassign expenditures without corresponding reassignments of revenues. Finally, a strong central ability to monitor and evaluate decentralization is required, such as a strong central government leadership on financial accounts, audit rules and knowledge on adjusting a grant distribution formula.

There is empirical evidence for the positive effects of fiscal decentralization. In Bolivia, in particular in smaller and poorer districts, decentralization led to a higher responsiveness to local needs and a shift of public expenditures towards education, health, and sanitation (Faguet 2004). In an econometric analysis of 19 OECD countries, Jiménez-Rubio et al. (2010) conclude that fiscal decentralization had a positive impact on the effectiveness of improving health care, in particular on child mortality rates. Arze del Granado et al. (2012) show that decentralized governance (defined as fiscal decentralization) has an effect on the reallocation of resources in the public sector concerning health and education. In their study of 59 countries, they show that “decentralization trends all over the world are likely to result in a reallocation of resources in the public sectors” and that the *“higher emphasis of expenditures on education and health may not only yield increases in allocative efficiency and overall welfare, but may also support, given the key importance of expenditures on those services, national efforts on poverty alleviation and improving economic growth”* (Arze del Granado et al. 2012: 23).

Nonetheless, there are also risks and constraints associated with decentralization: Partial decentralization can create perverse incentives; an unclear delegation of responsibilities, authorities and resources can generate conflicts, ambiguities, and service gaps, and sub-national preferences may undermine national priorities (ibid: 44). As for the health sector, decentralization might cause an inefficient allocation of health facilities by a local decision-maker accountable to local electors or encourage local jurisdiction to “free-ride” on the services of neighboring jurisdictions, e.g. in the case of immunization services (Jiménez-Rubio et al. 2010). Additionally, according to Bardhan (2002), population mobility might not be high enough to enable the positive effects of increasing competition in local government policies, especially in developing countries. Jiménez-Rubio et al. (2010) even argue that the

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<sup>2</sup> Local governments, having considerable discretionary power on fiscal decisions (ability to raise debts and/or own revenues) cannot rely on „bail-outs“ by the central government and face costs once budgetary requirements are not met. Here the central government has to credibly commit to a no-bail out policy (ex-ante).

positive effects of fiscal decentralization tend to be overestimated by conventional measures of fiscal decentralization and that decentralization might even increase regional disparities without an adequate transfer mechanism in place.

For Indonesia, Kis-Katos and Sjahrir (2013) analyzed the effect of decentralization and democratization on budget allocation at the sub-national level. Their empirical evidence shows that decentralization increased the responsiveness of local governments' investments to close public service delivery gaps.<sup>3</sup> Since health services are already decentralized in Indonesia, we are not going to discuss whether decentralization of health services is a suitable mechanism for improvement itself<sup>4</sup>, but rather how the underlying intergovernmental transfers systems can improve health services.

According to Harjowiryo (2012: 124), a well-designed intergovernmental transfer system is key to a successful decentralization reform. Bardhan and Mookherjee (2006: 124) argue that *“the effects of decentralizing service delivery will depend on the method chosen for financing local governments”*. Without an adequate transfer design, local government heads might not act in the interest of vulnerable groups (e.g. overprovided services for the elite) or capture rents (Bardhan & Mookherjee 2005, 2006).

Bahl identifies the following requirements for the design of an Intergovernmental Transfer System (Bahl 1999: n.p.): (1) local differences in the capabilities to deliver services; to finance services; and the ability to borrow needs to be accounted for (e.g. not one intergovernmental transfer system for the rural and urban sector). (2) The system should be as simple as possible in order to keep the cost of local administration and the need and cost of central government monitoring low (ibid.). (3) Complicated grant allocation formulas that cannot be calculated adequately by existing data should be avoided (ibid.). (4) The design of the intergovernmental transfer system should match with the specific objectives of the decentralization reform (ibid.). This might be a simple and straightforward criterion, however, according to Bahl, it often gets violated (Bahl 1999: n.p.).

However, despite these rather general requirements presented, one has to keep in mind that the overall effect of fiscal decentralization depends on the specific design of the intergovernmental transfer system in a particular country. There is no “one size fits all” approach.

### *Participatory Governance*

Since *“the effectiveness of fiscal decentralization increases with the level of political decentralization”* (Jiménez-Rubio et al. 2010: 6) supported by empirical results of Mahal et al. (2000), we will now focus on the political aspects of decentralization, in particular on community or citizen participation on the demand side as another pathway to improve service delivery (Wetterberg & Brinkerhoff 2012: 4). As “participatory governance” is a very broad concept

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<sup>3</sup> The effects of democratization show similar effects, although they are not statistically significant. In the case of directly elected local government heads, the relative responsiveness even decreased, especially in districts with low political competition. The authors explain this effect by the relative weakness of the newly established local direct democracy. Expenditure decentralization in Indonesia made local governments more responsive to local public infrastructure needs, independently of the fiscal revenue effect from decentralization (Kis-Katos & Sjahrir 2014). Analyzing democratization, however, this increase in responsiveness could not be shown accordingly. For example, directly elected district heads were less responsive regarding health infrastructure and invested less in districts with relatively low public healthcare coverage (ibid.).

<sup>4</sup> For more empirical evidence regarding this controversy see Jütting et al. (2007), Kruse et al. (2012), and Khaleghian (2004).

and can include satisfaction surveys, community oversight mechanisms, and service co-production, the mode of participation has to be clearly defined. Cohen and Uphoff (1980: 21) distinguish between citizen participation in decision-making, implementation, benefits, and evaluation. Our focus lies on citizen participation in the deliberative planning process and its implications for health services, thus mainly on participation in decision-making.

The promotion of participatory governance in the framework of “good governance”, especially in so-called developing and emerging countries, is based on the assumption that certain forms of participation can lead towards more sustainable, effective, and innovative politics (Benz 2004: 17; Hill 2005: 220). Participatory governance refers to a type of direct participation and interaction of citizens that goes beyond their participation in elections. Through the direct inclusion in negotiations with other agents, citizens are believed to influence and shape the political deliberative process (Heinelt 2002: 25). However, different mechanisms of participatory planning result in different degrees of citizens' actual power within decision-making structures, ranging from a merely advisory function in participation meetings to absolute decision-making authority, not only on policy but also on budget planning.

The necessary degree of citizen participation in a democracy has been controversially debated between proponents of direct democracy and of representative democracy. For instance, there is no consensus among theorists of participatory democracy on the question whether the deliberation process should include only members of institutions or also the public sphere and civil society, even though proponents from both sides strive for a radicalization of the ideals of democracy (Cini 2011: n.p.). Therefore, theorists of participatory governance can be distinguished by two different modes of legitimization: one group postulates deliberative democracy, legitimizing participation with improved output, while the other group calls for participatory democracy, legitimizing decision-making through the equal chance for input in the decision-making process (Wolf 2002: 39).

Deliberative democracy, on the one hand, is based on the assumption of rational decision-making. Its supporters assume that in the decision-making process, different arguments are proposed and that the best argument wins consensually after a thorough deliberation (Cini 2011: n.p.). From this perspective, aiming at more effectiveness and efficiency, participation is a tool to improve the output of a decision-making process (Grote 2002: 24; Wolf 2002: 39). Thus, only so-called “holders” are allowed to participate in the deliberation process. Critics claim that there is much space for arbitrariness in the selection of the participating group. Furthermore, marginalized groups, which by definition do not belong to the few who are considered to be “holders”, might be further excluded, whereas the already privileged can gain even more influence (Grote 2002: 26-27).

Participatory democracy, on the other hand, is rather input-oriented and focused on grassroots democracy. Here, the inclusion of citizens serves to legitimize decisions that affect them (Wolf 2002: 40). The main point of criticism against this position is that it can be difficult to provide less educated citizens with a substantial understanding of the situation, enabling them to make an informed decision. Facilitation through NGOs can be a way to overcome this information gap and to prevent an “expertocracy”, in which mainly educated citizens – again “holders” – can speak (Wolf 2002: 40).

As the two approaches diverge so fundamentally, they are sometimes considered as incommensurable: some supporters of deliberative democracy claim that the participation of “ordinary citizens” would impair the quality of decisions, while advocates of (quantitatively oriented) participatory democracy argue that people directly affected by a decision are often more capable of finding the “appropriate” solution than unrelated

experts and that participation legitimizes decision-making processes (Heinelt 2002: 25; Cini 2011: n.p.). For this reason, many “input-oriented” theorists do not agree with the division between output- and input-orientation of the two concepts, pointing out that their participation model is output-oriented as well (Cini 2011: n.p.). In recent years, it has been elaborated convincingly that deliberation and participation are not mutually exclusive concepts, and some authors have claimed a combination of both approaches, assuming that participatory deliberative governance can lead to more sustainable, efficient, and innovative decisions than top-down governance (Benz 2004: 17, Cini 2011: n.p.). Wolf, who favors a combined approach, sees a third option in Habermas' understanding of deliberative democracy, in which the input component is not subordinate to an output focus. This approach aims at enhancing the discourse on the goals to be achieved and at developing the actors' “deliberative competence” (Habermas 19966; Wolf 2002: 41 f.).

Citizen participation is proposed by critics of traditional democracy who do not deem it sufficient to meet newly emergent problems in growing and increasingly heterogeneous polities (Fung & Wright 2001a: 5). Despite the criticism mentioned, Fung and Wright claim that a deliberative approach enables a state action that is effective and equitable and invites broad, deep, and sustained participation, thereby strengthening three important democratic values (ibid.: 25): With regard to effectiveness, they claim that deliberative democracy can empower individuals directly related to their livelihoods and interests. Furthermore, they state that groups affected by a decision have an intimate knowledge about the situation (and could therefore be termed as “holders”), are often most realistic and creative on how to improve the situation, and are likely to generate better solutions than aggregation procedures, which are more distanced and hierarchical (Fung & Wright 2001b: 28). For this reason, they deem it a superordinate achievement that there are newly established “*channels of voice over issues about which potential participants care deeply*” (Fung & Wright 2001b: 27). As a consequence, the decisions made by the citizens are more connected to their real aspirations and interests than those made in an election (ibid.: 27).<sup>5</sup> In addition, there is a shortened “feedback loop”, which makes it easy to respond quickly to strategies that prove to be insufficient and avoids one-size-fits-all approaches in fields where the needs diverge significantly (ibid.: 26). Concerning equality, Fung and Wright underline that many participative pilot projects focus on the problems of disadvantaged people, who are often widely excluded from the political sphere, for instance through a lack of knowledge or capacity. Following the presumption that a decision that marginalized groups can influence will benefit them rather than any other outsider's decision, Fung and Wright deem the mere fact of participation as a crucial step towards equity. Furthermore they assume that through debates and different proposals, decision-finding processes will be “*regulated according to the lights of reason*” (ibid.: 27).

Speer points out, the academic literature widely agrees on two basic conditions required for effective participatory governance: a well-organized, active civil society and the public officials' interest and willingness to pursue participatory governance. In other words, the success depends on the actors involved (Speer 2012: 2383). Fung and Wright conclude from their observations in several pilot projects in different parts of the world that a balance of power between the different actors engaged in the deliberation process is an important enabling condition for successful participation (2001a: 24). Furthermore, they deem the

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<sup>5</sup> As opposed to critics' voices, Fung and Wright argue that it is more difficult for citizens – even for well-educated ones – to deal with the surplus of information needed to make a decision for one party or candidate in an election than to understand specific issues affecting them and to contribute to them. According to them, this lack of orientation in the election process leads to an orientation towards politicians' personalities or represented party identities (Fung & Wright 2001b: 28).

relation of decision-making and implementation crucial for successful participation as there is often no guarantee that the decisions made are subsequently implemented. In case the decisions taken with their participation are not implemented, participants will become frustrated (ibid.: 31)<sup>6</sup>.

As Western development cooperation agencies have been claiming that participatory governance makes governments more accountable and responsible, it has been promoted and implemented as part of good governance measures in many developing countries. Yet, there is not one single form of participatory governance; it can have different shapes, such as public hearings, vigilance committees, participatory budgeting, and forums for participatory planning and decision-making (Speer 2012: 2379).

## Methodology

This paper builds on three months of interdisciplinary fieldwork in Indonesia, namely in Jakarta and Mataram. As interns in different program components of the GIZ<sup>7</sup> Decentralization as a Contribution to Good Governance (DeCGG) project, we approached our research questions from three different angles, namely from our disciplinary backgrounds of economics, political science, and cultural and social anthropology.

### *Case selection*

The present study is a single case study (cf. Gerring 2008) with in-case comparisons. Mataram was chosen as a typical case of the relationship between decentralization reform and public service delivery. The city is the capital of the province West Nusa Tenggara, which – although it is still in the lowest rank among provinces in Indonesia – has made considerable progress in human development since the beginning of the decentralization reforms. If the universe of cases comprises all 33 provinces in Indonesia (or all 33 province capitals) with regard to the relationship between decentralization and public service delivery in health, Mataram/NTB can be considered typical due to the general positive trend of human development. It is even considered a “success story of development process in the region” concerning health (Afifi 2012: 9). While the HDI for Indonesia increased from 0.66 to 0.71 between 2002 and 2008 (BPS 2014),<sup>8</sup> the HDI in Mataram/NTB increased from 0.58 in 2002 to 0.64 in 2008. The positive health development is also demonstrated by the increasing rate of health indicators including infant mortality rate, maternal mortality rate, life expectancy, birth attended by skilled attendants, and the malnutrition and morbidity rates (BPS 2014; Afifi 2012: 29).

In NTB, health performance in a decentralization context is primarily influenced by social and economic variables and only to a lesser extent by infrastructure and resources. Education of the community is of special concern since it enhances the capacity of people to prevent diseases (Afifi 2012: 37). The typicality of the case of Mataram lies in the causal relationship between specific aspects of decentralization (social and economic) and health service delivery. As Gerring (2008: 649) points out, cases with untypical scores on a particular dimension (e.g. very high or very low) may still be typical examples of a causal

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<sup>6</sup> This shows that participatory governance cannot be treated as a mono-causal determinant for successful public service delivery. The authors cited assume that participatory governance can have a positive impact on public service delivery, however, that it depends on many more factors, such as the general degree of decentralization, the integrity of government officials or a properly designed intergovernmental transfer system.

<sup>7</sup> Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

<sup>8</sup> [http://www.bps.go.id/eng/tab\\_sub/view.php?tabel=1&daftar=1&id\\_subyek=26&notab=2](http://www.bps.go.id/eng/tab_sub/view.php?tabel=1&daftar=1&id_subyek=26&notab=2).

relationship. Mataram has untypical scores on the dimension of HDI compared to Indonesia's other provinces, but is still typical of the causal relationship between social and economic variables and health service delivery. Thus, in this case study a causal understanding of typicality is employed.

Causal typicality involves the selection of a case that conforms to expectations about a general causal relationship. In this case our research interest is to explore causal mechanisms concerning the relationship between fiscal and political decentralization and public service delivery (PSD) in the health sector. We seek to confirm or disconfirm the hypothesis that participatory governance (as an indicator of political decentralization) and performance-based transfers (as an indicator of fiscal decentralization) improve PSD in health and, if so, to analyze via which pathways this happens.

Case study research suffers by definition from problems of representativeness since it includes only few cases or a single one, which weakens its external validity. Its value is internal validity since it is often easier to establish the veracity of a causal relationship of a single case than that of a larger set of cases (Gerring 2009: 1144). Synchronic in-case comparisons can strengthen the validity of the case study's finding, which are in this case provided by comparing the experience of Mataram to those of Indonesia in general.

### *Access to the field*

Based in three GIZ program components in the Ministry of Finance (MoF), the national planning agency (BAPPENAS), and the Ministry of Women Empowerment and Child Protection (MoWECP), we gained insights into the existing discourses concerning our research interest. In our research, we used mainly qualitative methods, in particular semi-structured qualitative interviews (see, for instance, Schlehe 2008). Our sample consisted of different stakeholders; confining ourselves to an expert-based approach,<sup>9</sup> we conducted interviews with experts in different fields.

When accessing the field, we first collected rather general information through intensive literature research, participant observation, and informal conversations as well as through semi-structured interviews within the GIZ context<sup>10</sup>. In a second step, we conducted semi-structured interviews with different stakeholders, such as experts working for GIZ in the local context, local government officials of regional planning bureaus in Mataram, and academic researchers dealing with the issue in general and the case of Mataram in particular. Finally, we completed our research by conducting interviews with Civil Society activists and experts of various international donor agencies, such as GIZ, UNDP, World Bank, and USAID.

In all of our interviews, we clearly focused on our interview partners' perception and interpretation of the issues we asked them about. This means that we are not presenting an objective account of the situation in this paper, but an analysis of a set of expert perspectives on public service delivery in the health sector, from which one might be able to conclude certain general statements.

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<sup>9</sup> The notion of 'experts' is used according to the understanding in the context of qualitative interviews in social sciences. According to this understanding, an "expert" is a person who has the specific role of being a source of specialized knowledge about the issue which is being researched (Gläser & Laudel 2009: 12).

<sup>10</sup> Our research benefitted from contacts with GIZ staff as we could learn from their experience and insights in Indonesian politics and as they provided us with contacts to various influential actors. By participating in everyday office activities of GIZ and discussing our research interests with colleagues, we could identify some tendencies in the assessment and the perception of these issues.

## *Analysis of the Field Data*

For the analysis of our findings, we proceeded as follows: First, we identified three key categories, namely (1) the stakeholders' assessment of the situation and key shortcomings; (2) best practice examples named by stakeholders; and (3) their suggestions for change and improvement of the system in place. The remainder of this paper is based on these categories. Among the mentioned categories, we identified the most frequently discussed issues as sub-categories, which shape the micro-structure of the paper. We will refer back to the categories in chapter four, where we will discuss stakeholders' perception of PSD in the health sector with regards the intergovernmental transfer system, performance-based grants and participatory planning mechanisms. In opting for an interdisciplinary approach, we aim at providing a more comprehensive analysis of the empirical data.

## **Perceptions of Indonesia's Decentralization Reform**

### *Public Service Delivery in the Health Sector*

Scholarly accounts of public service delivery in Indonesia appreciate substantial improvements in the health sector after the independence of the country. After the first decade of independence, especially in the 1970s and 1980s, there were substantial improvements in the health care system under the authoritarian regime of President Suharto (Kristiansen & Santoso 2006: 247). The development from only a few hundred trained medical doctors in the early days of independence to the existence of hospitals in all districts and health centers (puskesmas) in all sub-districts was a big achievement. This measure had a considerable impact on health indicators like infant mortality or life expectancy (ibid.). However, there were significant regional disparities, especially between rural and urban regions. In 1998, for instance, the infant mortality rate was 27 per 1000 in Jakarta but 90 per 1000 in West Nusa Tenggara (ibid.: 249). When the economic crisis commenced, the health status in Indonesia was still far worse compared to neighboring countries, especially with regard to maternal mortality and rural areas. The economic crisis of 1997 and the following regime change in Indonesia endangered the previously promising development (ibid.: 249).

Decentralization led to a partial breakdown of health information systems and an unclear division of reporting responsibilities, which has been a problem for developing strategies and monitoring health programs in provinces and districts (WHO 2008: 10). The decentralization reforms has left regional governments with the main responsibility for health services. Parts of the district budget are earmarked for health services but are frequently misused for other purposes without public debate (Kristiansen & Santoso 2006: 249). Buehler states that “the bureaucracy is highly inefficient and ineffective in delivering public services at both the national [...] and sub-national level [---].” He claims that the quality of service delivery has stagnated since the 1990s (Buehler 2011: 66) and that “public expenditure management, organizational structures and mechanisms for staff allocation, recruitment and remuneration are all in dire need of reform” (ibid.). With regards to the situation of public health in Indonesia and using the example of children's and mothers' health, the WHO in 2008 drily commented that “[i]ndicators show that the health situation of mothers, children and adolescents in Indonesia still has much room for improvement” (WHO 2008: 8), since, for example, the mortality rate for children under five years was still as high as 46 per 1000 live births (ibid.). Health financing is reported to be highly inequitable and in favor of upper income groups (ibid.: 10), which again leads to low utilization of health services and low use of public hospitals by poor people. Only a minority

of the population, mostly formal sector employees, have an insurance (ibid.: 10). In 2006, 15 percent of the population held a private insurance (Kristiansen & Santoso 2006: 250). Kristiansen and Santoso comment that Indonesia “seems to be growing towards a U.S. style “entrepreneurial health care system“ (ibid.), in which the government's responsibility plays a minor part. Private doctors and clinics play an increasing role, especially in large cities, where the well-off can afford to consult them, whereas the role of puskesmas and public hospitals is reduced. Many public health facilities have already been closed due to a lack of funding (ibid.: 250). As a result, many people do not have access to health care when there are no public facilities and they cannot afford the private ones.

Another problem is the human resource situation since there are neither enough nor sufficiently skilled health workers, and since their distribution does not follow existing needs. This maldistribution and the low productivity of health workers is connected to many factors, but decentralization ranges quite prominently among them, due to the lack of mobility of civil servants across different levels of government, poor incentives, dual practice and expansion of the private sector in health services as well as a lack of strong accreditation and licensing procedures (WHO 2008: 11).

### *Decentralization in Indonesia*

Although Indonesia has been widely praised for its transition to democracy, scholars have warned that the consolidation of democracy is endangered by an oligarchic reorganization within the new framework of democratic institutions (Hadiz 2010). In this line of thought, “predatory interests” have “hijacked” the consolidation process, thereby blocking institutional and policy reform (Carnegie 2008: 515). Blunt et al. refer to Indonesia as being in a state of “patronage democracy,” which has been fostered by decentralization and a “symbiotic” relationship between patronage and development assistance (2012: 64). Sometimes the term “neo-patrimonial state” is also used (Khan 2005). Both descriptions refer to a situation in which patronage remains systemic within the government (Blunt et al. 2012: 65). These assessments show that the relationship between democratic consolidation and decentralization reform is by no means unproblematic for Indonesia. There is little agreement among scholars about the success and impact of the decentralization reform (for a discussion, see Rüländ 2012: 10), but the notion that decentralization and democracy are mutually reinforcing is highly contested. Hadiz stresses that governments do not rationally choose and implement the best policies available but that the realization of decentralization is shaped by social power, interests, and conflict (Hadiz 2010: 26). He states that “the way that decentralisation as the manifestation of the localisation of power actually takes place requires careful empirical investigation” (ibid: 26) and that “predatory politics” make it difficult for a reformist agenda and political action to take place (ibid: 28).

At the province and district level, national regulations are often not implemented or the implementation lags behind. This is a general problem for any reform process in Indonesia and especially virulent for the bureaucratic reform that is supposed to enhance public service delivery (Buehler 2012: n.p.; Prasojo 2012: n.p.).<sup>11</sup> Looking at the reform process from a democratization perspective, the current stagnation and partial regress of democratic consolidation is a worrying tendency that is reflected in democracy indexes such as Freedom House, Polity IV, and the World Bank's Governance indicators. In order to understand how democratic consolidation and reform processes are intertwined, it is

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<sup>11</sup> Interview with Marcia Soumokil, working for USAID's Kinerja project, 8 January 2013.

necessary to look at the role that the reform-averse elites play<sup>12</sup> (Mietzner 2012: 210). One major characteristic of the reform-averse group is “the perception of Indonesian democratization as having excessively empowered the citizens and local level and the subsequent call for a re-regulation of the political system to prevent the erosion of the state” (ibid: 211). However, despite the “entrenched” nature of elite influence and corruption in the political system (Aspinall 2010), Mietzner stresses the dynamic of progressing political rights and freedoms until 2005 and the subsequent attempts to gradually roll back reforms (Mietzner 2012: 212). These attempts of re-regulation are justified with government ineffectiveness that is allegedly caused by an excessive civil society involvement. The logic to justify a decrease in political freedoms is in line with Diamond's term of “bad governance,” a major factor for democratic decline (Carothers 2009; Diamond 2008). As Mietzner observes, anti-reformist elites believe “with Diamond – that societal discontent with government effectiveness leads to demands for the roll-back of democracy” and subsequently “hoped to invoke the former to achieve the latter” (Mietzner 2012: 217)<sup>13</sup>.

An example for this kind of logic is the current reform on property tax devolution at the local level. By 2014, district governments are supposed to levy property taxes.<sup>14</sup> The reticence of elites from the central level to put this reform into effect is shown by the relative lack of support, guidelines, and benchmarks, which districts have to build the necessary capacity to actually collect taxes.<sup>15</sup> While some districts do have the capacity to develop tax collecting infrastructure, others cannot achieve this on their own, and it cannot be determined whether “failures” of collecting property tax at the district level are created purposefully. However, districts that do not yet provide positive examples of local tax authority could be used by reform-averse elites as an argument for retaining power at the central level. During a visit to the local tax collection agency in Mataram, we found very limited knowledge about the property tax reform among those civil servants that in charge of its implementation. It was reported that in order to effectively collect property tax at the local level, investments into human resources, hardware, and software were direly needed.<sup>16</sup> The necessity of capacity building as a precondition to devolve tax authority to the district level is common knowledge among policy makers in Jakarta who repeatedly commit to it during official events<sup>17</sup>. A mismatch between needs at the district level and commitments in Jakarta is apparent.

Until 2005, the civil society successfully pushed for democratic reform, forcing reluctant elites to adopt new policies. Since then, the restorative tendencies driven by reform-averse elites have impeded popular involvement in the consolidation process, and the civil society has been forced into a “largely defensive posture”, in which it has to fend off “attempts by conservative factions in the elite to roll back already implemented reforms” (Mietzner 2012: 220). According to Mietzner, the risk of Indonesia to be stuck in an “incomplete” or

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<sup>12</sup> The notion of “elites” in Indonesia of course cannot be equaled to reform aversion, rather elites are heterogeneous and there are both progressive forces pushing for reform as well as anti-reformist elements.

<sup>13</sup> After the recent electoral reform that has most likely abandoned direct elections of provincial governors, district chiefs and mayors, the effects remain to be observed (Cochrane 2014: n.p.).

<sup>14</sup> Not for the sectors forestry, mining, and plantation.

<sup>15</sup> This problem was described by participants of the International Seminar on the Challenges to Collect Property Tax held in Jakarta on 27 November 2012.

<sup>16</sup> Interview with Erfan Anwar from the DISPENDA Provinsi NTB, the regional revenue bureau of West Nusa Tenggara, 20 December 2012.

<sup>17</sup> For example at the International Seminar on the Challenges to Collect Property Tax held in Jakarta on 27 November 2012.

“trapped” transition has to be countered by strengthening the civil society. International donors also have limited leverage to strengthen the civil society in Indonesia since the central government is very reticent to allow development agencies to have counterparts among civil society actors. This is especially true for political foundations, which have experienced difficulties in 2012 to negotiate their Memoranda of Understanding with the Indonesian government.<sup>18</sup> All this evidence points to the fact that civil society engagement is still severely hampered and, despite some promising examples that are mostly backed by international donors, is not yet empowered to the degree that public services in health can be significantly improved.

There are challenges with regards to local autonomy and the relationship between national and sub-national government levels that hamper the delivery of health services. In our interviews, we frequently heard accounts of defective or missing information. For example, concerning participation in health governance by complaint surveys, one interview partner reported that users of health services were often not informed about what they could expect from the service providers and thus did not have a benchmark against which to assess the actual performance. This was the case for the Minimum Service Standards (MSS), which were largely unknown at the district level and consequently were no valid benchmark for service users. “So how can they complain if they don't know their rights?”, was a question posed by one informant<sup>19</sup> working on participatory governance in the health sector at USAID's Kinerja program<sup>20</sup>.

In the context of information flows, it is interesting to look at the delineation of responsibilities. The lack of an institutionalized system that ensures information flows from the central to the district level often leads to an unclear delineation of responsibilities between the central and local government level, as interviewees reported repeatedly. What is equally important and lacking is a robust mentoring and supervision framework that provides guidance to local governance on how to implement new policies.<sup>21</sup>

Hadiz points out that the conducive circumstances for effective reform go beyond policy planning; they are shaped by social power, interests, and conflict (Hadiz 2010: 26). This is illustrated by the following example from maternal and child health care, where a regulative conflict between central and local government and conflicting interests between the private sector and local civil society advocacy are an issue. One characteristic of an incomplete decentralization process is that regulations issued at the national level are not transferred to the local level. This is significant for civil society participation as well as for public service delivery. For example, although there are several central governmental laws and regulations that promote exclusive breastfeeding from birth for a minimum of six months<sup>22</sup>, there is often no law or regulation at the district level that transposes it into a local regulation. Local regulations, however, are important since they create normative and legal pressure on the local authorities. Advocacy organizations expect that this pressure will also bring about budgetary consequences. Civil society advocacy at the grassroots is therefore necessary to push for such local regulations. This kind of advocacy is often promoted and supported by donor agencies. USAID's Kinerja, for example, supports the Immediate Breast Feeding Initiative (IBF) and Exclusive Breast Feeding (ASI Eksklusif), two

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<sup>18</sup> Authors' informal conversation with a member of a political foundation, 7 May 2013.

<sup>19</sup> Interview with Marcia Soumokil, working for USAID's Kinerja project, 8 January 2013.

<sup>20</sup> USAID's Kinerja program works to improve local government service provision in education, health and the business-enabling environment. The implementing agency is RTI International (RTI International 2011).

<sup>21</sup> *ibid.*

<sup>22</sup> For example in Health Law 36/2009, article 128 (Better Work Indonesia 2013: n.p.).

programs of the Ministry of Health. One part of implementing these national plans is issuing a local regulation, which was successfully pushed for by multi-stakeholder fora in West Kalimantan and Aceh.<sup>23</sup>

This case exemplifies how public participation can directly influence the quality of PSD but also shows that social pressure is needed to safeguard and monitor the quality of public service delivery. In this sense, civil society advocacy can act as a corrective force. Yet, the effectiveness of such a corrective force is highly dependent on the organization of civil society and the willingness of local governments to cooperate.

Effective information sharing is not only a challenge between levels, but also at the local level itself. The frustrating state of the implementation of agreed-on policies is often due to either incomplete knowledge at the local level or a lack of knowledge management. Even if a local government is committed to delivering services, the situation might change after an election and turnover of civil servants, either because the new government has different interests or because the relevant information is not provided to the successors. This lack of institutional memory might take its origin in the fact that specific issues like health care are politicized and thus become more prone to sabotage. This can be detrimental to the work of development organizations, which have to “start from zero” in such a case.<sup>24</sup>

### *The Intergovernmental Transfer System*

In Indonesia, local governments act as agents on behalf of the central government. They have limited revenue-raising authority and receive a large amount of central government transfers to implement services. Indonesia has three formal government levels: the central, the provincial, and the local level. The central government is responsible for judiciary, law enforcement, monetary and macroeconomic policies, currency, religious affairs, defense, foreign relations, and security policy. The sub-national governments are responsible for all remaining functions, especially for decentralized service sectors like health. In the health sector, local governments are responsible for the management and financing of health service providers, the administration, the financing of health sector staff, and the management and financing of health service infrastructure. Compared to local governments, provinces have limited responsibilities. They are mainly responsible for supervision and are supposed to intervene if cross-jurisdictional cooperation is required. The central government focuses on providing service delivery oversight and financial as well as technical support. It defines health policies and minimum service standards, implements social health programs, or provides transfers through Indonesia's Intergovernmental Transfer System (Shah 2012b). In 2010, these transfers financed 54 percent of the expenditures of the provinces, 86 percent of those of the cities, and 93 percent of the districts' expenditures and are still the most important source of revenue for sub-national governments in Indonesia (ibid.: 10).

The current Intergovernmental Transfer System was established under Law No. 25/1999 on fiscal balance between the central government and the regions, Law No. 33/2004 on sub-national governance, and Law No. 33/2004 on fiscal decentralization. Its three major transfer mechanisms are: the general allocation grant DAU (*Dana Alokasi Umum*), the specific allocation grant DAK (*Dana Alokasi Khusus*), and the natural resources and tax revenue sharing system DBH (*Dana Bagi Hasil*).

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<sup>23</sup> Interview with Marcia Soumokil, working for USAID's Kinerja project, 8 January 2013.

<sup>24</sup> Interview with Mellyana Frederika from UNDP-PGSP, 1 November 2012.

The DAU is a general-purpose grant and the main source of transfers to sub-national governments. It accounted for 52 percent of total sub-national revenue between 2001 and 2009 (Agustina et al. 2012: 372). It is non-earmarked, i.e. the local government has the full discretion about the use of DAU funding, and the amount for each jurisdiction is calculated by a formula that consists of a “basic allocation” plus a “fiscal gap”. The basic allocation is determined by the amount of the local government's salary expenses. The fiscal gap is calculated by the difference between the fiscal capacity (local governments' own source revenue<sup>25</sup> plus shared revenues through the DBH funding mechanism) and the fiscal need (a weighted index of population size, the surface area, the inverse of the HDI, a cost price index and the gross regional domestic products (GRDP)). Its main purpose is to reduce inter-regional disparities or so-called horizontal imbalances between regions by focusing on the reduction of the variations in the regional allocation of funds (measured by the coefficient of variation or Williamson Index).<sup>26</sup>

The DAK is a specific-purpose grant or conditional matching grant. Its size is determined by general criteria (e.g. financial capacity of a sub-national government), technical criteria (e.g. guidelines established by the according line ministry), and special criteria (e.g. determined by specific characteristics of a region). In contrast to DAU funding, DAK funding is earmarked; its main purpose is to fund physical capital investments and operational and maintenance needs in line with national priorities. When the DAK started in 2001, it only financed reforestation measures; health has been a DAK-funded sector since 2003 (McLeod & Fadliya 2010: 10). There is a matching-requirement in order to increase the “ownership” of a sub-national government, local governments have to contribute at least 10 percent of the total amount of the funding out of their budget.

The DBH is Indonesia's tax and natural resource revenue sharing system. Revenues generated by natural resources (forestry, oil, gas, general mining, and geothermal energy),<sup>27</sup> personal income tax, and property tax<sup>28</sup> are collected by the central government and distributed to sub-national governments by according shares. The objective of DBH is “to address the existing gap between own source revenue raising powers and expenditure responsibilities given to sub-national governments” (i.e. to reduce vertical imbalances) (Harjowiryo, 2012: 126). The revenue sharing system contains earmarked funding elements, e.g. 0,5 percent of the oil and gas revenue is earmarked to finance basic education at the sub-national level.

Additionally, there are Special Autonomy Funds<sup>29</sup> for Papua, Aceh, and West Papua, Adjustment Funds to provide financial ad hoc assistance (e.g. in the education sector), *hibah*<sup>30</sup>-transfers, external assistance in the infrastructure sector, and a Special Incentive Grant (DID), which is granted to provinces and cities with an above-average performance in public financial management or poverty reduction. According to Lewis (2014), the Indonesian government piloted two additional intergovernmental performance grants since 2010: *P2D2 (DAK reimbursement), in effect from 2011 to 2012*<sup>31</sup> and *targeting at an*

<sup>25</sup> Local government revenue generated from decentralized taxes.

<sup>26</sup> See Shah (2012b: 15) for more information about the according weights for provinces and city/district governments.

<sup>27</sup> See Agustina et al. (2012) for further information about Indonesia's revenue sharing system, especially in the case of natural resource revenue.

<sup>28</sup> The property tax (Territory and Building Tax, PBB and Property Title Transfer Fees, BPHTB) was developed to the sub-national level by 2014, however not for the mining, plantation and the forestry sector.

<sup>29</sup> Law No. 35 (2008), Law No. 11 (2006), Law No. 21 (2001).

<sup>30</sup> *Hibah* means Grant in Indonesian.

<sup>31</sup> Implemented by the World Bank

*increase of the amount of capital spending in infrastructure (roads, irrigation, water, and sanitation) and Water hibah<sup>32</sup>, which ran from 2010 to 2011 and aimed at encouraging districts and cities (kabupaten and kota) to invest more in their water enterprises (PDAMs)<sup>33</sup>. Under P2D2, local governments could get reimbursed for the matching requirement as part of the DAK funding (see above) when they met certain performance indicators<sup>34</sup>. Under the Water hibah, local governments could invest in their water enterprises (PDAM), backed by a promised grant by the Ministry of Finance (MoF). The local PDAMs used the investment made by the local government to build water connections at the household level, once these had been verified as operational, the MoF transferred the promised funds to the local government.*

The following section presents an overview of the shortcomings in Indonesia's Intergovernmental Transfer System, focusing on DAU, as currently discussed in the development policy literature and among practitioners in our interviews. This will illustrate the gap between the ideal (see chapter on fiscal decentralization), conceptualized by the academic discourse and the actual implementation, which is likely to hamper the positive effect of fiscal decentralization on better public service delivery at the local government level.

According to Shah, the design of the DAU fund is problematic since its “one size fits all” approach leads to fiscal inequity (Shah 2012a). While the DAU equalizes jurisdictions with widely dissimilar responsibilities and characteristics, the specific needs of these regions are disregarded. The high heterogeneity in e.g. literacy, poverty, health, and economic activity put considerable pressure on the fiscal system to ensure that minimum standards are met with regards to quantity, quality, and access to public services. However, the transfer design of DAU ignores the fiscal capacity and needs of the differently-sized and -classed municipalities. It assumes that they have the same per capita needs and revenue sources outside the DAU formula (ibid.: 236.).

Another point of criticism is that the current transfer system seems to give strong incentives for further regional proliferation (*pemekaran*) since newly established regions receive transfers from the equalization fund DAU right from the first year of their existence (Harjowiryono 2012: 137). Thus, “the capability of the economy, regional potential and fiscal capabilities” (Government Regulation No. 78/2007, § 6.1) or the ability to run government activities does not seem to be the main criterion to qualify for the separation of a region (Harjowiryono 2012). These new separations within a province affect the amount of DAU allocation as well as the amount of DAK funding. Matters are further complicated as civil servants often refuse to change their place of residence, which means that new personal has to be hired. “The increasing share of expenditures for employees caused decreasing shares of spending on development and public service provision over time” (Harjowiryono 2012: 139).

There is a lack of time consistency and uncertainty in transfers for local governments. Due to the design of the underlying revenue sharing system, shared revenues are often transferred at the end of the year (Harjowiryono 2012: 137). Additionally, the size of shared

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<sup>32</sup> The project was implemented by the Indonesian Infrastructure Initiative (IndII) and the Australian Government Department of Foreign Affairs and Trade (DFT/AusAID).

<sup>33</sup> Perusahaan Daerah Air Minum

<sup>34</sup> These indicators were oriented at the extent of earmarked DAK allocations actually spent, the provision of reference unit costs, the realization of planned spending outputs and the compliance with national procurement guidelines, environmental safeguards and technical standards.

revenue funds are affected by oil price changes, which leads to uncertainty in the amount of transfers.

The calculation of fiscal capacity within the DAU formula is misleading since various sources of revenues are given different weights arbitrarily and DAK funding is excluded from the calculation (Shah 2012a: 237). The use of GRDP and the inclusion of natural resources and mining inflate the fiscal capacity of resource-rich local jurisdictions, although significant portions of these incomes may accrue to foreigners or non-residents. According to Shah 2012a, the HDI implemented in the DAU formula uses arbitrary weights, and except for the indicators of population and area, the indicators used have little or no relation to service needs (ibid.: 238).

An increase in own source revenue (PAD) decreases transfers. This could cause disincentives in the collection of local tax revenue. Plus, it could have negative effects on tax compliance and capacity building in the local tax administration. Additionally, since the DAU “compensates a jurisdiction for excess needs” (Shah et al. 2012: 6), local governments might have incentives for overspending.

The amount of basic allocation of the DAU is determined by the local “wage bill” (amount of local government salary). This might hamper the transition process to a more efficient administration and a lower allocation of resources to local government administration. According to Hofman et al. (2006: 12), it “removes any incentive for regions to streamline their organizational structures and salary bills” but provides “an incentive to recruit an excessive number of civil servants at the sub-national level” (Harjowiryo 2012: 136).

The decentralization reforms on the expenditure side could lead to vertical imbalances without according decentralization on the revenue side<sup>35</sup>. In Indonesia, local governments are still highly dependent on transfers from the central government. According to Harjowiryo (2012: 130), over 70 percent of local government revenue comes from transfers by the central government. This high dependence of local governments could be an advantage, increase the control by the central government, after more conditionality of transfers was implemented via alternative transfer designs (e.g. output-based transfers).

In the light of this lack of incentive compatibility, in-transparency, and fiscal inequity, Indonesia's Intergovernmental Transfer system should be simplified to a system of output-based transfers accompanied by capital grants. This would preserve autonomy and enhance equity, simplicity, objectivity, transparency, and accountability (Shah 2012b). Lewis (2014) argues that policymakers should take far-reaching performance grant schemes into account once reforming Indonesia's intergovernmental system and its present reliance on strictly equity-based approaches. Performance-based transfer systems (including output-based transfers) as a pathway to improve public service delivery at the local level are our focus in the chapters on the role of incentives in performance based transfers for health and PNPM Generasi.

### *Participatory Planning*

In Indonesia, citizen participation in the planning process, beginning at the village level, is statutory. The national planning system was re-regularized by the central government through Law No. 25/2004 which introduced the mechanism of *musrenbang* (*musyawarah*

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<sup>35</sup>According to Shah (2006), a *vertical fiscal gap* is the revenue deficiency arising from a mismatch between revenue authority and expenditure responsibilities at the local level. A *vertical imbalance* occurs when a *vertical fiscal gap* is not addressed adequately by necessary reassignments of responsibilities or by fiscal transfers.

*rencana pembangunan* = deliberative development planning) (Antlöv et al. 2010: 424). It prescribes participatory meetings at each regional government level in which the annual planning takes place. The planning process starts at the village level and is then passed on to the sub-district level and accordingly stepwise to the respective higher levels. Ideally, in each *musrenbang*, the priorities of the subordinate meetings' plans are identified and, on this basis, a more abstract and comprehensive plan is designed. On the other hand, there is a top-down national development plan giving instructions for an overall national program. Furthermore, each regent (*bupati*) or mayor (*walikota*) designs his or her development plan, which is then discussed with the proposals from participatory planning meetings.<sup>36</sup> However, the concrete design of *musrenbang* is left to the province governments leading to a number of specific participation designs and regional regulations concerning participation (*ibid.*). While some are elaborate and referred to as success stories, the majority of planning mechanisms does not lead to substantially different planning results or their implementation compared to top-down planning, as it was often stated by our interview partners working for donor agencies. This chapter describes the current participation mechanisms and their assessment by development experts, academia, and local government officials, differentiating between the institutional side – the participation mechanism – on the one hand and the participation process and the actors involved, on the other.

Development experts regard it as an important first step towards the improvement of planning that many local governments have identified the weaknesses of the centrally implemented *musrenbang* and have therefore created their own parallel participatory planning systems. Despite of this creditable commitment, Hans Antlöv, who has been working for several donor agencies, currently the World Bank, is skeptical as to whether these systems will bring any substantial improvement for the future as the designs do not actually enhance the *musrenbang* mechanism but rather create a completely new mechanism. Therefore, advancements cannot be adopted easily by other provinces, which have already implemented the *musrenbang* mechanism. Another criticism is that the specific planning designs are heavily dependent on the person who launches the alternative mechanism and his or her commitment.<sup>37</sup> This problem, noted by most of our interviewees, and the frequent call for a “strong leader” by civil society organizations can be seen in the light of Weber's concept of charismatic authority (2005 [1922]). In this theory of authority and leadership, charismatic authority is legitimized by the person in power and his or her acceptance through the people. All decisive and leading power lies with this person and not with a bureaucratic apparatus. In the process of modernization, charismatic authority is superseded by bureaucratic and rational-legal authority, which does no longer depend on the person in power but on a transparent, functioning bureaucracy and the institution of a government (*ibid.*). In Indonesia, there is a bureaucracy apparatus in place, however not as rationalized as in the Weberian model. Accordingly, one of the reasons for the need of charismatic authority in Indonesia can be seen in the generally acknowledged non-transparency and inefficiency of the oversized and often corrupt Indonesian bureaucracy (Anwaruddin 2004). This does not mean that there was no process of modernization in Indonesia, but it certainly took on a different form than in Western democracies. The reliance on charismatic figures is historically grown in Indonesia, where a majority of the people still venerates Sukarno, the first president, and where many citizens talk of the former dictator Suharto in awe and it could be one of the main reasons why ordinary

<sup>36</sup> Interview with the responsible officer for participatory planning on the provincial planning board (BAPEDA) of NTB, 19 December 2013.

<sup>37</sup> Interview with Hans Antlöv, 1 September 2013.

citizens, but also subordinate officers, are not used to take on political responsibility and to be in charge of substantial tasks. Following theories of path dependency, historicity plays a major role in establishing habitualities like the one described: longtime local officers, not to mention ordinary citizens, who have internalized that they are not entitled to make political decisions along with an institutional culture of mere execution of instructions from above, influence also budding civil servants (Widianingsih & Morrell 2007: 5). In the description of their perception of the World Bank Kecamatan Development Project (KDP), a pilot project for more direct citizen participation in planning and budgeting, Banerjee and Duflo write that the meetings “*had an attendance of about fifty, out of the several hundred adults in the village, and half of those were members of the local elite. Most people who attended do not speak: In the KDP meetings, an average of eight people actually said something, of whom seven were from the elite*” (Banerjee & Duflo 2011: 249).

This way of group interaction can be understood in the context of the consensus-oriented decision-making model that Koentjaraningrat described as *musyawarah* (discussion) and *mufakat* (unanimous decision) and that he found to prevail in most Indonesian cultures (2007: 397). Still, Banerjee and Duflo did not conclude that oligarchy was the only possible way of political decision-making in Indonesia. Instead, the mechanism was adjusted and citizens received formal invitation letters that made more people attend the meetings, especially people who did not belong to the elite. Furthermore, a comment form that had used to be distributed by the village head during the meeting was then handed out by schools, leading to more critical comments on average (Banerjee & Duflo 2011: 249). This example shows that power structures are often not taken into account and that the elite can easily utilize the power gained through decentralization and capture the decision-making process at the local level. Banerjee and Duflo, therefore, argue that decentralization should be shaped and designed by the central government in order to protect the interests of the marginalized and less powerful (ibid. 2011: 249).

The economist Mansur Afifi from the University of Mataram (UNRAM) criticizes the common practice to assign local government positions not on the basis of politicians' professions but rather on their status and their importance for the election campaign, which generates a widespread lack of expertise. Similarly, Blunt et al. (2012) show how public service delivery in the health and education sector is negatively affected by systemic patronage. They name numerous examples of human resource management (HRM) malpractices, such as the lack of human resource planning, little or no performance appraisal of staff, training to generate income for related parties and accommodation allowances, little or no relationship between performance and remuneration, and high absenteeism (particularly among teachers and health care workers), among many others (ibid.: 71). As posts are deemed more important than expertise in the distribution of power, there is frequent rotation of bureaucrats between different sectorial bodies even though there is a task force to allocate bureaucrats to sector offices according to their professional background. This is the result of a reciprocal help system in which newly elected heads of district or mayors have to reward their success team members with executive positions. Afifi argues that, due to the resulting lack of expertise, community members often know better what is important for their wellbeing than the local government, but that they are passed over by the authorities.<sup>38</sup> He therefore insists in the importance of education. In his experience, there are only few local officers having an overview of the complex, sometimes self-contradictory legal situation, which results from conflicting national and regional laws.

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<sup>38</sup> Interview with Dr. Mansur Afifi, 18 January 2013.

Thus, he claims, it would be necessary to have better educated and responsible local politicians and civil servants.<sup>39</sup>

Local government officials frequently bemoan the incompetence of ordinary – especially rural – citizens as a factor prohibiting good planning results per se: as they are supposedly not able to distinguish between needs and wishes, they do not set priorities “right” in their proposals.<sup>40</sup>

This could indicate conflicting understandings of either development priorities or participation, perhaps both. People might have entirely different ideas than local politicians about what needs to be changed, and they might also define participation differently. As most citizens were excluded from any substantial political participation during Suharto's 30-year New Order Regime (Widianingsih & Morrell 2007), they are not used to deliberative mechanisms and might therefore lack a realistic assessment of their influence and the planning situation.

However, others see this argument mainly as a flimsy excuse by local bureaucrats who do not accept different priorities of the citizens and do not want to yield any of their power to the people.<sup>41</sup> Antlöv, for instance, criticizes a certain inertia in many local governments and argues that they do not really aim at substantial community empowerment. Even though the basic regulations that are supposed to ensure equally accessible, well-facilitated participation meetings are in place, they are not implemented in many regions the way they were supposed to. Furthermore, local governments do hardly ever undertake extra steps in order to integrate disadvantaged groups like women or the poor. Even though these deficiencies are noticed by the central government, it does not enforce an improvement due to the tension between the centralized polity and the localized autonomy.

As many of our informants suggested, another general problem is that government funds, which are at local governments' commands, are rather spent for infrastructure and facilities than invested in capacity building. In his research on the allocation of budgets in the health sector, economist Afifi finds that budgets are mainly used to provide facilities and not invested in capacities or in health education or promotion.<sup>43</sup>

The PNPM (*Program Nasional Pemberdayaan Masyarakat* – national program for the empowerment of the people), which is run by the Indonesian government in cooperation with the World Bank, is currently investigating the actual need of infrastructure improvements in the regions. Except for very few provinces and districts, it evaluates the infrastructure very positively and therefore argues that services have to be improved more specifically with regards to the competence of public servants and to access to service delivery. Indonesian academia as well as foreign donor and assistance agencies also often state that capacity and skills are in most cases much more needed than infrastructure and tangible facilities. Contrary to this assessments, the focus often lies on infrastructure in the planning process, both with or without citizen participation. This holds also true for

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<sup>39</sup> Ibid.

<sup>40</sup> Informal conversation with Astia Dendi from GIZ, 10 January 2013 and authors' interviews with two bureaucrats from the provincial and municipal planning bureau, 19 December 2013.

<sup>41</sup> Interview with Dr. Mansur Afifi, 18 January 2013.

<sup>42</sup> Interview with Hans Antlöv, 1 September 2013.

<sup>43</sup> Interview with Dr. Mansur Afifi, 18 January 2013.

<sup>44</sup> Interview with Hans Antlöv, 1 September 2013.

<sup>45</sup> Interview with Dr. Mansur Afifi, 18 January 2013.

<sup>46</sup> Interview with Hans Antlöv, 1 September 2013.

planning and budgeting in the health In the Mataram, for instance, there are enough well equipped health centers, whereas the capacity of health workers or bureaucrats has not improved sufficiently<sup>47</sup>.

This situation can be seen as a consequence of the poor facilitation skills of the persons in charge of the *musrenbang* meetings<sup>48</sup>. As a result, meetings often turn out to be “shouting contests”, in which the loudest and most powerful, such as a head of religion, head of neighborhood, or head of village, are heard while others remain silent<sup>49</sup>. The infrastructure bias in planning can be ascribed to a lack of capacity in facilitation. For instance, best practice examples from CAP (Community Action Plan), a specific facilitation instrument introduced by former GTZ's decentralization program, indicate that the quality of facilitation is crucial for the success of the participatory meeting. In CAP, the facilitators apply different methods, for instance operating with scale models, to make the issues discussed more understandable and tangible for all participants<sup>50</sup>. In Mataram, CAP was adapted and institutionalized into the alternative planning mechanism of MPBM (*musyawarah pembangunan bermitra masyarakat –deliberation in development partnering the community*<sup>51</sup>). Another possible explanation could be the visibility of infrastructure means: as many governments are criticized for misappropriating money through corruption, spending on infrastructure is a way for bureaucrats to prove their integrity and their willingness to spend money on public services<sup>52</sup>. Still, this does not explain why citizens participating in development planning also tend to support physical facilities rather than capacity building measures. As the Kinerja project found out in a complaint survey, complaint mechanisms, which are in place in order to enable citizens to hold local governments responsible for providing bad services, are mainly used to complain about lacking infrastructure and not about lacking service quality. „[W]hat we learn is, because although we strongly propose MSS<sup>53</sup> it is not well known by the community. So when they're complaining, they are more complaining on the infrastructure (...). They mostly complain about what they can see rather than the quality of the service.“<sup>54</sup>

This focus on infrastructure or facilities could indicate that “development” is understood in terms of tangible, material achievements rather than in terms of capacities and skills. Local government officials and citizens seem to have a very different assessment of development needs in their regions than development workers. Taking a community perspective, Antlöv, on the other hand, refers to infrastructure as the “lowest common denominator” in deliberative planning since it consists of public facilities everybody benefits from. From his point of view, participants in the PNPM meetings decide to finance infrastructure rather than other projects due to community dynamics. He considers the striving for harmony in the community as one of the main reasons behind these dynamics: in order to avoid conflicts, the community members decide to build more roads or bridges as this does not clearly privilege one group of the community<sup>55</sup>. Thus, the planning meeting remains calm and harmonious as no open conflict is stirred. Stating this, he refers to the Javanese concept

<sup>47</sup> Interview with Dr. Mansur Afifi, 18 January 2013.

<sup>48</sup> Informal conversation with Astia Dendi from GIZ, 10 January 2013.

<sup>49</sup> Interview with Hans Antlöv, 1 September 2013.

<sup>50</sup> Informal conversation with Astia Dendi from GIZ, 10 January 2013.

<sup>51</sup> N.N. (2009): GTZ 2009-0560-factsheet-Indonesia (Good Local Governance): 7.

<sup>52</sup> Interview with Hans Antlöv, 1 September 2013.

<sup>53</sup> Alongside Public Service Standards, they are supposed to ensure common service provision to citizens. If they are not provided with these services, citizens can claim them at public service providers, such as health centers (Fünfgeld et al. 2012).

<sup>54</sup> Interview with Marcia Soumokil, working for USAID's Kinerja project, 8 January 2013.

<sup>55</sup> Interview with Hans Antlöv, 1 September 2013.

of *rukun* (harmony), one of the central concepts in the *kejawen* worldview<sup>56</sup>. However, as he described the phenomenon earlier as a pan-Indonesian one, it is questionable whether the concept of *rukun* and, as a result, conflict avoidance can be applied to the whole country or whether it is only a possible explanation for the Javanese context<sup>57</sup>.

Mataram is the capital of the province of NTB, which ranks second last among thirty-three Indonesian provinces regarding the HDI, especially in the fields of education and health.<sup>58</sup> Particularly, child and maternal mortality rates are above average. It is frequently criticized that there are hardly any public services providing information about preventive measures against the health issues described. Instead, medication programs, which do not change the situation for villagers with a lack of knowledge in the field of health and hygiene, are offered<sup>59</sup>.

Afifi ascribes this fact partly to the socio-cultural peculiarity that people in rural areas are often organized in big family units with a specific hierarchy. They often do not make use of the health services provided because they first have to consult their family members in order to make a decision whether to go to the hospital or not.<sup>60</sup> „They have to discuss everything with [the] family [...]. So, think about, if you bring someone to the hospital you have to prepare many things, [...] about how they wear clothes [...] they bring what they - everything! And maybe people will accompany them to go to [the] hospital because sick is a social problem.“<sup>61</sup> Due to this lag of time, people with serious illnesses often do not arrive at hospitals in time and cannot get the required medical care. Socio-cultural factors like this, the economists Afifi and Zaini claim, have to be taken into account in regional development planning as otherwise health facilities are not accessible for everybody although theoretically they should be.<sup>62</sup>

A similar problem holds true for the administrative effort a person has to make in order to receive health services, for instance in the case of a medical emergency. This takes a lot of precious time, in which doctors should take action and discourages people to make use of public services.

These examples imply that a better education, e.g. in the form of health campaigns, is vital for the demand side to actually claim medical services. However, education is also crucial for the provider side. Especially in connection with the assignment of officials to their function, there are many mismatches in NTB, for example an official with a religious academic background leading a hospital, lacking the management skills required for such a leadership function.<sup>63</sup>

The missing institutional link between planning and budgeting often leads to an unfeasibility of the setting of development plans and a lack of planning reliability.<sup>64</sup> Generally, 30 percent of APBD (*Anggaran Pendapatan dan Belanja Daerah* - the yearly regional budget) are left for community development, the rest is earmarked. Even though this is

<sup>56</sup> Interview with Hans Antlöv, 1 September 2013.

<sup>57</sup> Interview with Hans Antlöv, 1 September 2013.

<sup>58</sup> Data provided by Badan Pusat Statistik (Federal Statistics Bureau)

([http://www.bps.go.id/eng/tab\\_sub/view.php?kat=1&tabel=1&daftar=1&id\\_subyek=26&notab=2](http://www.bps.go.id/eng/tab_sub/view.php?kat=1&tabel=1&daftar=1&id_subyek=26&notab=2); last access 10-08-13)

<sup>59</sup> Interview with the responsible officer for participatory planning on the provincial planning board (BAPEDA) of NTB, 19 December 2013.

<sup>60</sup> Interview with Dr. Mansur Afifi, 18 January 2013.

<sup>61</sup> Ibid.

<sup>62</sup> Ibid.

<sup>63</sup> Interview with Dr. Mansur Afifi, 18 January 2013.

<sup>64</sup> Informal conversation with Astia Dendi from GIZ, 10 January 2013.

quite a high number, the quality of spending remains contested. It is also criticized that the exact amount of transfers available for the regions is not known in advance as it is re-adjusted every year in accordance with the tax revenues, which makes it difficult for regional governments to plan ahead.<sup>65</sup>

Due to electoral politics, the budgeting process often results in pork barrel spending.<sup>66</sup> A popular example is the common concern that local governments tend to distribute funds unevenly in favor of sub-districts with a high support rate during elections and thereby consolidate their power and influence.<sup>67</sup>

Furthermore, civil society members, academics and consultants from various donor agencies criticize the lack of integration of planning and budgeting, often rendering participatory planning obsolete. Antlöv puts it like this: “if you have a perfect planning process at the village level with, you know, a strong input from women and marginalized groups and they aren't funded? (...) It doesn't mean anything, right?”<sup>68</sup>. As a result, villagers who are initially willing to contribute to the planning process become increasingly frustrated and demotivated when their efforts do not bear fruit. Reasons for the refusal of proposals are scarce resources and differing priorities of citizens and bureaucrats. Afifi gives the example of a village, in which the inhabitants proposed a new bridge they deemed useful for their daily ways. The budgeting team, however, decided to build a soccer field. According to his account, this is a very common story in regional budgeting.<sup>69</sup>

Part of the research outline was to focus on gender relations as an important aspect of participatory planning since women's concerns are often not represented adequately in political decision making. This also applies for female health issues, such as maternal health or reproductive health.

Chant and Gutmann (2005) point out that in development agendas, it is crucial to not only focus on women but on gender relations and to also include men in development programs. If not, they argue, based on various case studies in Latin America, the Caribbean, and Southeast Asia, the increasingly contested masculinity becomes a problem as the term “gender” applies to the relation between the socially constructed “genders” and not to women only. Moreover, men are likely to boycott development measures directed solely at women (Chant and Gutmann 2005: 241-244). The latter point could be an explanation why women's contributions to planning meetings are often very little, as development experts, such as Antlöv, have observed. He argues that the fact that gender is “mainstreamed” in the central Indonesian planning policy makes the issue appear to be considered extensively. In reality, however, it is severely neglected, as local planning officers do not know the national development plan (RPJMN) in detail and do not regard themselves as responsible for the gender issue. Even though Women take part in participatory planning meetings, they often do not dare to speak up and make proposals<sup>70</sup> This assumption is undergirded by a young female civil servant working for the BAPEDA (*Badan Perencanaan Daerah* - regional planning body) in Mataram. When asked whether the category of gender was taken into account in the planning process, she merely referred to the possibility of the local women

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<sup>65</sup> Interview with the responsible officer for participatory planning on the provincial planning board (BAPEDA) of NTB, 19 December 2013.

<sup>66</sup> Or, as Antlöv adjusted it to the Indonesian context “*kambing barrel*” (goat barrel).

<sup>67</sup> Interview with Hans Antlöv, 1 September 2013.

<sup>68</sup> Ibid.

<sup>69</sup> Interview with Dr. Mansur Afifi, 18 January 2013.

<sup>70</sup> Interview with Hans Antlöv, 1 September 2013.

empowerment body to make proposals during the meetings, just like any other government body.<sup>71</sup>

### *The Role of Incentives in Performance Based Transfers for Health Services*

Incentives of public service providers, which determine the amount and quality of services and the users of health services, which influence the effectiveness and long term effects of a provided health service, need to be aligned. In order that a policy, with the aim to increase the immunization rate of children, it must be ensured that people have adequate access to immunization centers and that all the vaccination appointments are kept (it often needs more than one vaccination for an immunization against a specific disease to be effective). A high absence rate of hospital staff or long waiting times at an immunization center, for example, will discourage people to get their children vaccinated since it increases their opportunity costs (time that could be used for productive purposes instead).

According to Banerjee and Duflo (2011), a lack of demand for lifesaving health services is not necessarily induced by a lack of understanding of their importance but rather by time inconsistent behavior inherent in human nature. Individuals tend to postpone small costs like standing in line to get vaccinated today to avoid the costs of not being vaccinated in the future. The authors conclude that “fines or incentives can push individuals to take some action that they themselves consider desirable but postpone taking” (Banerjee & Duflo 2011: 65). Here, performance-based transfer scheme can align the behavior of the supply side of services with the needs of the demand side for services. Doing so, performance-based transfer schemes can be crucial to ensure the amount, quality, and long-term effectiveness of public services.

In the following, we will further analyze the concept of performance-based transfer schemes and present empirical evidence regarding their effectiveness, focusing on the health sector. Steffensen & Fredborg (2005: 4) argue that, “as intergovernmental fiscal transfers are one of the main local government (LG) revenue sources in developing countries and account for more than 60 percent of the total LG sources in many countries, it is utmost important for the success of the overall decentralization process, that the transfers achieve their objectives and promote the right incentives”. The concept of performance-based grant systems (PBGTs) tries to incentivize improvements in performance by linking the local governments' performance in pre-determined areas with both access to and amount of funding (UNCDF: 2010). Lewis and Smoke (2012: 255) see “incentives as embedded features of a good governance system”. Appropriate behavior, e.g. the efficient use of resources to provide the necessary quantity and quality of public services to a country's citizens, has to be accompanied by benefits for those in charge of delivering such services at the local level. On the other hand, non-delivery has to be connected with costs. Only then, the theoretical benefits of decentralization can be realized (ibid.: 256). Compared to more input-oriented financing schemes, which tend to focus on strengthening the supply chain, construction, and training, performance incentive schemes do not simply assume that results follow automatically (Eichler & Levine 2009). They make results conditional for further financial transfers to the local level. Eichler & Levine define the broad concept of performance incentives as “the transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target” (ibid. 2009: 6). According to Shah, conditions are not imposed on the use of funds but rather on the attainment of defined standards in the quality and quantity of services as well as on the access to such services. They are therefore not affecting local government

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<sup>71</sup>Authors' interview on 19 December 2012.

incentives for cost efficiency but encourage compliance with national standards (Shah 2006).

There has been a growing amount of empirical research and country evidence on the question whether or not performance-based transfer schemes lead to behavioral changes and improvements in public service delivery. In Bangladesh, rewarding health workers for successfully teaching mothers to prepare oral rehydration therapy (to treat diarrhea) had significant positive effects on mothers acquiring knowledge (Chowdhury 2001). In Nicaragua, paying providers who reach immunization coverage targets and conditional cash transfers to households increased the immunization level of 12-23 months old children by 18 percent, especially in poor households (Eichler & Levine 2009: 35). In Cambodia, primary health care services were contracted to NGOs, one of which used performance incentives at the staff level. This led to significant improvements in areas such as antenatal care and to a stronger focus on the poorer half of the population (Schwartz & Bhushan 2005). In Rwanda, performance incentives were introduced as part of a national strategy in order to improve the actual quality of health care and to ensure that health facilities would not just focus on the quantity of services. Since 2005, district health teams have carried out evaluations of the service quality in some provinces, which have been the basis for performance payments. As a result, provinces with these incentives to improve quality had on average a significantly higher service quality (Eichler & Levine 2009: 37). In Haiti, “the potential to earn rewards motivated individual health workers and inspired efficiency enhancing organizational change” (ibid.: 38). According to Lewis (2014), who analyzed the two pilot performance-based grant schemes in Indonesia described in chapter 4.2.1, P2D2 participation had no significant effect on per capita capital spending. However, an additional rupiah of DAK led to higher per capita capital spending (2.05 Rp) of local governments participating in P2D2 compared to local governments not participating in the program (1.34 Rp). Lewis (2014) argues that local governments participating in P2D2 use DAK to crowd-in additional capital spending to a higher extent than nonparticipating local governments. Regarding the Water Hibah program, he shows that it encourages local governments to increase investments towards their water enterprises to a larger extent than they would have done without program participation. According to Lewis (2014) further research on the long term effects and on the exact channels of both programs is required. However, disentangling the impact of the incentive from that of other interventions introduced simultaneously is often problematic and the “relative scarcity of negative results may be related to a publication bias” (Eichler & Levine 2009: 24).

Performance-based grants (PBGs) can have a variety of different designs and one needs to be aware that “different labels exist for essentially the same concept or are associated with different incentives and payment arrangements” (Musgrove 2011: 1).<sup>72</sup> For example, PBG systems can vary by the type of performance (specific service delivery outputs or general institutional development) or by the use of funds (multi-sector or sector-specific usage) (Steffensen & Fredborg 2005: 7). Concerning public service delivery in the health sector, we focus on performance-based grants, defining performance as a specific set of outputs.<sup>73</sup>

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<sup>72</sup> Grants and transfers are often used interchangeable in the literature.

<sup>73</sup> It is important to distinguish between outputs and outcomes. An output refers to the specific quality or quantity of a service and its accessibility (e.g. the amount of health facilities in a region), whereas an outcome is a possible long-run consequence of public service delivery provision (e.g. a higher life expectancy in a region). Therefore, outcomes can be influenced by factors outside the responsibility of a service provider (or service user) and should therefore not be used as a condition for transfers (Shah 2006).

Output-based transfers vary in different regards: they can be paid to an individual or a collective, they can intend to increase quantity (e.g. immunization coverage) or quality (doctor's time and accuracy in consulting patients), and the funding can either come from a central government or a donor agency. Another distinction is who receives the transfers, the supply side (the service provider) for achieving a certain quantity or quality of service or the demand side (the user of certain services) for using the existing service infrastructure (e.g. a family that sends their children to regular weight checks). The latter are so-called “conditional cash transfers”. According to Olken et al. (2011:16), such classical demand side conditional cash transfer programs (CCTs) are “*inappropriate in many developing world contexts, where beneficiaries do not have adequate access to health and education services*”. Under such conditions, programs that directly address the supply and the demand side constraints would be more useful. The specific design and the empirical evaluation of the effectiveness of such a program, the PNPM *Generasi* in Indonesia, is presented in the next chapter.

Eichler & Levine (2009) identified the following key aspects for performance-based transfer design to health service providers: (1) Performance-based transfers can only have an effect if the problems are directly related to the behavior of a service provider/user or to a system (its organizational structure and management) and not to a lack of resources. This lack in the quality of spending rather than the quantity of spending is a concern that is expressed about Indonesian Intergovernmental Transfers as well.<sup>74</sup> (2) The magnitude of incentives has to overcome incentives induced by existing reimbursement schemes (Eichler & Levine 2009). (3) Performance payments should be transferred to the personnel of a service provider instead of the management in order to induce behavioral changes and to avoid being captured by the local elites. (4) All stakeholders should participate as this would maximize the effectiveness of the scheme, minimize interference with the implementation, and increase the understanding of the specific environment. According to Eichler & Levine (2009: 51), performance incentives are “*about what the results should be and then letting the key actors – the patients, the providers – figure out how to achieve them*”. (5) A monitoring system using “*relevant, understandable, attributable, measurable, and verifiable*” indicators (ibid.: 60) at the level of both the service user and the service provider side is necessary to guarantee that the measure is considered as fair by the stakeholders (ibid.: 55). To enable stakeholders to adapt the new payment schemes, an (6) adjustment period should be considered and refinements should be introduced along the way (ibid.: 51). (7) It is crucial to find the right balance between desirable outcomes and feasibility, to understand the behavior rewarded by the already existing incentives, to decide on the terms of incentives (penalty or reward), to ensure that incentives do not lead to unintended outcomes or increase disparities, and to find the right amount of indicators. A small number of indicators, for example, decreases complexity, increases the understanding by stakeholders, and enables to focus on changes. However, if the indicators cover only a few sectors of the service provision, the potential recipients of performance payments might only focus on those (ibid.: 61). (8) Furthermore, it has to be decided if performance on the supply side is verified by independent verification (e.g. surveys) or by self-reporting by the providers combined with random audits. Independent audits can most likely not be influenced (manipulated) by the providers; however, this is not going to promote the development of an information system within the targeted organizations (ibid. 2009). (9) Moreover, the maximum cost of a performance-based transfer program has to be projected accurately, which is a challenging task if payments are made for each additional service unit provided and are not determined

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<sup>74</sup>Interview with Pattinasarany Daan and Agustina Cut Dian R.D, World Bank Indonesia, 15 January 2013.

by reaching a predetermined target (ibid.: 58). Finally, (10) an evaluation of the impact of the project that “must go beyond collecting useful, timely, and accurate data” (ibid.: 70) is necessary. In order to account for spillover effects, services not included in the list of potential performance payments should be included and not only just for monitoring reasons but also in order to identify the impact on service delivery performance only by the program (ibid.: 70). This incentive effect of performance based grants, however, is often difficult to identify since performance incentive programs are commonly implemented parallel to other interventions. In the following we describe a performance-based transfer design in Indonesia where this isolation and the measurement of its effect on health performance was achieved.

### *PNPM Generasi*

In 2007, the Indonesian government, the World Bank, and a selection of donors<sup>75</sup> implemented a pilot program in order to improve public services in the sectors of health and education by an incentivized community block grant program called *PNPM Generasi*<sup>76</sup>. As a follow-up to the *Kecamatan Development Program (KDP)*, *PNPM Generasi* gives block grants to villages, which are selected on the basis of the population size and poverty level of a sub-district.

In order to give communities an incentive to spend these grants most effectively, 20 percent of the size of the grant in the following year depend on the village's performance in twelve targeted indicators (Olken et al. 2011: 2), which are related to performance in the health (e.g. frequency of weight checks, child immunization, postnatal care etc.)<sup>77</sup> and education (e.g. school enrollment) sector. Performance is measured relative to a constant predicted minimum attainment level<sup>78</sup> based on a historical national dataset and not by looking at improvements against an actual baseline (ibid.: 20). How to use the block grants is decided in a participatory planning process of the villagers with the assistance of trained program facilitators and service delivery workers (Olken et al. 2011: 2).<sup>79</sup> According to Olken et al. (2011), “[t]he *generasi* project thereby takes the idea of performance incentives from conditional cash transfer programs and applies it in a way that allows communities the flexibility to address supply constraints, demand constraints, or some combination” (ibid.: 2). It combines community block grants and performance bonuses for communities.

An important design feature of *PNPM Generasi* is, that performance bonuses are related relatively to the performance of other villages within the same sub-district, which accounts for unobserved differences in the capabilities of different areas (ibid.: 19). Performance measures are always seen relatively to other villages in the same sub-district, just because a district had higher performance standards from the start does not mean all villages within this district receive higher bonuses. This limits the possibility of increases in (initial) disparity across sub-districts and villages always “compete” for bonuses within their sub-district.

<sup>75</sup> AusAID, Danida, the United Kingdom Department for International Development (DFID), the Government of the Netherlands, the European Union, and USAID.

<sup>76</sup> *Generasi* means generation in Indonesian.

<sup>77</sup> See Olken et al. (2011: 17) for the complete list of health indicators.

<sup>78</sup> See Olken et al. (2011: 22) for a detailed description of the minimum attainment level.

<sup>79</sup> Unfortunately, the final evaluation report of the project does not give much attention to the concrete participation design and procedure so that it is difficult to evaluate in this context. What is stated, however, is that the design aimed at an improvement of the national *musrenbang* design (Olken et al. 2011: 5).

In order to identify the incentive effect of the program, sub-districts (*kecamatan*) were randomly assigned to the *Generasi* program or to a control group. The participating sub-districts were randomly assigned to an “incentivized” group with the performance-based transfer component or to a “non-incentivized” group without this component. This ensured that all villages within a sub-district received the same treatment and all potential within-sub-district spillovers would be captured in other treatment villages (cluster-randomized design). According to the Final Impact Evaluation Report (*ibid.*: 22), the three groups of sub-districts had similar pre-project characteristics (*ibid.*: 22). To separate the incentive effect from the effect of the block grant itself, i.e. to have more financial resources, the non-incentivized control group, which had received block grants, was compared to the incentivized group, receiving block grants as well. The result, between 50-75 percent of the total impact on health indicators, can be attributed to the performance incentives (*ibid.*: 38).

There were three evaluations at different points in time after the project was implemented. According to the Final Impact Evaluation Report, the program had, on average, a statistically significant positive impact across all twelve indicators (*ibid.*: 40). The strongest improvements in health were made regarding the frequency of weight checks for young children and the amount of iron sachets pregnant mothers received at antenatal care visits. Results show a 6.8 percent increase of weight checks and a 4.7 percent increase of mothers receiving sachets compared to the average level in control areas (*ibid.*: 37). The strongest improvements in education were realized for the school participation rate among the primary school age group. The results of the interim evaluations only showed significant effects in the health sector, not in the education sector, however Olken et al. (2012) argue that the baseline levels for health were lower and that education targets may have been more difficult to achieve, especially in the short run (*ibid.*: 4). The main long term impact regarding health was a decrease in malnutrition (by 2.2 percentage points, a 10 percent reduction in comparison to the control level). Although, reductions in child and infant mortality could be identified in the interim evaluation the same level of reduction in mortality rates could not be sustained in the final evaluation.

## Discussion

### *Performance based transfers*

According to academics, political advisors, and other stakeholders, the design of Indonesia's intergovernmental transfer system suffers from significant shortcomings: an imbalanced and incomplete devolution of fiscal revenue authority and expenditure responsibilities to the regions, a high degree of uncertainty in transfers, the inadequate deployment of incentive schemes, and a lack in the quality of spending. Compared with Bahl's (1999) claim for simplicity and the avoidance of complicated grant formulas, Indonesia's Intergovernmental transfer systems' “super complexity leads to a lack of transparency, inequity and uncertainty in allocation” (Shah et al. 2012: 4). As we have seen in the chapter on the Intergovernmental Transfer System, the transfer systems lack to account for different capabilities to deliver services by local governments, at least if we look at the largest amount of government transfers (DAU) to local governments. All this is most likely hampering the quantity and quality of health services at the local level. We have presented empirical evidence for performance-based transfers as one pathway to improve public service delivery in the health sector at the local level. Performance-based transfers can induce organizational changes at the level of the service provider, improve the quality of

spending, and lead to positive behavioral changes at the level of the service user. In the case of PNPM Generasi, to a decrease in malnutrition and child mortality rates as well as to an increase in the frequency of weight checks for young children.

Despite the positive results, there are some concerns regarding the success of performance-based transfer projects. According to Wetterberg & Brinkerhoff (2012: 34), “the critical issue for broader impact and sustainability is how to move from these islands of effectiveness to institutionalization”.

There might be conditions under which performance-based transfer systems would increase existing (fiscal) disparities between regions even further since stronger performing regions would be able to generate more fiscal revenue. Looking only at supply side approaches, governments might prohibit reward payments to civil servants since they base transfers on input costs (e.g. on salaries, as this is partly the case in Indonesia's DAU-formula). Focusing only on demand side approaches might not be the right choice either, due to a lack of accessibility in services, especially in emerging economies.

We demonstrated how the project PNPM Generasi addresses demand as well as supply side constraints of health services in Indonesia. It relates performance bonuses to the performance in other villages in the same sub-district in order to account for unobserved differences and to avoid increases in disparities between regions. PNPM Generasi as a donor-initiated innovation has been expanded to become a national program, thus moved away from just being an “island of effectiveness”.

With respect to general reforms, some stakeholders and academics call for increasing the amount of funding transferred by DID (Special Incentive Grant, see chapter on the Intergovernmental Transfer System) since it currently only accounts for approximately 1 percent of total transfers. It would also be possible to increase the amount of conditional DAK funding (specific purpose grant, see same chapter) at the expense of unconditional DAU funding. According to Harjowiryo (2012: 137), DAK as an earmarked grant “is best suited to support the achievement of minimum standards in specific public services at the sub-national level such as education, health, and infrastructure (road, irrigation, draining, water supply)”. As we have seen in the chapter on the intergovernmental transfer system the first according measures are undertaken by Indonesia's government, implementing P2D2 and Water Hibah.

As for potential alternatives to the current intergovernmental transfer system, it would be possible to cluster (group) local governments according to their population size, area, and class before determining transfers.<sup>80</sup> This would account for specific fiscal needs more accurately. Furthermore, a sunset clause of five years could be implemented and ceilings and floors could be integrated into the DAU-formula to make the amount of transfers more predictable and stable (Shah et al. 2012). It is often argued that it would not only be necessary to increase the effectiveness of transfers but also to raise the local revenue raising authority and capacity in order to make transfers to local governments unnecessary in the long run. At the conference “Looking back – thinking forward: learning from 20 years of Decentralization Support”,<sup>81</sup> Budi Sitepu, GIZ Indonesia and rapporteur for the group discussion on Fiscal Decentralization, concluded: “the existing fiscal decentralization policies have contributed significantly to support the development of local autonomy. This is indicated by the substantial increase of fiscal transfer from national budget to local budget over years and the enhancement of local taxing power. However, some problems

<sup>80</sup> Interview with Daan Pattinasarany Agustina Cut Dian R.D., World Bank Indonesia, 15 January 2013.

<sup>81</sup> Jakarta, October 2012.

persist in this regard. Like the imbalance between transfers and local revenues, the quality of the expenditure and a lack of financial accountability. In order to deal with the imbalances it is claimed for more local taxing power to promote autonomy and accountability.”<sup>82</sup>

Until 2014, the property tax (Territory and Building Tax, PBB and Property Titel Transfer Fees, BPHTB) was devolved to the sub-national level, albeit not for revenues from the mining, plantation, and forestry sector. Here one should consider the devolution of the remaining property tax (mining, plantation, forestry) to local governments, the application of piggyback on income taxes, the optimization of local charges/fees as well as a simplification of the local tax systems.

Another pathway to improved PSD, unrelated to Indonesia's current Intergovernmental Transfer System, is to provide non-fiscal incentives to local governments to perform better, such as reputation and image. According to our interview partners, this is a current trend among development cooperation agencies,<sup>83</sup> which, however, has not been systematically integrated as a possible pathway to service delivery in the relevant literature yet. An example for this approach is the University Network for Governance Innovation at Gadjah Mada University (UGM) in Yogyakarta. The network hosts a competition for best practice stories about good local governance from Aceh, West Kalimantan, East Java, and South Sulawesi, which are presented at an “Innovation Summit” at UGM. The summit serves as a platform to bring *bupati* and *walikota* (heads of the regencies and cities) and stakeholders from local governments together to exchange experiences and get support from each other in order to implement these practices in their districts. The award plans to help local governments to gain reputation and legitimacy among their constituencies, which, in return, is seen as an incentive to invest into good local governance.<sup>84</sup> According to an interviewee, “community participation in good governance is still something new in Indonesia, especially for local governments,”<sup>85</sup> so the focus on ceremony and prestige as in UGM's “Innovation Summit” can contribute significantly to awareness raising. This inclusion of actors from academia has the potential to play a bigger role in participatory governance for better public service delivery since the role of a broker or intermediary body between stakeholders at central and local levels often remains vacant. An involvement of members of universities, acting as knowledge brokers between local governments, central governments and donor agencies, are a key factor for the success of participatory governance schemes at the local level. These actors are knowledgeable on technical issues of public service delivery, committed to working with the communities, and trusted by donors, community members, and local and central government officials alike.<sup>86</sup> They are perceived as neutral and can thereby mediate if there are antagonisms and information asymmetries.

### *Participation*

To sum up, the majority of our interview partners stated that, in their experience, successful participation is heavily dependent on local government leaders. Although deliberation and participation have become part of the governance process in Indonesia,

<sup>82</sup> Unpublished report of the conference: “Looking Back- Thinking Forward. Learning From 20 Years of Decentralisation Support”, 30 October 2012, Jakarta.

<sup>83</sup> Informal conversation with Astia Dendi from GIZ, 10 January 2013 and Interview with Marcia Soumokil, working for USAID's Kinerja project, 8 January 2013.

<sup>84</sup> Interview with Marcia Soumokil, working for USAID's Kinerja project, 8 January 2013.

<sup>85</sup> Ibid.

<sup>86</sup> Informal conversation with Astia Dendi from GIZ, 10 January 2013.

the way in which the centrally implemented participation mechanism *musrenbang* is practiced seems not to empower citizens just by virtue of its existence. This can be partially explained by the consensual decision making which traditionally plays a big role in Indonesian cultures as Koentjaraningrat has shown. Another reason could be the design of the planning mechanism. Even though local governments can improve and adjust *musrenbang* according to the local situations, this only happened in some pilot projects launched by donor agencies or under committed local government leaders. In most districts and cities (*kabupaten and kota*), there is still no linkage between planning and budgeting, which often makes participatory planning obsolete as local bureaucrats in the budgeting agencies and committees can easily enforce funding for their prioritized proposals. In general, most of our interview partners deemed an integration of participatory planning with budgeting necessary as it would allow the realization of more proposals made by citizens.

A remarkable finding was the strong preference of infrastructure projects over capacity building projects in local politics – with or without citizen participation. In contrast to this, all our interview partners agreed on the evaluation that infrastructure and especially health facilities were already in place and that there was rather a lack of capacity among local bureaucrats and civil servants on a) how to facilitate planning meetings, b) how to distinguish the most important development needs, and c) how to address citizens through elaborate service designs.

A point of criticism that is leveled frequently by (local) bureaucrats is that the populace lack reasoning powers, which supposedly prevents them from deciding between wishes and needs in their proposals. Other interview partners, however, ascribed the responsibility to participation facilitators, who should, in their eyes, enable each citizen to make a valid decision on what she or he needs.

The efficacy of political decentralization in general and of participatory planning in particular is constrained by numerous factors. Political decentralization is often associated with good governance, however, in our interviews we very often came across accounts that depicted participatory governance as flawed and thereby connected it rather to chaotic and ineffective governance. An element that we repeatedly encountered in our interviews pertains to “knowledge management”. Remarkably, the local government officials we talked to did not know in detail the legal situation they had to deal with. When asked about local tax revenues, for instance, a high ranking officer from BAPEDA NTB did not know which of the taxes are collected by the province. On the one hand, this can be ascribed to the frequently criticized performance of bureaucrats in Indonesia (e.g. Prasojo 2012). On the other it could also indicate that they are simply lacking expertise: bureaucrats, who are now placed in sector bodies are often still not used to have much responsibility, since their function under the authoritarian New Order regime was primarily representative. As elaborated above, the lack of guidance for tax collection at the provincial level could also be interpreted as the purposeful creation of a failure in order to demonstrate that tax collection power should stay at the central level.

Furthermore, lacking information flows between the central and the provincial and district levels were a much cited constraint. This has been a problem since decentralization was initiated and has hampered the planning and implementation of strategies in districts and provinces. Citizens are not well informed about their rights concerning public service delivery, e.g. about their right to standards of healthcare and the possible ways to access health facilities. The result is that citizens cannot fully benefit from the existing health structures. Connected to this is the situation created by political turnovers and the ensuing

lack of an “institutional memory”. Even if a local government is committed to delivering services, the situation after an election and turnover of civil servants might change, either because of other interests within the new government or because the relevant information is not provided to the successors.

The implementation of a national legislation on health in districts and provinces is often hampered by the fact that there are no local regulations that implement these central stipulations. As the implementation is at the discretion of officials at district and province level, advocacy organizations that push for such regulations are very important. Local regulations are crucial since they exert normative and legal pressure on the local authorities. That local regulations are issued is again contingent on the interest and willingness of officials to include civil society actors into the decision-making process, which pertains to the political culture of participation in the still relatively new context of decentralization. A “pre-reformasi orientation” (Wetterberg & Brinkerhoff 2012: 36) discourages citizen participation and frames it as an intrusion into government affairs (Buehler 2011). Therefore, although there is evidence that citizen participation can improve service delivery, the shift from pilot projects to a nationwide implementation of best practices is an ongoing challenge (Wetterberg & Brinkerhoff 2012: 36). Another issue is a “participation fatigue” of citizens that have already participated or tried to participate in some kind of consultation process. We heard accounts of a high frustration among civil society stakeholders because decisions they were involved in are sometimes never put into practice. This can discourage citizens to participate again, especially when the cost of participation is high, for example due to long journeys and the subsequent loss of income.<sup>87</sup>

With regard to an improvement of bottom-up planning results, an approach focusing on the capacities of bureaucrats seems sustainable. However, this is an undertaking closely intertwined with a general bureaucracy reform and the reduction of bureaucracy and thereby corruption (McLeod 2008). As such, it is a huge enterprise depending on a variety of factors. Still, we identified some aspects that could be taken into account in future policies.

In order to improve the planning and implementation of public services, education in a broad sense turns out to be crucial: First, bureaucrats in Indonesia often lack a substantial understanding of their field of responsibility and the laws that are supposed to determine their action in the field of planning and budgeting. They often do not receive sufficient training in order to conduct participatory meetings as facilitators and lack the capacity of including socially marginalized groups. Second, with regard to accessibility of public services, citizens should get more information and education regarding hygiene, health, prevention, and the public services in place. In order to develop an agenda for this kind of education, a close and differentiated assessment of region-specific social and cultural circumstances is crucial.

This focus on education applies particularly for the formulation of local regulations concerning participatory planning. Afifi claimed that the mechanism could be improved easily, for instance through nationwide briefings for local government officials who have to put the national law into local practice or through a rather concrete, less complicated formulation of laws. Afifi indicates that the fact that these kind of briefings do not exist yet are due to a lack of foresight of most local bureaucrats, which again results from an inadequate understanding of their own work.<sup>88</sup> As this analysis shows, cooperation with academia specialized on local contexts could be fruitful for an assessment of the situation,

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<sup>87</sup> Interview with Dr. Mansur Afifi, 18 January 2013.

<sup>88</sup> Ibid.

as it has been the case in Mataram, where the municipality was counseled by economists from UNRAM. Such cooperations could be broadened through the involvement of political scientists, economists, and anthropologists or sociologists in order to take local socio-cultural or economic specialties and scientific insights on policy designs into account. As Dendi argues, well-trained facilitators would be able to make the community members, who are fairly inexperienced in a democratic (all the more deliberative) political sphere, understand the concept of participatory planning and make them aware of possible benefits. They could help them to identify their own needs and therefore make the participatory planning process more fruitful.<sup>89</sup> In order to achieve this goal, notwithstanding the alleged lack of capacity among government officials, civil society organizations could be included more often. Already now, local NGOs often participate in planning meetings as they know the local context and have close cooperation with the community. Sometimes, they even set the facilitator in planning meetings.

## Conclusion

This paper has given an overview of participatory governance and performance-based transfers as central aspects of fiscal and political decentralization in their potential function to improve public service delivery in the health sector in Indonesia. A review of the state of the art showed that development theory ascribes a high potential to improve PSD in the health sector to both pathways. A comparison of the scenario from the theoretical debate with current perceptions among practitioners and researchers in Indonesia showed the gap between theory and practice. The case study from Mataram revealed that in practice, although offering many opportunities, both participatory governance mechanisms and performance-based transfers have to date not been as effective as they could be.

With regards to the effectiveness of participatory governance mechanisms, one of the constraints is the problematic relationship between decentralization, democratic and efficient governance, and the fact that participatory mechanisms are still nascent in Indonesia. Building on alternative mechanisms that include reputation of and lessons-sharing among local governments could foster a better acceptance of participatory governance mechanisms. The effectiveness of deliberation and participation mechanisms hinge on the degree that local leaders allow these mechanisms to empower citizens. A caveat of participatory planning is the fact that planning and budgeting are not integrated, which often renders participatory mechanisms meaningless since local bureaucrats can easily enforce funding for their prioritized proposals. Another constraint is the lack of capacity among local bureaucrats and civil servants regarding facilitation skills, identification of development needs, and the knowledge how to address citizens through service designs. In terms of knowledge management, transparent communication channels, and the integration of national policies at the sub-national level, the involvement of academic as well as civil society actors as facilitators has proven to be helpful in the case of Mataram.

As for Indonesia's intergovernmental transfer system, shortcomings that are often identified by academics, political advisors, and other stakeholders are an imbalanced and incomplete devolution of fiscal revenue authority and expenditure responsibilities to the regions, a high degree of uncertainty in transfers, the inadequate deployment of incentive

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<sup>89</sup> This, however, poses the problem that the local governments are criticized for their lack of capacity themselves so that it is questionable for many of them whether they can train good facilitators (Informal conversation with Astia Dendi from GIZ, 10 January 2013).

schemes, and a low quality of spending, all having a negative impact on public health service delivery. In this regard, performance-based transfers can induce organizational changes at the service provider level, improve the quality of spending, and lead to positive behavioral changes at the service user level. Empirical evidence shows that performance-based transfer schemes can improve public health outcomes (PNPM Generasi) and that the government is increasingly aware of the potential of such schemes (Water Hibah, P2D2). However, the success of performance-based transfer programs depends on the specific circumstances and the details of the project design; there is no “one size fits all” approach. To secure long term effectiveness, programs have to be institutionalized and should take regional disparities between regions into account. Since emerging economies often face a lack of accessibility in services, performance-based transfers should not only focus on demand side approaches (conditional cash transfers).

Evaluating the impact of performance-based transfers independently of other measures is challenging when activities go beyond a pilot project design (PNPM generasi). Additionally, the broader positive empirical country evidence might be prone to a publication bias. Here, further research on the effectiveness of performance-based transfers is needed. Other measures to encounter the shortcomings of Indonesia's intergovernmental transfer system should therefore be considered as well, such as an increase of funding channeled through the existing DID (Special Incentive Grant), the clustering of local governments once determining transfers in order to account for local needs more accurately, or an increase of local governments' revenue raising authority. The effectiveness of the latter, being implemented since 2014, by a devolution of parts of the property tax to the local governments, will have to be evaluated.

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