

ARTICLE

Call for Asymmetric Health Decentralisation in Indonesia

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How to cite: Nugroho, Arief Priyo., & Handayani, Sri. (2022). Call for Asymmetric Health Decentralisation in Indonesia. *Jurnal Borneo Administrator*, 18(2), 139-154. <https://doi.org/10.24258/jba.v18i2.999>

Article History

Received: 3 November 2021

Accepted: 30 June 2022

Keywords:

Health decentralisation,
Inequality,
Inequity,
Asymmetric.

ABSTRACT

Disparities, Inequalities and inequities are still significant problems after decades of experiencing health decentralisation. This study arranges massive issues on health decentralisation to endorse improvement. The analysis offers insight into decentralisation practices in Indonesia to perform health affairs. A systematic review approach was practised to identify the Scopus database and PubMed MEDLINE from 1999 to 2020, using the terms "health" and "decentralisation." Inclusion criteria were final manuscript, full-text access, and elaborate health administration in the decentralised era. Non-journal articles and non-Indonesia research sites were applied as exclusion criteria. The study analysed 32 reports through Vosviewer tools to confirm health decentralisation trends based on word frequency mentioned in the abstract. Using Atlas.ti qualitative apps tools, the full text of the identified manuscript was analysed into the categorisation of main decentralisation issues; 1) intergovernmental relations, 2) fiscal capacity, 3) regional capacity and capability to elaborate on implementation gap, obstacles, and pros and cons of Indonesia's experience in health decentralisation. The study found that changing decentralisation patterns that mismanaged unequal distribution of health resources raises inequality issues. Second, there is conflictual relation between national and regional health administration-sandwich function caused by the unclear division of government authority. Third, the health policy necessity of a symmetrical approach to coping with regional disparities in fiscal capacity, local government capacity, and capability to provide health services, and inequity problems follow. Moreover, various specific local needs and contexts do not fit in with national health policy. In this context, an asymmetrical approach to managing health answers diverse context responses in implementing decentralisation and inequality and inequity issues.

A. INTRODUCTION

Welfare issues, especially in the health sector, are still a concern in Indonesia. Health indicators, such as the stunting rate to health insurance, issues still call for improvement. Efforts to encourage improvements in the delivery of health services with decentralised governance have also not met the expected results. Although decentralisation has impacted several health indicators (Yuniza, 2014), its implementation still raises problematic issues. Decentralisation has not significantly improved health service delivery (Lewis, 2017).

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The experience of managing decentralisation in governance in Indonesia shows several paradoxes. Starting from Law 22 of 1999, the latest revision of Law No. 9 of 2015 stipulates the shrinking authority of local governments. Furthermore, most recently, the existence of the Job Creation Law has further emphasised the reduced authority of local governments (Kasim et al., 2020; Lestari, 2021). One of them, decentralisation, which should encourage regional autonomy and independence, has turned out to be the dependence of local governments on the central government (Dhea & Sujarwoto, 2015). Local government dependence can be seen in the indications that local governments still depend on funds from the central government, especially for regions with insufficient fiscal capacity.

The policy response to the less successful decentralisation by returning the authority to the central government is inappropriate. Unsuccessful implementation in some regions does not mean that other areas cannot maximise decentralised governance. In the initial experience when decentralisation was held, innovations in the delivery of health services became open. One of the innovation stories is the emergence of health insurance in the regions, which began in the Jember district in 2000 (Rosser & Wilson, 2012).

Along the way, decentralisation management in Indonesia is more likely to restore the role of the central government as a response to unwanted results (Harsasto, 2020). This reduced role and authority of local governments are unfortunate. The unsuccessful decentralisation pattern does not mean returning it to de-concentration or even centralisation. In contrast, the success of the implementation of health decentralisation depends on the context and regional capabilities in implementing it (Sumah, Baatiema, & Abimbola, 2016). Each region, in addition to having different characteristics, also has different abilities and needs. Inappropriate response to the diversity context with a de-concentration or centralisation policy, implementing policies symmetrically. Each region is managed and treated equally regardless of the varying needs and capabilities.

Asymmetric decentralisation is designed to put different authorities for local governments in managing public services (Lele, 2019). In Indonesia, an asymmetric approach to capture diverse needs that have been implemented only based on social-political reasons (Isra, Villiers, & Arifin, 2019). At the same time, problems regarding conflicts of authority (Alm, Aten, & Bahl, 2001), fiscal authority and its impact on services (Nurfauziya, Prakosa, & Kusuma, 2018), as well as regional capacity and capability to provide health services (Sumah, Baatiema, & Abimbola, 2016) require policy development in managing health services. Further, there is an academic proposal to implement an asymmetric approach to providing public services (Madubun, Akib, & Jasruddin, 2017). Those previous findings indicate that asymmetric is necessary to apply health decentralisation for some improvement.

Therefore, instead of only just confirming the previous study's findings, this paper attempts to see how decentralisation develops and adapts to health service delivery needs in Indonesia. Through a systematic literature review, this paper will elaborate on the opportunities and challenges of implementing decentralisation through the experience of providing Indonesian health services for approximately two decades and why an asymmetric approach is needed to improve health service. The dynamics of experience from implementing decentralisation in the health sector are expected to draw a knot to provide the proper response to encourage improving health services in Indonesia.

B. LITERATURE REVIEW

Indonesia has changed from a centralised country to a decentralised country since 2001. Theoretically, decentralisation can make the government more responsive to local conditions in the development process (Ostwald, Tajima, & Samphantharak, 2016). The decentralised policy supports the improvement of local government because of its authority in managing

regional public policies, including the distribution of community needs (Rudy, Hasyimzum, Heryandi, & Khoiriah, 2017).

Decentralisation attempts to give local governments the role of managing public services. The role of public service management to local governments is seen as better because it is considered a level of government that can capture the needs and challenges of the community (Rosser & Wilson, 2012). In decentralisation, it is possible to grant authority or autonomy to local governments to run their government. This authority and independence are considered a solution to improve public service in the health sector (Dwicaksono & Fox, 2018).

The inclusion of health in the decentralised authority of health is the antithesis of the experience of centralised governance, especially during the Soeharto era. Although in practice, centralised governance does tend to encourage more efficient governance patterns. The family planning program (KB) to control the population is one example of the efficiency of centralised management. However, centralisation produces inequality between regions simultaneously (Booth, 2003). The issue of equality prompted the implementation of decentralisation, which was considered an opportunity to overcome it.

Since decentralisation has been implemented in Indonesia, there has been no significant contribution to improving Indonesia's health system. The research of 10 regions in Indonesia revealed that the allocation budget for health had increased significantly (Heywood & Choi, 2010). Nevertheless, the amount of the health budget only made minor changes to the health system in every region. Another research shows that implementing decentralisation in eastern Indonesia does not necessarily create accessible public services (Shoesmith, Franklin, & Hidayat, 2020). In line with this study, another study found that decentralisation did not guarantee health service improvements, especially in immunisation outcomes (Maharani & Tampubolon, 2014).

Decentralisation is expected to improve the health conditions of the poor. However, in practice, the gap in health status and access to health between the rich and the poor persists. Health access gaps can occur due to inefficient and ineffective health programs related to institutional and policy factors in each region (Utomo, Sucahya, & Utami, 2011). Another study by McCollum (2018) revealed that healthcare services inequity still occurs in Indonesia's decentralisation era.

Moreover, providing an overview of health decentralisation implementation will enhance health care services. The elaboration of the discussion on decentralisation of health in Indonesia focuses on several things. First, at the level of how local governments innovate and improve public services (Rosser & Wilson, 2012). Public service innovation, especially in the health sector, has increased significantly in the era of decentralisation. The idea of health insurance is one of the innovations that emerged when the decentralisation of health began to be carried out. However, in practice, decentralisation did not fully meet expectations. Secondly, implementing decentralisation in health explains the dynamics, challenges, and obstacles in delivering public services (Jung, 2016). In this area, several academics have also discussed conflicts between levels of government in the delivery of health services (Aulia, 2014).

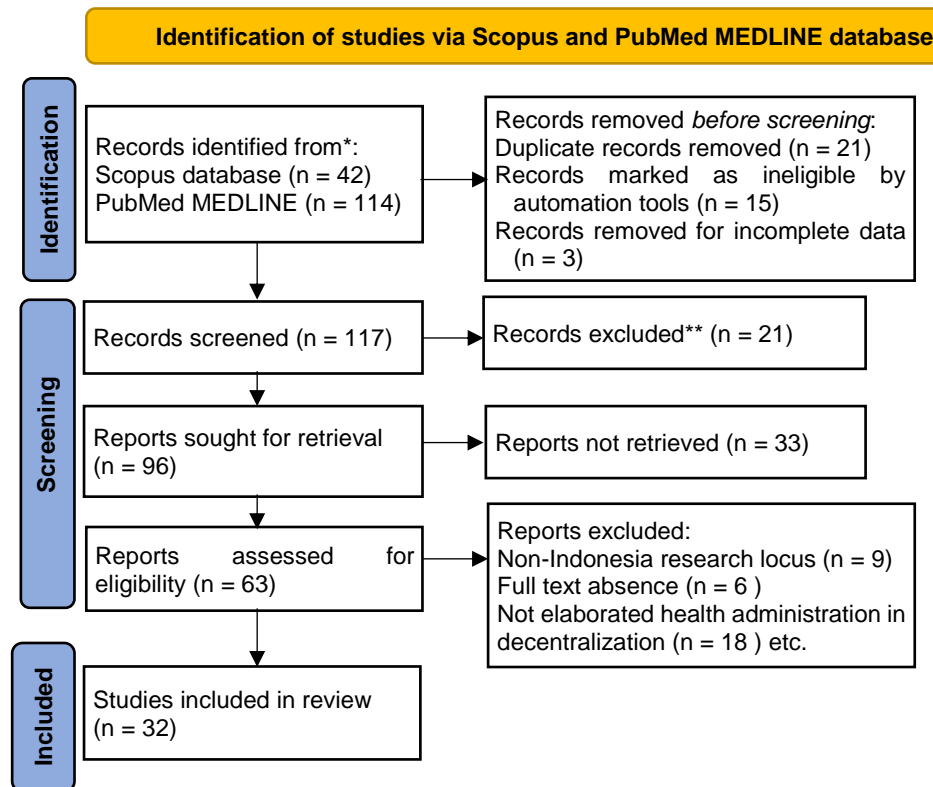
The third is the local government's capacity and capability to provide health services. Experience in Indonesia shows differences in the power and capability of local governments to deliver public services (Sumah, Baatiema, & Abimbola, 2016). One of the visible differences is the difference in fiscal capacity between regions (Lewis, 2017). The difference in fiscal capacity is essential because it is a source for local government to provide public services.

The three main points academics have elaborated in explaining the issue of implementing health decentralisation are indeed quite comprehensive.

Therefore, this study aims to provide an exciting view on developing ideas and approaches to decentralisation implemented by the government. This study will comprehensively describe the dynamics of health decentralisation implementation over the past

two decades. Understanding the experience of implementing decentralised health will better explain questions and problems in the health sector which have not been resolved, especially in explaining the occurrence of inequity in the delivery of health services in the era of decentralisation (Pardosi, Parr, & Muhidin, 2016).

C. METHOD



Source: Adapted from PRISMA Systematic Review 2020 (Page et al., 2021)

Figure 1. Literature Search Strategy

A systematic review approach has been used to describe the idea and implementation of decentralisation development in Indonesia. The search strategy uses Scopus and PubMed MEDLINE databases from 1999 to 2020 with "health" and "decentralisation." keywords. This search strategy was intended to capture the decentralisation scheme being implemented at first. At least there were three main steps operated according to PRISMA guidance. Automatic tools assisted initial identification provided by Scopus and PubMed MEDLINE tools. Later, the paper screening was performed manually by reading the abstract and guided by inclusion criteria (final manuscript, full-text access, and elaborating health governance in the era of decentralisation) and exclusion criteria (non-journal/non-peer review articles and research locus outside Indonesia). In the final screening, the authors did a skimming reading of the full text to finalise the included study.

To minimise study bias, first, the study acquires PRISMA systematic review process as guidance. Second, the authors operated a two-sided review in making decisions for including the study and analysing of the article. Third, to minimise biased study results, the authors operated a surface web search in google scholar and performed scanning reading about the health decentralisation issue.

The trend analysis of the decentralised management of the health sector is based on the frequency of words in the abstract, which is analysed using the Vosviewer application. Full-text analysis was conducted using a bottom-up coding approach according to prominent issues

Discussion of regional practices and experiences in providing health services dominates and elaborates on the health sector's positive impacts and excesses of decentralisation. During this period, studies in health decentralisation tended to evaluate the provision of health services. The implementation of health services in the early era did not fully produce the expected impact. The implementation of decentralisation encountered several challenges, especially related to conflicts between levels of government. Based on the vast authority that transferred to regency/municipality in managing health, coordinating roles and harmonisation that were put in the design of long-term policy were in trouble. There were disharmonised planning and realisation in health policy and development (Wicaksono, 2012). The response to this problem was an amendment of regional governance policy with law number 32 Year 2004. The pattern of managing regional government relations began to be reorganised by placing the provincial government's role, which was previously marginalised.

In the latest development, discussing decentralisation in the health sector, they began to explore and look for the midpoint of local governance. The keywords frequently elaborated in health decentralisation studies were local, government, authority, and effect. Those studies discuss overlapping authority at the government level practised in health decentralisation. Based on keywords found in the literature studies, at least three significant clusters related to studies about health decentralisation and dynamic relations among central and local governments over decades. Besides, it shows that the pattern of decentralisation, especially in the provision of health services, is still trying to find the correct pattern to encourage the desired improvements and overcome inequity issues. De-concentration became a prominent approach. De-concentration is considered a booster of local government capability in funding public service delivery (Lewis, 2017).

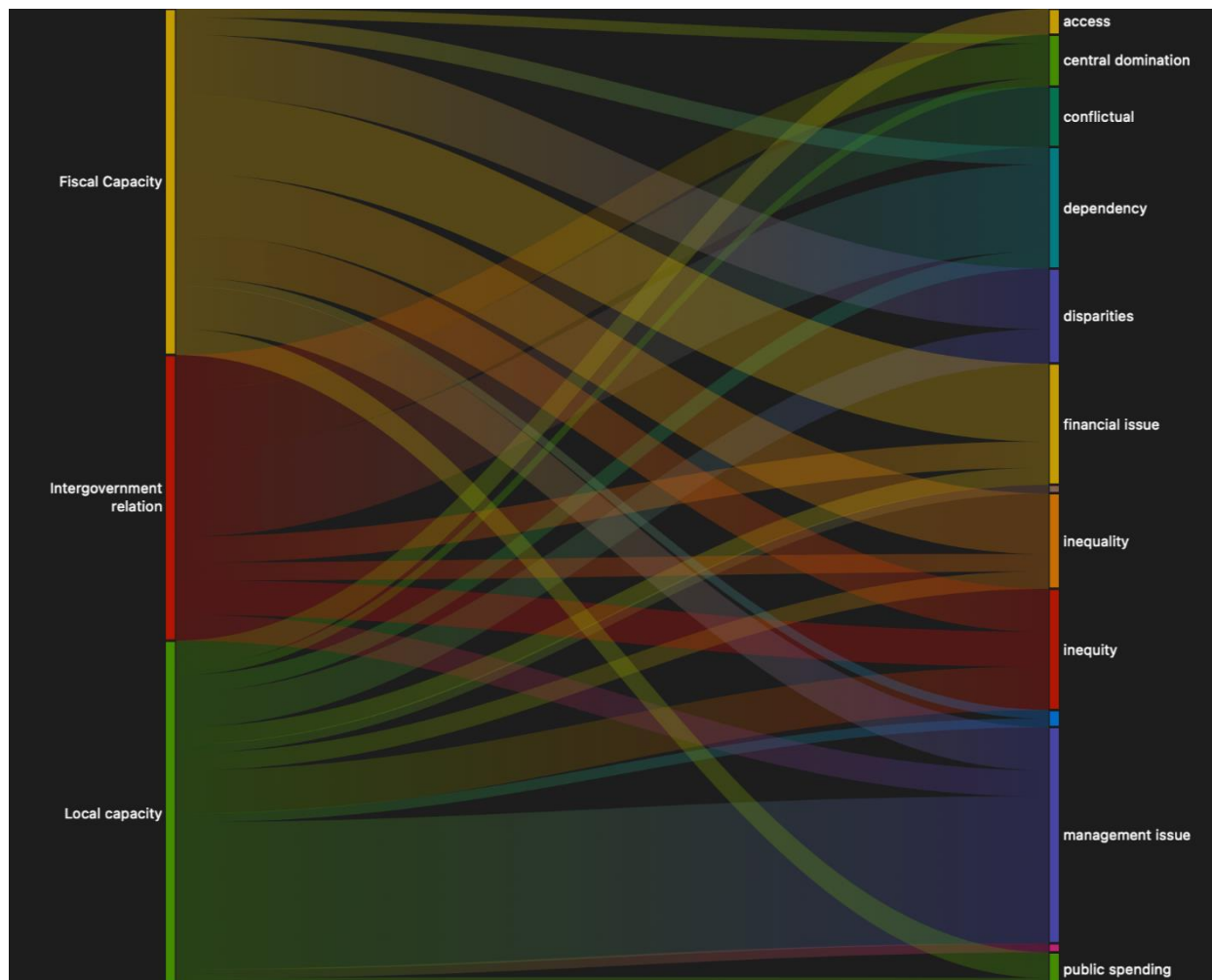
Overlapping Authority

Inequity problems arising in implementing health services in decentralised governance occur due to several conditions-the main issues related to the dynamics of the relationship between the local and central government in government administration. Decentralisation was initially expected to promote public service delivery effectiveness and was a source of inefficiency and conflict in its governance. One thing that stands out in the relationship in decentralised control is the overlapping authority of each level of government. The devolution approach applied in the decentralisation scheme from the central government to local governments is fragile (Fatmawati, 2018). An unclear division of authority resulted in an intersection in managing health. The unclear intersection in the practice of decentralisation is seen in some of the management of health service delivery. In providing health workers, local governments still face quite complex problems providing health workers with medical devices (Sumiarsih & Nurlinawati, 2020). A sample practice, the pattern of supervision and synergy in the efforts to monitor the circulation of medical devices (Wifaqah, 2020).

Health decentralisation studies show strategic issues in managing decentralisation in Indonesia since 1999 (see Figure 3). At least there were 6 (six) decisive challenges that demanded resolve, i.e., management issues, inequity, inequality, financial issue, dependency, and disparities. Those issues can be categorised into three primary problems, namely 1). Local capacity, 2). Intergovernmental relations, and 3). Fiscal capacity.

For example, the relationship between the central and local governments can lead to political conflict due to the contestation of authority. Authority issue was a result of intergovernmental relations that originate from management issues. The conflictual condition can be seen in various policy responses at each government level to overcome the pandemic, which shows that the management of central and regional relations has holes in conflicts (Fauzi, Harianto, & Affandi, 2020). For example, there is a mismanaging in health routine data management different routine data need to facilitate public health services among central and

local governments (Nugroho et al., 2021). The tendency for potential conflicts to exist is a consequence of the distribution of authority between the central and local governments. This pattern is further emphasised by the concurrent division of authority from the central, provincial, and district government levels (Wifaqah, 2020).



Source: an Analysis Based on Qualitative Full-Text Analysis and Comprehension Issues Tracing using Atlas.ti Application. [n:32]

Figure 3. Issues in Decentralisation Study, 1999-2000

The Disparity In Local Fiscal Capacity

In decentralised management, fiscal capacity has an important role. Fiscal capacity is a resource needed by the government in carrying out its authority in providing public services, especially in the health sector (Behera & Dash, 2020). In the experience of local governments, there are challenges due to the lack of adequate fiscal capacity in providing public services. Regions often still have a dependence on the central government because they have the inadequate fiscal capacity, as can be seen from the gap between fiscal needs and their fiscal capacity (Marlissa & Blesia, 2018; Pujawati, Badri, & Agustiani, 2019).

The central government's pattern of fiscal relations tends to use an interventionist pattern that places allocation patterns with various schemes to encourage regional fiscal capacity (Gonschorek & Schulze, 2018). In several studies, the pattern of fiscal transfers is the answer to encourage the ability of local governments to provide public services, including health (Behera & Dash, 2020; Gonschorek & Schulze, 2018). De-concentration funds are divided

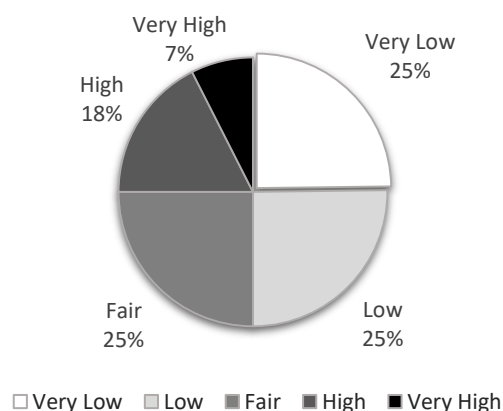
according to different functions. In the health sector, a pattern of special allocation funds has emerged. There are physical as well as non-physical special allocation funds with various uses.

The special allocation funds (*Dana alokasi khusus* - DAK) for health have not been used optimally to improve the region's health status. DAK funds only increase local government assets instead of being used to support health programs' promotive and preventive efforts (Karlina, Laksmiarti, & Kusnali, 2017). Activity planning using DAK allocations is carried out top-down, where the local government is not directly involved in decision-making (Manulusi, Siring, & Hasbi, 2021). The implementation of DAK is executed with uniform policies that apply nationally without giving room for differences for regions with different conditions (Fatmawati, 2018). An example of DAK uniformity in procuring supporting tools for improving the quality of education and health. DAK implementation is less integrated with regional planning and development mechanisms (National Planning Board/BAPPENAS, 2011).

The pattern of fiscal transfer has become the main pattern carried out by the central government (Gonschorek & Schulze, 2018). This approach instantly gives impetus to local governments to provide public services. However, this approach is increasingly dependent on local governments and does not solve the problem of fiscal capacity disparities (Lewis, 2017). Fiscal capacity in supporting the implementation of public services, especially health, is not always fully correlated (Cahyaningsih & Fitriady, 2019). Even fiscal decentralisation is not directly correlated with public health, especially in life expectancy indicators (Nurfauziya, Prakosa, & Kusuma, 2018).

Fiscal capacity is essential because it is a government resource to finance local government spending on health services (Gonschorek & Schulze, 2018). Even though local government spending only positively impacts health services when government administration has a low level of corruption (Lewis, 2017). Fiscal capacity still plays an important role as local governments source to provide public services (Meheus & McIntyre, 2017). Local governments budget only for supporting government operational budget rather than public service spending (Sjahrir, Kis-Katos, & Schulze, 2013). However, the fiscal transfer via DAK impacts some health indicators instantaneously (Karlina, Laksmiarti, & Kusnali, 2017). In this context, fiscal transfer via DAK takes a prominent role. DAK dominantly affects the local government's dependence on central authority funds (Manulusi et al., 2021). Local government dependency raises issues about decentralisation philosophy, which is intended to provide local autonomy and government innovation. Moreover, evidence also revealed some fiscal transfer schemes to meet failure to boost public service improvement (Shoesmith, Franklin, & Hidayat, 2020).

Graph 1. Local Government Fiscal Capacity Index (Regency/Municipality)

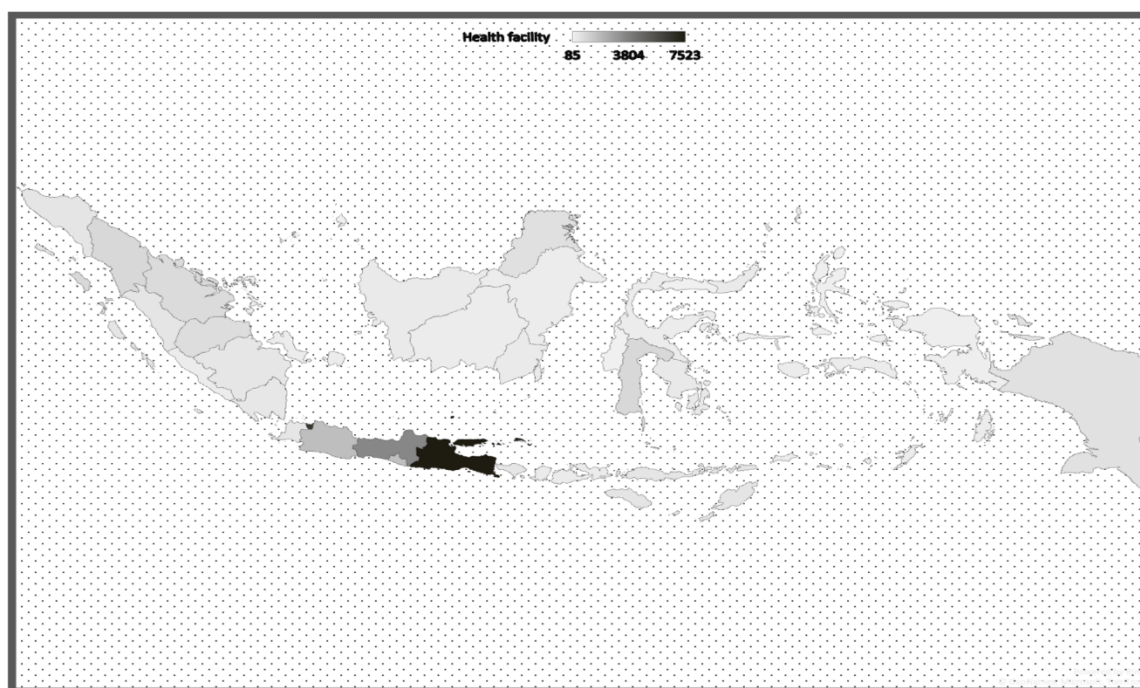


Source: Minister of Finance Regulation No. 116/PMK.07/2021

Capacity and Capability Variation of Local Government

Fiscal capacity is the starting point for local governments to provide public services, especially health. However, the fiscal capacity of the regions does not necessarily result in good health services (Cahyaningsih & Fitriady, 2019). The unexpected result because the existing fiscal capacity also requires adequate resources for its management to provide good public services (Lewis, 2017). These resources are the embodiment of the capacity and capability of the local government.

The capacity and capability of local governments show unsatisfactory results. Local governments often face several resource constraints, from human resources to infrastructure resources (Heo, 2018; Heywood & Harahap, 2009; Kristiansen & Santoso, 2006; Paramita, Yamazaki, Setiawati, & Koyama, 2018; Shoemith, Franklin, & Hidayat, 2020). Implementation constraint makes the decentralisation management movement in Indonesia adjust. Implementation adjustment aims to maximise the concept of decentralisation to achieve community welfare efforts. The decentralisation implementation revisions trend is moving towards a revitalised central government role. There is inconsistency in implementing decentralisation (Jati, 2012).



Source: http://bppsdmk.kemkes.go.id/info_sdmk/info/renbut Accessed: November 3, 2021

Figure 4. Health Facility Availability

The decentralisation experience in Indonesia shows many stories of failure due to inadequate regional capacities and capabilities (Hosseinpour et al., 2018; Suparmi, Nambiar, Trihono, & Hosseinpour, 2018). Every local government in Indonesia has various capabilities. Apart from the unequal fiscal capacity, several things such as human resources and geographical conditions make local governments not have the same power and capability to provide public services, especially in the health sector.

The gap in the capacity and capability of local governments in providing health services is in several indicators—first, the existence of health service infrastructure. The existence of health facilities still unequal in health service infrastructure is one of the indications. The number of health service facilities is still relatively inadequate (Hodge, Firth, Jimenez-Soto, & Trisnantoro, 2015; Mulyanto, Kunst, & Kringos, 2019). In addition, the availability of health

services is also not evenly distributed from one area to another. The number of health facilities at the national level is unequal, especially between Java and outside Java (see Figure 4). Furthermore, it turns out that the disparity between regions then does not only occur at the national level. Even districts/cities within a province show inequality in the delivery of health services in Indonesia (Suparmi, Nambiar, Trihono, & Hosseinpoor, 2018).

Second, the condition of the infrastructure disparity is in the context of the unequal distribution of health workers. Nationally, the ratio of health workers to population may be ideal. However, if viewed per region, it will show a concentration of availability of health workers in certain areas, especially urban areas (Efendi, 2012; Mulyanto, Kringos, & Kunst, 2019). The existing disparities in providing health services show local governments' various capacities and capabilities in providing health services. This capacity and capability are due to the different fiscal capacities of local governments and the geographical landscape that makes local governments have different needs in delivering health services (Cahyaningsih & Fitriady, 2019; Kusumawardani, Tarigan, Suparmi, & Schlottheuber, 2018).

Asymmetric demand in administrating health decentralisation

Decentralisation is not working well in some areas. To respond to the specific needs of each region, an asymmetrical approach to decentralised governance holds out hopes (Madubun, Akib, & Jasruddin, 2017). The asymmetric pattern allows the central government to rearrange authority relations based on local government capacity and capability (Purwanto & Pramusinto, 2018). The asymmetry scheme allows regions with sufficient capacity and capability to provide innovation in delivering services without central government assistance. On the other hand, regions with inadequate capacities and capabilities could be given special treatment and assistance from the central government to provide good health services.

In the experience of Indonesia, decentralisation has been implemented by giving equal authority to each local government. In principle, regions could manage government and provide public services (Isra, Villiers, & Arifin, 2019). Although in this case, there are exceptions in some areas, namely the Special Capital Region of Jakarta, the Special Region of Yogyakarta, Nanggroe Aceh Darussalam, Papua, and West Papua Provinces. The five special regions have different authorities than other regions in Indonesia for political reasons (Lele, 2019).

In several regions' experience, decentralisation has encouraged innovation and improvement in several regions in providing health services (Miharti, Holzhacker, & Wittek, 2016; Rakmawati, Hinchcliff, & Pardosi, 2019). At the same time, decentralisation raises issues of inequality and inequity between regions (Nababan et al., 2017; Pardosi, Parr, & Muhidin, 2016). Decentralisation faces the challenge that the granting of authority to each region does not fully produce the same impact. Each region has different capacities and capabilities. Each region's different capacities and capabilities require asymmetrical governance (Tan, 2019). The disparity of capacity and capability means that the area would be mismanaged if treated symmetrically. The gap in capacity and capability between regions must be a concern for the central government in managing decentralisation. Problems in implementing decentralisation are how the central government gives appropriate responses and approaches. Retracting governance to become centralised will give developed regions that can manage their authority properly in providing health services lost their scope.

Based on Indonesia's experience, the application of asymmetric health decentralisation has become a necessity. Nevertheless, the application of asymmetric health decentralisation does have some challenges. The asymmetrical approach's appropriateness must be suitable for the Indonesian unitary state. However, the concept of asymmetry in governance in Indonesia has been implemented in several areas. However, the asymmetry pattern still tends to be based solely on political and economic considerations (Hayati & Ifansyah., 2019; Tauda, 2018).

Asymmetric governance based on considerations of regional capacity and capability to maximise health service delivery has not been fully practised in Indonesia.

The asymmetric approach carried out in five regions does not consider the aspect of local government capacity and capability (Lele, 2019). A study proposed an asymmetric approach to maximise public services but only focused on geographical challenges (Madubun, Akib, & Jasruddin, 2017). Asymmetric approaches to providing health services have not received sufficient attention despite their promising possibility (Fatmawati, 2018). These studies not only recommend raising asymmetric decentralisation as the previous research did but also give at least two indicators in designing its policy: local capacity and capability. Local capacity and capability indicate how local government qualifications manage its public service obligation. However, this study has limitations in answering how local capacity and capability can be measured. Local capacity and capability assessment to assign asymmetrical health decentralisation demand further elaboration.

E. CONCLUSION

Health decentralisation studies in two decades show inequity and inequality in health services in Indonesia. These studies revealed injustice and equality have resulted from inappropriate central government symmetric approaches to health service delivery. The central government tends to strengthen the de-concentration approach rather than improve decentralisation implementation. The de-concentration approach cannot accommodate diverse local contexts to deliver health services and local dependence on the central government. The asymmetric idea in managing health decentralisation became more perspective to handle inequity, inequality, and diverse local contexts.

This systematic review of studies captured academic discussions and debates about health service delivery in the decentralisation era. Based on the findings, asymmetrical is raising an issue to overcome inequity and inequality in health service delivery. On the other hand, this study has limitations in stating what asymmetrical is suitable for Indonesia to deliver health services.

Asymmetry is not an entirely brand-new concept in Indonesia, but it tends to be based on a strong emphasis on political considerations. Efforts to do so in maximising health services are prospective. In terms of legislation, the central government's decisive role is prominent. Starting in local autonomy act No.22 Year 1999 and finally related to the regulation of the Omnibus law on job creation, it shows the tendency of the autonomy setback towards the crucial role of the central government.

This study confirms the previous research and proposes a prospect of non-social politics based on implementing asymmetric decentralisation. This finding urges asymmetric decentralisation studies perspectives based on local government capacity and capability to deliver health services. Further, the de-concentration approach dominates the comparative discourse on health decentralisation policy trends. The asymmetric approach in implementing health decentralisation has an opportunity to settle inequity in health service delivery policy. Especially, the necessity for an asymmetric approach is especially based on social-political judgment and a wide range of diverse local government needs, capacities, and capabilities. The idea of asymmetry in delivering health services is essential when considering the broad range of aspects of diverse local contexts. Asymmetric health decentralisation will encourage efficiency and capture variations in the capacity of local governments in terms of fiscal capacity, human resources, and infrastructure suggestions. Besides, asymmetric health decentralisation will escalate the equity need in the health sector and return to the spirit of encouraging prosperity, independence, and the creation of local government.

Further studies are needed to explore the prospects for asymmetric principles in the administration and division of authority between the central and local governments in

managing health service delivery. They are notably elaborating and considering the socio-juridical aspects related to geographical landscapes, various regional capacities and capabilities, and asymmetric governance in the delivery of health services. The asymmetrical approach is not only to pursue the efficiency of the implementation of health services alone but also to the effectiveness of the spirit of regional autonomy implementation, namely, the local government's ability to provide public services.

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