

De-Polarization in Delivering Public Services? Impacts of the Minimum Service Standards (MSS) to the Quality of Health Services in Indonesia

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The Asian Conference on the Social Sciences 2015
Official Conference Proceedings

Abstract

The debate on the merits and costs of decentralization policy has put attentions of many scholars in the subject of politics, economics and public administration for a long time. It often argues that decentralization policy tends to create polarization or increasing inequality between districts/cities or local governments. The introduction of the Minimum Service Standards (MSS) in 2005, as the key focus of the implementation of decentralization policy in Indonesia, is a strategy that sought to deal with this problem. Since MSS sets the same targets for a minimum quality of basic public services should be fulfilled by districts across regions, it seems reasonable to expect that a depolarization in the quality of services will occur.

This paper will examine the impact of MSS on depolarization in the quality of public services across districts in Indonesia, focusing in the quality of health services. Using data on the achievement of MSS in the health sector of 54 districts from 534 districts in Indonesia from 2010 to 2013, we find the improvement of health service quality across regions. Apart of the weaknessness of self-assessment report of local governments on the achievement of MSS, major local government in our samples do better on improving health quality and reduce the gap between current service and minimum service. If this phenomenon continues, MSS could create de-polarization on the quality of public services as the effort to minimize the disparities/inequality traps. In addition, difference of fiscal resources among local governments is also associated with achievement of MSS.

Keywords: Decentralization, Public Service, Minimum Standard Service

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Introduction

The debate on the merits and costs of decentralization policy has put attentions of many scholars in the subject of politics, economics and public administration for a long time. Refer to the concept of multi-level governance, in decentralization policy, most power and authority will be devolved to the lowest tiers of government and local governments will enjoy certain degrees of autonomy to optimally utilize their financial and economic resources in achieving their goals due to the different capacities and choice of suitable strategies.. As the consequence, it seems reasonable to say that decentralization policy tends to create polarization or increasing inequality between districts/cities or local governments

In terms of public services provision, it is argued that rich natural resources and prosperous districts have better opportunities to provide good quality service provision compared to the poor economics and financial districts/cities. As the result, the gap in the quality of public services among local governments will increase or it is known as the polarization.

The introduction of the Minimum Service Standards (MSS) in 2005, as the key focus of the implementation of decentralization policy in Indonesia, is a strategy that sought to deal with this problem. Since MSS sets the same output and time targets for a minimum quality of basic public services should be fulfilled by districts across regions, it seems reasonable to expect that a depolarization in the quality of services will occur.

This paper will examine the impact of MSS on depolarization across districts in Indonesia, focusing in the quality of health services. Two research questions will be addressed:

1. Firstly, does decentralization policy in Indonesia cause polarization on the quality basic public services among districts? If yes, what are the rationale and empirical evidence? If no, what the empirical evidence shows and why?
2. Secondly, does the introduction of MSS is being able to set depolarization in the quality of health services across regions? What is the explanation and empirical evidence?

This paper will begin with the concept and rationale of Indonesia's decentralization due to the public services. It continues with the rationale why decentralization could lead to inequality traps on resources and public services as well as the current

condition in Indonesia's public services. Later, it will discuss concepts, design and institutional arrangement of MSS and its potential merits to cause depolarization of public services in Indonesia. Finally, empirical result on the effects of MSS to depolarization on quality of public services, especially in the health sector will be revealed which includes limitation on methodologies and data as well as potential research in the future.

Concept and rationale of decentralization in Indonesia due to public services

Indonesia, as the one of the most diverse country in the world in terms of their ethnicity, cultures and languages; adopt the concept of political decentralization suggested by Smith (1985) who emphasis to two main elements of decentralization. Firstly is the delimitation of territory which is realized through the creation of local governments. Local governments split in greater number after the implementation of decentralization from 27 provinces and 314 districts in 1998 into 34 provinces and 503 districts in 2014. Second element is transfer of power. In Indonesia, most of the central government's powers and functions have been transferred to both the first (provincial) or the second tiers (districts/cities) except the 6 (six) main powers such as defence, security, fiscal; which left to the central government on account of their national and international implications. Most international experts and scholars such as Aspinall and Feally (2003), Alm (et al, 2004), Hofman and Kaiser (2006) note this policy as the 'big bang' policy and characterize Indonesia as the one of the most decentralized countries in the world since all government's powers and authorities have been radically, rapidly and significantly devolved to local governments as autonomy entities.

Indonesia decentralization policy was introduced in 1999. The implementation was started by the stipulation of Law 22/1999 on local governance, which later was revised as Law 32/2004 becomes the basis and grand design to implement decentralization policy in Indonesia. Two rationales can be identified in the implementation of Indonesia's decentralization: allocate fair resources as well enhance public services.

Fair allocation of financial resources between the central government and local governments and between local governments is one rationale in the implementation of Indonesia's decentralization. This rationale is caused by dissatisfaction of local governments to the central government because most of their non-renewable valuable

resources such as oil, gas and mining are taken without any fair mutual benefits or feedbacks to regions especially to those rich resources region.

Another rationale is enhancing quality public of services. It is believed that decentralization policy will improve efficiency of service by increasing intergovernmental competition, makes government closer to people and improving accountability of local governments. The inter-regional competition to attract people live on its territory as well as its ability to capture the interests and needs of local people better than the central government makes a local government as the lowest level of government is better more reactive, sensitive and responsive to local needs and interests as it is elaborated by Seabright (1966) and Oates (1972). Bardhan and Mookherjee (2006) argue that local government as the lowest level of government is the most efficient way to deliver the services since it can be best to match local preference and supply of services as well as gaining the real and accurate information from local people in the short time.

Decentralization policy is simultaneously working with local democratization also improves the accountability of local people and shortens the accountability in provision of public service. Decentralization policy requires local leader to be more accountable to local parliament and local people rather than the central government. Local leader will continually improve their performance, put the performance of bureaucracy as the main concern, increase his/her transparency and accountability to local parliament and people, and increase the satisfaction of their people on service they deliver; as the efforts to win the competition in election or to be re-elected in the next election. Because of there are tight competition for election, there are big incentives for local leaders to deliver best quality of services as well as influence the public managers to be more transparent and accountable to them and local people (Schulze and Sjahrir 2014; Faguet 2011). As the consequence, the performance and accountability of local leaders as well as overall local governments could improve and more likely leading to more effective and efficient public services delivery.

Decentralization policy also improves the accountability of local government through shortens a long route of accountability as it is presented by the World Bank (2003) and Ahmad (et al. 2006) in figure.1 and 2 below. Instead of taking a long route of accountability while national policy makers and providers are held by the poor people and accountability of providers are held by policy makers; a short route of accountability between the national policy makers, poor people and providers with local policy makers are established.

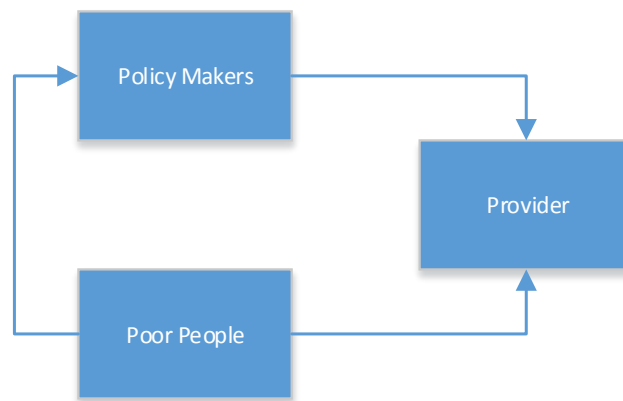


Figure 1. Accountability Under Centralized System

Source: Adapted and Modified from World Bank (2003, p. 6-10) and Ahmad (et al. 2006, p. 243-259)

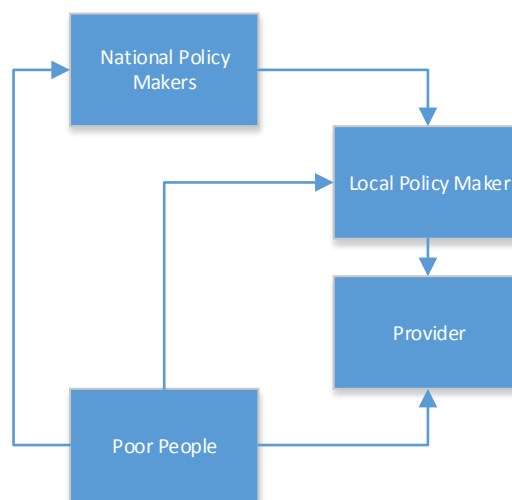


Figure 2. Accountability Under Decentralization System

Source: Adapted and Modified from World Bank (2003, p. 6-10) and Ahmad (et al. 2006, p. 243-259)

Decentralization and inequality traps on resources and public services

From the discussion about the rationale of Indonesia in introducing decentralization policy, it seem reasonable to expect that services are quicker to deliver, government is more responsive and reactive to local issues and problems as well as performance of government in delivering services are better in capture local interests. All these rationales seems leading to the improvement of quality of public services and

de-polarization in the quality of services across regions. However, in the practice, the relations between decentralization policy and public service improvement is not robust and in positive correlation as it is shown by Ahmad and Brosio (2009), taking cases from developing countries such as in Ethiopia and Pakistan in education, health and infrastructure sectors.

In Indonesia, good quality and efficient public services can be seen in some sectors and regions. Bahl (2009) show that more than 70 percent of household in some regions in Indonesia agree that services in health, education, administrative and police services have been improved since the introduction of decentralization policy in 1999. Using set of regression with some variable which represent the quality of services in health, education and infrastructure, decentralization policy seems increase the quality of services in some regions especially those which previously have low quality of services (Schulze and Sjahrir 2014). It seems that this improvement lead to the convergence in the quality of education and infrastructure across regions.

The basic public services neither significantly affect the low income people nor significantly improved. Figure 3 shows the relation between income per capita and life expectancy rate in Indonesia years 2013. It implies that high income region could provide better health service quality. The low income region has low life expectancy rate and performs low quality of health service. Similarly, decentralization policy in the education sector in Indonesia neither improves transparency, accountability and financial allocation to primary and secondary education nor the inequality of these services across regions (Kristiansen and Pratikno, 2006).

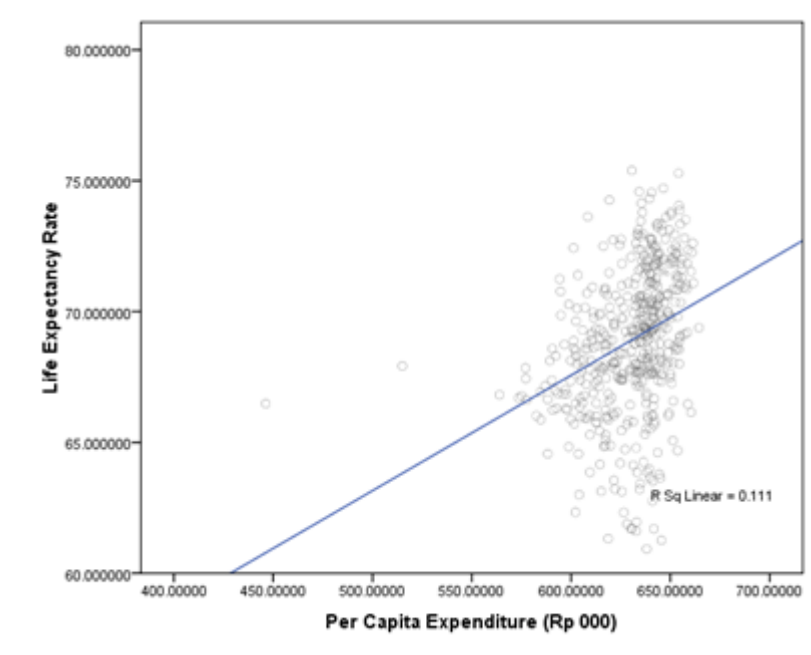


Figure 3, Life Expectancy Rate and Per Capita Expenditure in Indonesia, 2013

Empirical evidence also shows polarization in the quality of public services as the consequences on the inequality of the economic and social level between regions after the implementation of decentralization policy in Indonesia. Aritenang (2008, 2009) utilizing Gini and Williamson Index, shows the phenomenon of disparity across regions because the difference on financial capacity and impacts of the central government transfer. Using Gini Coefficient, there is a positive relation between inequality and fiscal decentralization in Indonesia in year 2012. It implies that high fiscal expenditure of local governments will lead to high inequality of income.

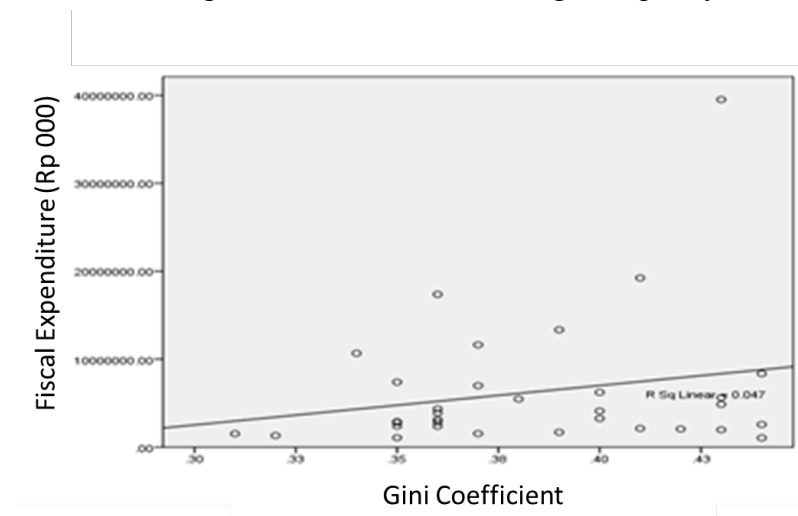


Figure 4, Relationship between Inequality and Fiscal Expenditure

It can be also considered that reducing dissatisfactions of local governments to the central government to the unfair revenue sharing as one of rationale of Indonesia's decentralization discussed above, has relatively shown satisfactory results; while the enhancement of quality of public services and reduce inequality on quality across regions has remained the main challenges for the implementation of Indonesia's decentralization. That is why the problems of low quality of public services and inequality of services among regions are considered as an 'unfinished agenda' in a decade on the implementation of Indonesia decentralization by Strategic Asia (2013).

Minimum service standards and its potential to reduce inequality on public services

As the responses to the current condition of public service in Indonesia, in 2005, the central government introduced Minimum Service Standards (MSS). The policymakers believe that this strategy could improve the performance and accountability of local governments to provide basic public services in minimum required quality. There is an expectation that MSS could play its roles as the breakthrough and key focus on running decentralization aiming to enhance quality and efficiency of basic public services as well as reduce inequality of these services across regions.

Minimum Service Standards (MSS) is actually a performance measurement regime of local governments in Indonesia decentralized system. MSS has been applied by stipulation of Government of Regulation (GR) 65/2005 as the guidance for the sector ministries to set indicators and targets of MSS and mechanism for local governments to implement MSS in local level on their sector. In GR 65/2005 MSS is defined as the types and quality of basic public services that should be received by each citizen to a minimum level.

Some scholars have different interpretations to definitions of MSS. Ferrazzi (2005) defines MSS as a tool to influence and control local governments in fulfilling its 'obligatory functions' in delivering basic services at particular quality standards required which are set by the central government. Roudo (2014) also argues that MSS is not only the key strategy of the decentralization policy to accelerate the improvement of quality of public services, but also the efforts to reduce regional disparity in the provision of basic public services.

From the definition, we could acknowledge that MSS is potential to significantly reduce the inequality on the quality services across regions which leads to

de-polarization on the quality of service by setting the same standards in the quality of service and ensures each local government fulfil the indicators and targets have been agreed and set. To ensure its potency to create de-polarization, we will seek a brief observation to the policy design and institutional arrangement of MSS.

In design, MSS is embedded to local obligatory functions that are strongly related to the provision of public services. Obligatory function refers to all ‘concurrent’ functions’ or ‘shared competence that is compulsorily implemented by each local government regardless its capacities. There are 26 obligatory functions stated in Government Regulation (GR) 38/2007 but only few of them are classified as basic public services which reflect the minimum citizen’s socio-economic needs and rights that should be fulfilled by the government and is guaranteed by constitution such as education, health, and infrastructure. Haryanto (2010) notes these basic services which are protected by constitutions and is related to the fulfilment of basic welfare, public order, national unity, and commitment of national and international conventions. Based on those criteria, in 2012, 15 MSS have been set and applied in district level and 9 in provincial level which consists of 65 services and 174 indicators and targets. In term of institutional arrangement, the relation between actors on MSS achievement can be seen in the figure 5 below.

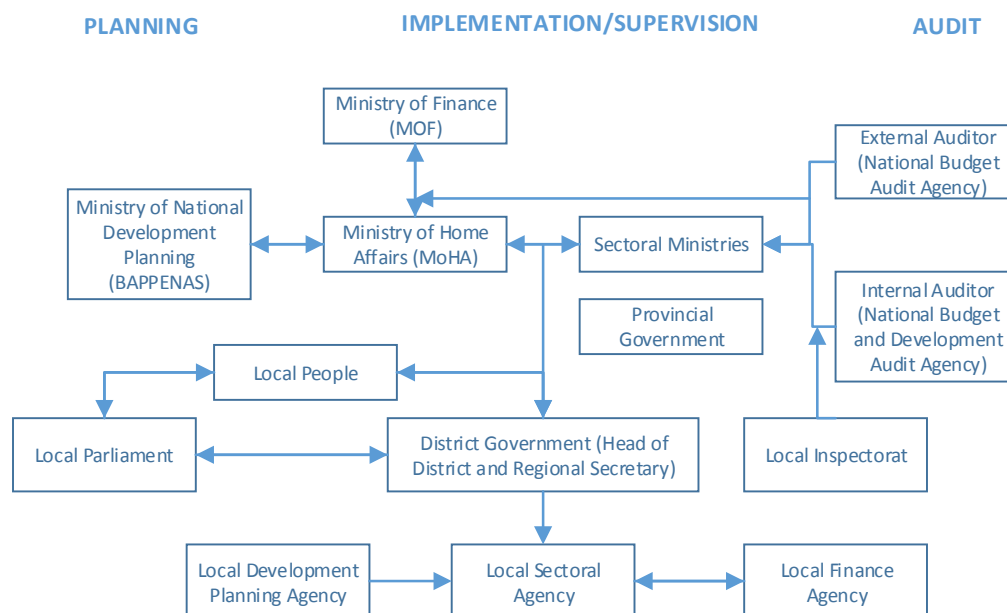


Figure 5, Relations Between Actors in the Implementation of MSS

From figure 5, it could be known also that achievement in each local government will be simultaneously assessed by the central government, local parliament and local people about the achievement of MSS. In the central level, at least 3 (three) main

actors/stakeholders who have roles in doing assessment and evaluations of the achievement on the targets of MSS can be identified: MoHA, Sectoral Ministries and both internal and external auditor. The process in doing the assessment is started by self-assessment or self-evaluation of local governments for their achievement before it is rechecked and validated by sectoral ministries. Governor as the extension of the central government helps the sectoral ministries in compiling data about the achievement on the targets of MSS from districts/cities on their regions besides achievement of targets in the provincial level.

Moreover, the accountability mechanism which set in MSS gives high pressure for each local government to achieve targets in MSS and continually improves their performance in delivering services. Local leaders will continually improve their performance and accountability in delivering services to local parliament and people, as the efforts to gaining popularity in the next election. Public managers and bureaucrats are also more responsive to increase the satisfaction of local leaders as the form of their accountability. Since there is a high level of pressure emerges from the institutional arrangement of MSS, the improvement in the quality of public services in each local government as well as the de-polarization on the services could be achieved.

Empirical results from local government self-assessment

Among many sectors in MSS, two main sectors, education and health becomes the heart on the implementation of MSS besides those sectors are most required in all aspects of people's life without any intention to deny the importance of other sectors. Besides that, those sectors, especially the health sector becomes the most preparedness sector in MSS in terms of supported regulation as well as monitoring system by the provision of the data on the achievement of MSS's target. Thus, to seek empirical evidence whether the introduction of MSS could cause de-polarization in the quality of services, we will focus on the MSS in the health sector.

Minimum Standard of Services of health was designed by Health Ministry, as mandated on Law No. 32 year 2004, and Government Regulation No. 65 year 2005 with other regulation. Minimum Standard Services of Health regulated on Health Minister Act No. 741/MENKES/PER/VII/2008 on Minimum Standard Services of Health in Municipal and City Level. The MSS consist of 4 types of service and 18 target indicators. Detail of Health MSS and its indicator is shown at table 2.

Table 2 Minimum Standard Service of Health Target and Indicator

No	Types of Services	Indicators	Targets	Targeted Year
1	Basic Services	Scope of daily visit of Pregnant Mother (K4 criteria)	95%	2015
		Scope of visit to Pregnant Mother with complicated problems	80%	2015
		Scope of aid from health workers or nurses	90%	2015
		Scope of service to mother after giving birth (childbed)	90 %	2015
		Scope of neo-natal with complicated problems	80%	2010
		Scope of baby visits	90%	2010
		Scope of Universal Child Immunization in Sub Districts	100 %	2010
		Scope of services to under 5 years old children	90 %	2010
		Scope of provision of additional food to breast-milk to children from poor families from 6 months into 2 years	100%	2010
		Scope of services to under 5 years old children who are malnutrition and get special treatment	100%	2010
		Scope of quality of health of students in primary schools	100%	2010
		Scope of member of active family planning	70%	2010
		Scope of observation and treatment illness people	100%	2010
		Scope of basic health services to the poor families	100%	2015
2	Recommended Services	Scope of recommended services to the poor families	100%	2015
		Scope of emergency service first level that should be supported by health		

No	Types of Services	Indicators	Targets	Targeted Year
		infrastructures in districts		
3	Epidemiology Investigation and cure to special occasion	Scope of Village or sub districts with special condition through epidemiology investigations less than 24 hours	100%	2015
4	Health promotion and people empowerment	Scope of Active Alert Village	80 %	2015

The local governments were asked to fulfil the target indicator of health service delivery using their own budget refer to the implementation mechanism which was stipulated on Health Minister Decree No.317/MENKES/SK/V/2009 on Technical Guidance for Health MSS Planning and Budgeting at Municipal and City Level.

In analysis we utilize data which are compiled by the Ministry of Home Affairs and Ministry of Health on the achievements of each district to targets set in MSS. This target is based on the district's self-assessments which mean that local governments or unit which is responsible to implement MSS in its sector, fill their own achievement based on their guidance made by the central government. In the data compiled by MoHA, we found not every local government reported the achievement set in MSS. The difficulties are related with incomplete annual report, various variant of target measurement, and some other format report submitted, that lead to not necessary information included in the report.

To investigate the polarization of quality on basic public service among district, time series data is necessary. Complete time series data of health service will reveal any particular trend of health service quality year by year. From the data compiled by MoHA, we select 54 local governments from 534 local governments in total, considering the region representation and completeness of the data. The selected samples are shown in figure 6.

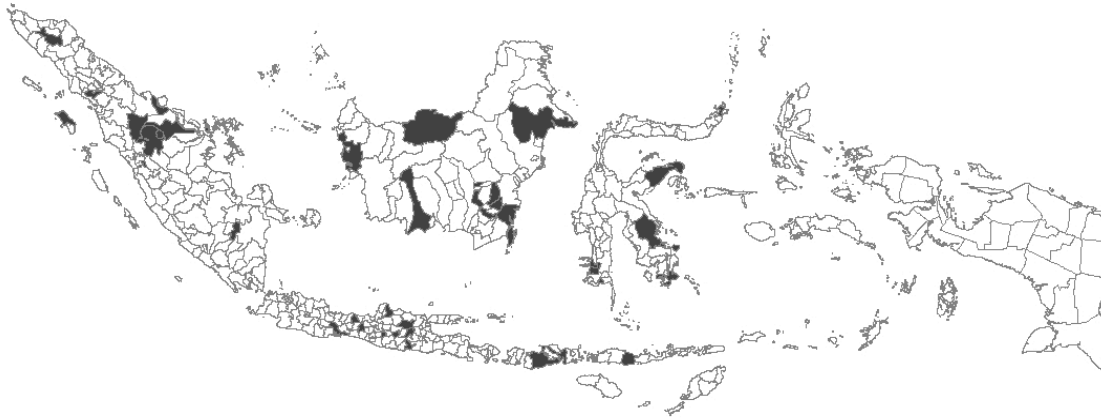


Figure 6, Distribution of Municipals and Cities Selected Sample

The time period of observation is 4 years, from 2010 to 2013. We consider 2010 as effective start year for implementation of MSS. Hence, the technical guidance of health MSS was published at 2009 then the local governments are assumed will be effectively implemented at 2010. Since only few of sample up to date until 2014, we decide to utilize 2013 data as the final date of observation. In order to make generalization of health service quality, we taking the average of health performance indicators, measured by essentially calculating an average of standardized 14 core health service indices. The 14 core health service indices are listed on basic service type, as can be seen from health MSS table.

Overall, the quality of health service is increasing from 2010 to 2013. By setting the MSS indicator target average value by 91,25%, the average achievement of local government samples is 74,58% at 2010. Then the quality of health service steadily grow to 76,79% in 2011, 77,46% in 2012, and 76,01% in 2013. Although the quality of health service is still far from minimum target that set in MSS, it has positive growth. It can be observed that de-polarization in the quality of services could potentially occur across regions in the future by reducing gaps between their performance and targets, as set by MSS for districts who are not able to reach the targets, as well as maintaining the performance of some districts which have achieved outputs exceeding the targets.

In addition, the compactness of scatter plot, as can be seen at figure 7, has climbing trend to reach minimum level of target. The trend implies that some local governments do better in order reducing the gap within their performance and targets. We calculate 39 samples of local governments (72%) reported that they improved the health service quality. In the other hand, 16 local government samples (18%) do

worse off on improving the health service quality, while few of them have fluctuating performance, and the rest do consistently worse off.

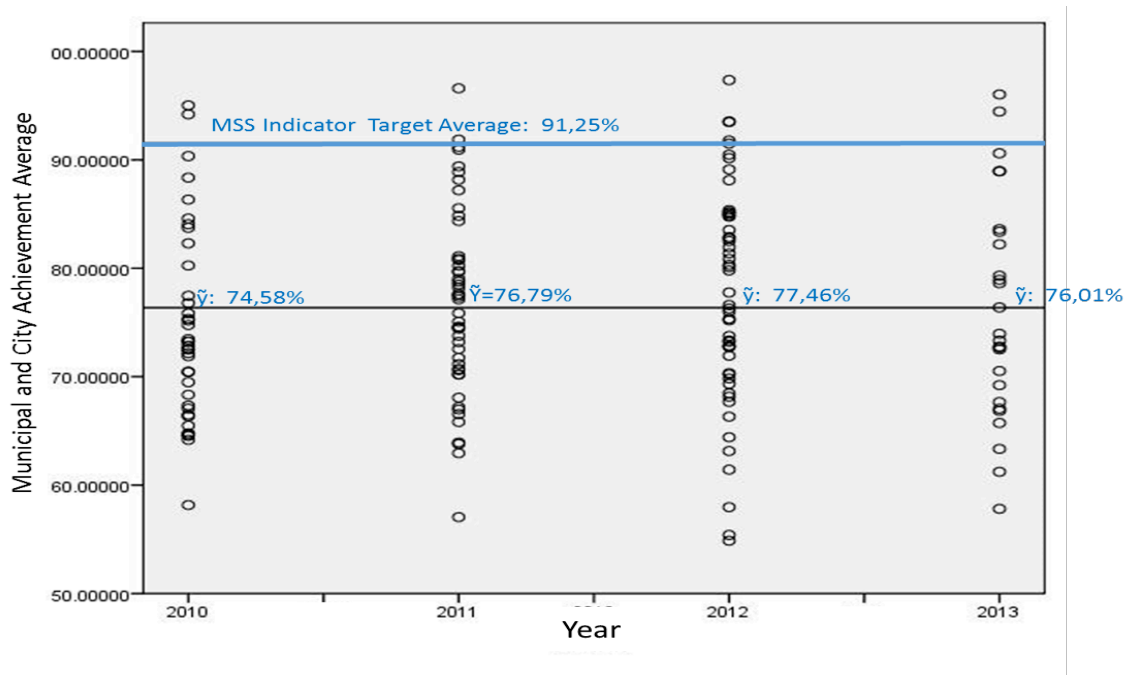


Figure 7, Depolarization of Health Service Quality on Local Government

However, we acknowledge the weakness on validity of self-assessment data. First, lack of knowledge and skills to officially fill the targets, overrating the achievements and targets as well as the lack of independent data to confirm the self-assessment data. This problem also confirmed by report of World Bank (2011) that constructing data-base to assess the achievement on the target of MSS become main challenge of local government. We did some adjustments to the raw data because some local government exceed the maximal indicator. For instance, the report from Pringsewu district shows that they achieved 130,5% coverage of baby care visit in hospital at 2010, which is unreasonable because the maximum coverage is 100%. World Bank (2011) acknowledges this problem as the lack of understanding in technical guidance from Ministry of Health, especially numerator and de-numerator used to translate the data which are collected from field into MSS indices.

Secondly, there is weak mechanism on reporting the achievement of target. Local governments are often confuses where they have to report the MSS's achievement, whether to sectoral ministry or MoHA or even to both organizations. There is also a lack of coordination in the central government. The report that is submitted to MoHA is often not rechecked by the responsible sectoral ministry but while local

governments are not successfully achieved the targets in MSS, MoHA will be blamed as their faulty. From this perspective, it seem that nor local governments and central government ready effectively implement MSS. This also includes which institutions will do feedback to the reports as well as what are the roles of auditors in the reports.

Apart from the weakness on the validity of self-assessment data, we also acknowledge that difference in financial, economic and resources become the main determinants why one district is more successful in achieving the targets than the other districts. We do regression analysis to check any correlation of difference on income of local government on achievement of local government to improve health services. In this analysis, we use cross tabulation data analysis to seek empirical evidence of financial resources with health quality services. The Income of local government variable is divided into 2 categories: (1) original regional revenue, the local government income which generated from tax levy on their region; and (2) Fiscal transfer, which consists of three types: general allocation funds, revenue sharing, and specific allocation funds. We utilize municipalities and cities data which is generated from Ministry of finance in year 2013.

We utilize the achievement of MDG as an indicator to measure health quality of services in Indonesia instead of the achievement of MSS's targets that are reported by local government due the similarities and the reliability of data. World Bank (2011) has analysed each indicator of health MSS and found some indicators of MSS is similar with MDGs indicators in the health sector. For instance, in goal 6 MDGs, Improve Maternal Health, target 5A, Reduce by three-quarters, between 1990 and 2015, the under-five mortality rate; one of indicator which is stated is proportion of births attended by skilled health personnel. This MDGs target is similar with MSS health indicator 1.3., the scope of aid from health workers or nurses. MDGs data are also more reliable because they gathered by MDGs joint-Secretariat, Ministry of National Development Planning (BAPPENAS), Ministry of Health, and National Statistical Agency. These data include all cases of municipalities and cities in year 2013. The indicators that we are seeking their relations with local government's income are: (1) Percentage of infant whom get breastfeeding; (2) Percentage of infant whom get immunization; (3) Percentage of Pregnant Mother who get childbed treatment; (4) Percentage of woman who participate on Family Planning; (5) Infant death rate; (6) Percentage of infant who is given exclusive breastfeed.

From table 3, the relation between health service quality and local government revenue is various. However, few coefficients have significant relationship with local

government revenue. Origin Regional Revenue and revenue sharing have significant positive relationship with percentage of infant whom get immunization. This implies that municipal or city government which have high origin's regional income and revenue sharing will have high percentage in delivering child immunization service. The other variable that shows significant relation is specific allocation funds with percentage of pregnant women who get childbed treatment. The coefficient shows significantly positive relation between high allocation of specific allocation funds and service to mother after giving birth.

Table 3 Relation of MSS and Local Government Income

Standardized Coefficient (t-value)	Origin	General	Specific	
	Regional Income	Allocation Funds	Allocation Funds	Revenue Sharing
Percentage of infant whom get breastfeeding	0.391 (0.699)	-0.344 (0.733)	0.945 (0.353)	-0.107 (0.837)
Percentage of infant whom get immunization	0.933** (2.089)	-0.244 (-0.686)	-0.323 (-0.94)	0.835** (1.978)
Percentage of Pregnant Mother who get childbed treatment	0.345 (0.762)	0.414 (1.144)	0.805** (2.306)	-0.248 (-0.578)
Percentage of woman who participate on Family Planning	0.729 (1.582)	0.004 (0.012)	-0.548 (-1.546)	-0.877** (-2.014)
Infant death rate	-0.6 (-1.284)	-0.274 (-0.735)	0.589* (1.638)	0.425 (0.962)
Percentage of infant who is given exclusive breastfeed	-0.252 (0)	-0.004 (-0.01)	-0.158 (-0.373)	0.229 (0.439)

Figure in parentheses (**) and (*) denote significance at 5% and 10% level respectively. For two way error components the quantities in (.) are t-value.

Conclusion

In conclusion, two research questions are set above can be answered. Firstly, some literature and empirical evidence shows that decentralization policy seems cause polarization on the quality basic public services among districts. The trend shows that this inequality will significantly increase from year to year. Secondly, lying on the rationale that MSS set the same standards in the quality of services across regions, from the empirical evidence, it can be shown that the introduction of MSS causes

depolarization in the quality of services across regions

Moreover, taking case on the achievement of MSS in the health sector, we observe an improvement of health service quality across regions. Apart of the weaknesses of self-assessment report of local governments on the achievement of MSS, Major local government in our samples do better on improving health quality, which they can reduce the gap between current service and minimum service. If this phenomenon continues, MSS could create de-polarization on the quality of public services as the effort to minimize the disparities/inequality traps which is indicated by Homme (1995) and Fuhr (2011) as one of negative consequences of decentralization policy. In addition, difference of fiscal resources among local governments associated with achievement of MSS. Abundant local governments have easy effort to achieve MSS, and vice-versa.

Finally, it is considered that MSS is important starting and checkpoint to reduce inequality of public service across regions. However, due the difference of resources, the proper fiscal transfer need to be designed in order to create de-polarization of public service, at least put the quality of service of each region at minimum level. It is not only in the health sector but also in other sector in MSS.

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