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Beyond "Good Governance": The Multi-level Politics of Health Insurance for the Poor in Indonesia

DIEGO FOSSATI*
ISEAS-Yusof Ishak Institute, Singapore
Griffith University, Australia

Summary. — Recent decentralization reforms in low- and middle-income countries have revived a long-standing debate on the benefits and drawbacks of empowering local governments. While some scholars highlight advances in local democratic accountability, others emphasize the dangers of decentralized governance when democratic practices are poorly institutionalized. This paper studies the case of health politics in Indonesian local government to contend that the focus on democratic accountability and good governance may be insufficient to explain major policy outcomes associated with decentralization. I show that the quality of local democracy affects health insurance policy during the first stages of the decentralization process. However, to understand policy trajectories over a longer time frame, relations between politicians at different levels of government become the crucial factor. Using original qualitative and quantitative data from nearly 400 Indonesian districts and provinces, I find that regions in which cooperation between provincial and district authorities has emerged display systematically higher levels of health insurance coverage. I explain why multi-level cooperation improves local policy outcomes, and I show that the positive effect of cooperation does not depend exclusively on patronage networks. These findings contribute to the literature on decentralization and development by showing that policy cooperation across levels of government is crucial for the implementation of complex social policies, and that multi-level cooperation can have beneficial effects even when local democratic institutions are weak.

Key words — decentralization, democratization, social policy, healthcare, multi-level governance, Indonesia

1. INTRODUCTION

Decentralization reforms implemented in the last two decades have fundamentally transformed governance in many low- and middle-income countries. Research on decentralization suggests that such reforms can be beneficial in fostering desirable policy outcomes, but only in the presence of virtuous dynamics of democratic accountability at the local level. Such a focus on local government and democratic accountability, however, neglects that decentralization reforms give rise to multi-level political systems, in which complex policies are enacted at different levels of government, often with overlapping jurisdictions and potentially conflicting preferences. This paper studies the case of health politics in Indonesian local government to argue that relations between different levels of government are crucial in affecting the quality of social policy implementation. While the quality of local democracy and governance helps explain health policy innovation in the early stage of decentralization, the long-term sustainability of such policies depends on the ability and the willingness of local political leaders at various levels of government to work together and address common policy challenges.

Decentralized governance has often been promoted as necessary to achieve development policy goals. Building on theories of fiscal federalism (Oates, 1972, 1999; Tiebout, 1956), advocates of decentralization have argued that empowering local authorities fosters desirable policy outcomes and strengthens democracy in local government. The empirical record of decentralization reforms in the developing world, however, is mixed. After a first wave of decentralization reforms was implemented in the late 1980s and early 1990s, empirical evidence began to mount that increased local autonomy was not alleviating deep-seated evils such as corruption, poverty, and inequality (Burki, Perry, & Dillinger, 1999). Many observers attributed such disappointing outcomes to the poor functioning of democratic institutions at the local level, where low levels of socioeconomic development often impeded the emergence of robust dynamics of democratic participation and competition (Bardhan & Mookherjee, 2000, 2006; Cai & Treisman, 2006; Keefer & Khemani, 2005; Shah, 1999).

Although the quality of local democratic institutions is key for understanding decentralization outcomes, the focus on local-level factors predominant in this literature has neglected that decentralization reforms create multi-level political systems, in which policy is designed, implemented, coordinated, and sometimes vetoed by elected officials at various levels of government (Hooghe & Marks, 2003). Building on the literature on federalism and multi-level governance in socioeconomically advanced democracies (Stephenson, 2013; Wibbels, 2006), I argue that policy cooperation across levels of government is crucial to ensure social service delivery at the local level. In low- and middle-income countries, where many local governments suffer from low levels of financial and institutional capacity, social policy implementation is often inadequate, and assistance in policy implementation from higher levels of government is vital to achieve desirable policy

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outcomes (Prud'Homme, 1995). I focus, in particular, on the role of a set of actors that are neither local nor national. Cooperation between local government and these "meso-level" political units, such as regions and provinces, is beneficial for local policy outcomes. On one hand, intermediate-level governments dispose of higher levels of institutional capacity and financial resources, and can thus offer local government valuable assistance in implementing social policy. On the other hand, the larger size of meso-level units allows them to exploit economies of scale better than local government, thus avoiding the inefficiencies of excessively localized social service delivery (Ahmad, Devarajan, Khemani, & Shah, 2005). As intergovernmental cooperation may improve both policy outcomes and the quality of local institutions, neglecting meso-level governments may lead analysts to overstate the importance of local democratic accountability in fostering desirable policies.

Indonesia is an illustrative example of how a profound restructuring of a centralized state has yielded mixed policy results. After the demise of the authoritarian regime led by President Suharto in the late 1990s, this country implemented a package of radical reforms granting substantial autonomy to its local administrations. Districts-level local governments, in particular, were empowered with important prerogatives in a number of policy areas, while provinces, larger political units between the district and the national level, received more limited powers. The outcomes of such reforms, in terms of development policy, are somewhat disappointing: while the country has continued on a stable trajectory of economic growth, local-level advancements in key policy areas such as social service provision and poverty alleviation have continued at a pace closely reminiscent of the years of centralized planning (Ilmma & Wai-Poi, 2014), and there is wide variation in local government success in attaining policy goals (Lewis, 2014a). Students of Indonesian politics have often explained these varying results by studying how democracy works in Indonesian local government, stressing factors such as civic participation and informal linkages between elected officials and social groups, and the dominance of predatory interests in democratic competition (Pepinsky & Wihardja, 2011; Von Luebke, McCulloch, & Patunru, 2009). In this paper, I study the case of the politics of free healthcare for the poor in Indonesian local government to argue that the prevailing attention on local factors has neglected relations among politicians at *different* levels of government. Although various Indonesian districts, especially those with strong democratic institutions, implemented innovative policies in the early stage of the decentralization process, such policy experiments have often proved unsustainable. The empirical data that I present demonstrate that, over a longer time frame, districts that cooperated closely with provincial governments in the implementation of institutionalized, accurately targeted, and financially sustainable local health insurance plans have achieved higher health insurance coverage rates.

The remainder of this paper proceeds as follows. In the next section, I review the literature on decentralization and service delivery in low- and middle-income countries, with a particular focus on Indonesia, and I discuss why relations between various levels of government should be investigated with greater attention. I then transition to the empirical section of the paper, presenting the diffusion of local health insurance programs in Indonesia as a two-stage process. In the early stage of decentralization, when local government served as a laboratory for policy innovation, the quality of local institutions played a key role, as innovative policies were more likely to be adopted in districts with strong democratic accountability dynamics. However, such policy experimentations were often unsustainable beyond the short-term. In a second stage of the policy diffusion process, national and provincial authorities gradually took the center stage in designing health insurance policies, putting issues of multi-level coordination at the forefront of the policy debate. I then outline the research design and I analyze quantitative data showing that districts in which multi-level cooperation between districts and provinces emerged have provided higher rates of health insurance coverage. I also show that the effect of multi-level cooperation on local policy outcomes does not depend on district-level institutional and political factors. I conclude by discussing the implications of these findings for the literature on decentralization and development, and by identifying avenues for further research.

2. DECENTRALIZATION, ACCOUNTABILITY AND SERVICE DELIVERY: THE MULTI-LEVEL DIMENSION

Seminal work on decentralized governance argued that federal institutions foster desirable policy outcomes because of two main reasons. First, local government has better knowledge of local conditions and policy preferences (Hayek, 1945). Second, federalism promotes a process of competition among subnational units through which citizens can choose the policies they prefer by sorting themselves into different jurisdictions (Tiebout, 1956). Some presumed benefits of empowering local authorities include more efficient public goods provision, better economic performance, smaller government, and enhanced accountability and representation at the local level (Oates, 1999). These theoretical tenets have informed the shift toward more decentralized governance in developing countries since the mid-1980s, as consolidated models of central planning to promote economic development and reduce poverty started to fall into disrepute. A few years after decentralization experiments had begun to proliferate, however, the empirical record of decentralization projects in the developing world was already mixed (Burki *et al.*, 1999): the promise of cleaner, more efficient and responsive public administration often contrasted with policies that failed to address persistent problems such as inequality, poverty, and corruption. One explanation for these disappointing outcomes is the quality of local democracy: local-level democratic institutions in developing countries are often very different from those subsumed in the theoretical literature [1]: due to low levels of socioeconomic development, local democracy is often plagued with problems such as lack of public information, participation and awareness, low levels of political competition, absence of credible institutions, and service delivery targeted to clients of local officials (Bardhan & Mookherjee, 2000, 2006; Keefer & Khemani, 2005; Shah, 1999). As a result, the virtuous circle of democratic accountability posited in theory often fails to establish itself in practice, and resources that should be devoted to improve popular welfare are "captured" by local elites (Golden & Min, 2013, p. 88).

Indonesia illustrates the mismatch between the positive expectations propelling decentralization reform and its empirical outcomes. In the late 1990s, after the breakdown of the authoritarian regime led by President Suharto, Indonesian legislators implemented a package of institutional reforms that would quickly transform Indonesia into a more democratic and decentralized political system. The "regional autonomy" (*otonomi daerah*) laws, in particular, introduced substantial autonomy for local government, a remarkable departure from

the New Order regime, in which Indonesian regions were governed by centrally appointed bureaucrats.[2] Law 22/1999 specifies that there are two main levels of local government, namely districts and provinces, and provides a strong mandate for them to govern in full autonomy, according to the preferences and priorities of their local constituents. Most policy prerogatives are assigned to the district level, as the law lists a series of policy areas, including healthcare, in which district government is supposed to perform an "obligatory" function. However, the division of powers between the various levels of government remains murky (Seymour & Turner, 2002), as the law does not clearly enumerate the responsibilities of district vis-à-vis provincial governments, and it only indicates that local government powers exclude foreign policy, defense, and security, the judicial system, religion, monetary policy, and "other matters".[3] As a result, Indonesia is currently a decentralized country in which policy prerogatives in a number of areas, including the provision of social services, are shared across three main levels of government, namely district, provincial, and national authorities.

More than a decade after the implementation of the regional autonomy laws, the prevailing view in policy circles is that, as Lewis notes, "decentralization has been somewhat of a disappointment" (Lewis, 2014a, p. 135). Recent data suggest that decentralization reforms have done little, if anything, to accelerate the development trajectory that Indonesia was following under authoritarianism and centralized rule: regional poverty rates have been converging at the same pace as they were under the New Order (Ilmma & Wai-Poi, 2014), extreme variation in the quality of local governance persists (Patunru & Rahman, 2014), economic growth has not accelerated (Pepinsky & Wihardja, 2011), and the record of social service delivery is still mixed at best (Lewis, 2014a). Students of Indonesian politics have examined various facets of local politics to account for decentralization outcomes, focusing in particular on the dynamics of democratic competition and accountability. For instance, Pepinsky and Wihardja (2011) find through qualitative analysis that poor socioeconomic conditions undermine local democratic institutions, producing subpar policy outcomes; Von Luebke *et al.* (2009) study informal linkages of cooperation and accountability between elected officials and representatives of the private sector as a source of effective economic policies; Rosser and Wilson (2012) focus on the role of civil society organizations and local leaders in building "reform coalitions" for the provision of free social services to the poor.

The emphasis on local-level factors in the scholarship on decentralization has overlooked a crucial by-product of decentralization reforms: decentralization creates political systems in which different levels of government share policy prerogatives and overlapping jurisdictions (Hooghe & Marks, 2003). The large body of research on federalism and multi-level governance has studied the causes and the effects of the vertical dispersion of power from different perspectives.[4] One strand of this literature, of particular interest for the purposes of this paper, looks at intergovernmental relations in multi-level political systems. Different levels of government often have divergent policy preferences on issues such as taxation, regulation, and the provision of public goods, and they may thus engage in "vertical competition" (Treisman, 2002), or conflict over policy choices with other levels of government. As Elazar notes, this tension between the federal government and its constituent units is "an integral part of the federal relationship, and its character does much to determine the future of federalism in each system" (Elazar, 1987, p. 185). As argued by Stepan (2004), subnational units in multi-level political systems can also function as de facto veto players (Tsebelis, 1995, 2002), thus hindering the adoption of beneficial policy reforms. In his seminal study of federalism, Riker (1964) addressed this point by arguing that a strong, vertically integrated party system is necessary to ensure cooperation between politicians at different levels of government. As national politicians control the careers of their co-partisans at the local level, they are able to compel them to implement policies that they would not otherwise adopt. More recently, the literature on self-organizing federalism (Feiock & Scholz, 2009) has identified more informal and voluntary forms of intergovernmental cooperation, most prominently coordination through various types of policy networks. Whether cooperation is ensured through central compulsion or less hierarchical channels, policy coordination is crucial to address adequately a number of key policy challenges in contemporary multi-level political systems.

Although the literature on multi-level governance has focused on a small number of federal countries and the European Union, the insights are relevant for development policy in highly decentralized low- and middle-income countries. For instance, research on natural resource management has shown that decentralization reforms often create ambiguous institutional arrangements in which lack of clarity about the division of power across levels of government can generate conflict (Béné *et al.*, 2009; McCarthy, 2004; Verbrugge, 2015). As for social policy, since local governments in developing countries typically suffer from a lack of financial resources and limited capacity to plan and carry out policy initiatives, local-level policy implementation is often severely flawed. In his critique of decentralization, Prud'Homme presents the provision of social services as a prime example of a policy area in which intergovernmental cooperation is essential to foster desirable policy outcomes, and he advocates the adoption of practices such as "subsidies (of various types), mandates, constraints, guidelines, floors and ceilings, coordination mechanisms, contracts between various levels of governments" (Prud'Homme, 1995, p. 218). When local authorities work with higher levels of government to address common policy challenges, they can receive assistance on several fronts, including in securing the financial resources needed to fund social programs, and in various issues related to their implementation, such as the targeting of beneficiaries, personnel training, management, and logistics. Since intergovernmental cooperation can have a positive impact on the quality of local policy outcomes and institutions, neglecting the multi-level context in which local government is embedded can lead to an overstatement of the importance of local democratic institutions.

The importance of intergovernmental relations has long been acknowledged in the literature on decentralization and development (Bird, 1990; Gershberg, 1998). However, scholarly work has devoted scant attention to the issue of multi-level governance. While scholars of development have often studied relations among politicians at various levels of government, this work suffers from two main weaknesses. First, the main focus in existing work has been on cooperation as an instance of patronage politics rather than of policy coordination. Relations between national and local politicians in low- and middle-income countries are typically conceptualized in terms of partisan or ethnic patronage networks able to target service delivery to political clients at various levels of government. The vast literature on intergovernmental fiscal transfers has exposed the politicized allocation of national budgets in places as diverse Latin America (Calvo & Murillo, 2004; Kraemer, 1997; Remmer, 2007; Timmons & Broid, 2013), India (Khemani, 2003; Rao & Singh, 2003), and Africa

(Banful, 2011; Barkan & Chege, 1989; Caldeira, 2012; Weinstein, 2011), finding robust evidence that fiscal transfers from central governments are larger for subnational units led by co-partisans of national executives. In this paper, I show that intergovernmental policy coordination, unlike patronage spending, can have beneficial effects on local-level policy outcomes regardless of partisan alignments among policy-makers at different levels of government.

Second, the literature on decentralization and development has not exhaustively investigated the full scope of intergovernmental relations. A key institutional feature of many decentralized countries is that important policy prerogatives are granted to a level of government that is neither local nor national. While such "meso-level", or "first-level" institutions like provinces, states, and regions, have been the primary focus of the literature on federalism, work on decentralization and development has typically studied relations between the local and the national level. This level of governance may be crucial in improving the delivery of social services, even in countries that are not formally federal, for two reasons. First, intermediate-level administrative units are usually endowed with higher levels of financial resources and more professionalized bureaucracies than local government. As Prud'Homme observes, local administrations are at a disadvantage vis-à-vis central government in recruiting qualified professionals as civil servants, as they lack the capacity to offer attractive careers and to invest in research and development (Prud'Homme, 1995, pp. 209–210). Since they are larger organizations, first-level governments are on average better funded and better able to recruit more qualified and motivated personnel. Second, this level of governance includes units that, although smaller than national governments, may be large enough to exploit economies of scale or scope in the provision of social services, thus avoiding the inefficiencies of excessively localized social service delivery (Ahmad *et al.*, 2005; Shah, 2004). In this respect, social service provision at the intermediate level may be a compromise between the efficiency of centralized policies and the goal of catering to policy preferences that vary across subnational units. I show in this paper that meso-level government can improve social policy outcomes, and that such positive effect is observed even when local government is bedeviled by low institutional capacity. More broadly, I conceptualize local government as embedded in a multi-level institutional network in which *meso-level* political units play a crucial role in shaping *local* policy outcomes.

The scholarship on decentralization in Indonesia exemplifies how the issue of multi-level politics has been neglected. Center-periphery relations, and fiscal relations in particular, have been crucial in the process of state development in the archipelago (Booth, 2014). However, while the pitfalls of the lack of coordination among local authorities have been exposed in some case-studies (Firman, 2009a, 2009b), research about the nexus between intergovernmental cooperation and policy outcomes is almost nonexistent. The most significant treatment of the issue of multi-level politics is Kimura's work on "territorial coalitions", which argues that cooperation between politicians at different levels of government was instrumental in driving the process of territorial proliferation through which eight new provinces were established since 1999 (Kimura, 2013). This contribution, however, does not clarify if elite relations across different levels of government also shape local-level outcomes in specific policy areas. In this paper, I show that they have, using the local politics of health insurance for the poor as a case study. I start my analysis in the next section with an account of the early stage of the diffusion of health insurance policies in Indonesian local government (2001–07), a time of policy experimentation in which local-level factors were key for explaining local policy outcomes. I then turn to the later stage of the policy diffusion process (starting from 2008), and I show that multi-level cooperation became a more important factor than the quality of local institutions in widening access to healthcare among the poor.[5]

3. POLICY INNOVATION IN INDONESIAN LOCAL GOVERNMENT: ON THE ROAD TO HEALTHCARE FOR ALL

Indonesian national policy-makers have shown interest in broadening access to healthcare for decades.[6] For instance, to mitigate the devastating effects of the financial crisis in the late 1990s, the central government launched a number of social security programs, including *Kartu Sehat* (health card), a scheme that offered free healthcare to indigent citizens (Sparrow, 2008). Yet such initiatives were contingent and limited in scope, and health insurance was a luxury reserved to a narrow segment of the Indonesian workforce, namely to those employed in government institutions and in the formal sector.[7] It was not until the mid-2000s when significant steps were taken to establish a comprehensive health insurance system that would cover all Indonesian poor households. *Askeskin*, renamed *Jamkesmas* in 2007, was a program launched in 2005 to expand access to healthcare dramatically to an initial membership of 60 million poor Indonesians and informal workers. With this system, patients could receive free basic outpatient care and in-patient services in public hospitals, which could then submit claims to government agencies for the services provided to members of the program (Sparrow, Suryahadi, & Widyanti, 2013).[8]

While national efforts to build a more inclusive health system had some beneficial effects in expanding access to healthcare, three crucial aspects of the *Jamkesmas* framework were flawed (World Bank, 2012). First, in many regions, *Jamkesmas* quotas were insufficient to cover poor residents. While some districts were allocated quotas much larger than the size of their low-income population, some others received less than what they needed to insure all poor households.[9] Second, *Jamkesmas* utilization rates remained fairly low among the poorest. Due to factors such as low awareness of benefits, mistargeting, poor quality of healthcare services in many regions, and still overwhelming out-of-pocket costs, the national health insurance plan was unappealing for many poor households.[10] Third, *Jamkesmas* did not include near-poor citizens and the non-poor, leaving about half of the Indonesian population without coverage from any government-run health insurance schemes. Furthermore, local government has maintained key responsibilities in the implementation of *Jamkesmas,* as district authorities are in charge of defining the beneficiary list, socializing the program, and verifying and reimbursing the claims submitted by healthcare service providers. Subnational authorities have thus been crucial in addressing, or, through inaction, failing to address both long-standing inequalities in access to healthcare and new imbalances created by *Jamkesmas* implementation. For this reason, studying the politics of free healthcare for the poor in Indonesian provides an ideal empirical setting to investigate the provision of social services by local government.

The two major institutional changes that restructured the Indonesian state in the late 1990s, democratization and decentralization, had profound consequences for local politics. The first is that local government was granted the opportunity to

innovate in various policy fields. Despite the persistence of deep-seated governance deficiencies in many regions, Indonesian local governments have so far demonstrated their ability to design and implement innovative, reformist policies in areas ranging from primary education to procurement reform, sanitation, budgeting, bureaucratic simplification, and participatory planning (World Bank, 2006). Second, the introduction of direct elections for district and provincial heads has created new incentives for the implementation of pro-poor policies. [11] Although early accounts of local politics in decentralized Indonesia suggested that patterns of elite capture and oligarchic consolidation were prevalent (Hadiz, 2003; Hadiz & Robison, 2005), recent scholarship has recognized that democratization has opened up new venues for meaningful civic participation, both through electoral and informal channels (Aspinall, 2013; Davidson, 2007; Mietzner, 2013; Pepinsky, 2013).

The politics of health insurance programs for the poor are a powerful illustration of the innovative capacity of local government and of the appeal that pro-poor programs have gained as a result of democratization in the Indonesian regions (Aspinall, 2014; Aspinall & Warburton, 2013). Since the early 2000s, when no major national health insurance scheme was being implemented, a small number of districts started to expand access to healthcare services with health insurance programs targeted at poor households. Such programs, known in Indonesia as *Jamkesda* (*jaminan kesehatan daerah*, or regional health insurance), varied in crucial aspects such as legal and institutional status, membership criteria, benefit packages, implementation strategies, and financing mechanisms. However, *Jamkesda* programs may constructively be viewed as local-level responses to a common policy challenge that was rooted in the lack of a comprehensive national health insurance policy. As national-level policy makers were procrastinating to address the issue of low levels of access to healthcare among the Indonesian poor, some local administrations used their newly acquired prerogatives to fill this policy vacuum. [12] An often-cited example of such activism is the case of Jembrana Regency in Bali, where the local regent implemented a universal health insurance scheme that offered free basic healthcare to the district's residents (Rosser & Wilson, 2012). A survey conducted in June 2007 by the Indonesian Ministry of Health, followed by a series of field visits, found that 24 districts had already been running local health insurance schemes for at least 1 year, and that an additional 72 districts had plans to implement similar programs (Gani *et al.*, 2008). [13] Figure 1 displays the geographic distribution of these "pioneer" districts, showing that *Jamkesda* programs emerged in many different regions.

The first years following the implementation of decentralization reforms were thus a phase of policy experimentation in local health policy, in which some districts took significant steps toward building more inclusive local health systems. A key question regarding this process concerns the drivers of such activism: did these pioneer districts display some common features explaining why they were at the forefront of this movement toward more inclusive health insurance policies? Table 1 provides some empirical evidence by comparing pioneer and non-pioneer districts along a host of socioeconomic and governance-related indicators. For each variable, I perform a one-tailed *t*-test comparing the mean value across the two groups, and I report the p-value for the .05 threshold. [14] The results demonstrate that socioeconomic development and the quality of local institutions are strongly associated with the adoption of policy innovation. First, pioneer districts are significantly more socioeconomically advanced than non-pioneers, showing markedly higher levels of urbanization and per capita GDP and lower incidence of poverty. Second, there is some evidence that pioneer districts have a more vibrant associational life, as they score higher averages for associations per capita (the *p*-values for this indicator is very close to the .05 level of significance). Third, pioneer districts display higher degrees of penetration of local and national television networks. This indicator might be interpreted as a proxy for television watching (Olken, 2009) and how informed citizens are about politics, which in turn is closely associated with democratic accountability. Finally, Table 1 reports the Local Economic Governance Index, a direct measure of the quality of governance at the district level. [15] The *t*-test shows

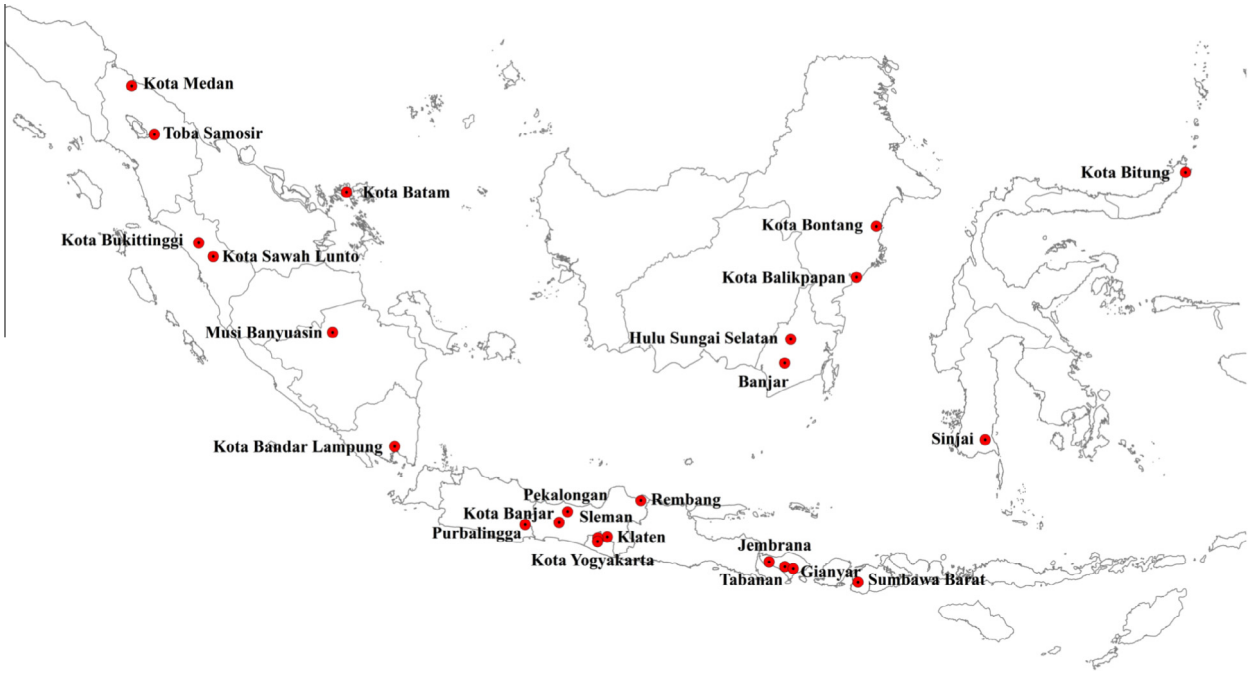

Figure 1. *Local health insurance programs in 2007.*

Table 1. *Difference in means between pioneer and baseline districts*

	Pioneer districts	Other districts	*p*-Value	*N*
Urban population (% of total population, 2005)	58.89	35.41	0.0002	373
Per capita GDP (IDR millions in 2000 constant prices, 2007)	10.12	6.19	0.0052	441
Poverty (share of total population below official poverty line, 2007)	13.11	18.53	0.0086	440
Inequality (Gini coefficient, 2007)	25.75	24.22	0.9592	440
Literacy rate (2007)	93.21	91.81	0.1859	440
Associations per 10,000 residents (2011)	12.06	8.96	0.0569	449
TV penetration (share of villages reporting TV access, 2011)	0.82	0.53	0.0003	449
Local economic governance index (KPPOD, 2007)	63.79	60.03	0.009	202

a difference between the two groups significant at the .05 level, as pioneer district score an average of 63.79 points against 60.03 points for non-pioneer districts.

In sum, empirical evidence from this first stage of policy diffusion points to the importance of local conditions, both socioeconomic and political. In the policy experimentation phase, Indonesia conformed to the theoretical expectations in the literature, as accountability linkages appear to have driven the adoption of reformist policies. In the next sections, however, I argue that the correlation between the quality of local democracy and policy outcomes was only temporary, as new actors at higher levels of government became more involved in this policy area and started to shape local-level policy outcomes.

4. THE INSTITUTIONALIZATION OF LOCAL HEALTH REGIMES

The innovative approaches developed by pioneer districts in health insurance policy were soon imitated by several other local administrations. Although year-by-year data are not available for all districts, there is evidence of a large-scale policy diffusion process through which virtually all Indonesian districts and cities adopted at least some form of *Jamkesda* after 2007, with most of them starting policy implementation during 2008–11. According to a study of the Center for Health Insurance Financing of the Indonesian Ministry of Health carried out in January 2011, 479 districts, or more than 97% of the total, had implemented a local health insurance program or had plans to do so by the end of 2011.[16] Data from the same report also suggest an exponential increase in the number of Indonesians enrolled in *Jamkesda* programs: for example, in 72 districts sampled for additional analysis, membership figures increased from only 8,500 people in 2006 to more than 8 million in 2013, which translates into an estimate of almost 70 million *Jamkesda* individual members nationwide (Thabrany *et al.*, 2014, p. 12). In short, *Jamkesda* schemes quickly transitioned from being a policy innovation benefiting a very limited number of Indonesian citizens in a small number of districts to a standard practice in local government.

As Aspinall (2014) argues, the developments unleashed by the introduction of local direct elections are a key force behind such a rapid diffusion process, and the nexus between institutional change, electoral incentives, and social policy mirrors the developments observed in other countries in East and Southeast Asia such as Thailand, South Korea, and Taiwan (Hicken & Selway, 2012; Selway, 2011; Wong, 2004). However, the proliferation of *Jamkesda* schemes is closely related to the increasingly assertive role in this policy area of two major players, namely the national government and provincial administrations, who actively promoted the development of local health insurance plans.

After the launching of *Jamkesmas*, national policy-makers started encouraging local government to design policies that would complement it. In 2007, Government Regulation 38 was issued to clarify confusion about the prerogatives of local government in various policy areas. It reiterates that the provision of basic social services, including healthcare, is an "obligatory function" for provincial and district authorities. Furthermore, government agencies supported the proliferation of *Jamkesda* through political communication and various support initiatives.[17] Despite such encouragement, however, evidence emerged that local health insurance programs were mired in all sorts of implementation problems, ranging from financial deficiencies to corruption, poor targeting, lack of coordination among service providers, and implementation delays. The dispersion of policy prerogatives across levels of government was indeed among the factors that hindered health policy implementation. For instance, a World Bank report on the implementation of nutrition programs found that the division of responsibilities between province- and district-level government was often unclear to local health officials (Choi, Saadah, Marks, Heywood, & Friedman, 2006, p. 64); as a result, bureaucrats at different levels of government shared little information about their respective activities in this area, which led to serious inefficiencies in the allocation of already scarce resources. Moreover, the contingent nature of health insurance reform in most districts was increasingly being revealed. As health insurance plans were often initiated by executive decisions of the district head, without involving the local legislative council, such reforms were sometimes as short-lived as the tenure of the incumbent local leader.[18]

Against such a backdrop of uncertainty over the sustainability of *Jamkesda* programs and the ability of district authorities to implement them, provincial governments emerged as major players in expanding access to healthcare.[19] Provinces such as West Sumatra, Bali, East Kalimantan, Central Java, and South Sulawesi started in the mid-2000s to devise plans of cooperation with the districts under their jurisdiction, laying the foundation for integrated, province-wide health insurance schemes. Provincial government has typically taken the lead in initiating such agreements by surveying district governments about their willingness to participate in jointly run health insurance schemes, and by negotiating the terms of the agreement. For instance, provincial authorities in Bali repeatedly organized meetings with their district counterparts starting from 2008, finally reaching in the following year an agreement on a formula to calculate the subsides to healthcare costs that the province would commit to paying.[20]

Although cooperative arrangements varied substantially in their provisions, they shared some key commonalities. First, these multi-level pacts were formal agreements, with a legal basis that typically included legislation passed by local legislative councils:[21] this aspect was crucial in mitigating the contingency of *Jamkesda* programs and in reducing the risk of reform rollback. Second, they stipulated cost-sharing arrange-

ments to finance the expansion of health insurance programs, as provincial governments agreed to pay a share of the health insurance costs incurred by districts.[22] These provisions were instrumental in overcoming the lack of financial resources in some districts and sub-provincial inequalities in access to healthcare. Third, cooperation agreements provided for a unified system with an integrated list of beneficiaries of healthcare services, which greatly reduced the potential for fraud and the occurrence of spillovers of free healthcare services to non-members.

To summarize, the stage of policy innovation was followed by a new phase in which issues of policy implementation and sustainability took the center stage. Local health insurance schemes proliferated rapidly by imitation, and the lack of institutional and financial capacity in many districts posed a substantial threat to their viability. The ability of district governments to cooperate with their counterparts at the provincial level was a crucial factor in the consolidation of local reform efforts. In the next two sections, I show through quantitative analysis that where such cooperative institutions emerged, local health insurance schemes provided wider access to healthcare services.

5. RESEARCH DESIGN

In 2010, 3 years after the launching of *Jamkesmas*, only 13 out of 31 Indonesian provinces were implementing integrated health insurance schemes in cooperation with district government.[23] Here, I use an original dataset I have assembled from various sources to show that this difference in multi-level cooperative institutions has had a pivotal effect on policy outcomes at the local level: *districts located in provinces that facilitated cooperation across administrations provided wider access to healthcare to their citizens.*

The dependent variable I use to measure the quality of policy implementation at the local level is built from a special fielding of the Indonesian National Socioeconomic Survey (SUSENAS) in July 2010. A new question asked survey respondents if they were members of a free healthcare program such as *Jamkesda* or *Jamkesmas*. Although this question does not distinguish between local and national programs, it can be considered a valid measure of access to healthcare at the local level for two reasons. First, this indicator focuses on policy *implementation*, which is the crucial aspect in service delivery in less developed countries. Instead of relying on local-level official membership figures that may be inflated or inaccurate, I use survey data that measure not only the extent of coverage, but also local government performance in implementing health insurance policies. All else being equal, a higher share of respondents reporting free healthcare coverage suggests that local government has performed better in its function of socializing and targeting such programs. Second, local government has had key responsibilities in the implementation of national as well as local health insurance programs, and it is plausible that local-level performance in implementation of various policy programs is closely correlated. To help the reader gauge the extent of variation in this variable, Figure 2 reports boxplots of the distribution of health insurance coverage in 28 Indonesian provinces grouped into five macro-regions, showing extensive subnational variation.[24]

Measuring inter-jurisdictional cooperation across administration levels can be daunting, as cooperation is often informal and difficult to observe. To address this challenge, I exploit the fact that multi-level cooperation in health policy has required the implementation of formal agreements between districts

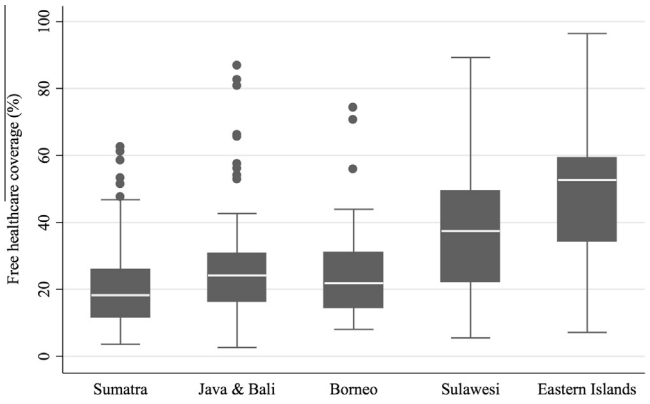

Figure 2. *Distribution of free healthcare coverage in five Indonesian regions.*

and provinces. I use the emergence of such integrated health insurance schemes as a proxy for multi-level cooperation, and I build a dummy variable that assumes the value of 1 for districts located in provinces in which a joint health insurance scheme was running in 2010, and of 0 otherwise. Data to code this variable were acquired over several months of fieldwork in Indonesia, mainly through the consultation of published and unpublished policy reports and through semi-structured interviews with informed respondents.[25] Following the characterization of district-province agreements introduced in the previous section, I adopt three criteria to code a province as having a cooperative arrangement: agreements need to be formal (the legal basis is typically a regulation by local legislative bodies), to entail some form of financial assistance from provincial to district governments, and to identify beneficiaries individually, through an integrated list. While these three criteria may be insufficient to guarantee that cooperation will have a positive effect on local policy outcomes, they ensure that other forms of more discretionary, contingent and unilateral policies (for instance, the allocation of funds to assist non-identified indigent citizens) are not coded as intergovernmental cooperation.

The ideal research design to test this hypothesis would allow for an analysis of free healthcare coverage rates over time and across space with panel data. By comparing how trends in health insurance coverage evolved in districts located in provinces with and without agreements, I could accurately identify the effect of multi-level cooperation on policy outcomes. Unfortunately, the survey data I am using to build the outcome variable is not available before 2010, so my analysis rests on cross-sectional analysis alone. As the argument I have formulated posits the effect of a province-level variable, namely the emergence of multi-level policy cooperation, on a district-level outcome, I model the relationship between the two with a hierarchical linear model (Raudenbush & Bryk, 2002) in which health insurance coverage is a function of multi-level cooperation and random intercepts for provinces. The basic specification of this model can be written as follows:

$$y_{ij} = \beta_0 + \beta_{1j}(COOPERATION) + \zeta_j + \varepsilon_{ij}$$

where y_{ij} is the free healthcare coverage rate observed in district i located in province j, β_0 is the baseline intercept, ζ_j is the random intercept for province j, and ε_{ij} is the unique error term for district i in province j. This model specification is suitable for the purposes of this paper because it allows us to estimate the effect of covariates at both levels of government. Furthermore, by using a hierarchical linear model, I can explore the interactions between multi-level cooperation

and district-level variables, which is necessary to ascertain if the effect of cooperation is conditional on specific local-level factors. I build on this basic equation by controlling for a number of district-level covariates that may be closely related to performance in service delivery and healthcare in particular.[26] Finally, to account for the substantial variation across macro-regions displayed in Figure 2, I include fixed-effects for islands in all estimations.[27]

Identifying the effect of multi-level cooperation on local policy outcomes is problematic due to the presence of province-level factors that may be confounding the relationship between the two variables. First, in some provinces, districts might be less likely to cooperate with provincial authorities because they face greater challenges in *implementing* health policy. Multi-level cooperation could thus be more likely to emerge in provinces with lower poverty rates and a history of better health policy outcomes, and cooperative behavior may be epiphenomenal to local historical trajectories in health policy.[28] To account for this causal path, I use data on the incidence of poverty in 1996, a year preceding the Asian Financial Crisis and the beginning of decentralization, to proxy for different baseline levels in access to social services.[29] Second, electoral politics may be a key driver of cooperation among politicians across levels of government. On one hand, cooperation is plausibly more likely in provinces with higher "partisan harmony" (i.e., where many district heads are from the same party of the provincial governor). Districts in these provinces may also exhibit higher coverage rates because they are linked to provincial politicians through patronage party networks. On the other hand, electoral competitiveness may have a positive effect on multi-level cooperation and local policy outcomes, as politicians might have higher incentives to adopt reformist policies when it is harder for them to secure re-election. Unfortunately, the Indonesian Electoral Commission does not have a central repository with data on the first round of local direct elections (2005–09). I therefore use official results of district-level direct elections published from the newspaper *Kompas*, one of Indonesia's leading news sources, to build province-level indicators of partisan harmony and electoral competitiveness.[30] Finally, a policy diffusion process may have been unfolding through which reformist policies spread vertically from district to province government. In this case, neglecting the diffusion process may underestimate the effect of cooperation, as cooperative behavior would be associated with provinces where district-level policy outcomes have already benefited from the introduction of the innovative policies previously described. I thus control for the number of pioneer districts in each province when estimating the effect of multi-level cooperation.

6. COOPERATION AND POLICY OUTCOMES: A QUANTITATIVE ANALYSIS

Table 2 reports estimation results for various models with different sets of province-level control factors. Model 1 is a baseline model in which free healthcare coverage is a function of intergovernmental cooperation and a host of district-level covariates. The coefficient for cooperative agreement, estimated at 0.043, is signed as expected and significant at the .01 level. This suggests that there is a systematic difference in policy outcomes between provinces with and without a cooperation agreement. In the absence of cooperation, the model estimates the average free healthcare coverage rate at 26.66%. However, for districts located in provinces that are implementing an integrated, multi-level health insurance scheme the predicted value increases to 30.97%.[31] When province-level average values of historical poverty rates are added in Model 2, the estimated coefficient of multi-level cooperation decreases to 0.037. As expected, the coefficient for the variable that proxies previous levels of access to social services is negative and significant, suggesting that historical legacies play an important role in shaping contemporary policy outcomes. However, the estimated coefficient for cooperation remains positive and significant after accounting for this causal channel. When indicators of electoral politics are added in Model 3, the estimated effect of cooperation increases in magnitude to 0.059, and it is again significant at the .01 level. While the role of electoral competition and partisan alignment may not be fully captured by these two measures, the estimation results suggest that neither factor is a significant confounding factors in the link between multi-level cooperation and policy outcomes. In Model 4, I add the indicator tracking the number of pioneer districts in each province. The magnitude and significance of the estimated coefficient for multi-level cooperation change only slightly, suggesting that policy diffusion dynamics are not a crucial factor in shaping intergovernmental cooperation. Model 5 includes all province-level factors discussed in the previous section: the estimated coefficient for multi-level cooperation is .069 and significant at the .05 level, indicating a sizeable difference of about seven percentage points between districts located in provinces implementing multi-level agreements and other districts. The results reported in Table 2 show that, while the magnitude of the coefficient for the cooperation indicator varies to some extent across model specifications, the effect of multi-level cooperation on local-level health policy outcomes is consistently positive, and that it is observed even after controlling for confounding factors related to path dependency, electoral politics, and policy diffusion.

As for district-level parameters, all models show that, as expected, *Jamkesmas* quotas have strong and positive effects on free healthcare coverage, indicating that the role of national programs was crucial in expanding access to healthcare. Similarly, poverty rates are positively associated with reported coverage, as free healthcare programs are typically targeting low-income citizens. Finally, some of the district-level factors related to governance also appear to have an effect on policy outcomes. The coefficient for the Local Economic Governance Index, in particular, estimated at 0.326 in Model 5, is signed as expected and significant at the 0.01 level. This suggests that the factors that were driving policy innovation in the early stage of decentralization are still relevant to explain medium to long-term policy outcomes. However, the quality of local institutions does not appear to be as decisive as it was in the early stage of decentralization. For example, a dramatic increase of twenty points in the governance index (roughly, this is the difference observed between districts in the 10th and the 95th percentile) only increases estimated coverage rates of 6.51%. This suggests that, as free healthcare policies have spread to virtually all districts, and provincial and national governments have implemented major policy initiatives, policy cooperation across levels of government has become the predominant driver of local-level policy outcomes.

In the models reported in Table 3, I explore cross-level interaction effects between cooperative agreements and local-level factors. As Indonesian districts differ dramatically in various aspects related to health policy, the effect of multi-level cooperation may be contingent upon specific characteristics that shape local-level implementation of health insurance programs. More precisely, studies evaluating the effect of social policy interventions in Indonesia have sometimes found that

Table 2. *The effect of multi-level cooperation on health coverage rates*

Variables	Model 1	Model 2	Model 3	Model 4	Model 5
Province-level					
Multi-level cooperation	0.0431**	0.0370*	0.0592**	0.0464*	0.0694*
	(0.0153)	(0.0154)	(0.0194)	(0.0225)	(0.0302)
Average poverty rate in 1996		−0.283**			−0.365**
		(0.110)			(0.117)
Partisan harmony			−0.0496		−0.0691
			(0.0393)		(0.0427)
Average electoral competitiveness			0.0258		−0.129
			(0.224)		(0.186)
Pioneers in the province				−0.00214	−0.00587
				(0.00994)	(0.0103)
District-level					
Jamkesmas quota	0.335***	0.378***	0.319***	0.337***	0.362***
	(0.0507)	(0.0541)	(0.0510)	(0.0494)	(0.0534)
Municipality	0.0217	0.0310	0.0242	0.0218	0.0357
	(0.0567)	(0.0549)	(0.0550)	(0.0572)	(0.0504)
Population (millions)	−0.0188	−0.0218*	−0.0182	−0.0190	−0.0239*
	(0.0120)	(0.0110)	(0.0114)	(0.0119)	(0.0100)
Population density	−0.00175	−0.00202	−0.00184	−0.00176	−0.00214
	(0.00381)	(0.00365)	(0.00382)	(0.00378)	(0.00364)
Per capita GDP	−0.000375	−0.000668	−0.000463	−0.000389	−0.000894
	(0.00104)	(0.00110)	(0.00110)	(0.00109)	(0.00127)
Poverty rate	0.0805*	0.105**	0.0763*	0.0808*	0.0982**
	(0.0347)	(0.0347)	(0.0350)	(0.0345)	(0.0336)
Inequality (Gini coefficient)	0.0715	0.135	0.0857	0.0672	0.140
	(0.213)	(0.212)	(0.222)	(0.214)	(0.219)
Urban population (%)	−0.0294	−0.0367	−0.0406	−0.0285	−0.0531
	(0.0808)	(0.0790)	(0.0755)	(0.0847)	(0.0733)
Literacy rate	−0.198	−0.185	−0.181	−0.196	−0.160
	(0.241)	(0.241)	(0.226)	(0.241)	(0.225)
Associations per 10,000 residents	0.00113	0.000778	0.00101	0.00120	0.000699
	(0.000685)	(0.000603)	(0.000699)	(0.000682)	(0.000599)
KPPOD LEG index	0.399***	0.383***	0.375**	0.397***	0.326**
	(0.114)	(0.108)	(0.115)	(0.115)	(0.112)
KPPOD data are from 2011 survey	−0.0237	−0.0160	−0.0266	−0.0251	−0.0260
	(0.0206)	(0.0192)	(0.0207)	(0.0190)	(0.0172)
TV penetration	−0.0412	−0.0477	−0.0397	−0.0408	−0.0419
	(0.0333)	(0.0334)	(0.0342)	(0.0331)	(0.0340)
Constant	0.0481	0.0641	0.0523	0.0486	0.174
	(0.259)	(0.264)	(0.241)	(0.260)	(0.260)
Observations	351	351	351	351	351
Number of groups	28	28	28	28	28
Log-likelihood	214.8	216.8	215.4	214.8	218.5

Robust standard errors in parentheses. All models include fixed effects for islands, not reported.
*** $p < 0.001$.
** $p < 0.01$.
* $p < 0.05$.

that the effects of such policy initiatives are stronger in localities with low baseline levels of social service provision (Olken, Onishi, & Wong, 2011; Wong, 2012). By this token, we should observe a larger effect of multi-level cooperation in districts with a history of deep-seated poverty and poor health policy outcomes, as it is under these conditions that policy interventions usually yield a higher marginal effect. To test this hypothesis, I build four baseline indicators using 2005 as the baseline year, namely poverty rates, morbidity rates, number of doctors and number of clinics per capita.[32] If the effect of multi-level cooperation is mediated by local-level contingencies, the estimated interaction terms should be statistically significant, show a stronger effect in districts with higher poverty and morbidity rates, and a more limited effect in districts with denser networks of doctors and local clinics. In the estimations reported in Table 3, all interaction terms are signed as expected: they are positive for interactions with morbidity and poverty rates, and negative for interactions with doctors and local clinics per capita. However, none of the estimated multiplicative terms is significant at conventional levels. This indicates that the effect of multi-level cooperation is not contingent on local-level factors related to socioeconomic development or the institutional capacity to implement health policy: the benefits of intergovernmental cooperation are observed regardless of the baseline levels of poverty and social service provision.

Table 3. *Multi-level cooperation and district-level factors*

Variables	Model 6	Model 7	Model 8	Model 9
Province-level				
Multi-level cooperation	0.0498	−0.0292	0.111*	0.0776
	(0.0421)	(0.0580)	(0.0466)	(0.0477)
Average poverty rate in 1996	−0.408**	−0.356**	−0.452***	−0.426***
	(0.125)	(0.111)	(0.125)	(0.124)
Partisan harmony	−0.0652	−0.0275	−0.0793	−0.0715
	(0.0470)	(0.0453)	(0.0469)	(0.0466)
Average electoral competitiveness	−0.182	−0.309	−0.115	−0.137
	(0.169)	(0.170)	(0.152)	(0.192)
Pioneers in the province	−0.00628	−0.00366	−0.00901	−0.00294
	(0.00969)	(0.00960)	(0.00999)	(0.00964)
Interaction				
Multi-level cooperation * poverty rate (2005)	0.123			
	(0.255)			
Multi-level cooperation * morbidity rate (2005)		0.299		
		(0.184)		
Multi-level cooperation * clinics per 1,000 people (2005)			−0.158	
			(0.120)	
Multi-level cooperation * doctors per 1,000 people (2005)				−0.0566
				(0.132)
District-level				
Poverty rate (2005)	−0.0604			
	(0.210)			
Morbidity rate (2005)		0.0810		
		(0.0949)		
Clinics per 1,000 people (2005)			0.0874	
			(0.0872)	
Doctors per 1,000 people (2005)				−0.0563
				(0.0641)
Constant	0.159	0.193	0.182	0.171
	(0.228)	(0.221)	(0.236)	(0.242)
Observations	343	343	342	342
Number of groups	28	28	28	28
Log-likelihood	216.3	218.5	218.5	218.7

Robust standard errors in parentheses. All models include dummy for islands and the district-level control variables included in estimations reported in Table 2.
*** $p < 0.001$.
** $p < 0.01$.
* $p < 0.05$.

7. CAUSAL MECHANISM

I have argued that multi-level cooperation improves local-level health policy outcomes because of policy coordination and financial assistance from province to district government. When policy-makers at different levels of government coordinate their health policy efforts and join their resources, many of the problems arising from the lack of local-level institutional and financial capacity in low- and middle-income countries are mitigated. However, there are two other mechanisms through which multi-level cooperation may affect policy outcomes at the local level. First, cooperative behavior may be driven by ideology. As political parties have different social policy platforms, members of some parties may be more inclined than others to engage in intergovernmental cooperation to provide generous social policy programs. This causal channel, however, is an implausible explanation for the Indonesian case. In Indonesian local politics, no discernible systematic differences among political parties exist in social policy platforms. To be sure, scholars studying political parties in post-Suharto Indonesia have long identified an ideological distinction between secularist and Islamic parties (Mujani & Liddle, 2009). However, this divide over the role of Islam in public life has not led to differentiation in policy platforms. For example, Ufen argues that economic policy cleavages are hardly significant, and that secular and Islamic parties alike lack meaningful political platforms (Ufen, 2008a, 2008b). The marginality of the secularist-Islamic cleavage for policy platforms is even clearer in local politics, where coalitions are formed regardless of ideology (Pratikno, 2009). More generally, Indonesian politics lacks the left–right divide typical of consolidated part systems, as the large-scale eradication of the political left in 1965–66 sharply shifted the center of politics to the right (Bourchier & Hadiz, 2003, p. 8).

Second, district and provincial politicians may be engaged in more traditional forms of patronage politics. Strong party networks in some provinces may be related to multi-level cooperation, intergovernmental transfers, and patronage spending at the local and provincial level. The difference between this scenario and the policy coordination mechanism is that patronage networks are typically based on clientelistic relationships, and the provision of social services may thus

Table 4. *Causal mechanisms*

Variables	
Province-level	
Multi-level cooperation	0.0937**
	(0.0324)
Average poverty rate in 1996	−0.333**
	(0.128)
Partisan harmony	−0.0463
	(0.0489)
Average electoral competitiveness	−0.167
	(0.158)
Pioneers in the province	−0.00575
	(0.00968)
Interaction	
Multi-level cooperation * co-partisan district	−0.0631
	(0.0379)
District-level	
Co-partisan district	0.00989
	(0.0311)
Constant	0.215
	(0.249)
Observations	347
Number of groups	28
Log-likelihood	218.0

Robust standard errors in parentheses. All models include dummy for islands and the district-level control variables included in estimations reported in Table 2.
*** $p < 0.001$, * $p < 0.05$.
** $p < 0.01$.

provide a larger scope for exclusionary practices based on electoral support for incumbent politicians. To assess the strength of patronage networks in the politics of free healthcare, I test if the positive effect of intergovernmental cooperation is conditional on the partisanship of elected officials at the district level. If the provision of free healthcare is mainly or exclusively a matter of clientelistic relations, I should observe a stronger effect of multi-level cooperation when district heads are from the same party of the provincial governor. While identifying exactly the political party affiliation of district heads is not possible with the available data, I can measure whether the district head has been supported by at least one of the parties that constitute the winning coalition of the provincial governor.[33] I build a dummy variable with this information and I estimate a random intercept model in which I interact this indicator with the variable measuring multi-level cooperation. If the patronage mechanism is the predominant channel, the cross-level interaction term should be positive and statistically significant. Results reported in Table 4, however, suggest that this is not the case. The multiplicative term, estimated at -0.063, is signed contrary to expectations and it is not significant at conventional levels. To be sure, this finding is insufficient to rule out that clientelism and corruption are, at least to some extent, affecting the provision of free healthcare programs in Indonesia. There is little doubt that Indonesian local politics is often dominated by clientelistic practices, and that the implementation of health insurance schemes for the poor is sometimes plagued with corrupt behavior by health officials and illegal practices such as charging fees for services that should be provided for free to poor patients (Rosser, 2012). However, the results reported in Table 4 indicate that multi-level cooperation in health policy goes beyond patronage politics, as the effects of cooperative agreements are not contingent on the partisanship of elected officials at the local level.

8. CONCLUSION

Decentralization reforms empower local government, but they do so by creating political systems in which local authorities are still closely tied to higher levels of government through various channels. This paper has shown that relations between politicians at different levels of government are consequential for local-level social policy outcomes in low- and middle-income countries, even when local institutions are weak. Through an analysis of the politics of health insurance for the poor in Indonesian districts and cities, I have argued that multi-level cooperation has a direct impact on local policy outcomes. Policy coordination across levels of government is key to address policy implementation challenges due to low institutional capacity at the local level: when cooperative patterns emerge, service delivery at the local level improves, even in the absence of robust local democratic institutions. Furthermore, the effect of intergovernmental cooperation does not appear to be contingent on specific local-level factors, or to the partisan affiliation of incumbent local politicians.

Political scientists have long asked why ambitious institutional changes often fail to deliver what they promise. The literature on decentralization has supplied convincing evidence that the outcomes of decentralization at the local level are very much a product of local politics: where vibrant democratic institutions are absent, decentralization is likely to fall prey to elite capture rather than mark a genuine discontinuity with the disappointing results of central planning. This paper contributes to this work by suggesting two main points about the nexus between democratic accountability and decentralization outcomes. First, although the quality of local institutions remains of pivotal importance, a significant improvement in policy outcomes can occur even when local institutions are weak. To be sure, multi-level policy coordination is not a substitute for vibrant democratic life, civic engagement and transparent governance. Yet policy coordination across levels of government may alleviate some of the policy failures that emerge from low levels of democratic participation and competition. Second, this paper indicates that the focus on local-level factors in studies of decentralization must be broadened to include interactions between local government and higher administrative levels. Such a change of analytical scope allows a more accurate assessment of the effects of local-level variables on the outcomes of decentralization, and a more complete investigation of the institutional settings in which local government is embedded.

I have analyzed health policy in Indonesia as a typical case of multi-level politics in which policy-making prerogatives are shared by three main levels of government. The extent to which this characterization of the politics of free healthcare in Indonesia will hold in the near future is contingent on some key institutional changes currently unfolding in Indonesia. The most prominent of these developments is the move toward universal healthcare within the framework of the new National Social Security System, established by Law 40/2004 and following regulations. The National Health Insurance program, launched in early 2014, aims to become the largest single-payer system in the world by the end of 2019, when all Indonesian citizens should be covered by the new scheme. It is plausible that the relevance of local government will decline as its traditional functions of target-

ing and socialization are increasingly being nationalized. Second, a recent update to the decentralization laws has introduced some changes in the balance of power between districts and provinces (Law 23/2014). The text of the new law provides explicitly for a role of district government in health policy implementation, but the law is typically seen as consolidating a broader trend in the Yudhoyono presidency toward a re-centralization of power in various policy areas, and the strengthening of the role of province vis-à-vis district government (Tomsa, 2015). Third, the process of *pemekaran*, or district-splitting, has been a distinctive feature of Indonesian decentralization (Fitrani, Hofman, & Kaiser, 2005; Pierskalla, 2016). Recent research suggests that rapid administrative unit proliferation may weaken the bargaining power of local government in decentralized political systems, thus favoring the re-centralization of power by national authorities (Lewis, 2014b).

Further work may explore more thoroughly the sources of intergovernmental coordination, and probe the generalizability of the findings. The section on research design has identified possible drivers of cooperative behavior across levels of government, such as partisan alignments, policy legacies, and structural factors. Although I have controlled for these variables in regression analysis, a more thorough study of the origins of multi-level cooperation is beyond the scope of this paper. Additional research can address this question, for instance by investigating more exhaustively through qualitative historical research the role of path dependency in facilitating intergovernmental cooperation. An equally compelling question concerns the nexus between partisan allegiances and multi-level cooperation, especially in young democracies such as Indonesia, in which social policy platforms do not show substantial variation across political parties. The role of policy coordination as a causal mechanism also needs to be further explored. This paper has shown that patronage alone does not explain the effect of multi-level cooperation, but more fine-grained information is necessary to validate the causal mechanism I posit. Finally, the generalizability of the findings reported in this paper is a question that deserves further empirical exploration. In many respects, the case analyzed here is typical of the politics of social policy in low- and middle-income countries, especially of diverse, decentralized young democracies such as Indonesia. However, there are country and policy-related specificities that may pose a challenge to the external validity of the findings. Further research can address this issue by probing how effectively the framework developed in this paper applies to other geographic regions and policy areas.

NOTES

1. To be sure, democratic accountability dynamics are not the only divergence between the assumptions of the fiscal federalism literature and the empirical reality of many low- and middle-income decentralized countries. Factors such as population mobility, fiscal institutions, and state capacity also play an important role (Bardhan, 2002).

2. In 2010, Indonesia had a total of 497 districts (including 99 municipalities) with an average population of about 250,000. The number of districts in each province ranges from 5 to 38, and the 33 provincial governments include five provinces with special autonomy (Aceh, Papua, West Papua, Jakarta and Yogyakarta). Local jurisdictions vary dramatically in geography, economy, social development, and local politics.

3. As for the fiscal structure of decentralized government in Indonesia, Law 25/1999 provides the foundations for a system to finance local administrations through equalizing transfers from the central government. Under these arrangements, local governments enjoy almost complete autonomy in allocating their budgets, which have increased substantially in the first years after decentralization reform (Lewis, 2014a, p. 138), but they have limited fiscal powers. Most of their revenues come from general and special allocation funds (*dana alokasi umum and dana alokasi khusus*, respectively) from the central government, which constituted in 2010 about 70% of total district-level revenues, the rest coming from non-tax revenues and a small share of own taxes. While this is an important difference from federalist systems, it is a feature common to many low- and middle-income countries that, although not formally federal, show largely decentralized spending patterns.

4. See Wibbels (2006) and Stephenson (2013) for exhaustive reviews of research on comparative federalism and multi-level governance in the European Union, respectively.

5. These two stages are, to a certain extent, overlapping. However, as I show in the next two sections, a distinction can be drawn between a policy "innovation" phase, in which health insurance policies were running only in a limited number of districts, and a policy "institutionalization" phase, in which such programs proliferated rapidly and were adopted by most local governments.

6. Although I focus on developments in the post-Suharto era, significant initiatives to broaden access to basic healthcare were also implemented during the New Order. Chief among such policies was a program called *INPRES Kesehatan*, launched in 1975, which gave a decisive contribution to the expansion of the local clinic (*puskesmas*) network, especially in rural areas (Booth, 2003).

7. A the peak of the Asian Financial Crisis in 1998, the *Kartu Sehat* program only covered 1.87% of the population (Soendoro, 2009, pp. 98–99).

8. In 2014, *Jamkesmas* was merged into the new *National Social Security System* (*SJSN*), a new program with a mandate to establish a comprehensive social security net for all Indonesians, including an ambitious plan to achieve universal healthcare coverage in 2019.

9. The reason for this discrepancy is that poverty rates were only one of the two main criteria used to determine *Jamkesmas* quotas in 2008, the other being "fiscal capacity": districts with a stronger revenue structure (for example, those with a larger tax base or with non-tax revenues from natural resources) were allocated smaller quotas, under the assumption that local government would cover the excluded poor. Information collected in multiple interviews with officials at the Team for the Acceleration of Poverty Reduction (TNP2K), carried out in January 2014 in Jakarta.

10. On the low levels of demand for healthcare services in Indonesia, see also Winters, Karim, and Martawardaya (2014).

11. Direct elections for local leaders, known in Indonesia with the acronym *pilkada*, were introduced only in 2005, a few years after the implementation of decentralization reforms.

12. The financial resources needed to carry out such ambitious policy initiatives came from various sources. In some districts, savings from public expenditure on personnel and other policy areas were an important factor to free up resources to channel into social programs. In others, revenues from natural resources facilitated the adoption of generous social spending. Some districts also implemented schemes in which beneficiaries covered a share of the costs through insurance premiums.

13. Indonesia had a total of 459 districts in 2007.

14. The socioeconomic indicators reported in the table (urban population, per capita GDP excluding oil and gas sector, poverty rate, literacy rate) are from the DAPOER, the World Bank Indonesian Database for Policy and Economic Research. Data for associational life and media penetration are district aggregations from the village-level survey PODES, implemented in 2011 by the BPS, the Indonesian Central Statistics Office.

15. The Local Economic Governance Index is built form a survey of local businesses by the Indonesian think-tank KPPOD, and it tracks local government performance in a range of policy areas such as transparency, access to land, transaction costs, effectiveness of local legislation, and security. Scores range from 0 (very poor governance) to 100 (very good governance).

16. Reported in Thabrany, Sari, Tilden, Dunlop, and Hajaraeni (2014, p. 20).

17. For instance, the Health Minister publicly appealed to local governments to implement *Jamkesda* in 2008, and in the following year the Ministry of Home Affairs organized an informal meeting to offer legal support to districts implementing *Jamkesda* (Thabrany *et al.*, 2014, p. 185).

18. Again, the case of Jembrana Regency illustrates this point: after a series of financial irregularities in *Jamkesda* implementation surfaced, the regent's reelection bid failed, and his successor dismantled the program.

19. An important institutional development that facilitated the rise of provinces as key actors in the politics of health was the implementation of new decentralization laws in 2004. Law 32, in particular, strengthened the legal standing of provincial government (Bertrand, 2007, pp. 592–593), stipulating in Articles 13 and 14 that the provision of healthcare services is a mandatory function for both provinces and districts.

20. Interview with the Head of Health Department, Province of Bali. Denpasar, Bali, January 16, 2014.

21. Such legislative measures are known in Indonesia as PERDA (*peraturan daerah*, or local regulation).

22. The share of costs paid by provincial governments can vary significantly across regions, but it is often set between 30% and 50% of the total costs.

23. According to data from policy reports and documents collected from various sources, the provinces with cooperative agreements were: Aceh, West Sumatra, Jambi, South Sumatra, Lampung, Bangka Belitung Archipelago, Riau Archipelago, Central Java, Bali, South Kalimantan, East Kalimantan, South Sulawesi, and Gorontalo.

24. This figure follows prevailing conventions for the representation of data distribution using boxplots. Data are divided into four quartiles, and each box represents observations in the interquartile range (IQR), namely data between the 25th and the 75th percentile. The horizontal line in each box corresponds to the median value, and whiskers are drawn to include all data points within 1.5 IQR below the lower quartile and 1.5 IQR above the upper quartile. Values outside this range are represented with individual dots.

25. Informed respondents were surveyed in international donor organizations (World Bank, USAID, AUSAID), national-level government institutions (Ministry of Health, Center for the Financing of Health Insurance, Team for the Acceleration of Poverty Reduction), leading Indonesian academic institutions (Faculty of Public Health at University of Indonesia, Center for Policy and Finance Management for Health Insurance at Gadjah Mada University), and departments of health in provincial or district governments located in the provinces of North Sumatra, Bengkulu, Jambi, Jakarta, Yogyakarta, West Java, Bali, East Kalimantan, South Sulawesi, and Gorontalo. The provinces for which no information about intergovernmental cooperation was available were coded as 0.

26. See the Appendix A for additional information and a table with descriptive statistics.

27. To ensure that a wide range of legal and institutional characteristics are controlled for in the analysis, I perform estimations only with districts located in provinces with ordinary statutes (this excludes the special autonomy provinces of Aceh, Jakarta, Yogyakarta, Papua, and West Papua). By comparing cases embedded in the same institutional environment, I exploit an important advantage of subnational comparative research designs (Pepinsky, 2014; Snyder, 2001).

28. While the development of local health insurance programs is a recent phenomenon, Indonesia has a long history of substantial subnational inequalities in access to social services (Akita & Lukman, 1995; Booth, 2003).

29. The indicator is an average of district-level poverty rates in 1996. Data from the INDO-DAPOER database.

30. More precisely, I measure electoral competitiveness with the share of votes received by the winner in local direct elections for district heads and mayors during 2005–09 (higher values of this indicator denote lower values of electoral competitiveness), and I use this indicator to calculate province-level average values. As for partisan harmony, I build a dummy variable tracking if the district head was supported by at least one of the parties in the provincial governor's winning coalition, and I then compute the share of districts, in each province, that satisfy this condition.

31. The estimated free healthcare coverage rates discussed in this section were obtained by varying the value of some key explanatory factors (in this case, the dummy variable measuring multi-level cooperation) and keeping all remaining variables at their respective means.

32. Poverty and morbidity rates are from the INDO-DAPOER dataset. To build the indicators for doctors and clinics per capita, I aggregate village-level data from the PODES 2005 to calculate district-level totals of doctors and clinics. I choose 2005 as the baseline year as the PODES survey is implemented once every 3 years, so that 2005 is the last available year before cooperative agreements were institutionalized in some provinces. As the number of districts has increased during 2005–10, I include in the analysis only districts that did not experience territorial change during this time period.

33. To do so, I use the same data I have used to build the province-level indicator of partisan harmony.

34. The variable for the *Jamkesmas* quota, which should be strongly correlated with reported free healthcare coverage, is built from administrative data from the Center for Health Insurance Finance at the

Indonesian Ministry of Health, and measures the share of the district population covered by *Jamkesmas*, according to administrative records in Jakarta. Population and population density data are available from the INDO-DAPOER, the Indonesian Database for Policy and Economic Research of the World Bank.

35. As the KPPOD Local Economic Governance Index is built from a survey that was implemented in two waves (2007 and 2011), I also include a dummy variable that tracks whether the data come from the first or the second survey implementation. I code this variable as missing for the districts that experienced territorial change during 2007–11.

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APPENDIX A

As mentioned in the research design section, all models estimated include a range of district-level controls for factors that may be related to the provision of social services. First, I include data on local government type (municipality vs. district), total population, population density, and an indicator of the *Jamkesmas* quotas allotted to the district.[34] Second, I control for the socioeconomic development and governance indicators I have used to perform the *t*-tests reported in Table 1.[35]

The table below reports descriptive statistics for the indicators used in the estimated models.

Variable	*N*	Mean	SD	Min	Max
Province-level					
Multi-level cooperation	28	0.43	0.5	0	1
Average poverty rate in 1996	28	0.19	0.11	0.06	0.47
Partisan harmony	28	0.38	0.25	0	0.86
Average electoral competitiveness	28	0.46	0.06	0.36	0.57
Pioneers in the province	28	0.79	1.07	0	4
District-level					
Jamkesmas/Jamkesda coverage	423	0.29	0.18	0.03	0.96
Jamkesmas quota	401	0.33	0.23	0.02	3.73
Municipality (1 = yes, 0 = no)	423	0.2	0.4	0	1
Population (millions)	423	0.51	0.57	0.02	4.77
Population density (thousands per square km)	413	0.99	2.09	0.001	14.26
Per capita GDP (IDR millions, 2000 constant prices)	423	6.92	6.63	0.36	81.81
Poverty rate	423	0.14	0.13	0.01	1.94
Inequality (Gini coefficient)	423	0.28	0.04	0.2	0.42
Urban population (%)	419	0.39	0.31	0.01	1
Literacy rate	423	0.93	0.06	0.66	1
Associations per 10,000 residents	423	9.29	9.45	0	71.53
KPPOD LEG Index	353	0.62	0.07	0.41	0.79
KPPOD data are from 2011 survey	398	0.4	0.49	0	1
TV penetration	423	0.56	0.39	0	1
Doctors per 1,000 people (2005)	377	0.19	0.16	0.04	1.2
Clinics per 1,000 people (2005)	377	0.24	0.16	0.02	0.83
Poverty rate (2005)	379	0.18	0.12	0.02	1.68
Morbidity rate (2005)	379	0.27	0.07	0.11	0.62
Copartisan district (1 = yes, 0 = no)	395	0.36	0.48	0	1