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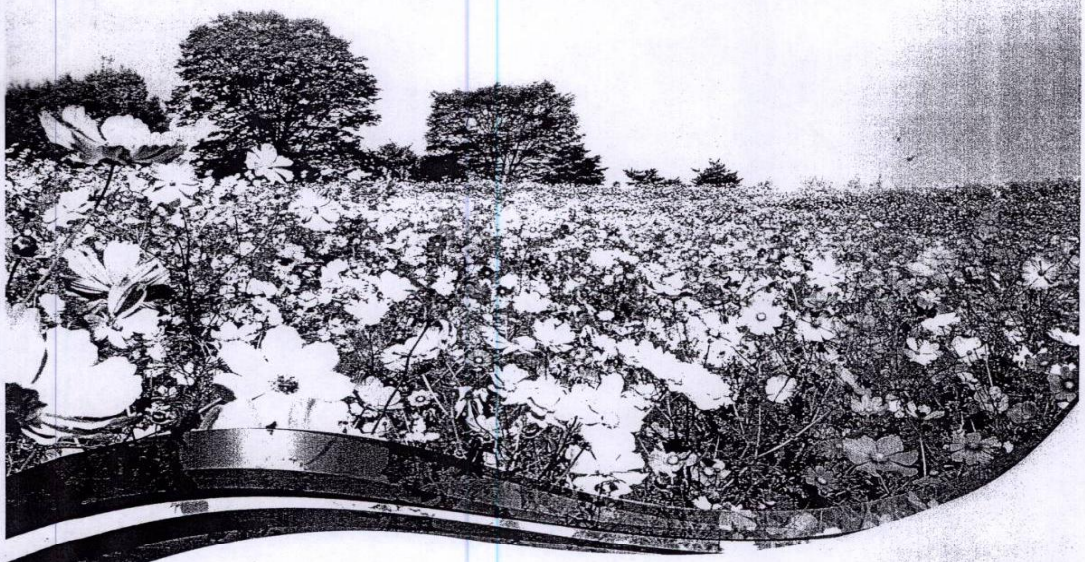

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welfare, nursing care and medical care within their communities. By putting them into action, the city endeavors to develop as a sustainable and vital city even in a challenging environment.

「創造性豊かな　海園・田園・人間都市へ」

これからの人口減少，少子超高齢社会を見据え，高松市では，都市機能を集約し景観にも配慮した「コンパクトで美しいまちづくり」，都市ブランドを確立し活力と潤いのある「創造都市の推進」，人と人とのつながりを取り戻し住民自治の充実をめざす「コミュニティの再生」，住み慣れた地域で福祉・介護・医療を受けられる「地域ケアの充実」という４つのキーワードの方向性にそって，新しいまちづくりに取り組んでいます。これらの実現により，厳しい環境においても，持続可能で活力あるまちとして発展してまいりたいと考えています。

OHTA, Kyoko
University of Tokyo, Japan
太田　響子（東京大学）

"The top-down policy process for the decentralization of adult social care: legacy and innovation in the national care insurance system in Japan"
(Sub-Theme C)

In 2000, in order to secure financial resources and develop care services in the aging society, the national care insurance system was introduced in Japan. This was labeled as one of the biggest welfare reforms in 30 years, since the new insurance system was designed to "socialize" and "decentralize" social care for the aging population, which had long been delivered mainly within family or through centralized measures (such as institutionalization). The stigmatized element of old services was replaced by the contract-based services by private as well as public sector providers. Also, local authorities were given the central responsibility for the management of new system. However, the new care insurance system inherits some of the important services elaborated within the preceding system. For example, small-sized multi-functional home care, which is now one of the core services delivered in the new system, has originated from the local non-profit sector services for filling the service gaps in the old system. The unique point is, even though it is true that the reform was the products of the top-down policy process by the state bureaucracy (Ministry of Welfare), interest groups (advisory council) and the politicians (main political parties), that these policy makers adopted the ideas and lessons from local innovations in order to develop the new system. This paper critically evaluates the top-down policy process for the "localization" of social care for the aging population, and explains why this happened.

「高齢者介護施策の「地域化」：日本の公的介護保険制度における遺産と革新」

高齢社会における介護財政の安定化と介護サービスの発展を目指し、日本では２０００年に公的介護保険制度が導入された。長年、家族介護あるいは公的老人福祉施設・病院への入所・入院によって対応されてきた高齢者介護を「社会化」し「分権化」するものとして、この制度改革は過去 30 年で最大の福祉改革の一つとも評された。過去の措置制度時代のサービスのうちスティグマ化されていた要素は、民間部門を含めた供給者による契約ベースのサービスに代替され、基礎自治体は保険者として運営の中心的役割を担うこととなった。しかし、新しい介護保険制度は、旧来の制度下で創意工夫された重要なサービスのいくつかを引き継いでいる。例えば、小規模多機能型居宅介護は、新制度で提供される中核的サービスの一つと位置付けられているが、これは旧来の制度におけるサービス間の溝を埋めていた地域の民間非営利部門のサービスに起源を持つ。興味深い点は、制度改革が、厚生官僚、審議会、与党議員らによるトップダウンの政策過程の産物であるにも関わらず、これらの政策立案者らは新制度の構想において地域の革新的取り組みのアイデアや教訓を採用したことである。本稿は、こうした高齢者介護施策における上からの「地域化」の過程を検討し、なぜこうしたことが生じたかを説明する。

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"Free Health Service Policy in South Sumatera, Indonesia (Analysis on The Collaboration between South Sumatera Government and Private Hospital)"
(Sub-Theme C)

One of the indicators of human development index is health quality of the people. In its relation to his working performance, therefore, the Governor of South Sumatera, Indonesia has made a policy which is

Free Health Service Policy in South Sumatera, Indonesia
(Analysis on The Collaboration between South Sumatera Government and Private Hospital)

Dr. Radiyati Umi Partan, SpPD, CCD, M.Kes, Finasim.

Introduction

One of the basic needs, in general, for, especially mankind, is health. Therefore, it has become one of the parameters of human development index. Even though, it is very important, unfortunately, fulfilling this extremely essential need is not that simple for many people, primarily, in developing countries. The classical reasons, in common, are due to poverty, low quality life, and high cost. Therefore, some power hungry politicians have made use of this situation for their political gains. Almost all high rank functionaries candidates, such as the candidates of a Governor, a Mayor, a District Head, a parliament member, or even, a President, in their campaigns for election always raise this issue and promise this service for free, if they are elected. The candidates fight for their constituents by "selling" this policy issue for their electabilities. Nakamura and Srnallwood (1980) claim "policy makers occupy their positions of authority in democratic political system as long as they are able to satisfy their constituents. Their actions can be explained in terms of their desire to maintain or expand their power".

It is true. When a candidate wins the election and becomes a high rank functionary, he or she makes a policy in forms of free health service program to complete the promise. However, the free health service program tends to be not comprehensive, well planned, and effective. The program is not comprehensive because only some medicines are included in the service. While some others which are precisely very much needed are not covered in the program. It is, off course, hard for the people to get the medicines since they have no money. In addition, the service tends to be not well planned for the reasons that the supporting facilities remain the same just like before the program is launched. The number of paramedic, doctors, tools, rooms for the sick, and medicines – both by quantity and quality - is not increased. In fact, on the other hand, the number of patients grows significantly. Besides that, it makes the working load of the doctors and paramedics heavier. For this, they cannot look after the patients satisfactorily. Furthermore, the remuneration they receive is inappropriate. It is, then, reasonable if only some of them are encouraged to take a part in the program. Others always try to find some reasons to get rid of it. This condition surely does not support the success of the program. For all those reasons above, the care seems not extremely effective.

***A paper presented in 2013 EROPA International Conference, in Tachikawa city, Japan, 14-19 October, 2013,**
****A lecturer at Medical Faculty of Sriwijaya University, Palembang city, Indonesia.**

Public policies have always been labels for good or for bad. Frequently, they serve as entices to attract voters. In reality, some of the promised policies have been forgotten to make. Although, some others are fulfilled. However, some the completed polices cannot achieve their goals for the reason that they are not well formulated. If they are, then the problems move to the implementation. Policy implementation has also become a critical issue to the success of a policy in accomplishing its goals. Mazmanian and Sabatier (1983:7-13), air themselves that "critical issues in policy implementation are the relationship between policy formulator and the implementor – the changes, criteria and focus of policy evaluation – outputs or outcomes, and the perspective – policy maker, implementing officials, or target group".

Ultimately, on average, only few policies, especially those made by the authoritative in developing countries, that really work and be effective in satisfying the needs of the people. While most of them remains mysteries.

Public Policy and The Essence

Thomas R.Dye (1992:2) defines public policy as "whatever governments choose to do or not to do". While, Al Fatih (2010:2), in his book entitling policy implementation and Social Empowerment, claims that public policy is "any decision or action is purposely as well as legally made or taken by governments for the sake of public interest, public problems solution, public empowerment, and social welfare". From the definition of public policy above, especially the second one, we know that public policies are made not for nothing. They are supposed to give some maximal benefits, primarily, to the people. According to Smith (2011) in a developed country, like USA, as soon as a policy is made, it is implemented and the result is close to policy maker expectation. In other countries, it is different. Indeed, the societies often are devoid of all or some of these conditions.

The existence of a policy is meant to protect the rights and to maintain the obligations of the people. A policy is made for solutions to public problems. The people become capable due to the power of public policies. They are made prosperous. If the policies result in few advantages only, moreover, they are not quality ones, it means that there must be something wrong with the policies. They might, even, be abused.

If we relate a public policy making and the implementation to, for example, free health service program, it means – on one hand - the deserved people have smoothly accesses to medicinal treatment without spending any money as well as feel absolutely healthy and happy with ease. On the other hand, the health service providers are able to look after the health of the people appropriately, easily, gladly, accountably, and with a pride as well. This is the essence of a policy.

For the above purpose, governmental officers ought to formulate the program very carefully and comprehensively in order to make it aspirative, accommodative, and effective, then. For such, the formulators are obliged to do feasibility study on the appropriate availability of human resources, medicines, tools, rooms, the system, remuneration, fund, and other supporting facilities. There must

be a reasonable ratio between the number of patients and the facilities. This is, say, rational model of policy making. The purpose of making use of this model is to ascertain that the program works effectively.

After a policy is well formulated. Then, it should be legitimated by the in authority. Next, the program is implemented. It is a must to make the implementors understand exactly what and how to carry out the program. The policy implementors must have the perception in accordance with policy makers. Therefore, the both parties have to have continuous meetings and discussions for the right things. There should also be a continuous evaluation and an improvement. In this way, it is hoped that the program achieves it goals.

So, making a policy is not just giving demonstrative instruction to subordinates just like that. It should be with a good plan as well as a successful implementation.

According to Francine Rabitnovitz, et al, in Al Fatih (2008), there are 3 principles in policy implementation. Namely:

1. Policy implementation must refer to what is said in the policy accurately
2. Policy implementation must be able to raise the commitment of the policy implementors.
3. Policy implementation must be able to fulfill public's wishes. Therefore, There must be a consensus between the implementor organization and prevailing political system.

In the work of Ripley and Franklin (1986:232-233), it is stated that a successful policy implementation has 3 measurements. They are:

1. The degree of compliance
2. The smoothness of routine functions
3. The achievement of the desired performance and impacts.

The first dimension is the degree of compliance. It indicates that the policy – the free health service program – has certain directives or conditions to follow. They are, for examples, who are eligible for the program, poor certificate from the Head of neighborhood, the kinds of disease, medical actions, and medicines covered in the program, what hospital referred to, how, when, where, and the conditions for the hospital to claim the pay to the concerned government level, remuneration for doctors and paramedic, etc. All of these things must be obeyed. The higher obedience degree is, the more successful the policy implementation will be. This condition fits to the first policy implementation principle suggested by Francine Rabitnovitz, et al above that policy implementation must refer to what is said in the policy accurately.

The next measure is the smoothness of routine function. It refers to day to day service delivery relating to free health care program. Here, the subject matters are competence of the doctors and the paramedic, the availability of supporting facilities, the difficulty faced by the patients, the complaints of the hospital, and the government. In other words, it deals with keeping "the show" goes on normally. This measurement talks about the barriers to implement the program. This condition

relates to the second policy implementation principle proposed by Francine Rabitnovitz, et al above that policy implementation must be able to raise the commitment of the policy implementors.

The last criterion is the achievement of the desired performance and impacts. The implementation of free health service program can be shown if more people get access to the service easily and pleasantly and those people are healthy. The impacts of the program implementation are the people have become optimistic about their lives and more productive in any positive forms. This atmosphere suits the last policy implementation principle expressed by Francine Rabitnovitz, et al above that policy implementation must be able to fulfill public's wishes.

Regarding policy implementation, George C.Edward III (1980) claims there are 4 critical factors to it. The variables are:

1. Communication: transmission, clearance, and consistency
2. Resources: staff, information, authority, facilities
3. Disposition: Effects of disposition, incentives
4. Bureaucratic Structure: standard operating procedures, fragmentation.

The Implementation of Free Health Service Program in Palembang, South Sumatera

The thing that is going to be analyzed is the implementation of free health service program in Palembang city, South Sumatera province which is the collaboration between South Sumatera province government and Muhammadiyah private hospital.

The free health service program in Palembang city, South Sumatera province is regulated by the Decree of The Governor of South Sumatera. It says that free health service is available for the needy with some conditions. The kinds of medical services available for the the poor for free can be seen in table 1.

Table 1

The Kinds of Medical Services Covered in Free Health Program in Muhammadiyah Hospital

No	The Kinds of Medical Services	Remarks
1	Internal medicine treatment	All the services are delivered everyday during working days.
2	Pediatric Service	
3	Ear, Nose, and Throat Theraphy	
4	Obstetric and Geneccology	
5	Dentistry	
6	General Surgery	
7	Urology Surgery	
8	Oncology Surgery	
9	Orthopedic Surgery	

10	Digestic Surgery	
11	Neurologic Surgery	
12	Orthodensic Surgery	
13	Pediatric Surgery	
14	Estetiic Surgery	
15	Neurology service	
16	Opthalmology service	
17	Skin Desease service	
18	Heart Desease service	
19	Lung Desease service	
21	General practice service	
22	Physio Theraphy	
23	Psychiatric service	

Source: Muhammadiyah Hospital, Report for May, 2013

The table above shows kinds of treatments available for the participants of free health servive program. It seems that – in terms of desease theraphies – the medical services are quite complete. It is good that Muhammadiyah hospital can make various medical treatments available. There are 23 kinds of treatments available for the patients. If a participant of free health servive program suffers from anyone of those deseases, he/she can get the service because all of the services are covered in the program. It means more sick people can make use of the program for their health. At the same time, it also means the hospital – especially for the treatment coverage – can serve more patients suffering from diverse sicknesses. The hospital is quite reliable. The services are obtainable during the working days because the cliniques are open only during that time for outpatients.

For inpatient theraphy, service has also been ready, especially in terms of rooms availability. The rooms are various by the class. See table 2 for detail.

Table 2
Classes Available for Inpatients of Free Health Service Program in Muhammadiyah Hospital

No	The Classes	Remarks
1	Class I II A	For general inpatients
2	Class III B	For inpatients of Free Health Program
3	Class IIA	
4	Class IIB	
5	Class I A	
6	Class I B	
7	Class VIP	

8	ICU/ICCU	For general inpatients and inpatients of Free Health Program

Source: Muhammadiyah Hospital, Report for May, 2013

There are 7 III B rooms for inpatients of Free Health Program at Muhammadiyah hospital. One III B room comsists of 8 beds. Altogether, there exists 56 rooms. The number of inpatient is quite many. It is, for example in May 2013, there are 642 inpateints of free health service program. On average, the inpatients stays in the hospital for the treatment range from 2 to 15 days depending on the kind of the desease and the severity.

Referring to the theory of Ripley and Franklin saying a successful policy implementation is measured with the degree of compliance. In General, all patients from Free Health Services Program have access to the various health services, rooms for inpatients, and some medicines for free. It means the implementor of the policy, Muhammadiyah hospital, obey the commitment. Therefore, this point of the policy is fulfilled.

The next measurement of the idea is the smoothness of routine functions. The fact that every working day the cliniques, the rooms (wards), pharmacy, and other facilities are available for the patients from Free Health Services Program. The doctors, paramedics, and other employees of the hospital keep on giving services to them. It means the program works and the hospital does its duties. Those things keep on functioning every day. This second idea is proved. As the result, the hospital can do claim for the services. Check table 3 below.

Table 3

The Description of Fund Claim for Free Health Service Program Insurance By Hospital

No	The Names of Hospitals	Fund Claim (in IDR Per Month	Remarks
1	Muhammad Hoesin	9 Billions (Milyar)	The biggest and the main public hospital in Palembang city
2	Muhammadiyah Palembang	1 – 1,5 Billions (Milyar)	Islamic Private Hospital
3	Bari	900 Millions (Juta)	Local government hospital
4	Siti Khadijah	400 – 500 Mllions (Juta)	Islamic Private Hospital
5	Cipto Mangun Kusumo	200 – 300 Millions (Juta)	public hospital in Jakarta city
6	Harapan Kita	200- 300 Millions (Juta)	Hospital, especially for Heart disease

Source: Sumatera Ekspres, June 13th, 2013.

The data indicate that Palembang Muhammadiyah hospital is the second top payment claimer among the six hospitals. It means that this hospital is populer and committed to help the needy.

The last dimension of the theory is the desired performance, it seems that the goal can be achieved for the health service is accessable for more (poor) people. This situation fits also to the idea of Francine Rabitnovitz, et al in which policy implementation must be able to fulfill public's wish. Public wishes to have access to health service and it gets it, even, for free.

It can be concluded that the collaboration between the government of South Sumatera Province and Muhammadiyah hospital in implementing free health service program is quite successful.

The Quality of The Service

As it has been stated before that the number of, especially, outpatients of Free Health Service Program at Muhammadiyah hospital increases significantly from time to time. It can be proved, for example, in internal medicine Clinique. See table 4.

Table 4
The Description of Health Service for Internal Medicine in Muhammadiyah Hospital Palembang By The Kind of Insurance

No	Kinds of Insurance Service	Number of Outpatients	Remarks
1	General Patients	107	Those who do not deserve health service for free
2	Government Officers Health Insurance (Askes PNS)	549	Government officers have their own health insurance called ASKES
3	Society Health Guarantee Insurance (Jamkesmas)	935	Health insurance from Central government for poor people. The members must have the cards.
4	**Free health service program (Askeskin)**	**1.885**	**The policy of South Sumatera Governor for the people. They do not have to have any card.**
5	Health service insurance (JPK)	102	General health insurance (private)
6	Health service insurance (ASL)	16	General health insurance for VIP (private)

Source: Muhammadiyah Hospital, Report for May, 2013

Data above show the number of outpatients served by means of various insurances. As a whole, there are – in general - 3.594 patients per month taken care in internal medicine clinique. If that number is divided by 25 (working days). It means an internal medicine specialist serves 143 patients a day in internal medicine clinique – one day only one internal medicine specialist available. The ideal ratio for a specialist doctor is 1:25. It means a specialist doctor must serve more patients, far beyond than she/he should be.

In specific, especially, the number of outpatients making use of free health service program (Askeskin) is 75 patients per day (1.885: 25). It means the ration is 1:75. It is also far beyond the ideal ratio.

In terms of quality health service, with that ratio, it is certainly not close to the ideal ratio. That the people get health service for free is certain. However, for the quality one, it seems uncertain, The service quality is questionable because with that number, a specialist docter cannot look after the outpatients very accurately.

Some other barriers to the quality service are that some medicines, primarily, those which are very needed by the patients and some laboratory and examination actions are not available for the the patients. The reasons are that the medicines are quite expensive and the tools are not available in the hospital.

It seems that in terms of quality service, the health performance or the public's wish is not fulfilled yet.

Conclusion

The collaboration in implementing the free health service program between the government of South Sumatera Province and Palembang Muhammadiyah hospital is quite successful. Neverthelass, the emphasis of the free health service programimplementation – so far - seems to be on the quantity of the service rather than on the quality. It may be enough for the people for time being. Nevertheless, the collaboration keeps on going. The government seems quite satisfied with the result. The people feel lucky for the access to the free health service. The hospital supports the commitment of government to look after the health of the poor people and it finally leads also to financial benefit.

Recommendations

The resources availability between before and after the free health service program in practice should be different. It must be better because the number of patients served has been more. Regarding this, there are some recommendations to propose. They are:

1. Human resources must be increased and improved
2. Rooms class III for inpatients of the free health service program must be more
3. The quantity and quality of medicines for the free health service program patients must be heightened.
4. Basically, the number of specialist doctors in the hospital is quait many. Nevertheless, only few are interested in participating in the program. It makes the ratio between the doctor and the patient has not been close to ideal. This situation is due to low remuneration for the doctors. Hence, it is recommended that government improves the payment.

T.S. Elliot, in George C.Edward III (1980), says "Between the idea and reality. Between the motion and the act falls the shadow.

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