ELECTIONS, PARTIES, AND POLICY: THE MULTILEVEL POLITICS OF FREE HEALTHCARE IN INDONESIA

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ELECTIONS, PARTIES, AND POLICY: THE MULTILEVEL POLITICS OF FREE HEALTHCARE IN INDONESIA

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This dissertation studies the politics of free healthcare in Indonesia, a country in which national and local governments have recently championed various initiatives to expand access to healthcare among the poor. I document striking spatial variation in the quality of health policy implementation, and develop an original theory of how multi-level governance and partisan politics interact to shape policy outcomes. Using insights from theories of federalism and multilevel governance, I argue that multi-level politics has been crucial in ensuring the delivery of social services at the local level. When districts cooperate with provinces, they receive substantial institutional and financial assistance, which improves the delivery of social services even when local institutions are weak. I also show that politicians, while responding to local electoral incentives, are embedded in political networks that go beyond the local. Political parties, in particular, facilitate cooperation across levels of government despite the lack of differences in their social policy platforms. I argue that this is due to the process of credit claiming for the implementation of popular, pro-poor health policy reforms. These findings have implications for the literatures on democratic consolidation, development, decentralization, and social policy in developing countries. They suggest that local policy outcomes result from a complex interplay between local, regional and national factors, and that political parties may be consequential for democratic consolidation even when they are weakly institutionalized.

BIOGRAPHICAL SKETCH

Diego Fossati is a Ph.D. Candidate at the Department of Government, Cornell University. His doctoral dissertation is supervised by Thomas Pepinsky (Chair of the Special Dissertation Committee), Nicolas Van de Walle, and Kenneth Roberts. He specializes in comparative politics, with a focus on democratic consolidation, social policy, multilevel governance, institutions, and Southeast Asian politics.

At Cornell, he has assisted teaching a number of undergraduate classes, including courses on international political economy, Latin American politics, Southeast Asian politics, and American politics. He has also designed and taught a first-year writing seminar titled *Development, Change and Politics: Who Wins, and Who Loses from Economic Growth in the Global South?*

Outside academia, he has held various appointments as a consultant at the World Bank since February 2014.

His research on the political economy of voting behavior recently appeared in the *European Journal of Political Research*.

To my family

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CHAPTER 1. Introduction

In this chapter, I briefly introduce the three dissertation papers by outlining some common features they present and their abstracts. I then discuss the significance of the findings for some fundamental questions in comparative politics, and I identify directions for further research.

Abstracts of the three dissertation papers

The three papers that constitute this dissertation present some key commonalities. First, they focus on the politics of health, and in particular on the design and implementation of "free healthcare" schemes. I include under this label a wide range of social security programs aiming to expand access to healthcare among low-income citizens by providing free health insurance for various healthcare services. In many low and middle-income countries, these policies have often gained saliency in the political debate, as they are programs supported by a large share of the population. Second, the empirical material on which I base my analysis in the three papers comes from Indonesian local politics. As I discuss in detail when I present the research design of the three papers, Indonesia is an ideal case to study variation in health policy implementation, because it features more than 500 subnational government units that have key responsibilities in policy implementation, and because subnational variation in policy outcomes is substantial. Finally, the research design of the three papers is similar, in that it is based on the comparative study of Indonesian districts, cities and provinces. All the three papers perform regression analysis of an original dataset in which I have collected detailed information on about five

hundred Indonesian districts, cities and provinces. By adopting a subnational research design, I control for a range of institutional factors that may confound causal inference.

The three papers can be read in a sequence in which I explore the determinants of the quality of implementation of free healthcare programs from different analytical perspectives. In the first paper, I focus on electoral incentives introduced by local direct elections, showing that local electoral cycles shape patterns of health policy implementation. In the second paper, I argue that local democratic accountability explains health policy implementation only to some extent. I show that cooperation across levels of government (in particular, between district and provincial authorities) is a crucial factor to understand why some local governments are implementing health policy better than others. Finally, I focus on the determinants of such multi-level cooperation patterns. I analyze, in particular, the role of political parties, and I develop a theory of why partisan harmony across levels of government fosters cooperation even if Indonesian parties are poorly institutionalized.

First paper: local direct elections and democratic accountability

Since decentralization in 2001, Indonesian local governments have acquired a key role in poverty alleviation and social service delivery. The extent to which they have been able to meet this challenge, however, is subject to debate. While some argue that corruption and elite domination in local politics have consolidated after democratization, others point at increased opportunities for participation and contestation. Systematic analyses of policy outcomes remains scarce. This paper contributes to the debate with a study of the district-level implementation of Jamkesmas, Indonesia's free healthcare program for the poor. Using original data on policy implementation, I show that local government is to some extent responsive to the needs of the most vulnerable. In

years when local elections (*pilkada*) are implemented, low-income households are targeted more accurately, suggesting that electoral incentives for local elites may increase access to social services among the poor. However, I also show that the positive effect of local direct elections is limited to districts with electorally competitive politics. The paper concludes with a discussion of the relevance of the findings for the consolidation of democracy in Indonesian local politics.

Second paper: multi-level governance and social policy outcomes

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. Using original qualitative and quantitative data from nearly 400 Indonesian districts and provinces, I argue that the quality of local democracy affects health insurance policy mainly during the first stages of the decentralization process. To understand policy trajectories over a longer time frame, relations between politicians at different levels of government are the crucial factor: regions in which cooperation between provincial and district authorities has emerged display substantially higher levels of health insurance coverage.

Third paper: partisan cooperation in young democracies

Political parties facilitate cooperation across levels of government. Most theories of partisan cooperation in intergovernmental relations hold that parties provide institutional links between

local and national policy-makers. This paper argues that there is another way in which co-partisanship can foster cooperation. In multilevel political systems, voters seldom understand the specific responsibilities of various levels of government. As a consequence, incumbents are unsure that voters will reward them for their policy efforts. Cooperation with co-partisans at other levels of government reduces such attributional uncertainty because politicians at both levels can coordinate on credit-claiming initiatives. Partisan harmony can thus foster cooperation even in unconsolidated party systems. Analysis of health policy cooperation in Indonesian local government provides robust empirical support for this argument.

Discussion of the findings

The findings of the three dissertation papers speak to long-standing debates in the literature on democratization, welfare states in low and middle-income countries, governance in decentralized political systems, and Indonesian politics. In the three papers' conclusive sections, I discuss in detail the specific contributions of each piece to various literatures. Here, I comment on some broader themes that emerge from this research project as a whole.

Democratization and social policy

The three papers analyze the case of health politics in Indonesia. Empirically, they cover a time frame that roughly overlaps with Indonesia's short life as a democratic political system, namely the period from the early 2000s to today. The research design I have adopted was not primarily conceived to identify the causal effect of democratization on social policy outcomes. However, the research findings present some interesting insights about the nexus between democratization and social policy outcomes.

The political economy literature on taxation and the size of government has long identified a connection between electoral rules and policy outcomes, arguing that universal suffrage leads to increased redistribution by decreasing the income of the median voter (Meltzer and Richard 1983, 1981). Following this framework, many have argued that democratic institutions foster a higher degree of income redistribution through pressures from previously disenfranchised groups that support redistributive social programs and increased protection from economic risks (Boix 2003). A thread in the literature on democracy and redistribution has focused more specifically on whether broad based-social services such as basic healthcare and education are better provided under democratic politics. Although some disagreement persists in the literature (Ross 2006), empirical studies mostly find that democracy is conducive to pro-poor policy outcomes and improved provision of social services (Brown and Hunter 1999, Sen 2001, Przeworski et al. 2000, Besley and Kudamatsu 2006, Kudamatsu 2012, Harding and Stasavage 2014, Stasavage 2005, Lake and Baum 2001).

The empirical analysis I conduct in the first paper speaks to this literature by providing new evidence that democratization can improve the quality of social services. The introduction of local direct elections in Indonesian districts and cities has generated electoral cycles that, to some extent, are shaping the implementation of free healthcare programs for the poor, as the targeting of beneficiaries improves in election years. However, my analysis reveals two important features of the relationship between democratization and the delivery of social services for the poor in Indonesia. The first is that the positive effect of local direct elections on health policy implementation is not uniform across districts. More precisely, a large share of the benefits appears to be concentrated in districts with competitive local politics. Where local electoral

politics is not competitive because of entrenched patterns of patronage and elite domination, the effect of local elections is negligible. This is an important qualification to the argument that democracy is conducive to pro-poor policy outcomes, because it suggests that the benefits of democratization may be conditional on specific features of local politics, and in particular to the structure of the party system at the local level and the overall competitiveness of political life.

The second critical aspect emerging from empirical analysis concerns the causal mechanism in the link between democratization and pro-poor policy outcomes. A key causal channel through which democracy is hypothesized to foster increased redistribution is that it opens up opportunities for the poor to mobilize and gain political influence, thus unleashing grassroots pressures from previously marginalized groups that can finally acquire their own voice in the political sphere. Indeed, economic theories of democratization often present the extension of voting rights as a strategy by economic elites to prevent bottom-up revolutions based on distributive conflicts (Acemoglu and Robinson 2000). An analysis of Indonesian politics does not supply much empirical evidence to corroborate this account of democratization and social policy outcomes. Qualitative interviews with bureaucrats, researchers, consultants, and advocacy groups point to the importance of political elites and local leaders in shaping public policy, and often discount the role of bottom-up societal pressures. If anything, confrontational political strategies adopted by community organizers and grassroots activists are often portrayed as disruptive for decisive political negotiations that happen behind closed doors, and damaging for the causes they claim to forward. In quantitative analysis, variables capturing bottom-up pressures such as the density of associational life and related civic engagement indicators are typically insignificant. This suggests that the reason why democratization in Indonesia appears to

be bearing some benefits for the poor should be sought in the way democratic institutions have transformed incentives for political elites, rather than in their opening up venues for deeper civic participation. To be sure, recent scholarship on Indonesian politics suggests that civil society actors have become more assertive and influential after democratization (Davidson 2007, Aspinall 2013, Rosser 2015). The emergence of new political actors advocating progressive, equitable policy reform is a crucial process for the consolidation of democracy in Indonesia and elsewhere, as it deepens the meaning of political participation and it consolidates the legitimacy of the new political system. However, the link between such participation experiences and specific policy outcomes remains to be established. My analysis of the implementation of Jamkesmas indicates that, as proposed by Lake & Baum (2001), Stasavage (2005), and Stasavage & Harding (2014), local direct elections in Indonesia are improving social policy outcomes mainly by introducing electoral incentives that increase competition among political elites.

Political parties and social policy

Political scientists have long acknowledged the importance of political parties in shaping policy outcomes. For the purposes of this discussion, two broad approaches to the study of political parties and policy outcomes can be identified in the literature. The first focuses on specific attributes of political parties, most notably on their ideology and policy platform. A prominent view among scholars working in this tradition originates in early studies of welfare state development in the West (Stephens 1979, Korpi 1980), and it contends that leftist parties and related social organizations are key actors in the expansion of the welfare state. From this angle, the strength of leftist parties and labor unions matters because they are crucial in mobilizing

workers: it is only when poorer voters gain substantial bargaining power vis-à-vis upper classes that their redistributive demands are formulated and accepted (Hicks 1999, Brady 2003, Huber and Stephens 2001). A related perspective looks at the kind of "linkages" between political parties and voters (Kitschelt 2000). Dating back to seminal work by Martin Shefter (1977), this line of research establishes a link between policy outcomes and electoral strategies followed by political parties, often drawing a distinction between programmatic and clientelistic parties (Kitschelt and Wilkinson 2007, Hicken 2011). From this perspective, the failure to deliver broad based social services may be traced back to the prevalence of clientelistic exchanges between politicians and voters, which perpetuate various forms of inequality and informational asymmetries between voters and their representatives (Keefer and Khemani 2005).

In studying the local politics of social policy in Indonesia, I have selected a case in which these two approaches yield limited explanatory power. On one hand, Indonesian political parties, although ideologically divided between Islamist and secular parties (Mujani and Liddle 2009), show virtually no difference in social policy platforms (Ufen 2008a), and leftist parties are absent from the political landscape due to decades of brutal repression under the New Order regime. On the other had, patronage politics and illegal financing practices appear to be widespread in Indonesian local politics (Buehler 2009, Mietzner 2008), to the extent that identifying a "programmatic" political party with a social policy platform consistently implemented at the local level is virtually impossible. The Indonesian party system therefore resembles the typical case of an unconsolidated, young democracy, in which no major distinction in programmatic appeals across parties has emerged. Scholars of comparative politics have often

dismissed the role of political parties in such institutional settings, arguing that they are little more than vehicles for personalistic campaigns and patronage politics.

My findings indicate that political parties can be consequential in shaping social policy outcomes even in "least likely" cases of young democracies such as Indonesia. The reason why the agency of political parties often appears negligible when parties do not have well-defined social policy platforms is that the predominant focus of analysis is on the local level. As we have studied political parties focusing on self-contained political units such as electoral districts, regencies, and municipalities, we have failed to identify a role for them. However, if we broaden the scope of our analytical lenses to include the full spectrum of multi-level governance, we uncover relations among political elites at different levels of government that can shape the adoption and the implementation of key social policy programs. Neglecting multi-level politics thus omits an important dimension of the nexus between political parties and social policy. The findings emerging from this dissertation project, and in particular from the analysis performed in the third dissertation paper, suggest that political parties can be consequential in shaping social policy outcomes even in institutional environments in which they are poorly institutionalized and clientelistic linkages dominate.

Decentralization and multi-level governance

Another contribution of this project is to the literature on development and decentralization. As I argue in greater detail in the second dissertation paper, the vast literature on the provision of social services in decentralized political systems has focused overwhelmingly on local-level factors to explain local policy outcomes in decentralized political systems (Bardhan 2002, Bardhan and Mookherjee 2000, Keefer and Khemani 2005). I show in this dissertation that,

although this literature has produced valuable insights, focusing exclusively on local-level factors may overestimate the importance of the quality of local democracy. I present robust empirical evidence that the dramatic subnational variation observed in the implementation of health insurance policies in Indonesian local government is only partially explained by the local electoral dynamics identified in the first paper. A crucial factor is cooperation between district and provincial government that has emerged in some Indonesian provinces. When politicians at different levels of government cooperate in providing social services, the quality of policy implementation at the local level improves. As I show in the second paper, such a positive effect of multi-level cooperation is not contingent on specific local-level factors or multi-level patronage networks: the benefits of cooperation are observed unconditionally, even in districts that have weak local institutions or local leaders who are not from the same party as the provincial governor. This suggests that coordination across levels of government, although not a substitute for a vibrant local democratic life, may alleviate some of the policy failures that emerge from low levels of democratic participation and competition.

Indonesian politics

This dissertation contributes to the literature on Indonesian politics by providing a detailed analysis of how the two intertwined processes of democratization and decentralization have unfolded in a specific policy field. Overall, the three dissertation papers portray a positive view of local democracy in Indonesia. To be sure, the establishment of robust accountability relations between citizens and politicians in Indonesian local government is still hindered by substantial obstacles rooted in low levels of socioeconomic development and by a legacy of authoritarian rule and elite domination in many regions. For many Indonesians, democracy and

decentralization have not yet delivered on the ambitious promises of increased equity, development, and civic participation free from need and fear. Yet my analysis of the politics of free healthcare in Indonesian regions indicates that Indonesia in recent years has moved closer to the fulfillment of such promises.

Since the implementation of decentralization reforms, local government in Indonesia has become a major player in the politics of healthcare. Districts, cities and provinces have been crucial in improving the life of millions of Indonesians, or in failing to do so by inaction or neglect. If we look at developments in health policy over the last ten or fifteen years, we must acknowledge that some local governments have designed innovative, ambitious policies that have dramatically expanded access to healthcare among the most vulnerable. In some instances, such efforts have included experimentation of universal coverage at the local level, and they have required innovative financing solutions and bold choices to break with long legacies of more narrowly targeted public spending. Most crucially, some local administrations have taken these steps well before the national government did, even though such large-scale expansions of health systems in low and middle-income countries are much more commonly spearheaded by national governments. We should certainly keep in mind that the vast majority of local governments did not show any interest in such progressive policies. However, the fact that at least some of them rose up to the challenge that came with their newly acquired prerogatives is a reason to be hopeful about the prospects of democratic consolidation in Indonesian regions.

I mention in the dissertation papers that scholars of Indonesian politics are divided between those who see Indonesian democracy as closely reminiscent of the years of authoritarianism (Winters 2011, Hadiz 2010) and those who point at increasing evidence of genuine democratic

engagement and accountability (Aspinall 2013). As I address the debate on the introduction of local direct elections in the first paper, I contribute to this literature by showing that elected policy makers have responded, at least to a certain extent, to the electoral incentives introduced by local direct elections. Like politicians elsewhere, Indonesian local leaders worry about losing power when they are up for reelection. In election years, they multiply their efforts to implement social policies well, hoping to convince their voters that they are worth being given another term. These new accountability relations, however, do not indicate that old patterns of elite capture and have disappeared from Indonesian politics, because the data show that only sufficiently competitive districts are experiencing the benefits of democratization.

Directions for further research

Further research may probe the various arguments proposed in the three dissertation papers along two main avenues. The first is a more accurate analysis of the causal mechanisms that I posit at various stages in this dissertation. The second is additional empirical studies to test if, and to what degree, the findings of this research project are generalizable.

Causal mechanisms

During fieldwork for this dissertation project, I have collected qualitative and quantitative data. Qualitative research was largely exploratory, and mostly based on interviews I conducted with informed respondents such as bureaucrats in local health policy agencies, members of advocacy networks supporting healthcare reform, politicians, and researchers. For quantitative analysis, I have gathered district-level and province-level data from various sources. By combining insights from qualitative and quantitative data, I have found significant empirical support for the

arguments I put forward in the three papers. However, the microfoundations of such arguments could be more exhaustively validated with additional research. The analysis presented in the first paper, for instance, could be complemented by a qualitative study focusing more closely on the nature of the relationship between citizens and elected officials uncovered in regression analysis. The data I analyze in that paper are insufficient to establish if the effect of electoral cycles is due to the establishment of new, genuine relations of democratic accountability or to the intensifying of clientelistic pressures due to democratization. Similarly, while the second paper documents the positive effect of multi-level cooperation, it does not identify empirically the specific channels through which multi-level cooperation results in better local policy outcomes. In the paper, I discuss some evidence indicating that the effect is not due exclusively to the presence of patronage networks. However, more fine-grained data is needed to establish if the positive effects of cooperation are due mainly to the redistributive role of provincial expenditure or to more policy-specific channels through which provincial governments increase local-level institutional performance in implementing health insurance schemes. Finally, the empirical regularities identified in the third paper need further corroboration. First, case-study analysis of specific examples of cooperation between districts and provinces is necessary to test if relations among political elites at different levels of government unfold in the way I hypothesize. Besides further testing my argument about partisan alignments and multi-level cooperation, such qualitative research could validate the hypotheses I have outlined about the degree of institutionalization of Indonesian political parties and about how local politicians perceive incentives for cooperative behavior. Second, voting behavior dynamics should be investigated as determinants of electoral incentives for local elites, for instance with survey data and

experimental research designs. This would allow testing whether voters respond to partisan cues when attributing credit or blame to local politicians, and ascertaining if the degree of political sophistication in the electorate is a key variable in this process.

Generalizability of the findings

Although the quantitative analysis performed in the three papers is based on a large number of cases, the findings discussed above are all based on empirical analysis of a single policy area in one country. This raises some potential concerns about the generalizability of the findings to other countries and other policy areas. In many respects, Indonesia is a typical case of a middle-income country that has only recently embraced a democratic, decentralized political system. On other accounts, however, there may be specificities of the Indonesian case that may hinder the ability of the arguments I formulate here to travel to other countries and regions. For instance, Indonesia is particularly large and diverse, and this could be a reason why coordination across levels of government appears to be so decisive for policy implementation. Furthermore, in other countries decentralization reform may not have been as extensive as in Indonesia, and local governments may have been granted more limited autonomy.

As for the politics of health as a case study, Indonesia has been going through a process that is highly representative of trends observed in other low and middle-income countries. Rapid economic development and democratization are often associated with a substantial increase of the resources allocated to social welfare policies. In healthcare in particular, a key challenge for the development of health systems anywhere in the world is to expand their scale so that they can accommodate mass consumption of a range of basic and advanced healthcare services. However, this policy area also presents peculiarities that set it apart from many others. Most notably, the

local health insurance programs I study in this dissertation are typically policies that are very popular, as they are supported by a large share of voters in local elections. As I detail in the papers, this is a key reason why they have become a salient political issue in so many campaigns for local elections. Other policies may be much more controversial, and the process of credit-claiming may be more complex than hypothesized in this dissertation.

Finally, it remains to be verified if the patterns identified by my dissertation will survive the important changes that Indonesia political system is experiencing. First, health policy is an area in which the national government has become an increasingly important actor. The implementation of the new National Social Security Program, in particular, through which Indonesia is expected to reach universal healthcare coverage by 2019, shows a trend toward increasing re-centralization in health policy. In the future, the role of local government in this policy field may be less crucial than it has been during these first years of decentralization. Second, there is some evidence that Indonesian political parties are becoming more cohesive (Mietzner 2013b). This could change the institutional context of Indonesian politics substantially. If Indonesian parties started to differentiate their social policy platforms, more "traditional" partisan effects on policy outcomes such as those observed for leftist parties in more consolidated party systems may start to emerge. In this case, the link between partisanship and intergovernmental cooperation could change substantially.

CHAPTER 2. Is Indonesian local government accountable to the poor? Evidence from health policy implementation

Introduction

The sweeping decentralization reforms implemented in the early 2000s have granted Indonesian districts substantial prerogatives in several policy areas. As a result, local government has performed a key role in addressing pressing policy issues such as poverty alleviation and the delivery of social services. Our understanding of the outcomes of Indonesian decentralization, however, remains incomplete, as the quality of democracy in Indonesian regions remains a persistent concern. This paper studies democratic accountability in Indonesia with an analysis of the local-level implementation of Jamkesmas (Jaminan Kesehatan Masyarakat, or Social Health Insurance), the national free healthcare program for the poor. It argues that, although key policy challenges remain, local government has catered to the preferences of the poorest segments of Indonesian society in certain circumstances. Local policy-makers respond to the electoral incentives introduced with the implementation of local direct elections, known in Indonesian as *pilkada langsung* or *pilkada*. However, the benefits of such responsiveness are limited to districts with competitive local politics. These results suggest that the local dynamics of political competition play a crucial role in shaping patterns of subnational variation in the delivery of social services at the local level.

In the literature on Indonesian politics, a critical view of the democratization process has long prevailed (Hadiz 2010, Hadiz and Robison 2005, 2013, Winters 2013, 2011). From this perspective, post-Suharto Indonesia displays substantial continuity with its authoritarian past,

and its local politics feature the persistence of oligarchic domination and elite capture. As powerful structural forces and predatory interests have survived the New Order, the democratic institutions introduced after authoritarian breakdown have mostly failed to produce meaningful and sustainable political change. This view has come under increasing criticism, however, due to its inability to explain major developments in contemporary Indonesian politics such as the large-scale expansion of pro-poor social security programs both at the national and at the local level. More recent research has highlighted the emergence of new opportunities for previously marginalized social sectors, and the increasing political clout of various civil society groups (Aspinall 2013, Mietzner 2013a, Rosser 2015, Davidson 2007). This new focus on political agency and on shifting power relations between established and new political actors is a valuable development, as it allows a more accurate appraisal of recent changes in several policy areas. However, existing scholarship is mostly based on case studies or theoretical argumentation, and the degree to which its findings are generalizable across Indonesia is unclear. We still lack a comprehensive understanding of why, to what extent, and on what conditions these new social actors are influential, based on systematic analysis of cross-regional data.

My contribution to the literature on democratic accountability in Indonesian local politics is threefold. First, analyzing policy outcomes across Indonesia, I am able to investigate the full range of subnational variation in policy outcomes and possible explanatory factors. Although the nexus between health politics and democratic accountability has been fruitfully studied from different perspectives (Aspinall 2014, Aspinall and Warburton 2013, Dwickasono, Nurman, and Prasetya 2012, Rosser and Wilson 2012, Kristiansen and Santoso 2006, Dwicaksono et al. 2010, Nurman and Martiani 2008), available research does not offer a complete picture of how

subnational variation in health policy is related to the functioning of local democratic institutions, because it is based on the analysis of a limited number of case studies. By combining cross-sectional, district-level data on health insurance policy outcomes, sociodemographic factors, fiscal and institutional variables, and electoral politics for more than 400 Indonesian districts,[1] I am able to ascertain if, and to what degree, local politics shapes how a major social policy program is implemented.

Second, I study observable outcomes in a policy area, the implementation of free healthcare programs, which has a major and direct impact on the lives of the most vulnerable Indonesians. To be sure, social policy implementation in Indonesian local government has been extensively analyzed in development and health economics, and the issue of targeting social services to the poor has received special attention (Alatas et al. 2013, Alatas et al. 2012, Sparrow, Suryahadi, and Widyanti 2013). This literature, however, focuses on policy-related questions such as evaluating the impact of social programs or finding optimal implementation procedures: we do not know the extent to which local politics and political accountability affect policy outcomes. Furthermore, in studying a specific policy field I depart from a tradition in the study of Indonesian local politics that focuses on general, governance-related outcomes and on corruption in particular (Von Luebke 2009, Hadiz 2004, Mietzner 2007b). Although clean and efficient governance is surely beneficial to the whole population, this paper analyzes data that speaks

[1] Here and in the remainder of the paper, I use the term "district" to refer to regencies and municipalities (in Indonesian, *kabupaten* and *kota* respectively).

directly to the condition of the most vulnerable social segments, thus allowing a focus on groups traditionally excluded from politics.

Finally, I present some new insights on a topic hotly debated in Indonesian politics and media, namely the practice of direct elections for local leaders. Many scholars of Indonesian politics have often characterized *pilkada* in critical terms, exposing their limits in providing citizens with meaningful alternatives and warning of their potentially detrimental effects to already weak standards of transparency and political finance (Mietzner 2011, Hidayat 2009, Buehler 2013a). Evidence from public opinion surveys, however, suggests that Indonesian citizens are fond of their newly acquired right of voting their local leaders out of office (Gabrillin 2014). Despite the political saliency of the issue and extensive coverage in Indonesian media, we still lack systematic evidence about the role of *pilkada* in strengthening democratic accountability in local politics. My results show that local politicians are responsive to the incentives introduced by *pilkada,* but only if local politics is sufficiently competitive.

The remainder of this paper proceeds as follows. The next section outlines the development of national welfare state institutions and health insurance schemes in Indonesia. I then focus on local government, analyzing the proliferation of local health insurance schemes since decentralization reforms and the role of district authorities in Jamkesmas implementation. The following sections proceed to data analysis of an original quantitative dataset with district-level information on health policy and local governance. Using district-level Jamkesmas coverage rates for low-income Indonesians, I first discuss some descriptive statistics and patterns of subnational variation in policy outcomes. I then focus on the incidence of poverty and electoral competition as factors explaining health insurance coverage rates. I find through multivariate

regression analysis that coverage rates among the poor increase as a function of the incidence of poverty, and that the relationship between poverty and coverage is stronger in election years. Incumbents are more responsive to the preferences of their poor constituents when they are running for reelection, but only if local elections are competitive. The final section concludes by discussing the implications of the findings for democratic accountability in Indonesia and identifying some venues for further research.

Health insurance in Indonesia: from employment benefits to social security

Access to healthcare is an important, hotly debated political issue in contemporary Indonesia. In local politics, the electoral fortunes of many prominent politicians, including the current president Joko Widodo, have been closely tied to the provision of "free healthcare" services. At the national level, the government is currently implementing an ambitious plan to reach universal health insurance coverage by 2019, which would make Indonesia the largest single-payer health system in the world.

The current health insurance system is the result of a long process in which coverage was gradually extended to increasingly large sectors of the Indonesian population. The foundations of today's policies date back to the early years of the Indonesian state, with the introduction of social insurance plans for civil servants and formal sector workers in 1963 and 1964 respectively (Suryahadi, Febriany, and Yumna 2014, 6). Health insurance schemes were revamped and expanded at various stages during the New Order years. Most notably, a reform of social security in 1992 established two main agencies that would manage health insurance plans, namely PT Askes for civil servants and the military, and Jamsostek for the workforce employed in the

formal economy. Health insurance before democratization was thus a privilege reserved to three professional categories; when Suharto's regime collapsed in 1998, only about 17 million Indonesians, or 8% of the population, were enrolled in a health insurance plan (Achmad 1999, 9).[2] Although excluded from formal health insurance schemes, the rest of the population benefited from other health-related policies implemented under authoritarianism. The network of local clinics or *puskesmas*, for instance, was expanded substantially, especially in rural areas, providing basic healthcare services at a modest cost to a large number of patients.[3] Furthermore, the launch of JPKM (Program Jaminan Pemeliharaan Kesehatan Masyarakat) in the mid-1970s was a first attempt to facilitate access to healthcare for the poorest Indonesians. A community health insurance program implemented at the village level, JPKM was designed to mitigate the adverse effects of declining oil revenues on social spending, and it allocated funds to help indigent citizens to cover healthcare costs. The coverage of this program, however, was very limited, including a mere 1.87% of the population in 1998 (Soendoro 2009, 98-99): the

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[2] As for private health insurance schemes, the Indonesian market has traditionally been rather small. Although membership data for private insurance is not available, expenditure on private health insurance plans accounted for only 8.2% of the total expenditure on healthcare in 2000 (WHO 2002, 212).

[3] According to data from the Ministry of Health, the number of *puskesmas* increased rapidly from about 1,000 clinics in 1969 to more than 6,000 in 1991 (Golkar 1992, 154). As Booth reports, an important infrastructure-building program known as INPRES was instrumental in the expansion of basic healthcare and education facilities (Booth 2003).

overwhelming majority of low-income Indonesian households were thus excluded from the social safety net set up during the New Order.

The Asian Financial Crisis of the late 1990s exposed the vulnerability of indigent households to economic shocks. As the poverty rate spiked with the dramatic contraction of economic activity, the utilization of healthcare services declined sharply, and drug shortages and cutbacks in government social spending contributed to a deterioration in the quality of the services delivered at the *puskesmas* level (Sparrow 2008, 189-190). These developments highlighted the alarming contingencies of the social welfare gains attained during the New Order, and prompted policy makers to implement a social safety net package of measures known as JPS or Jaring Pengaman Sosial. The JPS programs, designed in consultation with the World Bank, included a health card for the poor (*kartu sehat*), rice subsidies, support to education, employment creation initiatives, and a community-driven development program based on the allocation of block grants to selected communities (Sumarto, Suryahadi, and Widyanti 2002). Although the JPS was an *ad hoc* response to the economic crisis and suffered from major implementation problems, it provided an embryonic framework for the expansion and development of future social programs. Perhaps most importantly, the Asian financial crisis and the JPS increased the saliency of social security as a political issue, and broadened support for a more active role of the state in sheltering the most vulnerable from economic fluctuations.

In 2005, the coverage of the JPS health program was expanded dramatically with the implementation of Askeskin, a health insurance program targeting about 60 million low-income Indonesians. With this scheme, renamed Jamkesmas in 2008, patients could receive free basic outpatient care and in-patient services in *puskesmas* and public hospitals, which could then

submit claims to government agencies for the services provided to members of the program. As Aspinall convincingly argues, this substantial expansion of free healthcare for the poor was closely tied to the democratization process, as politicians of all ideological orientations soon discovered the electoral attractiveness of pro-poor policy appeals (Aspinall 2014).[4] Regardless of the motives that inspired its implementation, however, Jamkesmas was a turning point in the development of social security institutions in Indonesia, as it was unprecedented in scope of coverage and range of benefits provided. To be sure, the program was not without flaws: it encountered important implementation challenges, and various episodes of mismanagement and corruption have surfaced throughout the years.[5] Yet there is little doubt that Askeskin and Jamkesmas have significantly improved access to healthcare for many low-income Indonesian households. In 2012, Jamkesmas boasted more than 76 million members, a budget Rp. 7.38 trillion and the involvement of over one thousand public and private hospitals (Faizal 2013). Existing studies of its implementation suggests that the bulk of Jamkesmas resources have been channeled towards poor and near-poor beneficiaries, and that they have increased the utilization of health services among the beneficiaries (Harimurti et al. 2013, World Bank 2012, Vidyattama, Miranti, and Resosudarmo 2014).

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[4] In this respect, Indonesia seems to have followed the trajectory of other countries in East and Southeast Asia, like South Korea and Taiwan, as they also experienced a rapid expansion of welfare state programs after democratization (Wong 2004, Haggard and Kaufman 2008).

[5] As these crucial issues are closely related to local government, I discuss them later in this paper.

In 2014, Jamkesmas and three other existing health insurance programs were merged into the National Social Security System (SJSN) established by Law 40/2004. The new National Health Insurance plan aims at achieving universal health coverage by 2019, and it was designed as a single-payer system that would eventually incorporate and unify all existing government health insurance programs, both national and local. As the focus of this paper is on local-level governance, an analysis of this landmark reform is beyond its scope.[6] However, I discuss in the conclusions some possible implications of the transitions to the new system for the role of local government in health policy.

Decentralization and local health insurance schemes

Local government in Indonesia has long played a role in health policy and development programs. The already mentioned JPKM program in the mid-1970s is an example of a policy initiative in which local authorities (village heads) had substantial autonomy in deciding how to allocate the funds they received. The room of maneuver of local government during the New Order, however, was in general very limited. At the village level, the central government maintained a tight grip on political activity, crippling any attempt at independent social mobilization or policy activism (Antlov 1994). At the district level, autonomy was limited by the scarcity of the available resources and by strict regulations and control by the central government

[6] For reference, see the informative introduction to the topic by Sulastomo, a key advocate of the reform and long time director of PT Askes (Sulastomo 2011), and the detailed analysis of the politics of social security reform by Wisnu (Wisnu 2012).

on how to allocate them. The institutional context in which local government was embedded, however, was not the sole reason for its limited role in health policy during the New Order. Health policy implementation was severely affected by low rates of healthcare service utilization, due to factors such as the prevalence of traditional healing practices, out-of-pocket costs, and distance from health facilities (Achmad 1999, 73-76). As a result, healthcare was simply not a priority for most local leaders, who were much more interested in the development of infrastructure such as roads, electricity, and irrigation projects (Achmad 1999, 32-33).

The breakdown of authoritarianism led to a profound restructuring of the Indonesian state and a redefinition of the role of local government. In the late 1990s, the Indonesian parliament approved a package of institutional reforms that would quickly transform Indonesia into a more democratic and decentralized political system. In shifting substantial powers to local government, security issues were a prominent concern for legislators, as the institutional reforms were implemented in a context of unrest and instability (Mietzner 2007a, Aspinall and Berger 2001). However, federalist institutional arrangements were also discussed as possible solutions to governance issues such as efficient government, effective social service provision, democratic development and civil society empowerment (Sularto and Koekerits 1999). Law 22/1999, in particular, incorporates principles of democratic accountability and good governance by mandating that provinces and districts have full autonomy to govern according to the preferences and priorities of their local constituents.7 While there has been some confusion about the specific

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[7] A related regulation, Law 25/1999, provides the foundations for a system to finance local government through equalizing transfers from the central government

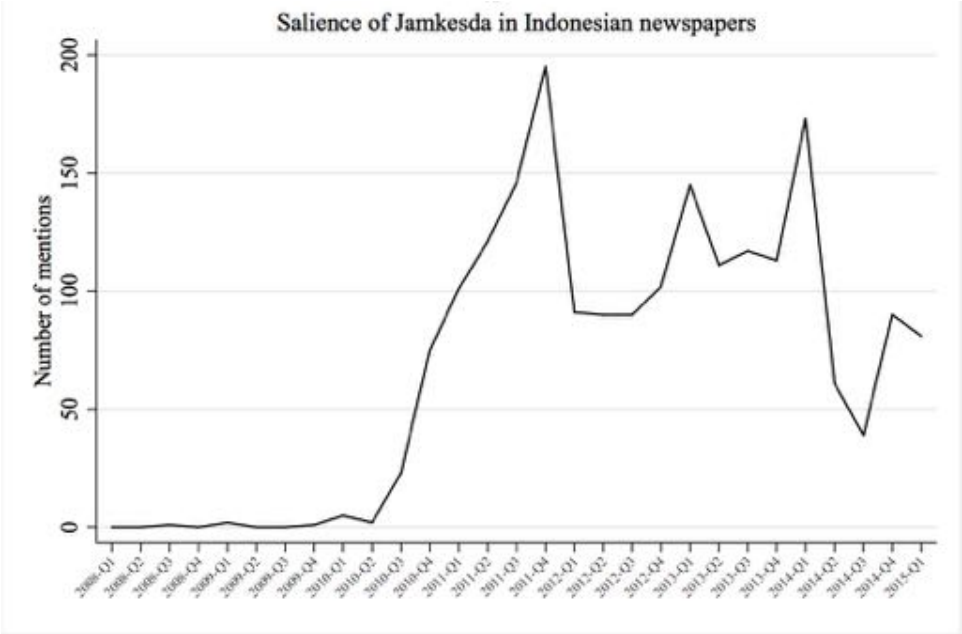
powers that the law reserves to the various levels of government (Seymour and Turner 2002, 43), Article 11, Paragraph 2 of Law 22/1999 states explicitly that districts are required to carry out government functions in several areas, including health policy. In 2004, the decentralization laws were updated to strengthen provincial government authority. Articles 13 and 14 of Law 32/2004 stipulate that healthcare is a mandatory function not only of district, but also of provincial governments. In short, in decentralized Indonesia health policy is designated as an area of shared responsibility: district, provincial and national authorities can take policy initiatives where they deem it appropriate.

This transition towards a decentralized, multi-level political system has changed the local politics of healthcare in two fundamental ways. The first is that the scope for local authorities, and districts in particular, to implement health policy broadened dramatically. A radical departure from the institutions of the New Order era, decentralization provided a legal basis for local government to take a much more active role in social service delivery, and to allocate their budget in complete autonomy. The results of this institutional shock in health policy were already visible in the early 2000s, when a small number of districts located in various regions started to experiment with policies that expanded access to healthcare among the poor. To be sure, these health insurance programs, known in Indonesia as Jamkesda (Jaminan Kesehatan Daerah), varied dramatically in crucial aspects such as legal and institutional status, membership criteria, benefit packages, implementation strategies and financing mechanisms (Dwickasono, Nurman, and Prasetya 2012, Thabrany et al. 2015). Yet such early Jamkesda programs may be considered as local-level responses to a common policy challenge: as national plans to build a more inclusive health system were experiencing delays and obstacles, some districts were filling

a policy vacuum with innovative policy solutions, as in the frequently-cited case of Jembrana in Bali, where the district head implemented a universal health insurance scheme that offered free basic healthcare to the district's residents (Rosser and 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 one year, and that an additional 72 districts had plans to implement similar programs (Gani et al. 2008). They only could have done so on their own initiative.

The second factor that transformed the politics of healthcare in Indonesian regions was the introduction of *pilkada*, the local direct elections for province and districts heads, established with Law 32/2004 on local government. Even before the first round of *pilkada* started in 2005, the prospect of direct local elections provided an immediate, strong incentive for local leaders to promise and implement pro-poor policies such as free healthcare schemes. As politicians of all political parties soon appreciated the electoral appeal of Jamkesda policies, many of them have used free healthcare to build successful political careers and reputations as reformist leaders: it is now common to witness local electoral campaigns in which free healthcare features as one of the key political issues being debated (Aspinall 2014, 814-815). Plausibly due to these bottom-up pressures, a large-scale policy diffusion process took place in concomitance with the first round of *pilkada*, with most districts starting Jamkesda implementation between 2008 and 2011. Although yearly diffusion data is not available, Figure 1, charting the mentions of the word "Jamkesda" in a sample of 25 Indonesian newspapers, shows that local health insurance

programs were a salient issue in Indonesian politics by late 2010.[8] Thabrany et al. (2015, 20) cite a study of the Center for Health Insurance Financing of the Indonesian Ministry of Health carried out in January 2011, according to which 479 districts, or more than 97% of the total, reported implementing Jamkesda or having plans to do so by the end of 2011. In short, local health insurance schemes quickly transitioned from being a policy innovation benefiting a very limited number of Indonesian citizens to a standard practice in local government, covering an estimated 14% of the population in 2012 (Departemen Kesehatan R. I. 2013, 234).



[8] Data used to produce Figure 1 come from a search of the word "Jamkesda" in Indonesian newspapers included in the Factiva database. The search was performed on April 2, 2015.

Figure 1. Salience of Jamkesda in Indonesian newspapers

Local government in the Jamkesmas era and beyond

The local policy experiments discussed above unfolded as policy-makers at the national level were showing interest for the expansion of health insurance programs as well. However, the introduction of large-scale welfare programs such as Askeskin and Jamkesmas did not marginalize the role of local government in providing access to healthcare for the poor. The design and implementation of Jamkesmas, in particular, suggest that there are two reasons why local government has maintained a key role in this policy area even in the wake of increased activism by national government. The first is that the Jamkesmas quotas allotted to districts were in many cases inadequate to cover the poor population. On one hand, with a total membership of about 76 million, Jamkesmas excluded a large number of "near-poor" Indonesians. Although these people do not qualify as indigent, they typically do not have health insurance of any kind, and their incomes, since they often come from employment in the informal sector, are highly vulnerable to economic fluctuations. On the other hand, some of the district quotas were intentionally designed as being insufficient to cover the poor population. While some districts received quotas much larger than the size of their low-income population, others had less than what they needed to insure all poor households. This is because poverty rates were only one of the two main criteria used to determine Jamkesmas quotas, the other being "fiscal capacity": districts with a larger tax base or with non-tax revenues from natural resources were allocated relatively smaller quotas, under the assumption that local government had sufficient resources to

cover the excluded poor.[9] Since the implementation of Jamkesmas, national government officials have repeatedly stressed that local government is expected to provide health insurance to the poor not covered by national schemes.[10]

Second, and more crucially, the *implementation and socialization* of Jamkesmas relies heavily on local government. The process of targeting, in particular, has entailed a prominent role for local administrations, as the lists of Jamkesmas beneficiaries used by the Ministry of Health is compiled according to input from local government (Sri Lestari and Subardi 2012, 36). In other words, district authorities have been in charge of deciding who qualifies as "poor". Such discretionary targeting procedures, especially in the early years of Jamkesmas implementation, have provided ample scope for clientelistic practices at the local level. As a result, a substantial share of the resources allocated to Jamkesmas is channeled towards higher-income recipients: data from the 2010 National Socioeconomic Survey suggest that about 20% of Jamkesmas beneficiaries are from the top three income deciles, and that only about 48% of the recipients are from the three lowest (Harimurti et al. 2013, 13). Besides the potential for clientelism and leakage of resources, corruption has been a major concern in the implementation of social welfare programs. For instance, in one of the many episodes reported in the media, a health

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[9] 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] For instance, the Ministry of Health in 2008 publicly encouraged local government to implement Jamkesda to cover any uninsured poor left out by Jamkesmas (Thabrany et al. 2015, 185).

official in South Palu Regency (South Sulawesi) was found guilty of using her personal bank account to manage Jamkesmas funds and embezzling about $31,000 (2010). Furthermore, the practice of charging low-income patients with illegal fees, or delivering lower quality services if they refuse to pay, is common (Rosser 2012). Finally, a recent audit by the watchdog government agency BPK (Badan Pemeriksa Keuangan) has found extensive delays in in another area for which local government is responsible, namely the verification and reimbursement of claims for the services delivered by healthcare providers (Sandi 2013).

The role of local government has therefore remained pivotal even in the wake of major health policy initiatives at the national level. Plans for the new National Social Security System, however, could lead to a de facto recentralization in this policy domain. If universal coverage is achieved in the next years, the presence of a colossal single-payer system enrolling more than 250 million Indonesian could substantially limit the scope of action for local government. The SJSN implementation schedule stipulates that the hundreds of Jamkesda schemes currently running be merged into BPJS Kesehatan (the agency that runs the new national health insurance scheme) by the end of 2016. Available data suggests that this process is slowly taking place, as 107 local government joined the new system before its nation-wide implementation in 2014 (Thabrany et al. 2015, 161). However, it is still unclear if the demise of local health insurance schemes is imminent, as suggested by national government officials. The regulation instituting BPJS, Law 24/2011, is silent about the role of local government in SJSN, and the Indonesian legal system provides strong foundations for an active role of local authorities in health policy. As discussed, regional autonomy laws are explicit in designating healthcare as a field in which local government can, and should, be active. A decision of the then new Constitutional Court in

2005 (007/PUU-III/2005)[11] further clarified this issue, stating that, even in a single-payer health system, local administrations have the right to design health insurance schemes and to establish institutions to implement them. Furthermore, among local policy-makers there is considerable confusion about the meaning of "integration" into BPJS Kesehatan. A recent survey of local health policy executives reports that, while 55% of respondents think that Jamkesda should be eliminated after 2016, the remaining 45% believe that it should continue existing, although with a more "specialized" role (Thabrany et al. 2015, 163). Similarly, interviews with health policy officers in several regions conducted by TNP2K, the Team for the Acceleration of Poverty Reduction, show beliefs among some respondents that local government will have major responsibilities in the integrated system, including designing contracts with healthcare facilities and managing claim reimbursements (TNP2K 2014, 161-166).

Are the poor getting what they should?

So far, I have discussed a number of issues that are familiar in the literature on Indonesian politics. The proliferation of health insurance programs after democratization suggests that they follow an electoral logic. We also know that the implementation of these programs, although beneficial for millions of low-income Indonesian households, has been inadequate in various dimensions. Most crucially, there is abundant evidence of extensive subnational variation in how well health insurance programs are implemented. As I have argued, such variation stems from

[11] http://hukum.unsrat.ac.id/mk/mk_7_2005.pdf, accessed July 22, 2015.

the key role that local government has maintained in this policy area despite a growing activism from national policy-makers.

In the remainder of the paper, I focus on the implementation of Jamkesmas to address two questions that have received less attention in the literature. The first is descriptive: it regards the extent and the patterns of subnational variation in the quality of Jamkesmas implementation. Although several empirical studies offer an overall picture of Jamkesmas implementation (Harimurti et al. 2013, World Bank 2012), the extent to which it varies across district is to a large extent unexplored. In this section, I present an original map of district-level Jamkesmas coverage rates among poor Indonesian households, and I discuss variation in implementation quality across districts, provinces and islands.

The second question concerns the origins of such variation in health policy implementation. More precisely, I explore the role of local-level policy preferences and local politics as determinants of policy outcomes. Indonesian districts vary dramatically with regard to the incidence of poverty, and for this reason poverty alleviation programs may be more salient, and better implemented, in localities in which poverty is an issue of greater concern. Furthermore, we still lack an understanding of the degree to which variation in policy outcomes originates in the quality of local democratic institutions, as empirical studies of Indonesian local politics typically rely on case-study analysis that are most useful for identifying particular best practices and success stories. In the next section, I use an original dataset with data on local electoral outcomes in *pilkada* elections to explore the nexus between local preferences, electoral politics, and health policy outcomes.

The key measures I use to investigate these three questions are built from the 2013 implementation of Susenas, the Indonesian National Socioeconomic Survey. There are, in particular, two variables I am using to provide an overall indicator of the quality of the implementation of health insurance programs for the poor. The first is a survey question that asks respondents if Jamkesmas covered them in 2013, the last year the program was implemented. The second tracks reported household income, which allows me to determine if a given household can be considered as "poor" or "near-poor". More precisely, I classify households as intended Jamkesmas recipients if they fall below the 30% of the national income distribution.[12] By matching these two indicators, I am able to determine the district-level share of poor households (i.e., of households that should be covered by Jamkesmas) reporting coverage in the Susenas survey. The simple idea behind this measure is that district government is using Jamkesmas funds effectively when it channels them towards their intended recipients, namely poor and near-poor households: the higher the share of intended recipients reporting coverage, the better job local authorities are doing at implementing free healthcare for the poor.

The choice of using survey data to measure health policy implementation can present some challenges. The first is that coverage may be underreported in survey data, as many respondents may be unaware of their benefits. However, this is precisely a reason why using survey data is so

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[12] The 30% threshold was adopted to determine the overall Jamkesmas membership. By this standard, the total number of households that fit into the "poor" or "near-poor" category is about 75 million, close to the reported Jamkesmas national membership of 76.4 million before its expansion into the new National Health Insurance system.

important for measuring implementation quality. As discussed in the previous section, socialization is a key responsibility of local government in implementing Jamkesmas: the fact that many poor households are unaware of the benefits they are entitled to reflects insufficient efforts by local authorities in socializing the program. A second weakness is that coverage is not the only dimension that captures the quality of health policy implementation. There may be districts in which reported coverage rates are high, but the quality of delivered services is low because health facilities are difficult to access, in poor conditions, overcrowded, and so forth. I assume here that the case of a local government that is performing well in socializing Jamkesmas and poorly in running it through its health facilities, although theoretically possible, is empirically rare. A more plausible and common case is that of local health authorities claiming high coverage levels and implementing their health insurance schemes poorly, or in a clientelistic fashion. By using survey data instead of the patchy coverage numbers provided by local government, I obtain a more accurate measure of implementation quality.

The data on coverage rates among poor Indonesian households show that only a minority of Jamkesmas's intended beneficiaries report being insured by the program: while about 46% of the poorest Indonesians report coverage, the remaining 54% say they are not covered by Jamkesmas. This national figure suggests fairly low overall levels of local government responsiveness to the preferences of low-income Indonesians, as only less than half of entitled recipients report being covered. However, the map of district-level Jamkesmas coverage shown in Figure 2 suggests that subnational variation in coverage rates is wide. Districts are represented with gray gradients and classified in five categories, ranging from those that are performing particularly poorly (coverage rates below 20%, represented in white) to districts with exceptionally high coverage (black in the

map, with coverage rates above 70%). The map shows that Indonesian islands and provinces differ significantly in how effectively they are insuring their low-income citizens. For example, while Javanese provinces show values around the national average, very low rates are reported in provinces in Kalimantan (average coverage of 33%) and Sumatra (36% on average, although the figure jumps to 69% in the special autonomy region of Aceh). Higher coverage rates appear in regions receiving generous Jamkesmas quotas in Eastern Indonesia, such as West and East Nusa Tenggara (53% and 71% average coverage, respectively) and Maluku (58%). In other islands, provinces differ substantially in average coverage rates: in Sulawesi, for instance values range from 42% in North Sulawesi to 72% in Gorontalo.

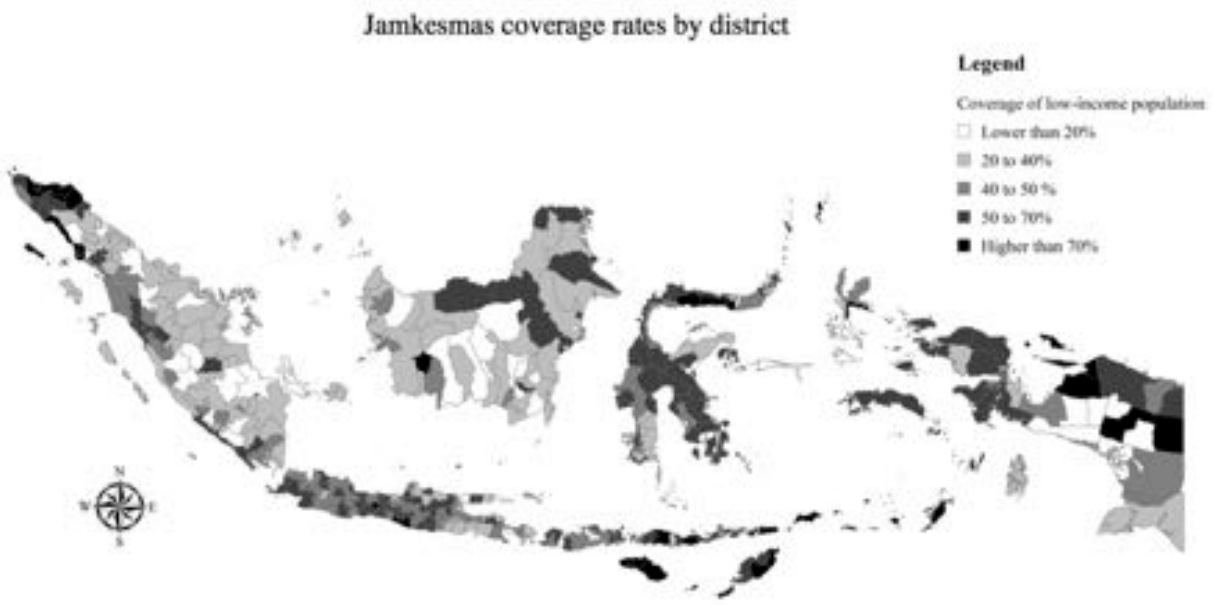

Figure 2. Jamkesmas coverage rates by district

In sum, the map shows that subnational variation is extensive and that it escapes broad categorizations such as a divide between poor and rich provinces, or between the center and the periphery of the archipelago. However, while visual inspection reveals some interesting

contrasts, it is important to turn to multivariate analysis to gauge the relationship between Jamkesmas implementation quality and theoretically relevant local-level factors.

Preferences, accountability and policy outcomes in Indonesian local politics

A possible driver of variation in how effectively Jamkesmas is implemented is variation in preferences over the implementation of free healthcare programs across districts. Indonesian regencies and municipalities vary in their incidence of poverty, and this could have a direct impact on the implementation of pro-poor policies like Jamkesmas. In districts with a high incidence of poverty, demand for free healthcare services for the poor may be higher, and the provision of free healthcare to the poor tends to be a more salient political issue. In these localities, elected government officials may have stronger incentives to target low-income voters accurately, as they constitute a larger share of the population and could thus carry more weight in electoral competitions. By contrast, in districts where poverty is low, low-income citizens represent a smaller share of the population, and could thus be a less decisive social group in shaping the outcomes of local electoral contests. We can thus hypothesize that, in districts in which poverty alleviation is not a particularly salient political issue, targeting low-income voters is not as crucial for incumbents to secure electoral support, and leakages of Jamkesmas resources to middle and upper classes are more common. Still, there are various reasons why the incidence of poverty may not translate into better implementation of pro-poor policies. For example, low levels of socioeconomic development may also be associated with lack of awareness on health issues, the absence of advocacy for broadening the access to healthcare among the poor, and the prevalence of traditional healing practices. More generally, the mechanism of democratic

accountability between voters and elected politicians may not work because of the poor quality of local electoral institutions, which is closely related to levels of civic engagement and transparency in local government (Pepinsky and Wihardja 2011).

In Indonesian local politics, a key development in the institutionalization of electoral accountability has been the introduction in 2005 of local direct elections for district heads and provincial governors (Erb and Sulistiyanto 2009). Since their introduction, *pilkada* elections have generated a debate between proponents and opponents of direct elections. From one perspective, *pilkada* are a crucial step in the consolidation of democracy in Indonesia, as they grant citizens the right to choose directly their representatives in local government, a level of the Indonesian state that holds considerable powers in many policy areas. Perhaps the most adamant proponents of this view are Indonesian citizens themselves, as public opinion surveys show that almost 90% of respondents report a preference for *pilkada* over indirect election of district heads (Gabrillin 2014). Critical concerns, however, have been raised both by scholars and political elites. Most notably, some have pointed out that it is not clear if *pilkada* are offering voters meaningful political choices: coalitions in local direct elections are formed without ideological and programmatic considerations (Pratikno 2009), and available evidence of suggests the prevalence of clientelistic practices, illicit political financing, auctioning of party endorsements, and increasing entrenchment of local political dynasties (Buehler 2013a, Buehler and Tan 2007, Mietzner 2008). Prominent national political figures such as former Minister of the Interior Gamawan Fauzi and presidential hopeful Prabowo Subianto have repeatedly voiced skepticism about the sustainability of *pilkada*, arguing that the excessive cost of campaigns for local direct elections threatens democratic politics. However, a major attempt to substitute *pilkada* with

indirect election by local legislative councils failed in 2014: after national legislators passed a law to abolish local direct elections, unleashing unprecedented popular protest, former president Yudhoyono issued an emergency decree to reverse the changes, and political parties previously supporting the bill changed their position.

Assessing whether the introduction of *pilkada* has had an overall positive effect on Indonesian democracy is a daunting task, since the quality of democracy is a complex idea that presents several conceptual dimensions (Diamond and Morlino 2005). Furthermore, identifying the causal effects of *pilkada* implementation is particularly challenging, as their introduction unfolded alongside broader patterns of democratization, decentralization and economic development. For these reasons, I will not attempt in this paper to provide a general evaluation of the effectiveness of *pilkada* in fostering democratic accountability. However, it is possible to investigate if, and to what degree, elected politicians respond to the incentives of direct electoral competition. The literature on political budget cycles in industrial democracies has robustly documented that elections have a direct effect on government spending patterns, especially in young democracies like Indonesia (Drazen and Eslava 2010, Shi and Svensson 2006, De Haan and Klomp 2013, Brender and Drazen 2005). This approach proposes that the electorate votes retrospectively, leading voters to condition their support for incumbents on incumbents' performance while in office. Although this approach has traditionally been applied to studies of fiscal policy, the same logic may extend to policy implementation: assuming that voters will reward elected officials for effectively implemented policies, incumbents have an incentive to target their constituents more accurately when they are running for reelection. To be sure, the occurrence of an electoral contest in itself is not a guarantee that health policy will be better implemented, as policy

preferences vary across districts. Furthermore, electoral cycles can also produce perverse incentives for policy makers, as research on illegal logging in Indonesia has shown (Burgess et al. 2011). However, direct elections may strengthen and consolidate the relationship between policy preferences and implementation. For Jamkesmas implementation, we can hypothesize that local government responsiveness to the preferences of low-income voters is higher in election years. In other words, the relationship between incidence of poverty and Jamkesmas coverage rates identified in the previous section is stronger in years for which *pilkada* elections are scheduled.

The staggered introduction of *pilkada* across Indonesian districts and provinces provides an ideal empirical setting to test this proposition. Local direct elections were implemented for the first time in 2005, but only in some districts, as there is cross-district variation in electoral cycles (i.e., in several districts the term of service for the incumbent district heads fell after 2005). We can therefore treat the timing of *pilkada* election implementation as exogenous to local politics, which provides powerful analytical leverage to investigate the role of electoral incentives for political elites. In 2013, the year in which the Susenas survey I used to calculate Jamkesmas coverage rates was implemented, a total of 117 Indonesian districts were scheduled to choose their head of government through local direct elections.[13] I am thus able to build a dichotomous variable that tracks pilkada implementation in 2013, dividing the sample between districts that did and did not run local elections in that year. The argument I propose is that preferences over

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[13] To determine in which districts 2013 was an election year, I use end-of-term and election schedule information available from the KPU, the Indonesian Electoral Commission.

health insurance policy implementation interact with the *pilkada* schedule in shaping health policy outcomes. A suitable empirical test is to estimate a regression model with a multiplicative term between these two factors. I thus expect the interaction term between the incidence of poverty and the dummy variable for *pilkada* in 2013 to be positively signed and statistically significant.

A quantitative analysis of local politics and health policy implementation

I test this hypothesis through regression analysis of district-level data collected from various sources. The main variable of interest in the analysis is the incidence of poverty at the district level, which I measure with the official poverty rates reported in the INDO-DAPOER, the World Bank's Indonesia Database for Policy and Economic Research.[14] In all models, I control for district type (regency vs. municipality) and for several other factors that may be related to incidence of poverty and health policy outcomes. First, I include a host of sociodemographic control variables, namely total population, population density, ethnic fractionalization, and

[14] This measure probably underestimates poverty, as it does not count near-poor individuals and households. It is perhaps better understood as a measure of extreme poverty. However, official poverty rates accurately capture differences in the incidence of poverty across districts, and they are thus a suitable indicator for this analysis. The median district-level poverty rate in 2012 was 11% (excluding Papua and Jakarta), with most districts reporting rates between 5% and 25%.

socioeconomic development (per capita GDP).[15] Second, I build a measure of total revenues per capita to account for the possibility that resource-rich districts may be allocating additional resources to Jamkesmas implementation.[16] Third, I include measures of associational life to capture the degree of civic engagement at the local level.[17] Fourth, I have built indicators of the overall structure of the local health system, namely the number of *puskesmas* and hospitals, morbidity rates, and the density of grassroots government organizations.[18] Finally, I include an indicator of the quality of governance at the local level, namely the KPPOD index of Local

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[15] The INDO-DAPOER database provides data on population, population density, and regional gross domestic product. I measure ethno-linguistic fractionalization with a Herfindahl index I calculate based on data from the 2010 Population Census.

[16] Data from INDO-DAPOER.

[17] To build this indicator, I aggregate village-level data on the number of associations available in the 2011 implementation of the Potensi Desa (PODES) survey.

[18] In Indonesian, *rukun warga* and *rukun tetangga*. These organizations, set up by the central government in the 1980s, play an important role in the process of identifying poverty alleviation programs beneficiaries (Kurasawa 2009). I aggregate village-level PODES data from 2011 to build indicators of grassroots government organization, *puskesmas*, and hospitals. Morbidity rates are from the INDO-DAPOER database, and they are calculated with data from the 2012 Susenas.

Economic Governance, which measures the quality of district-level economic governance with survey data.[19] [20]

As for the estimation method, linear regression analysis may be inadequate since the dependent variable, the share of low-income citizens reporting Jamkesmas coverage, has values bounded between zero and one. I thus estimate a fractional logistic model in which the response variable, reported free healthcare coverage, is assumed to have a binomial distribution, and is linked to the regressors by a logit-link function (Papke and Wooldridge 1996). To account for unobservable

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[19] The index ranges from 0 to 100, with higher scores denoting better local governance. Areas assessed by the index include transparency and corruption, access to land, local regulation, public safety, business development programs, and others. As the survey was implemented in two waves (the first in 2007 and the second in 2011), I include in estimations a dummy variable that tracks whether districts were surveyed in the first or in the second wave.

[20] A potentially important factor I am not controlling for is the partisanship of local government. In developed democracies and in regions such as Latin America, the partisanship of elected officials has been crucial in shaping the development of welfare state institutions, as leftist parties typically support higher government spending on social programs (Huber and Stephens 2012, Brady 2003, Hicks 1999). Similarly, important differences in policy outcomes may be associated with the prevalence of programmatic vis-à-vis clientelistic parties (Kitschelt and Wilkinson 2007, Kitschelt 2000). I assume in this paper that, in Indonesian local politics, political parties do not display meaningful and systematic differences in their social policy platforms. I elaborate on this point in the conclusions, as I discuss directions for further research.

province-specific factors and data clustering, I perform estimations with cluster-robust standard errors for provinces, and I include dummy variables for each of the provinces included in the sample. I expect the estimated coefficient for the interaction between poverty rate and election year to be positive and statistically significant at conventional levels, and to be greater in magnitude in electorally competitive districts.

Table 1 reports estimation results for models in which Jamkesmas coverage is a function of the incidence of poverty, electoral cycles, the interaction between the two, and the control variables discussed previously. In the first column, I estimate a model with no interaction effects between poverty rates and the implementation of local direct elections. The coefficient for poverty rate, estimated at 3.459, is positively signed, of sizeable magnitude and significant at .001 level. This suggests that the relationship between the incidence of poverty and the quality of Jamkesmas implementation is positive and strong in all Indonesian regions: the reported coverage of intended Jamkesmas recipients increases in districts with higher poverty rates. The estimation results reported in Table 1 allow us to calculate expected Jamkesmas coverage rates at various levels of poverty, controlling for the sociodemographic and governance-related factors included in the list of covariates. The predicted values of coverage change substantially as we move along the poverty rate range. For instance, while a district with a low incidence of poverty such as 5% is expected to have a coverage rate of only 39%, the expected coverage increases to 52% for a district with a high incidence of poverty of 20%. As for the coefficient of the dichotomous variable tracking the implementation of *pilkada* elections, it is positively signed (0.082) but not statistically significant. This indicates that direct elections themselves do not have a systematic, positive effect on the quality of Jamkesmas implementation. Rather, as the results of the three

other models show, it is the interaction between local preferences and electoral institutions that can affect how effectively health insurance programs are implemented.

Table 1. Local direct elections and Jamkesmas implementation

VARIABLES	Model 1 Full sample	Model 2 Full sample	Model 3 High competitiveness	Model 4 Low competitiveness
Electoral variables				
Pilkada in 2013	0.0818	-0.207	-0.451**	-0.173
	(0.074)	(0.136)	(0.143)	(0.231)
Pilkada in 2013*Poverty rate		2.419*	4.505***	1.664
		(1.113)	(1.211)	(1.793)
Control variables				
City	0.248	0.247	0.441*	0.145
	(0.142)	(0.145)	(0.198)	(0.198)
Total population	0.00112	0.000887	0.00505	-0.00573*
	(0.00188)	(0.00192)	(0.00525)	(0.00248)
Population density	-0.128	-0.111	-0.0492	-0.221
	(0.137)	(0.138)	(0.249)	(0.269)
Ethno-linguistic Fragmentation Index (2010)	-0.250	-0.251	-0.172	-0.261
	(0.158)	(0.151)	(0.164)	(0.235)
Poverty rate	3.569***	2.977**	4.802***	0.109
	(0.791)	(0.912)	(1.258)	(1.511)
Per capita GDP	-4.810	-4.679	0.0431	-13.34*
	(3.002)	(3.253)	(2.352)	(5.548)
Total revenues per capita	-1.13e-09	-5.99e-10	2.46e-08	-3.21e-08
	(7.77e-09)	(8.07e-09)	(2.31e-08)	(2.18e-08)
Associations per 10,000 residents	0.000375	0.000467	0.000815	-0.000274
	(0.000651)	(0.000696)	(0.00100)	(0.00199)
IO SW organizations per 1,000 residents	0.00179	0.00219	-0.00242	0.00200
	(0.00338)	(0.00334)	(0.00552)	(0.00550)
Puskesmas per capita	0.0222**	0.0229**	0.0267**	0.0206
	(0.00781)	(0.00814)	(0.00905)	(0.0189)
Hospital per capita	0.0509	0.0598	-0.0765	0.162
	(0.107)	(0.114)	(0.106)	(0.259)
Morbidity rate	1.095*	1.089*	0.416	2.369***
	(0.434)	(0.424)	(0.865)	(0.683)
KPPOD LEG Index	1.046	0.961	0.0948	1.046
	(0.911)	(0.898)	(1.138)	(1.005)
KPPOD data is from 2011 survey	-1.004***	-1.035***	-1.044**	-1.197***
	(0.105)	(0.186)	(0.327)	(0.225)
Pilkada in 2013	0.0818			
	(0.0740)			
Constant	-1.001	-0.902	-0.988	-0.295
	(0.637)	(0.645)	(0.900)	(0.714)
Observations	402	402	173	179
Log-likelihood	-176.3	-176.1	-75.55	-77.59

Robust standard errors in parentheses. All models include dummy variables for provinces, not reported. *** p<0.001, ** p<0.01, * p<0.05

Model 2 estimates a multiplicative interaction between poverty rate and election year with the full sample for which data is available. Regression analysis estimates the coefficient for the interaction term at 2.419, and different from 0 at the .05 level of statistical significance. To illustrate the meaning of these results, recall the example discussed in the previous section about the difference in estimated coverage between a low-poverty district (poverty rate of 5%) and a high-poverty one (20%). In that example, the poorer district is expected to have a coverage rate of 52%, about 13% higher than what is expected in the district with a low incidence of poverty. Now, consider what changes when we introduce in the model an interactive term between poverty rates and the *pilkada* electoral cycle. In years in which no elections are scheduled, the difference between the two districts is only 11%; however, in election years, the gap between the rich and the poor district increases considerably to about 20%. Figure 3 visualizes the difference between these two scenarios by plotting two curves and their relative 95% confidence intervals: one, the continuous line, represents estimation results for districts where a *pilkada* election took place in 2013; the other, dashed, displays estimated values for the remaining districts. As the figure shows, the line for election years is steeper, suggesting that differences in poverty rates (and thus, in preferences over Jamkesmas implementation) have a more decisive effect on coverage rates in election years. Although the difference between the two groups of districts is not dramatic, these results are consistent with the argument that policy-makers show increased responsiveness to the preferences of their constituents when they are up for reelection.

The results reported for Model 2 may seem surprising, since it is well-known that there is wide variation in how democratic institutions work at the local level, both in Indonesia and elsewhere. While governance in some districts benefits from competitive politics, an engaged citizenry and

civic-minded leaders, some other communities are mired in corruption, predatory government, and elite domination. As mentioned before, there are various dimensions to the quality of democracy (Diamond and Morlino 2005), and producing a comprehensive measure for a large number of districts is prohibitively costly. However, even by analyzing only some aspects of the functioning of local politics, we should be able to observe differences in accountability patterns between these two types of districts. To explore this intuition, I have collected data on *pilkada* election outcomes for all districts in the sample. As a measure of electoral competitiveness, which should be a suitable proxy for the quality and competitiveness of local democratic politics within districts, I use the share of votes for the winning candidate in local direct elections,[21] and I classify observations as competitive or non-competitive districts.[22]

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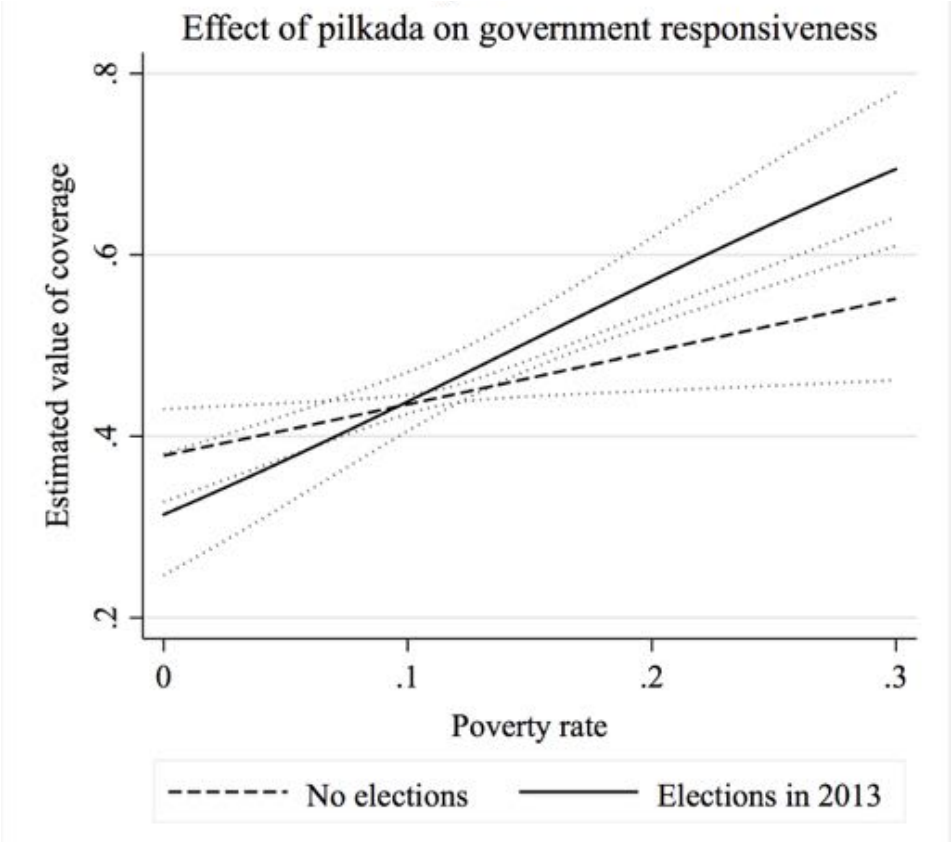
[21] Ideally, the second round of pilkada (2010-2014) should be used to measure electoral competitiveness. However, data for pilkada elections implemented in 2013 are not yet available, and I thus use data from the first round of pilkada (2005-2009). This assumes that local institutions show a substantial degree of stability over time, and that no dramatic institutional changes occurred in this period. A potentially important development at this regard is the process of *pemekaran*, or district proliferation, through which many Indonesian districts underwent territorial change after decentralization (Firman 2013, Pierskalla 2012). To account for this confounding factor, I restrict the analysis to the 352 districts in the sample that did not experience "district splitting" from 2005 to 2013. As for data sources, the Electoral Commission does not hold a central repository of local-level electoral results for the first round of *pilkada* elections. I thus use information collected from electoral maps available at the *Pusat Informasi*



Kompas in Jakarta. These maps are based on official election results collected from provincial offices of the Electoral Commission.

[22] According to the data, the median share of votes for the winner is 44.86%. I therefore use the threshold of 45% to determine if a district is classified as highly competitive (share of votes lower than 45%) or less competitive (share of votes higher than 45%). The results reported in Model 2 hold if, instead of splitting the sample into two groups, a linear indicator of electoral competitiveness is added to the model.

Figure 3. Effect of pilkada on government responsiveness

Models 3 and 4 in Table 1 show striking differences between competitive and uncompetitive districts. For high-competition districts (Model 3), the interaction term between poverty rates and election year is estimated at 4.505, substantially larger than in the model with the full sample, and statistically significant at the .001 level. By contrast, the same coefficient for less competitive districts (Model 4), although positively signed, is much more modest in magnitude (1.664), and it does not reach conventional levels of statistical significance. Figure 4 shows these stark differences by comparing estimated coverage rates for Model 3, in the left panel of the figure, and Model 4 in the right panel. For both groups of districts, the effect of local direct elections is displayed with curves similar to those in Figure 3. As shown, electorally competitive districts tend to have steeper curves for both election an non-election years, indicating that relationship between poverty rates and the quality of Jamkesmas implementation is stronger when local politics is competitive. Furthermore, the difference between the solid and the dashed curve is more substantial in the left panel, which suggests that the implementation of local direct elections has a stronger effect on democratic accountability in politically competitive districts. For example, in a competitive district with a high incidence of poverty (20%), an increase of 10.7 percentage points in reported coverage rates is observed in *pilkada* years; for non-competitive districts with similarly high poverty rates, the same difference is only 3.9%. Overall, these results suggest that subnational variation in the practice of democratic politics has a strong effect on how national social programs for the poor are implemented at the local level. Electoral incentives introduced by direct elections may change the behavior of elected local

officials, but the competitiveness of local democratic politics plays a central role in translating local policy preferences into policymaking outcomes.

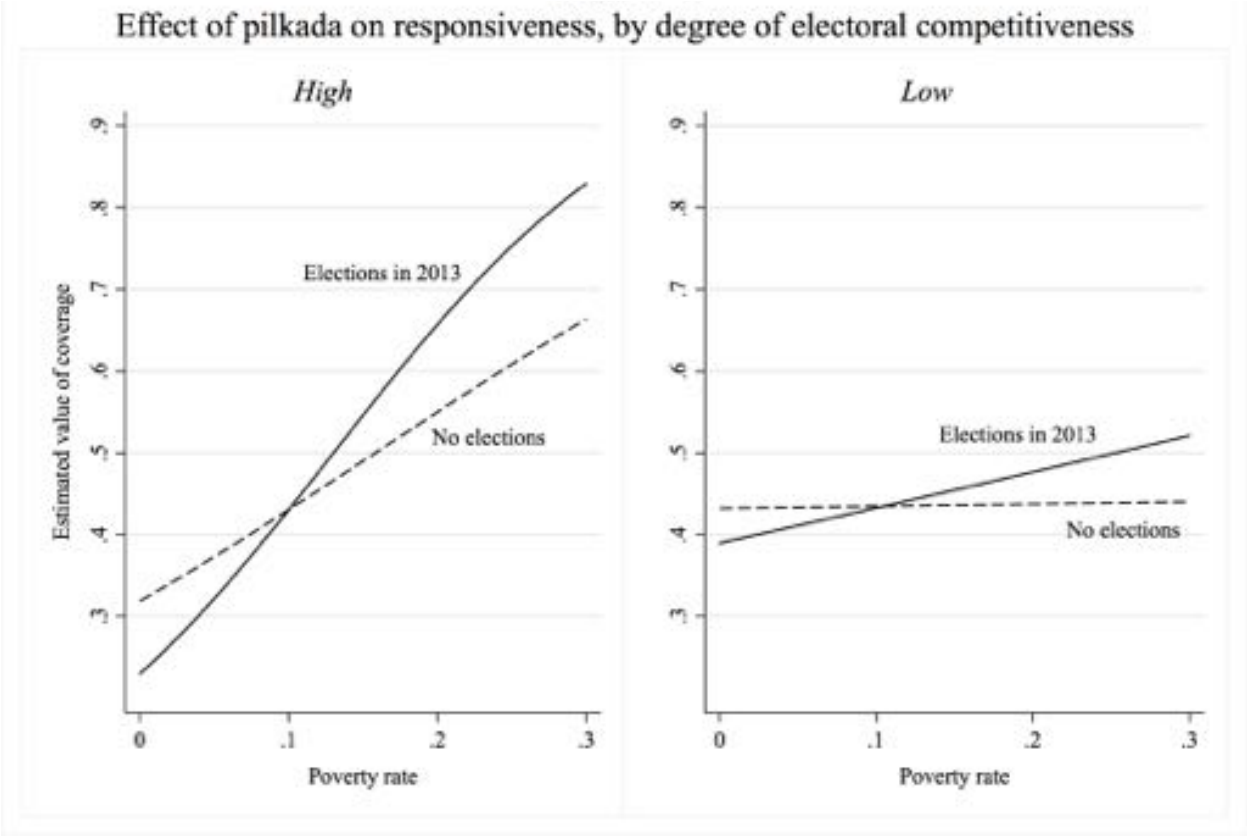


Figure 4. Effect of pilkada on responsiveness, by degree of electoral competitiveness

Conclusions

This paper has investigated if, and to what degree, local government in Indonesia is responsive to the preferences of low-income citizens. It advances our understanding of democratic accountability and local politics Indonesia by focusing on a policy area that directly affects the most vulnerable Indonesians, namely the implementation of Jamkesmas, the national health insurance program for the poor, and by analyzing the full extent of subnational variation in local government accountability and policy outcomes. By employing this research design, I am able to

identify how the electoral incentives associated with the introduction of local direct elections shape the responsiveness of local government to the policy preferences of the poor. The empirical analysis finds that local politicians are responsive to their low-income constituents, as electoral incentives appear to shape policy implementation. However, the results also indicate that the positive effects of electoral accountability are not observed in districts with weak democratic institutions. As a result, a large share of the intended beneficiaries of pro-poor social policy programs may not be benefiting from their implementation.

The main implications of this paper's findings concern the debate on the quality of democracy in Indonesian regions. As mentioned in the introduction, students of Indonesian local politics are divided in their assessment of democratization in Indonesian local government. While some emphasize the continuities with the authoritarian past (Hadiz 2010, Winters 2011), others see signs of increasing agency and clout from civil society groups (Aspinall 2013, Davidson 2007, Rosser 2015, Mietzner 2013a). This paper argues that both perspectives offer useful analytical insights. On one hand, Indonesian government has shown increased responsiveness to the policy preferences of the poor. At the national level, a large-scale health insurance program for the poor was launched in 2005, and it has been gradually expanding to include new beneficiaries. At the local level, politicians have implemented a variety of pro-poor health policies that are benefiting many low-income Indonesian households. Elected policy makers have thus responded, at least to a certain degree, to the incentives for providing broad-based social services introduced by democratization, and the introduction of *pilkada* elections appears to have strengthened the prospects for more accountable local government. On the other hand, there is ample evidence that these ambitious initiatives are often plagued by implementation shortcomings such as

inefficiencies, corruption and stubbornly high leakages of funds to non-poor recipients. Furthermore, this paper has documented dramatic regional variation in health policy implementation, and it has shown that such variation is closely related to how democracy works at the local level. In many Indonesian regions, despite democratization and sustained economic development, access to healthcare is still an insurmountable challenge for many poor households. The findings reported here also speak to the comparative literature on the nexus between democracy and the provision of social services. A long-standing debate in the scholarship on democratization has been on whether broad based-social services such as basic healthcare and education are better provided under democratic politics. While some studies have failed to establish an empirical connection between democracy and outcomes such as poverty or inequality (Ross 2006, Sirowy and Inkeles 1990), many others have argued that democracy is conducive to pro-poor policy outcomes and improved provision of social services (Brown and Hunter 1999, Sen 2001, Przeworski et al. 2000, Besley and Kudamatsu 2006, Kudamatsu 2012, Harding and Stasavage 2014, Stasavage 2005, Lake and Baum 2001). Democracy opens up opportunities for the poor to mobilize and gain political influence, and it introduces new incentives for politicians to provide public goods more broadly than in authoritarian regimes. My analysis of the implementation of Jamkesmas in Indonesian districts provides additional empirical evidence that increased political competition improves the delivery of social services. It also suggests that the degree of electoral competitiveness and the structure of the party system may be crucial moderating factors in the relationship between democracy and social policy outcomes. Finally, the evidence presented here indicates that, as proposed by Lake & Baum (2001), Stasavage (2005), and Stasavage & Harding (2014), local direct elections in Indonesia

are improving social policy outcomes by introducing new electoral incentives for local political elites, rather than by unleashing bottom-up pressures from grassroots mobilization.

Further research may probe the argument proposed in this paper and address its limitations along various avenues. A first, important caveat about the findings reported here is that the data I have analyzed does not allow a sufficiently thorough study of the nature of the accountability relationship observed between citizens and politicians in this policy area. In particular, it is unclear if the responsiveness patterns identified here are due to meaningful dynamics of democratic accountability or to a more superficial intensifying of clientelistic practices. Increased electoral competition may strengthen democratic accountability by providing incentives for programmatic linkages between voters and elected officials, as clientelism is typically associated with the lack of genuine competition among contenders for public office (Medina and Stokes 2002). In the case of Jamkesmas implementation, electoral incentives may have engendered a virtuous process through which the quality of health services gradually increases by incremental steps, with positive policy feedback effects that incentivize citizens to participate in local politics and defend their newly acquired entitlements. Some preliminary evidence from news reports about the implementation of the new National Health Insurance suggest that this is a likely scenario, as citizens appear to be increasingly aware of their rights and increasingly willing to complain when they are not fulfilled (2014). However, electoral competition can also increase the potential for vote buying and materialistic exchanges between voters and politicians, especially in constituencies with low levels of socioeconomic development (Weitz-Shapiro 2012). In many localities, politicians implementing Jamkesmas may still be able to exploit information asymmetries between them and their voters, and to

deploy various strategies to condition the delivery of social services on electoral support. Additional empirical research is thus needed to ascertain the causal mechanisms connecting local preferences, electoral dynamics, and policy outcomes.

Second, a profitable extension to this paper would be to investigate whether my findings apply to other policy areas. Local government responsibilities in Indonesia extend well beyond the provision of health insurance for the poor, and many of the prerogatives of local administrations have a close relationship with electoral politics. For example, free healthcare packages are often promised and offered in conjunction with other pro-poor policies such as free education. Subnational variation in policy outcomes is not limited to social policy, as it extends to areas as disparate as implementing e-government reforms (Kristiansen et al. 2009), setting minimum wage regulations (Caraway and Ford 2014), designing moral and religious laws (Buehler 2008), and many more: each of these fields offers great potential for exploration of the nexus between electoral incentives for political elites and policy outcomes. Third, I have argued that local government is still crucial even in a policy area, that of social security, that is experiencing strong re-centralization pressures. The extent to which this will remain an accurate characterization of health policy in the near future, however, should be assessed by further research, as the emergence of a universal health insurance system is slowly unfolding. Finally, this paper has not considered the role of political parties. In so doing, it has assumed that there is no consistent and consequential difference in the social policy platforms articulated by political parties at the local level. Although this is a widely shared view among scholars of Indonesian politics, there have been signs of increasing consolidation of the Indonesian party system in recent years (Mietzner 2013b). Further research may investigate the presence of partisan effects

in social policy, and perhaps hypothesize if such effects foreshadow the emergence of a left-right divide in Indonesian politics.

CHAPTER 3. Beyond "good governance": the multi-level politics of health insurance for the poor in Indonesia

Introduction

Decentralization reforms implemented in the last two decades have fundamentally transformed governance in many low and middle-income countries. Research on the decentralization suggests that such reforms can be beneficial in fostering desirable policy outcomes, but only in 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 can explain policy innovation in the early stages 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, Tiebout 1956, Oates 1999), 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, and 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 and Mookherjee 2006, 2000, Shah 1999, Keefer and Khemani 2005, Cai and Treisman 2006).

Although the quality of local democratic institutions is a key issue 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 and 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 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 et al. 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, Indonesia 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 and Wai-Poi 2014), and there is wide variation in local government success in attaining policy goals (Lewis 2014). 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, informal linkages between elected officials and social groups, and the dominance of predatory interests in democratic competition (Pepinsky and Wihardja 2011, Von Luebke, McCulloch, and Patunru 2009, Hadiz and Robison 2005). 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 stages 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 effective 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.

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 towards 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.[23] 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, Perry, and Dillinger 1999): the promise of cleaner, more efficient and responsive public administration

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[23] As Cheema and Rondinelli observe, however, the concept of "decentralized governance" has changed over time, eventually expanding to include not only government, but also social actors like the private sector and civil society associations (Cheema and Rondinelli 2007).

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[24]: 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 (Shah 1999, Bardhan and Mookherjee 2006, 2000, Keefer and Khemani 2005). 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 and Min 2013, 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

[24] 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).

Order regime, in which Indonesian regions were governed by centrally appointed bureaucrats. 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 and 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".[25] As a result, Indonesia is

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[25] 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, but they have limited fiscal powers. Most of the 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, have largely decentralized public expenditure. For a more exhaustive analysis of Indonesia's regional autonomy arrangements, see Bertrand (2007).

currently a highly decentralized country in which policy prerogatives in a number of areas are shared across three main levels of government, namely district, provincial, and national authorities.[26] As many have noted, security issues were prominent in facilitating the turn toward regional autonomy, as this policy shift took place in a context of unrest in various regions of the Indonesian archipelago, including widespread communal violence (Tajima 2014), the rise of resilient secessionist sentiments (Aspinall and Berger 2001), and an armed separatist conflict in Aceh. Under such highly volatile circumstances, many believed that appeasing autonomist demands was necessary to hold the country together, as increasing the powers of local government was seen as a tool to ease ethnic and political tensions (Lijphart 1979). Decentralized institutional arrangements were also widely discussed as possible solutions to governance issues such as efficient government, equitable social service provision, inequality reduction, democratic development and civil society empowerment.[27]

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[26] 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.

[27] See Sularto and Koekerits (1999) for a few examples of how the issue of regional autonomy was debated among Indonesian political and intellectual elites after the demise of Suharto's regime.

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 2014, 135). Recent data suggests 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 and Wai-Poi 2014), extreme variation in the quality of local governance persists (Patunru and Rahman 2014), economic growth has not accelerated (Pepinsky and Wihardja 2011), and the record of social service delivery is still mixed at best (Lewis 2014). 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 & 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. More critical perspectives have disregarded the issue of subnational variation in policy outcomes, questioning the legitimacy of the decentralization framework altogether. From this angle, local autonomy is a project rooted in the interests of old authoritarian elites, and the lack of genuine democratic accountability in Indonesian regions is a predictable consequence (Hadiz 2010, Hadiz and Robison 2005, Winters 2011).

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 and 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.[28] 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, 6), or even 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, 185). As argued by Stepan (2004), subnational units in multi-level political systems can also function as de facto veto players (Tsebelis 2002, 1995), 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-

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

organizing federalism (Feiock and Scholz 2009) has identified more informal and voluntary forms cooperation across levels of government, most prominently coordination through various types of policy networks (Berardo and Scholz 2010, Scholz, Berardo, and Kile 2008).[29] 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.[30]

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. In developing countries, social policy implementation is a vital issue for addressing long-standing inequalities and the imbalances generated by economic growth. As local governments typically suffer from poor governance, a lack of financial resources, and limited capacity to plan and carry out their own policy initiatives, local-level implementation of national social policy is often severely flawed. It is precisely under these conditions of low institutional capacity and uncertainty over local implementation outcomes that multi-level cooperation can be particularly beneficial. In his critique of

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[29] The focus of this literature, however, is mainly on policy coordination among subnational units at the same level of government (i.e. on "horizontal" rather than "vertical" coordination). See also Bolleyer & Börzel (2010).

[30] For space constraints, I do not delve into the various forms that the failure to coordinate policies across levels of government may assume. In the empirical section, I will present some illustrations of the effects of lack of multi-level coordination in health policy in Indonesia.

decentralization, Prud'Homme argues that the provision of social services is 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, 218). In short, when local authorities work with higher levels of government to address common policy challenges, they can receive assistance on various 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.

Despite such suggestions that policy coordination is pivotal to ensure good policy in decentralized institutional settings, scholarly work on decentralization and development 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. Specifically, the vast literature on intergovernmental fiscal transfers has exposed the politicized allocation of national budgets in places as diverse Latin America

(Remmer 2007, Kraemer 1997, Calvo and Murillo 2004, Timmons and Broid 2013), India (Rao and Singh 2003, Khemani 2003), and Africa (Banful 2011, Barkan and Chege 1989, Weinstein 2011, Caldeira 2012), finding robust evidence that fiscal transfers from central governments are larger for subnational units led by co-partisans of national executives. To be sure, the two mechanisms, coordination and patronage, can be concomitant in practice. However, in principle, multi-level cooperation does not have to follow a partisan, ethnic or clientelistic logic. 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. More precisely, 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 and multi-level governance, work on decentralization and development has typically studied relations between the local and the national level. In so doing, existing research has overlooked a level of governance that may be crucial in improving the delivery of social services even in countries that are not formally federal, because it is typically better equipped than local government to overcome some key shortcomings of decentralization. First, compared with local government, first-level administrative units are usually endowed with higher levels of financial resources and more professionalized bureaucracies. As Prud'Homme observes, local administration 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, 209-210). As they are larger organizations, intermediate-level governments are on average better funded and better able to recruit qualified and motivated individuals for their bureaucracies.[31] 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 (Shah 2004, Ahmad et al. 2005). In this respect, service delivery at the intermediate level of governance may increase the efficiency of social service delivery while at the same time account for the heterogeneity of preferences across subnational units. For these reasons, especially when local government is bedeviled by low institutional and financial capacity, intervention by meso-level governments, or the lack thereof, can shape local-level policy outcomes in consequential ways. Even in highly decentralized political systems, local government does not operate in an institutional vacuum. Rather, it is 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

[31] On the advantages of the sheer size of the political jurisdiction for the development of human resources, see also Lewis' discussion of the Indian case (Lewis 1991, 282-283).

case-studies (Firman 2009a, b), 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 valuable contribution, however, does not address the question of whether 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 stages of the diffusion of health insurance policies in Indonesian local government, a time of policy experimentation in which local-level factors were key for explaining local policy outcomes. I then turn to the later stages of the policy diffusion process, showing that multi-level cooperation became a more important factor than the quality of local institutions in widening access to healthcare among the poor.

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. 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.[32] 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, and Widyanti 2013).[33] 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.[34] Second, *Jamkesmas* utilization rates remained fairly low among the poorest. Due to

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[32] A the peak of the Asian Financial Crisis in 1998, the *Kartu Sehat* program only covered 1.87% of the population (Soendoro 2009, 98-99).

[33] In 2014, *Jamkesmas* was merged into the new *National Social Security System (SNJS),* 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 (Wisnu 2012).

[34] 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

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.[35] Third, *Jamkesmas* did not include near-poor citizens and the non-poor, leaving about 49% of the Indonesian population without coverage from any government-run health insurance schemes (Departemen Kesehatan R. I. 2008, 317). Because of these three major weaknesses, the role of local government has remained pivotal even in the wake of major policy initiatives at the national level. Furthermore, local government has maintained key responsibilities in the implementation of *Jamkesmas,* as district authorities are in charge of defining the beneficiary list and managing the process of 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.

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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.

[35] On the low levels of demand for healthcare services in Indonesia, see also M. S. Winters, Karim, & Martawardaya (2014).

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. To be sure, local autonomy in itself is not a guarantee that a virtuous process of competition for policy innovation will emerge among subnational units (Rose-Ackerman 1980), and authoritarianism can persist at the subnational level even in countries in which national politics is democratic (Gibson 2005, Sidel 2014). However, 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).[36] Second, the introduction of direct elections for district and provincial heads has created new incentives for the implementation of pro-poor policies.[37] Although early accounts of local politics in decentralized Indonesia suggested that patterns of elite capture and oligarchic consolidation were prevalent (Hadiz 2003, Hadiz and Robison 2005), recent scholarship has recognized that democratization has opened up new

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[36] It should be noted, however, that policy innovation has not always appeared in the guise of progressive, inclusive "best practices" for development projects. Buehler, for instance, analyzes the diffusion of local-level Islamic laws as a product of decentralization and local democracy (Buehler 2008).

[37] 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.

venues for meaningful civic participation, both through electoral and informal channels (Aspinall 2013, Pepinsky 2013, Mietzner 2013a, Davidson 2007).

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 and 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 (Dwickasono, Nurman, and Prasetya 2012, Thabrany et al. 2015). However, these differences notwithstanding, *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.[38] An often-cited example of such activism is the case of Jembrana Regency in Bali,

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[38] The financial resources needed to carry out such ambitious policy initiatives came from various sources. I 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

where the local regent implemented a universal health insurance scheme that offered free basic healthcare to the district's residents (Rosser and 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 one year, and that an additional 72 districts had plans to implement similar programs (Gani et al. 2008).[39] Figure 5 displays the geographic distribution of these "pioneer" districts, showing that *Jamkesda* programs emerged in many different regions.

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districts also implemented schemes in which beneficiaries covered a share of the costs through insurance premiums.

[39] Indonesia had a total of 459 districts in 2007.

Figure 5. Local health insurance programs in 2007

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 towards 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 that may explain why they were at the forefront of this movement toward more inclusive health insurance policies? Table 2 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.[40] 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, to gauge the level of civic participation, I analyze data on the number of non-governmental organizations in each district. As the table shows, there is some evidence that pioneer districts have a more vibrant associational life, as they score higher averages for associations and cooperatives per capita (p-values for both indicators are 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 2 reports the Local Economic Governance Index, a direct measure of the quality of governance at the district level.[41] The t-test

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[40] 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.

[41] 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

shows 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.

Table 2. 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
Cooperatives per 10, 000 residents (2011)	4.94	3.65	0.0511	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

In sum, empirical evidence from this first stage of policy diffusion points to the importance of local conditions, both socioeconomic and political. Districts implementing innovative health insurance plans had higher degrees of socioeconomic development and better performing local institutions. In the policy experimentation phase, Indonesia conformed to the theoretical expectations in the literature on decentralization in developing countries, 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.

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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).

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 is 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 between 2008 and 2011. 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.[42] Data from the same report also suggests 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. 2015, 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 bottom-up pressures 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 (Wong 2004, Selway 2011, Hicken and Selway 2012). However, the proliferation of *Jamkesda* schemes

[42] Reported in Thabrany et al. (2015, 20).

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 provided political support to the proliferation of health insurance schemes. 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. 2015, 185). 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.[43] The dispersion of policy prerogatives across levels of government was indeed among the factors that hindered health policy

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[43] Deficiencies in the implementation of health insurance programs have not been limited to local schemes, as they have extended to *Jamkesmas* as well. In a recent audit, the watchdog government agency BPK (Badan Pemeriksa Keuangan) found extensive irregularities in the implementation of *Jamkesmas*, especially in areas managed by district government such as the updating of the lists of beneficiaries and the distribution of membership cards (Sandi 2013).

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 et al. 2006, 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. 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.[44]

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.[45] Provinces such as West Sumatra, Bali, East Borneo,

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[44] In this respect, health policy reform presented the same precariousness observed in other policy areas, as reformist policies in local government often proved to be only as durable as the office terms of the incumbents who promoted them (Buehler 2012).

[45] 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, 592-593),

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 a 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.[46] 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:[47] this aspect was crucial in mitigating the contingency of *Jamkesda* programs and in reducing the risk of reform rollback. Second, they stipulated cost-sharing arrangements to finance the expansion of health insurance programs, as provincial governments agreed to pay a share of the health insurance costs incurred

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stipulating in Articles 13 and 14 that the provision of healthcare services is a mandatory function for both provinces and districts.

[46] Interview with the Head of Health Department, Province of Bali. Denpasar, Bali, 16 January 2014.

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

by districts.[48] 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.

Despite the benefits that integrated insurance schemes present, cooperation between provinces and districts has been hard to achieve in many regions. On one hand, reaching a cost-sharing agreement for the expansion of health insurance is often difficult because of controversies between provincial and district authorities at the negotiation stage. For example, policy makers in North Sumatra considered implementing an integrated health insurance scheme between 2010 and 2011. However, repeated meetings between province and districts failed to find a compromise on the share of costs that the province would cover, as district leaders demanded a 70% share and the provincial governor was only ready to concede a 30% share.[49] On the other hand, even when agreements are struck, free riding and credible commitment problems can still jeopardize effective cooperation. For instance, although the province of East Java had laid the legislative foundations for a province-wide health insurance scheme for the poor in 2008, implementation of the scheme only started in 2011 and featured substantial financial

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

[49] Interview with Head of Health Insurance Services, Department of Health, Province of North Sumatra. Medan, North Sumatra, 5 September 2013.

mismanagement in many districts (TNP2K 2014). In July 2012, tensions between district and provincial government intensified, as local and national media reported that six districts had not even started paying their half of the *Jamkesda* costs (Taufiq 2012). As several provinces found such difficulties insurmountable, many of them would simply budget a limited amount of funds that could be used to treat indigent patients in hospitals owned by the province. Since such measures were highly contingent and did not specify a list of beneficiaries, they were vulnerable to the same implementation problems that many *Jamkesda* schemes at the district level were already encountering.

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. In this new phase, 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 role of actors at higher levels of government, namely provincial and national authorities, thus became increasingly decisive. In particular, 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.

Research design and data

The difficulties described in the previous section in establishing multi-level cooperative agreements have produced substantial regional variation across Indonesian provinces. In 2010, three years after the launching of *Jamkesmas*, only 13 out of 31 Indonesian provinces were

successfully implementing integrated health insurance schemes in cooperation with district government.[50] This difference in multi-level cooperative institutions has had a pivotal effect on policy outcomes at the local level. Although the role of accountability linkages at the local level may have played a role beyond the policy innovation phase, as *Jamkesda* schemes were turning into more institutionalized, sustainable initiatives, relations between politicians across levels of government have become a key factor in explaining service delivery performance at the district level. Here, I show that *districts located in provinces that facilitated cooperation across administrations provided wider access to healthcare to their citizens*.

I have assembled from various sources an original dataset with detailed district-level information on a host of socioeconomic, demographic, policy-related and institutional factors. 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 policy performance 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

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[50] 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 Borneo, East Borneo, South Sulawesi, and Gorontalo.

membership figures that may be inflated or inaccurate, I use a more comprehensive measure that captures not only policy design, but also the quality of key implementation aspects such as socialization and targeting. 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 6 reports boxplots of the distribution of health insurance coverage in 28 Indonesian provinces grouped into five macro-regions. As the figure shows, variation across districts in coverage rates is dramatic, with a mean of about 31% of the total population and values ranging from 3% to 96%.

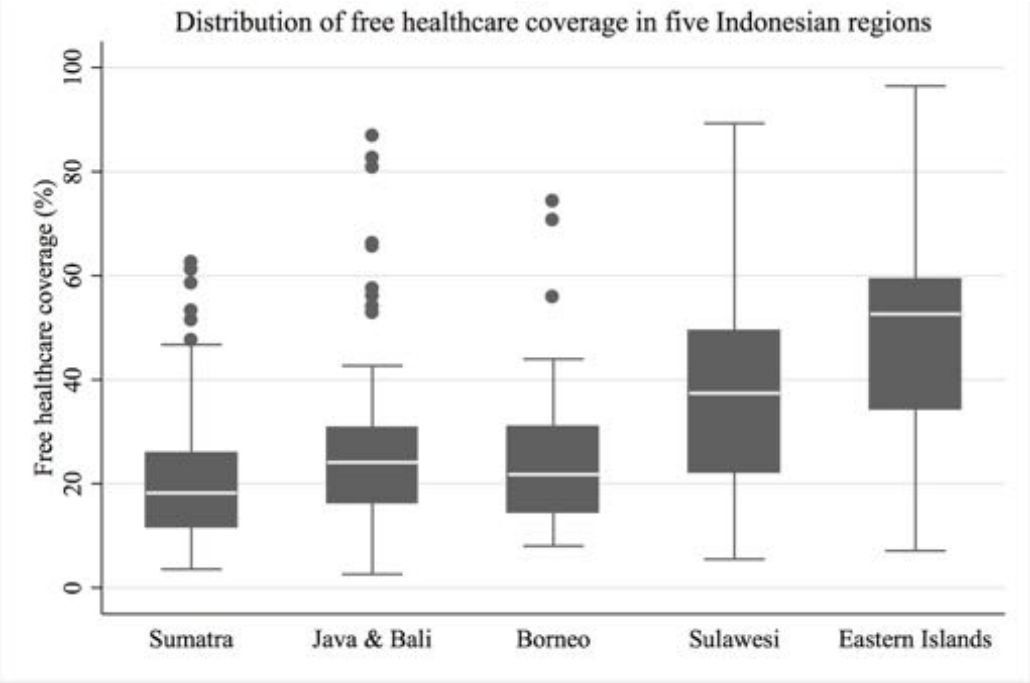

Figure 6. Distribution of free healthcare coverage in five Indonesian regions

To measure effective inter-jurisdictional cooperation across administration levels, I exploit the fact that these schemes require formal cooperation agreements to be implemented. I build a

dummy variable that assumes the value of 1 for districts located in provinces in which a joint health insurance scheme was successfully 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.[51] 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. These three criteria 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

[51] The author has surveyed informed respondents 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 Borneo, South Sulawesi, and Gorontalo.

intergovernmental cooperation.[52] My hypothesis is that provinces coded as cooperating with districts will have higher average health insurance coverage rates, suggesting a beneficial effect of multi-level cooperation on reported levels of health insurance coverage.

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, we 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 and 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:

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

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 me to estimate the effect of covariates at both levels of government. Furthermore, by

[52] The few provinces for which no information about intergovernmental cooperation was available were coded as 0.

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. First, all models include data on local government type (municipality vs. district), total population, population density, and an indicator of the *Jamkesmas* quotas allotted to the district.[53] Second, I control for the socioeconomic development and governance indicators I have used to perform the t-tests reported in Table 1.[54] Finally, to account for the substantial variation across macro-regions displayed in Figure 2, I include fixed-effects for islands in all estimations.[55]

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[53] 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 the *Jamkesmas* quota. Population and population density data are available from the INDO-DAPOER, the Indonesian Database for Policy and Economic Research of the World Bank.

[54] 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 comes from the first or the second survey implementation.

[55] To ensure that a wide range of legal and institutional characteristics is controlled for in the analysis, I perform estimations only with districts located in provinces with ordinary statutes

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.[56] To account for this causal path, I use data on the incidence of poverty in 1999, before the beginning of decentralization, to proxy for different baseline levels in access to social services.[57] 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

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(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 (Snyder 2001, Pepinsky 2014).

[56] 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 and Lukman 1995, Booth 2003).

[57] The indicator is an average of district-level poverty rates in 1999. Data from the INDO-DAPOER database.

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 (2005-2009). 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.[58] 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.

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[58] More precisely, I measure electoral competitiveness with the share of votes received by the winner in local direct elections for district heads and mayors between 2005 and 2009 (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.

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Cooperation and policy outcomes: a quantitative analysis

Table 3 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 0.037, is signed as expected and significant at the .05 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 27.38%. However, for districts located in provinces that are implementing an integrated, multi-level health insurance scheme the predicted value increases to 31.1%. When province-level average values of historical poverty rates are added in Model 2, the estimated coefficient of multi-level cooperation increases to 0.042. As expected, the coefficient for the variable that proxies previous levels of access to social services is negative, suggesting that effective multi-level cooperation is more likely to emerge in provinces with a history of better 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 slightly in magnitude to 0.048, and it is again significant at the .05 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 do not change substantially, 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 .09 and significant at the .01 level, indicating a sizeable difference of about 9 percentage points between districts located in provinces implementing multi-level agreements and other districts. The results reported in Table 2 suggest 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.

Table 3. Effect of multilevel cooperation on free healthcare coverage

VARIABLES	Model 1	Model 2	Model 3	Model 4	Model 5
Province-level					
Multi-level cooperation	0.0373*	0.0418*	0.0483*	0.0494*	0.0902**
	(0.0167)	(0.0169)	(0.0212)	(0.0206)	(0.0276)
Average poverty rate in 1999		-0.00278*			-0.00355**
		(0.00122)			(0.00113)
Partisan harmony			-0.0368		-0.0776
			(0.0403)		(0.0399)
Average electoral competitiveness			0.122		0.0225
			(0.221)		(0.176)
Pioneers in the province				-0.00981	-0.0187*
				(0.00846)	(0.00943)
District-level					
Jamkesmas quota	0.351***	0.405***	0.345***	0.359***	0.410***
	(0.0487)	(0.0481)	(0.0473)	(0.0494)	(0.0462)
Municipality	0.00766	0.0172	0.0106	0.00729	0.0212
	(0.0525)	(0.0508)	(0.0515)	(0.0520)	(0.0472)
Population (millions)	-0.0141	-0.0155	-0.0135	-0.0152	-0.0181*
	(0.0112)	(0.0104)	(0.0111)	(0.0107)	(0.00905)
Population density	-2.08e-06	-2.09e-06	-2.33e-06	-1.83e-06	-1.92e-06
	(3.82e-06)	(3.76e-06)	(3.78e-06)	(3.87e-06)	(3.89e-06)
Per capita GDP	-0.000411	-0.000557	-0.000473	-0.000503	-0.000831
	(0.00105)	(0.00104)	(0.00109)	(0.00111)	(0.00122)
Poverty rate	0.0781*	0.0973**	0.0818*	0.0772*	0.0921*
	(0.0375)	(0.0357)	(0.0371)	(0.0373)	(0.0359)
Inequality (Gini coefficient)	0.160	0.229	0.180	0.145	0.254
	(0.207)	(0.206)	(0.210)	(0.208)	(0.210)
Urban population (%)	0.00298	-0.00694	-0.00494	0.00708	-0.0192
	(0.0734)	(0.0711)	(0.0701)	(0.0743)	(0.0643)
Literacy rate	-0.311	-0.268	-0.289	-0.314	-0.248
	(0.228)	(0.230)	(0.217)	(0.232)	(0.224)
Associations per 10,000 residents	0.00148*	0.00111	0.00141*	0.00171*	0.00123*
	(0.000677)	(0.000649)	(0.000669)	(0.000682)	(0.000615)
Cooperatives per 10,000 residents	-0.000176	-0.000360	-0.000450	4.36e-05	-0.000581
	(0.00167)	(0.00174)	(0.00176)	(0.00165)	(0.00171)
KPPOD LEG Index	0.397**	0.392**	0.384**	0.390**	0.345**
	(0.131)	(0.120)	(0.127)	(0.137)	(0.120)
KPPOD data is from 2011 survey	-0.0274	-0.0141	-0.0273	-0.0377*	-0.0358*
	(0.0200)	(0.0190)	(0.0204)	(0.0189)	(0.0154)
TV penetration (any)	-0.0403	-0.0457	-0.0410	-0.0385	-0.0403
	(0.0330)	(0.0335)	(0.0335)	(0.0322)	(0.0328)
Constant	0.124	0.103	0.0659	0.138	0.146
	(0.231)	(0.233)	(0.234)	(0.232)	(0.244)
Observations	386	386	386	386	386
Number of groups	28	28	28	28	28
Log-likelihood	239.1	241.3	239.5	239.7	243.8

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

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 0.345 in Model 6, is signed as expected and significant at the 0.01 level. This suggests that the factors that were driving policy innovation in the early stages 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 stages 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 6.9%. 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 4, 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 that the effects of such policy initiatives are stronger in localities with low baseline levels of social service provision (Olken, Onishi, and 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.[59] 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 estimation reported in Table 4, 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 suggest 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.

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[59] 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 three years, so that 2005 is the last available year before cooperative agreements were institutionalized in some provinces. As the number of districts has increased between 2005 and 2010, I include in the analysis only districts that did not experience territorial change during this time period.

Table 4. Multilevel cooperation and district-level factors

VARIABLES	Model 6	Model 7	Model 8	Model 9
Province-level				
Multi-level cooperation	0.0828*	0.0126	0.121*	0.100*
	(0.0405)	(0.0607)	(0.0470)	(0.0491)
Average poverty rate in 1999	-0.00362*	-0.00324*	-0.00369**	-0.00390**
	(0.00146)	(0.00127)	(0.00125)	(0.00137)
Partisan harmony	-0.0899*	-0.0545	-0.105*	-0.100*
	(0.0422)	(0.0396)	(0.0440)	(0.0415)
Average electoral competitiveness	-0.108	-0.221	-0.0196	-0.0531
	(0.151)	(0.145)	(0.148)	(0.167)
Pioneers in the province	-0.0151	-0.0125	-0.0174	-0.0124
	(0.00894)	(0.00868)	(0.00996)	(0.00905)
Interaction				
Multi-level cooperation*Poverty rate (2005)	0.0504			
	(0.257)			
Multi-level cooperation*Morbidity rate (2005)		0.00213		
		(0.00185)		
Multi-level cooperation*Clinics per 1,000 people (2005)			-0.111	
			(0.121)	
Multi-level cooperation*Doctors per 1,000 people (2005)				-0.0548
				(0.132)
District-level				
Poverty rate (2005)	0.00189			
	(0.233)			
Morbidity rate (2005)		0.00150		
		(0.000956)		
Clinics per 1,000 people (2005)			0.0956	
			(0.0915)	
Doctors per 1,000 people (2005)				-0.0521
				(0.0633)
Constant	0.137	0.178	0.178	0.166
	(0.230)	(0.222)	(0.242)	(0.237)
Observations	343	343	342	342
Number of groups	28	28	28	28
Log-likelihood	216.4	218.8	218.6	218.9

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

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 and 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 2008b, a). The marginality of the secularist-Islamic cleavage for policy platforms is even clearer in local politics, where coalitions are formed regardless of ideological concerns (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 and Hadiz 2003, 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 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, we 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.[60] 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 5, however, suggest that this is not the case. The multiplicative term, estimated at -0.064, is signed contrary to expectations and it is not significant at conventional levels. To be

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

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 5 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.

Table 5. Causal mechanisms

VARIABLES	
Province-level	
Multi-level cooperation	0.114***
	(0.0272)
Average poverty rate in 1999	-0.00311*
	(0.00124)
Partisan harmony	-0.0636
	(0.0420)
Average electoral competitiveness	0.0187
	(0.156)
Pioneers in the province	-0.0190*
	(0.00865)
Interaction	
Multi-level cooperation*Co-partisan district	-0.0638
	(0.0375)
District-level	
Copartisan district	0.0142
	(0.0307)
Constant	0.156
	(0.235)
Observations	381
Number of groups	28
Log-likelihood	242.2

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

Conclusions

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. As the literature on decentralization has predominantly focused on the quality of local institutions and democratic accountability, the multi-level dimension of policy-making in decentralized developing countries is often neglected. Decentralization reforms do 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. Through an analysis of the politics of health insurance for the poor in Indonesian districts and cities, I have argued that multi-level relations have a direct impact on local policy outcomes. Multi-level politics matters because policy coordination across levels of government is key to address policy implementation challenges due to low institutional capacity at the local level: when such cooperative patterns emerge, service delivery at the local level improves even in the absence of robust local democratic institution.

Political scientists have long asked why ambitious institutional changes often fail to deliver what they promise. The literature on decentralization has produced numerous valuable insights, and it 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 thank 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, and of the democratic

linkages between citizens and elected officials in particular, remains of pivotal importance, there are circumstances under which a significant improvement in policy outcomes can occur even when local institutions are weak. To be sure, multi-level policy coordination is certainly 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. A particularly interesting aspect of multi-level politics is the role of political units between the local and the national level, such as provinces in Indonesia. This paper has show that such meso-level actors can be consequential in shaping local-level policy outcomes.

Further research may explore more thoroughly the sources of intergovernmental coordination, and probe the generalizability of the findings reported in this paper. 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, discussing the biases that omitting such confounding factors may introduce in quantitative analysis. 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. Although this paper has shown that patronage alone does not explain the effect of multi-level cooperation, more fine-grained information is necessary to validate empirically the causal mechanism I posit, and to ascertain if the observed positive effects of cooperation are mainly due to a redistributive role of provincial government or to institutional channels that improve policy implementation. Finally, the generalizability of the findings 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 large, 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. For instance, the dynamics of intergovernmental cooperation may unfold along different lines in countries in which policy prerogatives at the local level are not as extensive as in Indonesia. Further research can address this issue by probing how effectively the framework developed in this paper applies to other geographic regions and policy areas.

CHAPTER 4. Partisan cooperation in multi-level political systems: Evidence from healthcare reform in Indonesia

Introduction

In multilevel political systems, policy coordination across levels of government is crucial for effective governance. The literature has long acknowledged that the partisanship of political elites is a powerful predictor of policy cooperation, as local politicians are more likely to cooperate with co-partisan national leaders. Conventional wisdom suggests that the link between co-partisanship and policy cooperation is due to vertical integration in party networks. Strong political parties facilitate cooperation because they provide national politicians with carrots and sticks to discipline their co-partisans in local government. However, this view cannot account for partisan cooperation in unconsolidated party systems, in which local-level politicians enjoy substantial independence vis-à-vis their national counterparts, preventing elites from disciplining co-partisans at different levels of government. In this paper, I show that partisanship can foster intergovernmental cooperation even when political parties are weak, and I develop a theory that explains under what conditions co-partisans are likely to cooperate in unconsolidated multilevel democracies.

Building on research on voting behavior in federalist countries, I argue that the dispersion of authority over multiple and overlapping jurisdictions hinders the ability of voters to hold elected officials accountable for their performance (Anderson 2006, Arceneaux 2006, León 2012). This reduces incentives for local-level officials to cooperate and improve policy implementation: as politicians are not sure they will be able to claim credit for their efforts, the appeal of cooperation

as an electoral strategy diminishes. Partisan harmony, or the degree to which elected officials at different levels of government are from the same political party, fosters cooperative behavior precisely because it reduces such attributional uncertainty. When different levels of government are controlled by partisan rivals, voters attribute responsibility to each level based on their partisan orientations (Malhotra and Kuo 2008, Brown 2010). By contrast, when the same party controls both levels of government, attributional uncertainty is reduced, and cooperation becomes electorally attractive. On one hand, coordination improves policy implementation, which boosts evaluations of both incumbent politicians. On the other hand, leaders can cooperate in communication and campaign activities to claim credit for good government. My first contribution to the literature on political parties in multilevel political systems is thus to offer a novel account of why partisan harmony fosters policy cooperation.

The second contribution of this paper is to show that partisanship can be consequential even in unconsolidated party systems. The case of health politics in Indonesian local government is particularly interesting at this regard. With the ratification of decentralization reforms in 1999, Indonesian provinces were granted new budget allocation powers and new responsibilities in the provision of social services (Seymour and Turner 2002). While some of them have used such prerogatives to increase the scope of local health insurance programs, several others have not (Dwickasono, Nurman, and Prasetya 2012). Such subnational variation is puzzling because it is not explained by preeminent theories that focus on the role of programmatic political parties and citizen-politician linkages (Huber and Stephens 2012, Kitschelt 2000, Kitschelt and Wilkinson 2007). Data collected in various Indonesian regions suggest that provinces with high levels of health insurance coverage have cooperated closely with the districts in their jurisdictions. Under

these cooperative arrangements, various levels of government agree to increase health policy spending and to coordinate on matters such as the definition of the beneficiaries and policy implementation. I show in this paper that the emergence of such agreements has been facilitated by high degrees of intra-provincial partisan harmony.

The mechanism I posit is a unique in the literature on federalism and multilevel governance. The idea that political parties are key determinants of cooperation across levels of government is not new, and many have observed that policy cooperation is more likely if subnational government leaders are co-partisans of the national executive (Riker 1964, Rodden 2006, Filippov, Ordeshook, and Shvetsova 2004, Wibbels 2005). However, these theories of partisan harmony and cooperation cannot offer convincing explanations in emerging democracies with weak parties. According to a first group of explanations, political parties matter because they provide an institutional connection between national and local policy makers. When parties have strong vertical links, national leaders are able to discipline co-partisans at lower levels of government through channels such as the allocation of federal funds and endorsements to their political careers (Riker 1964, Filippov, Ordeshook, and Shvetsova 2004). This theory fits the Indonesian case poorly, because the Indonesian party system is not as consolidated as those observed in advanced federalist systems. In Indonesian local politics, personalistic appeals are often more important than party affiliations (Buehler 2009), political parties are weakly institutionalized (Choi 2011), illicit financing of political campaigns is widespread (Mietzner 2008), coalitions are formed regardless of ideological considerations (Pratikno 2009), local cadres are fairly autonomous vis-à-vis national offices (Tomsa 2006), and party endorsements are sold to the highest bidder (Buehler and Tan 2007).

A second group of theories focuses on electoral incentives for elected officials (Wibbels 2005, Rodden 2006). Work on American politics has long shown that subnational politicians benefit from the electoral success of their co-partisans at the national level because of partisan externalities, or "coattails" (Tufte 1975, Campbell 1986). When coattails are present, the electoral fortunes of local-level politicians and their higher-level co-partisans are closely tied: partisan harmony can thus foster cooperation even when parties are weak. The application of coattail explanations to the Indonesian case, however, is problematic. First, while partisan externalities might be at work in other federal systems, there is evidence suggesting that their dynamics may be substantially different from the American case. In countries with weaker party systems, the magnitude of national coattails may be smaller (Rodden and Wibbels 2011), and in young democracies it may even absent (Samuels 2003, 2000). Second, work on coattails is much more focused on quantifying their extent than on investigating their role in intergovernmental cooperation. With one remarkable exception (Wibbels 2005), the literature does not jointly test alternative causal mechanisms in the relationship between partisan harmony and policy cooperation. As a result, we do not know if, and to what extent, electoral externalities shape cooperative behavior independently from party network effects. Finally, recent work using sophisticated research designs suggests that coattail effects may have been significantly overestimated in previous empirical work (Broockman 2009, Meredith 2013). These recent findings indicate that electoral externalities alone may be too modest in magnitude to account for consequential divergences in policy outcomes such as those observed in Indonesia.

I illustrate my argument using an original dataset of 31 Indonesian provinces observed over a period of five years (2005 to 2009). To study intergovernmental cooperation, I track the

implementation of formal agreements in which provincial and district governments commit to the joint implementation of province-wide health insurance schemes. I show that such agreements are more likely to emerge in provinces with higher degrees of partisan harmony. Furthermore, the effect of partisan harmony declines in provinces in which attributional uncertainty is lower: when voters have better access to information, partisan harmony is substantially less important for intergovernmental cooperation. These findings suggest that the causal mechanism that links high degrees of partisan harmony to cooperative behavior is more plausibly associated with attributional uncertainty than with the effect of party networks or electoral externalities.

The remainder of the paper proceeds as follows. The next section reviews the literature, and section three outlines the foundations of an attributional theory of partisan harmony and policy cooperation. Section four introduces recent developments in local politics in Indonesia, focusing on the emergence of local health insurance schemes. The following two sections present the research design and the empirical findings. A final section concludes.

Partisan cooperation in multilevel systems

Foundational work on federalism argues that federal institutional arrangements, by bringing the government closer to the people and by generating a process of competition among subnational units, foster desirable outcomes such as more efficient public goods provision, superior economic performance, smaller government, and enhanced accountability and representation at

the local level (Tiebout 1956, Oates 1972)[61]. Such optimistic projections, however, have been rarely borne out by real-world developments, as federalism and decentralization reforms have often been coupled with economic mismanagement, government failures, and the exacerbation of inequalities and communal tensions. Such a mismatch between theoretical expectations and reality has prompted a redefinition of the theoretical tenets of the fiscal federalism literature (Weingast 1995), and it has sparkled scholarly interest for the relationship between various form of federalist institutions, such as fiscal and representational arrangements, and specific outcomes (Wibbels 2006). The role of political parties and partisan alignments across different levels of government, in particular, has been investigated in this literature from two main perspectives.

The preeminent approach looks at party networks, and in particular at relations between national and local-level party members, to account for patterns of intergovernmental policy coordination. A central claim of this scholarship, which traces its roots in early studies of federalism in the United States (Riker 1964, Wheare 1953), is that a strong, vertically integrated party system is necessary for the functioning of federalist systems. As power is distributed across multiple jurisdictions, each with potentially distinct policy preferences, conflicts often arise between policy-makers at different levels of government. However, when hierarchical, vertically integrated parties are present, national-level politicians can discipline subnational co-partisans using tools such as intergovernmental transfers (Ansolabehere and Snyder 2006) and various forms of support to their political careers (Filippov, Ordeshook, and Shvetsova 2004, 190-196).

[61] Throughout the paper, I use the term "local" to denote various kinds of subnational jurisdictions such as states, provinces, regions, districts, regencies, municipalities, and so forth.

Riker observed that the structure of the party system is a key determinant of the degree of centralization of federal systems, and that the extent of partisan "disharmony" is closely related to conflict between levels of government (Riker 1964, 130). This early finding has been supported by recent empirical research, which has studied issues such as the determinants of internal party links (Van Houten 2009), the dimensions of vertical integration (Thorlakson 2013), and the interplay between party organization and partisanship configurations (Bolleyer 2011). In young democracies with low levels of institutionalization, however, parties may be mere vehicles for patronage politics, party affiliations can be extremely volatile, and policy platforms may be virtually identical (Van de Walle 2003). In such institutional settings, national-level politicians are typically unable to discipline their local co-partisans.

A second line of research, instead of looking at the ability of parties to discipline their members, focuses more closely on electoral incentives (Wibbels 2005, Rodden 2006, 2003). Electoral explanations build on early work on American politics showing the existence of national "coattails", or partisan externalities, in local electoral competitions (Tufte 1975, Campbell 1986, Peltzman 1987). In subnational elections, voters often associate local candidates with national politicians of the same party label, so the prospects of local candidates are tied to the electoral fortunes of their co-partisans at the national level. Partisan harmony thus fosters cooperation even in the absence of a consolidated party system, because policy cooperation is a self-interested choice for politicians at both levels of government (Wibbels 2005, 39). If local politicians cooperate with national co-partisans, the implementation of national policies arguably improves substantially, which in turn boosts evaluations of national politicians and the magnitude of coattails.

The nexus between electoral externalities and cooperation across jurisdictions, however, remains unclear (Wibbels 2006, 176). First, the importance of coattails in electoral competitions is still a matter of debate in the literature. Work on congressional elections indicates that coattail effects are rarely decisive for election outcomes, even under favorable conditions such as elections for open house seats (Flemming 1995). More recently, empirical research has applied sophisticated identification strategies such as regression discontinuity and instrumental variable designs to suggest that the effect of partisan externalities has been overestimated in analyses using conventional quantitative techniques (Broockman 2009, Meredith 2013). Second, the role of coattails in countries other than the United States is not fully understood. Existing studies suggest that coattail effects may exist in other federal systems such as Canada (Gélineau and Bélanger 2005), Germany (Lohmann, Brady, and Rivers 1997, Kedar 2006), and Argentina (Remmer and Gélineau 2003). However, the magnitude of electoral externalities can vary significantly across cases (Rodden and Wibbels 2011). Furthermore, empirical research is mostly limited to a small subset of federal countries with consolidated party systems. This is an important limitation of the literature, because these case studies cannot identify if electoral incentives shape policy cooperation independently from party discipline or ideology.[62] In the few

[62] Wibbels' work on economic reform in developing countries is the only piece of research I am aware of that jointly tests different causal mechanisms linking partisan harmony and intergovernmental cooperation. Wibbels shows that, in a country such as Argentina, in which electoral coattails are modest, policy cooperation can occur through central compulsion, although with substantial challenges and limitations (Wibbels 2005, 123-161).

instances in which coattails have been studied in unconsolidated party systems, empirical evidence suggests that they are negligible. For example, in his study of congressional electoral politics in Brazil, Samuels finds that national coattails are absent, a result he attributes to the weakness of Brazilian political parties (Samuels 2000, 242). If coattail effects are weak or non-existent in young democracies, explanations based on electoral externalities alone are insufficient to account for the capacity of political parties to catalyze intergovernmental cooperation in such institutional settings.

An attributional theory of partisan cooperation

My account draws on the literature on responsibility attribution in shaping voting choices (Lau and Sears 1981, Iyengar 1989). Political choices are the product of a cognitive process in which voters establish causal links between a range of social and political phenomena and the performance of incumbent politicians. Such causal attributions, as observed by Gomez and Wilson, "are at the heart of all political opinion, especially given that the charge of democratic citizenries is to hold governments accountable for social and political outcomes" (Gomez and Wilson 2006, 130). A critical aspect of this feature of democratic accountability is that responsibility attribution is cognitively demanding: at a minimum, it requires citizens to be informed about current events and have a basic understanding of complex relations between political, economic and social factors. Indeed, empirical research has shown that voters often fail to attribute credit and blame correctly, as they significantly influenced by individual-level constraints such as the cost of acquiring information (Aidt 2000), cognitive limits (Paldam and

Nannestad 2000), ideology and partisanship (Rudolph 2003, Anderson, Mendes, and Tverdova 2004, Tilley and Hobolt 2011), and political sophistication (Gomez and Wilson 2006, 2001).

The centrality of causal attribution in voting behavior is consequential for the adoption of complex multilevel policies such as healthcare reform. In a seminal article, Geddes (1991) conceptualizes policy-makers as having two main strategies to secure reelection. The first, and most common, is patronage, in which targeted benefits are provided to nurture clientelistic relations with a small segment of the electorate. The second is to implement reforms that benefit a larger portion of the citizenry. This second choice increases electoral support for the incumbent, as she acquires a reputation as a reformer; however, it is also a costly strategy, because patronage is harder to sustain after reform implementation. Geddes argues that reform takes place on two conditions. First, there needs to be a certain demand for reform, and voters must be willing to reward reformers by voting for them. Second, government and opposition camps must have comparable access to patronage resources. Otherwise, patronage politics is always a dominant strategy for the incumbent. Yet the literature on responsibility attribution introduced above reminds us that there is another crucial requisite that needs to be met for reform to be electorally appealing: voters need to be able to *correctly attribute* the beneficial effects of reform to the incumbent's efforts. In other words, even when reform is salient and politics competitive, incumbents may have low incentives to abandon patronage because they are uncertain that they will be able to successfully claim credit for reform.

In multilevel political systems, where power is dispersed over multiple and overlapping jurisdictions, attributing responsibilities can be a particularly daunting task for voters. Following

seminal research by Powell and Whitten (1993), voting behavior scholars have shown that institutions can influence the process of responsibility attribution substantially. Among such contextual factors, federalist institutions can hinder the ability of voters to make causal attributions: cross-national studies (Anderson 2006) and research on specific multilevel systems such as Spain (León 2012), Canada (Cutler 2008, 2004, Arceneaux 2006), and the European Union (Tilley and Hobolt 2011), find that holding the government accountable for its performance is more difficult when policy responsibilities are shared by multiple levels of government. These findings are important for the theory proposed here because they suggest that decentralized countries present additional challenges for democratic accountability and the adoption of reformist policies. As multilevel governance exacerbates the uncertainty over responsibility attribution described above, acquiring a reputation as a "reformer" is more difficult, and the electoral incentives for reform adoption may thus be substantially weaker.

Against this backdrop of attributional uncertainty in multilevel politics, how can intergovernmental cooperation help local-level incumbents to claim credit for reform? A configuration of "vertically divided" government, in which elected officials at different levels of government are partisan rivals, provides low incentives for intergovernmental cooperation. When politicians at different levels of government are from different parties, existing research finds that voters tend to assign credit or blame according to their partisan orientations (Malhotra and Kuo 2008, Brown 2010). Low partisan harmony across levels of government will thus only increase uncertainty over responsibility attribution and further narrow the prospects for reform

adoption.[63] By contrast, in presence of high levels of partisan harmony, such divisive dynamics are muted. First, cooperation is more advantageous because local politicians may be benefiting from the partisan externalities described in the previous section. Second, co-partisans can coordinate communication efforts to claim credit for the beneficial effects of policy reform and multilevel policy coordination: this synergy between co-partisans at different levels of government, although not a guarantee that credit claiming will be successful, increases the chances that reform adoption will be electorally rewarding. Cooperation between co-partisans thus decreases the level of uncertainty over credit claiming for reform.[64]

The theory of partisan cooperation outlined above assumes that policy-makers are uncertain about the voters' ability to reward them for reform efforts. One key implication of my argument

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[63] I am assuming here a belief among elected officials that voters rely, at least to some extent, on partisan cues. As partisan identification is related to perceived programmatic differences among political parties (Aldrich 2011, 176-184), this assumption may be problematic for unconsolidated democracies. However, partisan affiliations may exist even in the absence of partisan policy differences in key areas such as economic and social policy. For example, partisan preferences may be related to identity politics factors such as ethnicity and religion.

[64] This treatment of the relationship between partisan harmony and cooperation assumes that policy implementation will lead to rewards when attributional uncertainty is low. To be sure, this case may be specific to popular policies such as healthcare reform in low and middle-income countries. When more controversial policy initiatives are implemented, clarity of attribution may facilitate blaming incumbents as well as praising them.

is that partisan harmony should only facilitate intergovernmental cooperation when electorates face attributional uncertainty. Without uncertainty, there is little incentive for parties to cooperate for policy or credit claiming in unconsolidated party systems. Abramowitz and coauthors found that voters who are more exposed to political news are more likely to attribute responsibility for their own personal conditions to the government (Abramowitz, Lanoue, and Ramesh 1988). Building on these early findings, Gomez and Wilson show in a series of papers that only politically sophisticated voters make causal attributions between their own economic wellbeing and systemic, political factors (Gomez and Wilson 2006, 2003, 2001). The logic here is similar: partisan harmony should be a particularly important driver of policy cooperation when voters are insufficiently informed about politics, as these are the conditions under which causal attribution is most challenging. Instead, when voters are more educated and have easy access to information about political events, they are in a better position to confer credit and blame: for incumbents at the local level it is easier to claim credit for reform, and the need to cooperate with higher levels of government is less urgent.[65] To state it precisely, the main hypothesis developed in this paper

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[65] Some may contend that electoral externalities are also associated with low levels of political sophistication. Indeed, early work on the psychology of coattails views them as resulting from cognitive shortcuts used by poorly educated voters to decide under cognitive constraints (Mondak 1993, Mondak and McCurley 1994). However, the microfoundations of coattail voting are still surprisingly poorly understood (Hogan 2005, 587-588). Some more recent conceptualizations suggest that partisan externalities are not heuristics, but an aspect of

is that *the effect of partisan harmony in facilitating policy cooperation is larger under conditions of higher attributional uncertainty.*

Empirical setting

After the breakdown of President Suharto's authoritarian regime during the Asian financial crisis of 1997-98, Indonesia embarked on an ambitious project of institutional reform. The decentralization of the Indonesian state, in particular, was hailed as a radical discontinuity with the New Order regime, under which provinces and districts were controlled from Jakarta through centrally appointed, and mostly Javanese, bureaucrats. As Indonesia was rattled by economic inequalities (Akita 2002), ethnic violence (Bertrand 2004, Davidson 2009, Tajima 2014), a resurgence of secessionist sentiments (Aspinall and Berger 2001), and a full-fledged separatist conflict in Aceh, an appeasement to autonomist demands was considered as necessary to hold the country together (Mietzner 2007a). Today, Indonesia is a highly decentralized country featuring three main levels of government, namely national, provincial (29 ordinary provinces and 5 special autonomy provinces), and district government (about 500 units, classified into municipalities and regencies).[66] Voters select the leaders for each administrative level through

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retrospective, performance-based voting by which rational voters hold elected politicians accountable (Rodden 2006, 125-126, Zudenkova 2011).

[66] The Indonesian terms for municipality and regency are *kota* and *kabupaten*, respectively. Recently, the National Assembly passed legislation (Law 6/2014) to strengthen the role of village government, thus adding an additional layer to the governance structure.

direct elections, and the various levels of government share prerogatives and responsibilities in a number of policy areas.[67]

The provision of social services is a prime example of how local government in Indonesia has actively exercised its new powers, to the extent that some scholars of Indonesian politics consider the emergence of more comprehensive welfare programs a key feature of democratization in Indonesian districts and provinces (Aspinall 2014, Aspinall and Warburton 2013). The rapid expansion of regional social programs, and of health insurance schemes in particular, was greatly facilitated by the introduction in 2005 of direct local elections for district heads and provincial governors, known in Indonesia as *pilkada*. Direct elections for local executives established a new, immediate relationship between voters and their representatives,

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[67] Law 22/1999 established that provinces and districts have full autonomy to govern according to the interests of local constituencies. Unfortunately, this directive does not clearly enumerate the powers attributed to the various kinds of local government, and it is thus problematic to provide a precise indication of the responsibilities of districts vis-à-vis provinces (Seymour and Turner 2002). However, Law 32/2004 clarifies that provincial and district governments share "obligatory" functions in a number of areas, including health policy. As for fiscal relations, Law 25/1999 provides for a system of fiscal transfers in which most of local government budget is funded through equalizing transfers from the center, and fiscal powers at the local level are limited.

and created new incentives for candidates to public office to promise, and later implement, pro-poor social policy programs.[68]

Before this key institutional change, however, important developments in health policy had already been taking place in local government. In the early 2000s, a small number of districts in Central Java, Bali and West Sumatra started pioneering policies that significantly expanded the scope of social safety nets, even in the absence of a legal basis to do so.[69] Perhaps the most well known example of such experimentations is the case of Jembrana Regency in Bali, where local authorities implemented in 2002 an innovative program to grant free healthcare to all of its residents (Rosser and Wilson 2012). Local health insurance and free healthcare programs, known collectively as *Jamkesda* (*Jaminan Kesehatan Daerah,* or Regional Health Insurance) proliferated in subsequent years, following a policy diffusion process that reached most

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[68] I am not suggesting here that health policy reform and similar social programs have been a salient factor in most local electoral competitions. Local politics in Indonesia is often dominated by identity politics and patronage networks, and demand for healthcare services remains low in several localities (Winters, Karim, and Martawardaya 2014). Yet undoubtedly, healthcare reform has featured prominently in many local direct elections, and it has been crucial in advancing the political careers of many local politicians (Aspinall 2014, 12-13).

[69] The factors driving this activism in health policy are unclear. In qualitative interviews, informed respondents often mention that "political will" and the quality of local leadership were decisive.

Indonesian provinces: a survey conducted in June 2007 found that 96 districts (out of a total of 459) reported implementing or planning various forms of *Jamkesda* programs (Gani et al. 2008).

The activism of district leaders was instrumental in putting the issue of the expansion of health insurance programs on the national agenda. In the mid-2000s, national authorities took significant steps to establish a comprehensive health insurance system that would cover most Indonesian poor households. *Askeskin*, later renamed *Jamkesmas (Jaminan Kesehatan Masyarakat,* or Health Insurance for the People), was a program launched in 2005 to expand access to healthcare to an initial membership of 60 million poor Indonesians and informal workers (Sparrow, Suryahadi, and Widyanti 2013). While *Jamkesmas* had beneficial effects in expanding access to healthcare, it was flawed in two important respects (World Bank 2012). First, in many districts, *Jamkesmas* quotas were insufficient. Some districts were allocated quotas much larger than the size of their low-income population, and some others received less than what they needed to insure all poor households.[70] Second, *Jamkesmas* did not include near-poor citizens and the non-poor, leaving an estimated 60% of the Indonesian population without health insurance provided by national schemes (Departemen Kesehatan R. I. 2008). For these

[70] 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 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.

reasons, the role of local government has remained pivotal even in the wake of major policy initiatives at the national level. Subnational authorities have been crucial in addressing, or failing to address, deep-seated inequalities in access to healthcare and new imbalances produced by policy-feedback effects from *Jamkesmas* implementation.

As *Jamkesmas* was becoming fully operational, the limits of district-level insurance schemes started to emerge. On one hand, local *Jamkesda* schemes were mired in implementation problems ranging from financial deficiencies to corruption, poor targeting, lack of coordination among service providers, delays, and insufficient socialization. For example, out of the 96 districts identified in the aforementioned study of July 2007, only 26 were found in subsequent field visits to have a running *Jamkesda* program (Gani et al. 2008). On the other hand, the contingent nature of health insurance reform in most districts was increasingly being exposed. 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.[71]

To tackle the weaknesses of *Jamkesda* schemes, some provincial governments started cooperating with districts in providing heath insurance programs. Although cooperative

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[71] Again, the case of Jembrana illustrates this point: as serious financial irregularities in *Jamkesda* implementation surfaced, the regent's reelection bid failed, and his successor eventually dismantled the program. Information collected in an interview with faculty members at University of Indonesia, Faculty of Public Health. Depok, West Java, 31 January 2014.

agreements varied substantially in their provisions, they also displayed some key commonalities. First, these pacts were formal agreements initiated by provincial authorities, with a legal basis that typically included legislation (*peraturan daerah*, or local regulation) ratified by provincial legislative councils. This aspect was crucial in consolidating reform efforts, and in reducing the risk of reform rollback often observed in district-level *Jamkesda*. Second, they stipulated cost sharing arrangements to finance the expansion of health insurance programs, as provincial governments agreed to pay a share of the health insurance costs incurred by districts. 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. In short, where multilevel cooperative agreements of this kind emerged, district and province governments cooperated in financing and implementing health insurance schemes. Typically, provincial government provided a substantial share of the financial resources needed for the programs and access to hospitals run by the province, while district governments were in charge of managing implementation in local clinics and identifying the beneficiaries of the programs.

Despite the benefits of integrated insurance schemes, major hurdles to province-district cooperation have emerged in two main areas. First, reaching a cost-sharing agreement has often been difficult because of controversies at the negotiation stage. For example, policy-makers in North Sumatra considered implementing an integrated health insurance scheme between 2010 and 2011. However, repeated meetings between district and province representatives failed to

find a compromise on the share of costs that the province would have to cover, as district leaders demanded a 70% share and the province was only ready to concede a 30% share.[72] Second, even when agreements are struck, free riding and credible commitment problems can jeopardize cooperation. For instance, although the province of East Java passed legislation for a province-wide health insurance scheme for the poor in 2008, the program was not implemented until 2011. In the first year of implementation, gross financial mismanagement surfaced in many districts, as 16 of them spent on reimbursement claims amounts largely exceeding those agreed with the province, with deficits ranging from two to five times the allotted budgets (TNP2K 2014, 56-57). In 2012, financial tensions between districts and province intensified to the point that six districts stopped paying their share of the Jamkesda costs altogether (Taufiq 2012).

Research design

Health policy cooperation between Indonesian districts and provinces provides an ideal illustration of the argument outlined above for two main reasons. The first is that this case study allows several much-needed empirical contributions to the literature on partisan cooperation in multilevel political systems. As mentioned, the vast majority of the knowledge accumulated by this scholarship relies on empirical studies of a limited number of federal countries. However, there is a much larger pool of countries that are not federal, yet are highly decentralized and elect

[72] Interview with Head of Health Insurance Services, Department of Health, Province of North Sumatra. Medan, North Sumatra, 5 September 2013.

government leaders at two or more levels of government.[73] Furthermore, the literature focuses on the interaction between the federal (national) level and the immediately inferior level of governance (provinces, states, etc.). Yet decentralization reforms in many countries have devolved a substantial amount of policy prerogatives to even more localized political units (regencies, municipalities, and so forth). To the best of my knowledge, this paper provides the first empirical investigation of the link between partisan harmony and policy cooperation at a lower level of governance.[74] Finally, most of what we know about performance voting originates from the analysis of economic policy, most prominently from the literature on economic voting. This paper provides an empirical example of causal attribution processes in a different policy

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[73] Indonesia is one of such countries, as local governments have more modest fiscal powers than in federal systems. In 2009, the last year of the panel dataset I am using, the median value of own tax revenues as a share of the total budget in Indonesian districts was below 5%. However, while the ability of local administrations to levy taxes is constrained, they enjoy almost complete autonomy in budget allocation. Although this is an important difference from the federal institutional arrangements discussed in the literature on partisan cooperation, the Indonesian case is in this respect representative of a broader category of low and middle income countries that have devolved significant powers to local government through decentralization reforms.

[74] An additional advantage of this research design is that it provides variation in province-district relations, as it studies 31 provinces, each having its own relationship with the districts in its territory. This contrasts with existing work on center-province relations, in which only one federal government is analyzed.

domain, health policy, offering an opportunity to ascertain the importance of responsibility attribution and performance voting in a different but no less critical domain.[75]

Second, a comparative study of Indonesian provinces increases inferential leverage in several ways. First, the adoption of a subnational comparative research design allows controlling for a host of national-level factors that may be omitted in cross-national analysis (Snyder 2001). Furthermore, "scaling down" the scope of comparative analysis fortifies causal inference by considering the substantial subnational variation observed in areas such as party strategies and party systems (Chhibber and Nooruddin 2004), the quality of democracy (Gervasoni 2010), and policy outcomes (Giraudy 2007). Second, Indonesia displays remarkable diversity in a wide range of dimensions, including the outcome of interest and potentially related factors such as socioeconomic development: this allows a thorough investigation of possible causal patterns and an empirical analysis over the full range of values of key variables. Finally, choosing Indonesia fortifies causal identification because of specific features of its party system. The literature typically studies political systems in which partisanship overlaps to a large extent with a left-right ideological cleavage. This poses a significant inferential threat because the ideological divide between the left and the right is closely related to policy preferences, and it could thus foster cooperation in ways independent from party networks or electoral incentives. By

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[75] At the same time, however, this research design does not allow to ascertain if the argument applies to other policy areas. In Indonesian local politics, health policy is often a highly salient issue: political dynamics maybe different for less salient policy areas, or in countries in which healthcare is not a key political issue.

performing an empirical test with data from Indonesian local politics, the potentially confounding roles of party discipline and preferences over social policy are accounted for by design.

As the assumption that Indonesian political parties have virtually identical social policy platforms is key for this research design, it deserves further elaboration. To portray the Indonesian party system as devoid of ideological cleavages would be a mischaracterization, as scholars studying political parties in post-Suharto Indonesia have long identified a distinction between secularist and Islamic parties (Mujani and Liddle 2009). This divide over the role of Islam in public life, however, 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 2008b, 28-29). Tan further reports that Indonesian parties drafted their electoral programs in 2004 only because they were required to do so to register at the Electoral Commission (Tan 2006, 99). The marginality of the secularist-Islamic cleavage for policy platforms is even clearer in local politics, where coalitions are formed regardless of ideological concerns (Pratikno 2009). More generally, Indonesian politics lacks the left-right divide typical of consolidated part systems, as the brutal, large-scale eradication of the political left in 1965-66 sharply shifted the center of politics to the right (Bourchier and Hadiz 2003, 8).

Indonesia has also had a long history of weakly institutionalized political parties. In his authoritative study of Indonesian politics before the New Order, Feith saw party organization as "in general very poorly developed", and political parties as plagued with very low levels of

internal cohesion (Feith 1962, 126). To be sure, Indonesian parties today do not appear as weak. For instance, in a recent book Mietzner argues that old models of Indonesian parties as poorly institutionalized vehicles for patronage politics are inadequate descriptions of the Indonesian party system today (Mietzner 2013b). Furthermore, the 2014 presidential elections featured a bitter conflict between two coalitions with some programmatic differences. However, such feeble trends towards greater party institutionalization have emerged only in recent years, and almost exclusively at the national level.[76] Scholarly work on contemporary local politics suggests the predominance of clientelistic practices and widespread weaknesses in the structure and functioning of political parties, including shady financing practices (Mietzner 2008), the prevalence of personalistic appeals and family dynasties (Buehler 2009, 2013a), internal factionalism (Tomsa 2006), the auctioning of party endorsements (Buehler and Tan 2007), and generally low levels of institutionalization (Choi 2011).[77]

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[76] In very recent news, a report by the Electoral Commission found that alliances among parties for the upcoming local elections do not follow the partisan alignments observed in national politics (2015).

[77] Note that, as mentioned in the theory section, voters may identify with political parties even in the absence of significant differences in policy platforms. Using survey data from the 1999 and the 2004 legislative and presidential elections, Liddle and Mujani show that party identification is among the most important drivers of voting behavior in Indonesia (Liddle and Mujani 2007), although the share of the electorate identifying with a political parties appears to have declined in more recent elections (Mujani and Liddle 2010).

An exhaustive test of the theory proposed in this paper requires microlevel data to measure how voters respond to partisan cues about social policy initiatives at various levels of government. This would allow to identify the specific attributional mechanism I posit, and to assess its strength vis-à-vis alternative causal paths. Unfortunately, such a dataset is not available. Here, I analyze data at a higher level of aggregation that nevertheless allows me to identify the most important observable implications of my argument. I have assembled an original dataset with panel data from 31 Indonesian provinces observed over a period of five years, namely from 2005 to 2009.[78] The choice of this time frame is dictated by the contingencies of local electoral cycles in Indonesia and by data availability: before 2005, local leaders were not directly elected, and partisanship affiliation data is not available; after 2009, a second round of local direct elections started in 2010, but data for 2010 elections is only available for a limited number of districts. Furthermore, important institutional changes were under way in 2010, as the national government began discussing plans for a more inclusive national health insurance program that would replace local health insurance schemes.[79]

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[78] A table with descriptive statistics is included in the appendix.

[79] An alternative research design may look at variation across districts rather than across provinces to track the emergence of multilevel cooperation. As districts may able to refuse to cooperate with provincial policies, there could be intra-province variation in cooperative behavior. This scenario, although theoretically possible, is in practice very rare, since agreements are typically only ratified when districts show almost unanimous support for their

The indicator that tracks the emergence of cooperative agreements between provincial and district government is a dummy variable that assumes the value of 1 for province-years in which an agreement for jointly run health insurance program exists, and of 0 otherwise. Data to code this variable were acquired over months of fieldwork in Indonesia, mainly through the consultation of published and unpublished policy reports and through semi-structured interviews with informed respondents.[80] The few provinces for which no information about intergovernmental cooperation was available were coded as 0. For operationalization purposes, agreements are defined as having three constitutive features: they are formal (the legal basis is typically a regulation by provincial legislative bodies), they entail some form of financial assistance from provincial to district governments, and they identify beneficiaries individually, through an integrated list. These criteria ensure that other forms of more discretionary,

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implementation. I therefore use provinces as the unit of analysis, even if some potentially interesting variation may be neglected with this approach.

[80] The author has surveyed informed respondents 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 Borneo, South Sulawesi, and Gorontalo.

contingent and unilateral policies (for instance, the allocation of funds to assist non-identified indigent citizens) are not coded as intergovernmental cooperation. The first health insurance agreements emerged in 2007, when four provinces agreed to run an integrated health insurance program. The number of provinces cooperating rose to seven in 2008 and thirteen in 2009.

The main independent variable of interest, partisan harmony, is generated from results for the first wave of local direct election in Indonesia (2005-2008), and it indicates the share of district heads that are co-partisans of the province's governor. As no single, integrated repository of data on local electoral outcomes exists in Indonesia (the Electoral Commission only started tracking data on local elections in 2011), the coding relies on two secondary data sources. Data on district-level elections was acquired at the *Pusat Informasi Kompas*, an archive in Jakarta where information on early implementations of local direct elections in Indonesia is stored;[81] data for provincial elections was coded from an unpublished report by an independent political consulting firm in Jakarta. As most local leaders are elected with support from a coalition of parties, I code districts as "co-partisan" of the governors if one of the main parties supporting the local leader is in the governor's winning coalition. This is a broad definition of co-partisanship, as it treats as co-partisans politicians from different parties belonging to the same electoral coalition. However, determining the precise party affiliation for each of the nearly 500 local leaders is impossible, since the law on local elections does not require disclosing the partisanship of candidates for public office. Although in principle partisan harmony is a time-varying covariate, as elections

[81] All data were coded from published electoral maps based on official electoral results obtained directly from the 31 provincial branches of the Electoral Commission.

may take place every year, the indicator used in regression analysis is constant over the observed years due to uncertainty about the timing of district-level elections.[82]

Turning to attributional uncertainty, I am unable to measure voters' political sophistication directly, and I therefore recur to proxy indicators of access to information in the electorate. More precisely, I follow Olken (2009) in using television reception as an exogenous determinant of television watching. The 2011 implementation of the *Potensi Desa (PODES)* survey tracks the presence, in each Indonesian village, of local and national public television networks signals. Although this indicator is not as ideal as a direct measure of political sophistication, it is a suitable proxy indicator, as existing surveys suggest that television is the most important source of information about local politics for Indonesian citizens (Sharma, Serpe, and Suryandari 2010, 18). I aggregate this measure to generate province-level indicators of the share of villages reporting access to local, national public and national private television networks.

I use this dataset to perform regression analysis on two sets of models. First, I test the hypothesis that partisan harmony facilitates intergovernmental cooperation with a simple logistic regression model in which the probability of intergovernmental cooperation is a function of partisan

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[82] About 60% of local direct elections took place for the first time by the end of 2006. By the end of 2008, the first cycle of local elections was completed. The two major political parties in this first wave were Golkar, the party most closely associated with the New Order authoritarian regime, and PDI-P, the winner of the first democratic elections in 1999. These two parties won in about 35% and 24% of the districts, respectively.

harmony and a battery of control variables.[83] Second, I extend this basic model to test multiplicative interactions between partisan harmony and attributional uncertainty, operationalized as described above. All estimated models include fixed effects for years, and reported standard errors are robust to data clustering within provinces.[84]

Identifying the causal effect of partisan harmony on intergovernmental cooperation is challenging due the confounding role of the quality of democratic institutions at the local level, which is plausibly linked both to policy outcomes and electoral politics. On one hand, provinces in which government is more transparent and accountable may be more likely to cooperate to provide services that benefit a large number of people. Intergovernmental cooperation may thus

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[83] In all models, I include the number of districts in each province, province population, population density, logged GDP per capita, poverty rate, and morbidity rate (data are aggregation of district-level variables from various publications by the Indonesian Central Office of Statistics, available from the *INDO-DAPOER Indonesia Database for Policy and Economic Research*). I also use data from the Indonesian Ministry of Finance to build two measures of fiscal capacity, namely total revenues per capita and the share of provincial revenues coming from transfers from the central government. This accounts for the hypothesis that local-level spending may be influenced by available fiscal resources and by the presence (or absence) of locally generated revenues (Rodden and Wibbels 2002).

[84] I do not estimate fixed effects for provinces given the limited number of time intervals in the panel and the non-linearity of the model. Under these circumstances, the maximum likelihood estimator may be inconsistent and biased (Greene 2004).

be epiphenomenal to "good governance" practices and local policy legacies in health policy.[85] On the other hand, provinces with better local politics tend to be more electorally competitive, and thus to show lower levels of partisan harmony. The identification strategy I follow in this paper relies on observational data I have collected to condition on these confounders. To measure the impact of policy legacy, I have built an indicator capturing the share of the population having health insurance in 2007, the year in which the first district-province agreements took place.[86] To account for the role of local governance and democratic institutions, I measure the competitiveness of local politics with the number of candidates and the share of vote obtained from the winning candidate in gubernatorial elections.

Finally, to explore the possibility that party networks may in fact play a role in fostering multilevel cooperation, I include in all models dummy variables that track the presence of specific political parties in the winning coalition of provincial governors. Throughout the paper, I have assumed that there are no substantial differences among Indonesian political parties with regard to their degree of institutionalization. The literature on Indonesian politics suggests that there are two parties that might constitute, to some limited extent, an exception to this premise. The first is Golkar, a party that is often considered to be the most institutionalized of Indonesian

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[85] Indonesia has a long history of subnational inequalities in socioeconomic development and the provision of social services. See Akita & Lukman (1995), and Booth (2003).

[86] Data from the Indonesian Ministry of Health (Departemen Kesehatan R. I. 2008, 318). This is, to my knowledge, the first year for which data on health insurance membership from various government and private schemes is available at the provincial level.

parties because it has been operational and electorally successful over several decades, both under authoritarianism and democratic rule (Tomsa 2008). The second is PKS, the Prosperous Justice Party. Recent research suggests that this Islamic party may have developed a sufficiently strong organization to be able to discipline party members at the local level (Buehler 2013b), and that it has been engaged in establishing a programmatic partnership with trade unions (Caraway, Ford, and Nugroho forthcoming).

Analysis

Table 6 reports logistic regression results for a series of models that estimate the effect of partisan harmony on intergovernmental cooperation and its contingency on the degree of attributional uncertainty. Model 1 is a baseline model in which the emergence of cooperative agreements is a function of partisan harmony, a host of sociodemographic and fiscal control variables, and the indicators that measure the competitiveness of local politics and the composition of the governor's winning coalition. The coefficient for partisan harmony is estimated at 5.856 and, although signed as expected, is not significant at conventional statistical levels. This suggests that partisan harmony does not have a strong, unconditionally positive effect on multilevel cooperation in all the provinces included in the sample. The positive value of the coefficient, however, indicates that cooperative agreements are more likely to emerge in provinces with higher values of partisan harmony. For example, while a province with 19% of co-partisan districts has a predicted probability of reaching an agreement of 7.91%, the estimated

probability for a province in which two-thirds of districts are co-partisans increases to 28.15%.[87] Figure 7 plots the estimation results for Model 1 with two charts of predicted probabilities: the left panel uses the results of estimation with the whole sample reported in Table 6, and the panel on the right re-estimates the model by excluding the two years in which cooperation between provinces and districts is not observed. Both panels show a positive association between the degree of partisan harmony and the predicted probability of cooperation. However, while in the left panel predicted probabilities are below .50 for all values of partisan harmony, the chart on the right predicts that an agreement will take place (expected probability higher than .50) for values of partisan harmony higher than .68. As for the other covariates, the variables measuring the competitiveness of local politics are signed as expected: the likelihood of cooperation increases in provinces with more competitive local elections, although neither indicator (share of votes for the winner and number of candidates) is consistently significant across model specification. Finally, the estimation results show no evidence that the presence of either Golkar or PKS in the governor's winning coalitions have a positive effect on the emergence of multilevel cooperative agreements.

[87] 19% and 67% are the 25th and 75th percentile values, respectively, of the distribution of partisan harmony.

Table 6. Partisan harmony, cooperation and attributional uncertainty

VARIABLES	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Partisan harmony	5.856		51.04**	25.22*	35.35**	27.00*
	(3.327)		(17.34)	(10.49)	(10.86)	(13.33)
Partisan harmony (at least 50% of co-partisan districts)		7.058**				
		(2.591)				
Number of districts in the province	0.199	0.289*	0.796*	0.609	0.510	0.750
	(0.113)	(0.121)	(0.320)	(0.326)	(0.287)	(0.409)
Total population (millions)	-0.144	-0.179	-1.116**	-0.588*	-0.709*	-0.974*
	(0.156)	(0.165)	(0.351)	(0.292)	(0.297)	(0.463)
Average population density (people/km2)	-0.000667	-0.00165	0.00326	-0.00268	-0.000207	0.00138
	(0.00164)	(0.00177)	(0.00265)	(0.00260)	(0.00256)	(0.00289)
Average GDP per capita (logged)	-1.904	-1.628	-10.47	-14.41	-14.29	-13.40
	(2.491)	(2.882)	(13.48)	(10.21)	(12.59)	(14.56)
Average poverty rate	-20.24	-44.57**	-41.03	-71.61	-62.91	-59.90
	(11.52)	(16.24)	(46.60)	(44.97)	(51.46)	(57.28)
Average revenues per capita (IDR millions)	0.181	0.893	2.277	2.257	2.532	1.987
	(0.404)	(0.567)	(1.331)	(1.283)	(1.583)	(1.681)
Average fiscal dependency	0.321	8.222	-1.737	-1.473	1.223	-4.566
	(7.210)	(7.919)	(8.906)	(5.639)	(5.181)	(8.284)
Share of people with health insurance in 2007	-0.603	1.944	7.464	7.232	2.051	4.520
	(4.731)	(5.304)	(4.054)	(4.814)	(2.868)	(3.724)
Share of votes for elected governor	-3.090	-12.36	-18.22	-36.35	-35.98	-21.32
	(5.430)	(7.386)	(22.42)	(22.61)	(26.22)	(23.12)
Number of candidates in provincial elections	0.701*	0.889**	1.178	2.020	1.457	0.963
	(0.324)	(0.344)	(0.790)	(1.113)	(0.887)	(0.966)
Golkar in governor's coalition	2.062	4.597*	7.507	12.54	11.31	8.867
	(1.379)	(1.789)	(4.483)	(6.561)	(6.973)	(7.086)
PKS in governor's coalition	-0.219	-0.366	0.0162	1.601	0.970	-0.806
	(1.531)	(1.664)	(3.196)	(2.348)	(3.200)	(3.346)
Average TV network penetration			57.94***			
			(14.73)			
Partisan harmony*Average TV network penetration			-75.34**			
			(25.20)			
Average TV network penetration (local)				40.42**		
				(15.61)		
Partisan harmony*Average TV network penetration (local)				-37.82*		
				(16.42)		
Average TV network penetration (national public)					47.25**	
					(16.71)	
Partisan harmony*Average TV network penetration (national public)					-53.18**	
					(18.17)	
Average TV network penetration (national private)						42.18*
						(18.94)
Partisan harmony*Average TV network penetration (national private)						-47.42*
						(23.93)
Constant	-20.55	-26.29*	-48.55	-14.23	-21.92	-20.70
	(10.57)	(10.64)	(40.33)	(14.49)	(20.87)	(27.81)
Observations	143	143	143	143	143	143
Long-likelihood	-30.90	-25.30	-14.40	-21.11	-18.61	-17.34

Cluster-robust standard errors in parentheses. All models include fixed effects for years, not reported. *** p<0.001, ** p<0.01, * p<0.05

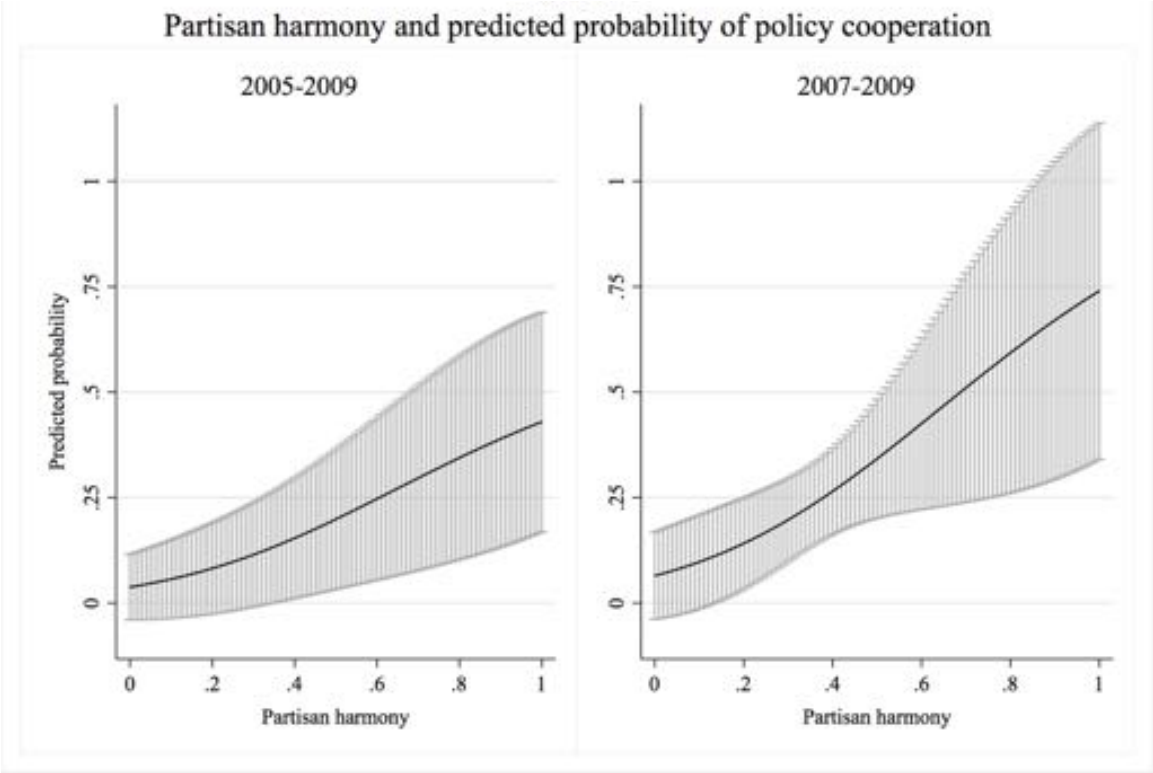

Figure 7. Partisan harmony and predicted probability of policy cooperation

Model 1 has a rather poor fit with the data when compared with the other models reported in Table 6, and it shows the lowest predictive value, as it classifies correctly only about two thirds of the cases of cooperation. In Model 2, I estimate a similar baseline model in which partisan harmony is operationalized with a dummy variable coded as 1 if the share of co-partisan districts in the province is 50% or higher, and 0 otherwise. The coefficient for this covariate is positive and significant at the .01 level. In provinces where half or more district leaders are co-partisan of the governor, the probability of observing multilevel cooperation is 30.19% higher. The much stronger results for the effect of partisan harmony reported in Model 2 suggest that the relationship between partisan harmony and cooperation may not be linear. Rather, there may be a critical threshold of co-partisan local leaders beyond which cooperation becomes more likely.

When partisan harmony is measured with the dichotomous variable used in Model 2, the fit with the data improves noticeably, and the share of cases of cooperation classified correctly increases to 77.27%.

The remaining models reported in Table 6 estimate multiplicative effects between partisan harmony and indicators of attributional uncertainty, measured by aggregated data on the penetration of local and national television networks. In Model 3, partisan harmony is interacted with a measure that tracks if at least one television network is accessible. The estimated coefficient of the interaction term is negative (-75.34), as expected, and significant at the .01 level. This indicates that attributional uncertainty is a crucial moderating factor in the relationship between partisan harmony and multilevel cooperation, as the marginal effect of partisan harmony declines in provinces where citizens have easier access to information on local politics. As hypothesized, the results suggest that partisan harmony is a significant determinant of cooperative behavior across levels of government only if attributional uncertainty is sufficiently high. For instance, consider the difference between two provinces, one with a low degree of television network penetration such as 25%, and one with a higher level of 65%.[88] In the former case, the estimated marginal effect of partisan harmony on cooperation is very strong (estimated at 32.21), positive, and statistically significant at the .01 level. In the latter case, however, the magnitude of the marginal effect drops dramatically to 2.07, with a p-value of .647. Model 3 classifies correctly almost all cases (95.24%) in which multilevel cooperation is observed, which suggests a substantially better fit with the data than the first two models. Models

[88] The median value for this variable is 42%.

4 to 6 estimate the same multiplicative model using data on each of the three television networks measured by the *PODES* survey, namely local, national public and national private television. All results are consistent with the argument, as the interaction terms are large, signed negatively, and statistically significant at least at the .05 level in all specifications. Figure 8 plots the estimation results for these three models, showing the estimated marginal effect of partisan harmony and 95% confidence intervals at different levels of accessibility of television networks. As the figure shows, the estimated marginal effect declines for higher values of television network penetration in all models, and it statistically significant only for sufficiently low values of the moderating variables. The charts display no dramatic differences across the three models in estimated multiplicative terms. However, results are stronger for the national public television network, as the interaction terms in Model 5 shows a larger coefficient and a smaller p-value compared with the other two models. This may be related to the traditionally strong role of public television in providing news to Indonesians, as news broadcasting was initially prohibited to commercial television (Hollander, d'Haenens, and Bardoel 2009, 40-41).

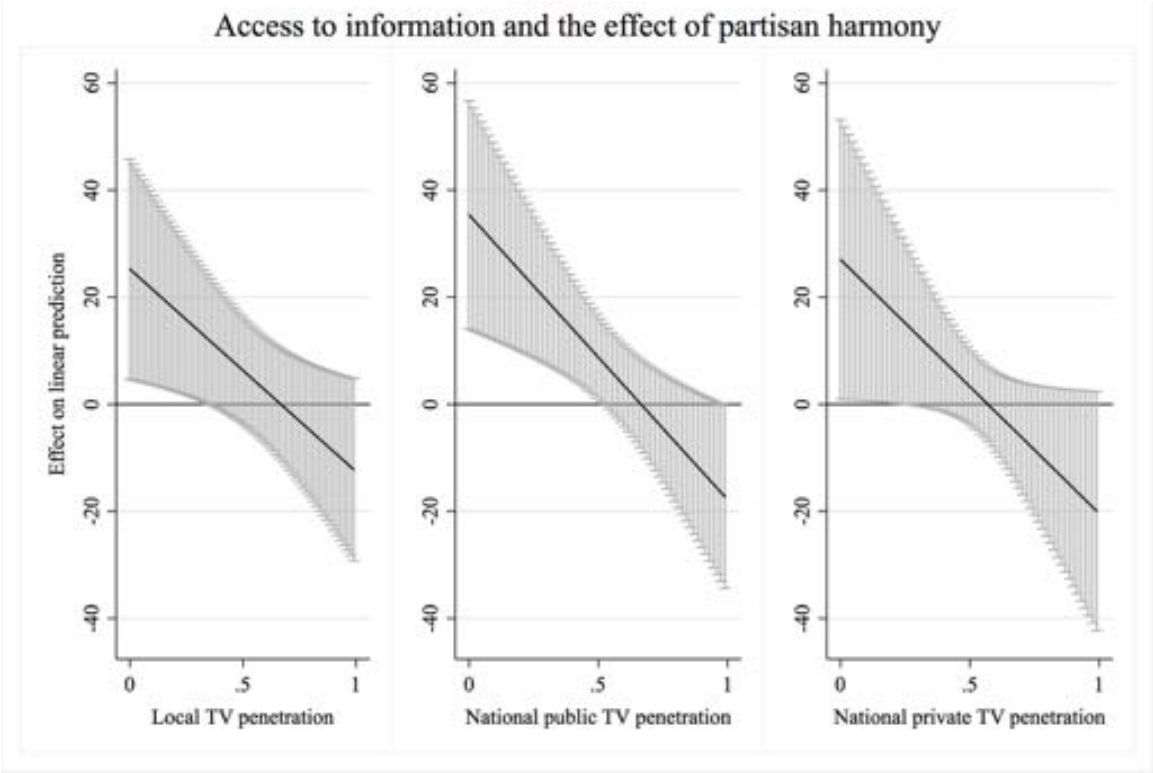

Figure 8. Access to information and the effect of partisan harmony

Conclusions

This article has demonstrated that political parties can be consequential in facilitating intergovernmental cooperation even when they are poorly institutionalized. As the prevailing focus on party networks and vertical integration is inadequate to account for this phenomenon, I study how partisan harmony is linked to electoral incentives to adopt reformist policies. In multilevel political systems, in which authority is dispersed across overlapping jurisdictions, incentives for cooperation on policy reform are often low because politicians are not sure that they will be rewarded electorally for their efforts. Political parties matter because, when

politicians at different levels of government are co-partisans, such attributional uncertainty is reduced, and credit claiming for incumbent politicians becomes easier.

Political scientists have long studied the role of parties in multilevel political systems, arguing that partisan harmony is crucial for policy cooperation in vertically fragmented polities. This literature, however, has so far been unable to ascertain if the association between partisan alignments and intergovernmental cooperation is due to party networks or other factors. My analysis of multilevel politics in an unconsolidated party system allows me to identify and isolate the specific effect of electoral incentives. The analysis suggests that partisan harmony has a positive effect on policy cooperation even when parties are unable to discipline their own members, and that this link depends on electoral incentives related to the process through which voters attribute responsibility for government performance.

Further research is needed to test the microfoundations of this paper's argument, and to ascertain the extent to which these findings are generalizable to other policy areas and countries. However, the analysis presented here has two main implications for the study of democratic accountability and social service provision in low and middle-income countries. The first is that the multilevel dimension of politics in decentralized countries should be investigated with greater attention. While most of the literature on social policy in the developing world has focused on self-contained political units like municipalities, regencies and electoral districts, the case of subnational welfare state development in Indonesia shows that this approach risks neglecting crucial determinants of policy outcomes. The nexus between political parties and social policy development should be studied over the full scale of intergovernmental interactions rather than

being confined to the analysis of issues such as policy platforms, ideology and citizen-politician linkages. More broadly, the analysis performed in this article indicates that becoming more programmatic and institutionalized may not be the only channel through which political parties can contribute to democratic consolidation.

Second, voting behavior dynamics should be investigated more thoroughly as determinants of the link between partisan harmony and policy cooperation patterns. The degree of information accessibility and political knowledge in the electorate may be especially crucial in determining when partisan alignments across levels of government shape policy outcomes. While research in this field on consolidated democratic polities has reached high levels of sophistication, our understanding of the same processes in institutional contexts typically associated with young democracies is still lacking in many respects. Future research may explore survey data and employ experimental research designs to test the microlevel dynamics postulated in this article, studying the complex web of relations between cognitive sophistication, responsibility attribution, social policy preferences and the use of multilevel partisan cues.

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