

STREET LEVEL BUREAUCRACY: DILLEMMAS OF PROVIDERS IN HEALTH CENTRES

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Executive Summary

Concern about the implementation of health service programs begins from the recognition that policies cannot be understood in isolation from the means of their execution. Using Michael Lipsky theory (1980) about street level bureaucracy, this paper aimed to analyze the role of the health center staffs as provider of health service programs. Lipsky used the term street level bureaucrat to describe those public service workers who interact directly with citizens in the course of their jobs and who have substantial discretion in the execution of their work. He argued that individual in the public services typically face choices and competing demands and dilemmas in their service works. Those problems were often neglected in policy implementation. The critical issues of his theory are on the aspects of the accountability of street level bureaucrats: accountability to the organization, to consumers, to the law, and finally to the professional norms. Each is often problematic.

The Puskesmas, a Indonesian acronym for community health center, is where the country's distinctive approach to Health for All (HFA) plays an important role in delivering health services. It has helped the poor by making services more accessible, though often at low quality standards. The diverse services organized through the country's health centers are delivered mainly by salaried public service workers. A typical health center employs about 28 staffs, including one or more doctors, a dentist, 4-6 nurses and midwives and a similar numbers of paramedics with various technical responsibilities, and 4-6 clerical workers, based in the health center.

This study was conducted in Purworejo district, Central Java, Indonesia. Focus group discussion was the main tool to gather data from the *Puskesmas* staffs and clients. This study found that the competence as well as the orientation, motivation, and public persona of *puskesmas* staffs are important because it is they who deal with actual and potential "customers". Their assignments are very broad, which cannot be done simultaneously. Health center staffs become the system in their clients' eyes by virtue of the incentives and signals they respond to and send out, the daily routines and habits they develop, the interpretations of policies and instructions they arrive at, and finally, the decision they make. Ultimately, since the government put a big concern on the success of health policy implementation, especially for the poor, the role of street level bureaucrats, and the way they are actually behaving cannot be neglected.

Introduction

After the policy of administrative decentralization that began in 2001, there were some changes in the mechanism of health service program, mainly in service delivery. Service delivery is where people meet most directly, as providers and users of interventions. Service delivery is an important aspect of governance at the local level, particularly in the current era of regional autonomy. According to the World Development Report 2004 published by the World Bank, good governance results in accountability, and accountability ensures adequate service delivery that works for everybody regardless of income or ability to pay. Thus, good governance and accountability are both essential pre-requisites for effective and efficient service delivery. Accountability requires efforts from every stakeholder - from policymakers to service providers to the people - because the failure of any actor can cause a breakdown in service delivery. Therefore, by examining the performance of service delivery, mainly in the process of delivery, one can gauge the quality of governance in an area.

Providers of health service programs who make each individual and public health intervention happened, are the most important of the health system's delivery. The performance of health care system depend ultimately on the knowledge, skills and motivation of the people responsible for delivering services. This paper concerns about the implementation of health service delivery, begins from the recognition that policies cannot be understood in isolation from the means of their execution. Using Michael Lipsky theory (1980) about street level bureaucracy, this paper aimed to analyze the role of the health center staffs as provider of health service programs. Lipsky used the term street level bureaucrat to describe those public service workers who interact directly with

citizens in the course of their jobs and who have substantial discretion in the execution of their work.

The argument of Lipsky (1980) is, the decisions of street level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out. Public policy is not best understood as made in legislatures or top-floor suites of high ranking administrators, because in important ways it is actually made in crowded offices and daily encounters of street level workers. Policy conflict is not only expressed as contention of interest group but also located in the struggles between individual workers and citizens who challenge or submit to client processing. The structure of street level bureaucracy confronts clients with dilemmas bearing in action. Consumers of public services, once they have decided on or been consigned to a place of residence, with rare exceptions cannot choose the public services to which they will be subject. He argued that individual in the public services typically face choices and competing demands and dilemmas in their service works. Those problems were often neglected in policy implementation.

The critical issues of his theory are on the aspects of the accountability of street level bureaucrats. Hudson (1989) distinguished four main types of accountability. There are accountability to the organization, to consumers, to the law, and finally to the professional norms. Each is often problematic. To increase the accountability to organization through administrative control is the most common effort to increase congruence between worker behavior and agency policy. But for the street level bureaucrat, the formal rewards of agency are likely to play only a minor role in directing behavior. Further, clients of health services who are relatively powerless. Ideally, clients

should be encourages to have greater autonomy, with proper support, advocacy, and particularly self-advocacy. In fact, it will be very difficult to establish the conditions under which clients of health services are fully informed about the variety of treatment, effects or side-effects of medical treatments and medicines. However, lack of responsiveness to clients' demand is sometimes happened. Obey to the law is preferred. Accountable to the law is hoped in increasing the compliance of street level bureaucrats. But, sometimes the legal system is not well equipped to deal with problems associated with the exercise of discretion by them. Lastly, professional norms can be seen as a guidance of street level behavior. Lipsky assumes that professionalism is a way of coping with the problems of street level bureaucracy. However, the problem lies in the gap between the service orientations of professionals in theory and in practice (Hudson, 1989).

Methodology

This study departs from an analysis of providers' role based on Lipsky's theory that happened in the arena of health service delivery. The main interest of this study is how providers who interact directly with citizens in the course of their jobs and who have substantial discretion in the execution of their work. Providers in the public services typically face choices and competing demands and dilemmas in their service works.

Apart from the study of relevant literature, a research took place in Purworejo district, Central Java, Indonesia. Focus group discussion with 6-8 participants was the main tool to obtain the necessary data from the *Puskemas* staffs and clients. Further data was also obtained through interviews with doctor (manager of *Puskemas*).

Context of the study: Indonesia's health system

Indonesia was one of the first countries to introduce an approach to primary health care concepts whose principles and features were endorsed at the landmark UN Health for All (HFA) conference in Alma Ata in 1979. That concept was focus on getting basic health services to the poor, relying on providers with modest training and operating in peripheral locations. The Government of Indonesia took on HFA in implementation, building and staffing over 7,400 *Puskesmas* (health center), 19,000 subcenters, and 285 district and 50 special referral hospitals. In addition, health center and hospital employees, numbering more than 200,000 and nearly all civil servants, support more than a quarter million *posyandus* (Integrated Community Healthcare Center), monthly village gatherings in which community volunteers promote maternal and child health and nutrition. *Bidan Desa* (village midwives) and *Polindes* (village maternity polyclinics) were made widely available across the country to support efforts to reduce the poor maternal mortality rate at the regional level.

The *Puskesmas*, an Indonesian acronym for (community) health center is at the forefront of the government's effort in ensuring universal access to health services. *Puskesmas* provide basic health services such as primary-level medical treatments (including emergency treatment), antenatal and postnatal care for women, family planning consultation, immunization, and several other basic health services. In general, the work area of a *puskesmas* covers a *kecamatan* (sub-district), but in some densely populated areas it covers a *kelurahan* (village).

The services organized through the country's health centers are delivered mainly by civil servants. A typical health center in Java and Bali employs about 28 people,

including one or more doctors, a dentist, 4-6 nurses and midwives and a similar number of paramedics with various technical responsibilities, and 4-6 clerical workers, based in the health center itself. Each of one or two the subcenters and the mobile health unit attached to most health centers is staffed by a midwife and an auxiliary worker. In remote areas outside Java and Bali, the number of health center staff can be in the 5-10 range. In the 1990s, a new government-paid field worker, the *bidan desa* (village midwife) was assigned to specified rural communities. Over 50,000 of these field workers were trained and hired on three year contracts which were renewed for three additional years. The overall *puskemas* team now includes 5-10 of these village-based workers.

Service delivery process and demand-side mechanisms.

Salary increases, training and other supply-side instruments may not be enough to promote responsive provider decisions and behavior. Different demand-side factors need to be activated and institutionalized as well. Providers need to be exposed to clients' questions and concerns and reminded continuously of their obligations to the recipients of services and their families (Lieberman & Marzoeke, 2000). In fact, however, many patients, especially poor, lack adequate information, have little or no cash to pay user fees and informal charges, are subjects to peer and social status pressures, and because of these factors have limited bargaining power, in effect, in dealing with providers. Sophisticated, continuing communication efforts are needed to inform poor beneficiaries of current program goals and details, standards, means of registering complaints, and penalties for poor performance, and to seek regular feedback on what clients think and feel about services and what they prefer.

Health officials also turned to administrative measures to facilitate *Puskesmas* program implementation. Like the decision to allow staff to pursue private income earning opportunities (World Bank, 1994), some seemingly unexceptionable policy steps brought significant and unanticipated outcomes. In this regard, decision makers were preoccupied with human resource constraints which were seen as possibly delaying efforts to broaden access to primary care and referral services. A specific concern was the limited training and experience of a health work force made up of newly recruited graduates and those assigned to malaria, leprosy, and other vertical programs who were converted suddenly into multi-purpose workers.

Findings from discussion with some midwives indicated that they were lack of technical competency. They sometimes doubted with their job assignments, and further they have to take responsibilities of those big tasks, particularly in curative treatments. They did those job almost without control, because the doctor (manager of *Puskesmas*) did not present regularly in curative jobs because of some managerial tasks outside the *Puskesmas*. However, they absolutely understand that those tasks are doctor authority. This findings is consistent with Sciortino's study in rural Central Java (1995) that there is a gap between policy rule and practice. Here, findings from FGD discussion stated by one of FGD participants.

“Kami belum sepenuhnya memahami tugas pengobatan yang sebenarnya. Idealnya, tugas kami yang sebenarnya hanya membantu, tapi malah jadi tugas pokok, karena tugas dokter tidak hanya melakukan pengobatan di Puskesmas, melainkan juga tugas-tugas manajemen, seperti rapat di kecamatan, di dinas, dan lainnya. Tapi apa boleh buat. Pasien kami tiap hari banyak sekali yang datang. Sementara pasien-pasien juga tidak mengeluh kalau yang mengobati bukan dokter. Padahal kami sebenarnya juga kadang-kadang ragu-ragu kalau ada kasus yang cukup berat, sementara dokter sedang tugas luar. Untuk kasus-kasus seperti ini biasanya kami hanya buat surat rujukan ke rumah sakit. Yah, beginilah tugas kami, agak tanggung.” We don't know yet our real tasks. Ideally,

our main task just assists the doctor, in fact it would be our main task. Doctor is not always present in medical section. His tasks are very broad. He does not only do some medical treatments, but also manage the *Puskesmas*, mainly administrative and managerial tasks, like for example: present in the district meeting, etc. On the other hand, we sometimes doubt with our performance, particularly in dealing with emergency cases. For these kind of cases, we just made a referral letter, and sent patient to the hospital. Yeah... these are our jobs....(*cited from Midwife FGD transcript*).

Policy makers' reservations probably went well beyond the particular technical skills which each worker had acquired. In fact, inadequate skills seems to have served as a shorthand expression or code not only for shortcomings in technical capacity but limitations in respect of how employees understood and approached their assignments and program goals and priorities overall. This broader concept of skills would also have included the inter-personal qualities and the level of intensity and commitment which staff brought to their jobs.

Above all, policy makers doubted the readiness of health staff generally to exercise independent judgment or make appropriate decisions in the health sphere. Authorities would have been aware, of course, that it was not unusual for health workers to find themselves in situations which encouraged the use of judgment. Geographic isolation and limited oversight from supervisors who had to monitor staff dispersed over broad areas despite constrained travel budgets were enough to guarantee some degree of worker autonomy. And several program design characteristics worked in effect to widen the scope of staff discretion. Thus, staff were often assigned informally to more than one program and activity, and usually were involved in several different components within one. Each of these job characteristics would have brought some scope for choice and initiative by health workers. Furthermore, staff exercised judgment over the intensity and

quality of their initial and any subsequent interactions with individual cases or patients. Using Lipsky's theory, they face choices and competing demands and dilemmas as to how to use their times.

To illustrate, the responsibilities assigned to health center-based midwives range from examining pregnant women and following up risky cases to training traditional birth attendants. These clearly cannot all be done simultaneously. She must decide, for instance, how often to visit the *puskesmas pembantu* (health subcenters), and how much time to spend on routine home visits, follow-up of risky cases, or supervision and support of village level workers. Similarly, the *bidan di desa* is assigned numerous tasks, and inevitably, even when given instructions by district and health center-based staff, chooses between competing activities and/or "customers." Here, finding from midwife and client focus group discussion (FGD) and field observation illustrated that they face a dilemma: serving clients and task competency.

(“Pengalaman pendidikan bidan rasanya sangat tidak cukup. Apalagi dibandingkan dengan teori dan praktek di lapangan, rasanya tidak ada apa-apanya. Di lapangan kadang-kadang ada banyak pertanyaan yang waktu sekolah dulu belum ditanyakan pada dosennya. Karena bidan desa itu bagian dari proyek, jadi “bisa atau tidak bisa” harus lulus. Kalau ibaratkan sebagai mangga, kami ini bukan mangga matang, tapi mangga karbitan (diberi zat kimia tertentu agak tampak luarnya matang). Istilahnya bidan karbitan, karena tidak mahir. Padahal masyarakat menganggap bidan itu ngerti kabeh. Jadi kalau tidak tahu, mau tanya siapa ?”) “Nurse education is not sufficient. Indeed, if it is compared with its theory and field practices, nurse education is nothing. There were several questions that never been asked during their school term. It is because village nurses are part of a project in which ‘graduation’ is a must. This case could be seen in the mango methapore in which ‘*mango karbitan*’ that force to be ripen before its time. In other words ‘*mango karbitan*’ means nurses with no sufficient knowledge. In contrast, the community in general expect/regard us as person who knows everything (health problems). As a result, if the nurses do not have the answer, who we can turn to?” *(cited from Midwife FGD transcript).*

(“Saya senang sekali ketika ada bidan ditempatkan di desa kami. Karena banyak orang yang membutuhkan, kami terpaksa harus sabar. Ya,.. tidak apa-apa. Tapi bu bidan seringkali juga menolak mengobati kami, karena sakit anak saya harus diobati di rumah sakit. Kami minta obat sementara, cuma janji saja.”) I was very happy when a midwife was assigned in our village. Because of many patients need her, we had to be patient. It’s OK. However, she sometimes refused us. She said that my son illness should be treated at the hospital. We asked for a temporary tablets, but it’s just promise.” (cited from Clients FGD transcript).

Information exchange between the people and providers is very limited. It is maintained by a lack of health education. For example, some providers respond to a strong demand for injections rather than tablets. The general perception is that injections are more powerful and work faster than tablets. What appears is that people base their judgment on their personal health knowledge. The main concern is to get better, as soon as possible. What should be learned from this lesson? What needs to be done to ensure that providers carry out such functions and responsibilities effectively? Skill levels and staff capacities overall were expected to improve. Although health staff have plenty of discretionary opportunities by virtue of the wide functions and activities assigned to them, health centers and associated subcenters and staff still followed service packages, guidelines and handbooks describing standard procedures.

In reality, since the policy of administrative decentralization that began in 2001 open some opportunities to make some changes in the mechanism of health service program, mainly in service delivery. Supervision and assessment procedures were based mainly on seniority and compliance with guidelines not actual performance, as happened before decentralization period. The problem was seen as reducing scope for decision making rather than helping staff to make better decisions. This seemed to make sense given the low salaries and seemingly limited capacity of a work force. The intention was

to ensure continuity in service delivery of predictable quality by specifying objectives, preparing for likely contingencies, and of course, limiting the choices available to government health staff if discretionary occasions arose.

Furthermore, much of time is also used inefficiently, e.g., spending excessive time on some tasks, or on private matters. This reflects not only the weakness of supervision arrangements, but a reluctance to acknowledge that providers have discretionary resources and need to be encouraged to use these effectively.

The compensation and task assignment and guidance measures together had a big influence on the performance of the health workers and the health delivery system itself. Indeed, these management adjustments were crucial features of Indonesia's interpretation of HFA. The impacts of these steps were seen in the indifferent results. It was seen as inability of the government-run health system to attract clients in large numbers on a sustained basis. As mentioned, the public system has never secured a sizable market share especially among the poor.

Based on Liberman & Marzoeke (2000) study, findings from interviews and field observation depict a passive and ineffective labor force, which seems disconnected from outcomes including the costs of their activities and distracted by the lure of private practice. In effect, an initially skeptical view of staff capacity on the part of policy makers became a self-fulfilling prophecy. A prescriptive management approach coupled with perverse incentives led to a system in which low patient loads, high unit costs, and questionable quality standards seemed to be acceptable.

What should be learned dan anticipated?

This can and should change. Staff autonomy and the exercise of judgment ought to be recognized as resources which need to be used effectively. Health personnel at all levels should receive examples and guidance on using discretionary powers, bolstered by the incentives and remuneration practices, supervision, and peer pressures required to sustain appropriate provider behavior. Creative solutions, which usually went unnoticed or may have brought reprimands in the past, should be captured, identified as appropriate behavior, and systematically recycled via training sessions, handbooks, task instructions, and guidelines. Supervision approaches need to change as well, while staff need to be rewarded for effective use of discretionary opportunities.

World Health Organization (WHO) report (2006) gives some critical and important ideas to deal with health workers. These are:

1. Strategies to improve the performance of the health workforce must initially focus on existing staff because of the time lag in training new health workers. Substantial improvements in the availability, competence, responsiveness and productivity of the workforce can be rapidly achieved through an array of low-cost and practical instruments.
2. Supervision makes a big difference. Supportive yet firm – and fair – supervision is one of the most effective instruments available to improve the competence of individual health workers, especially when coupled with clear job descriptions and feedback on performance. Moreover, supervision can build a practical integration of new skills acquired through on-the-job training.

3. Fair and reliable compensation. Decent pay that arrives on time is crucial. The way workers are paid, for example salaried or fee-for-service, has effects on productivity and quality of care that require careful monitoring.
4. Critical support systems. No matter how motivated and skilled health workers are, they cannot do their jobs properly in facilities that lack clean water, adequate lighting, heating, vehicles, drugs, working equipment and other supplies. Decisions to introduce new technologies – for diagnosis, treatment or communication – should be informed in part by an assessment of their implications for the health workforce.

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