WHO CONTROLS THE HANDLING OF COVID-19?
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Some local government policies to overcome the COVID-19 pandemic experienced a tug of war or were even rejected by the central government. The bureaucracy is long and slow to get permission to implement Large Scale Social Restriction, even rejection still occurs in some areas, such as Sorong City, Rote Ndau Regency, and Palangkaraya City. On the other hand, no doubt there are still many local governments that have not made sufficient preparations for the handling of this epidemic.

The division of authority becomes complicated in the situation of handling a pandemic in Indonesia. Should the control mandate be given to the central government so that the regional governments are able to carry out policies that are uniform and in accordance with the government’s agenda? Is there room for local governments to take over the wheel so that policies can be designed according to local contexts? Or in fact all that is needed is a clear division of authority?

COVID-19 IS A NATIONAL DISASTER: CONTROL BUTTON IN BNPB

Determination of the status of national disasters through Presidential Decree No.12 / 2020 places the National Disaster Management Agency (BNPB) in the control room on cue for handling COVID-19 at the national level. This stipulation annulled Presidential Decree No.11 / 2020 concerning Determination of Public Health Emergency Status two weeks earlier. It also formalized that the Minister of Health is no longer a war general.

The policy assigns the BNPB, through the COVID-19 Task Force for the Acceleration of Handling, as a center for coordination and communication between ministries and institutions, coordination of elements of society and as a central point of decision-maker regarding the steps for handling the national outbreak. In addition, the Task Force has the flexibility to assess the situation and mobilize resources.

However, BNPB, as a ministerial level non-departmental government agency, does not fully understand that the context of handling a pandemic is different from the natural disaster situation, which is the DNA of BNPB. So, not surprisingly, we were treated to scenes of fighting over the stage by other ministries and institutions.

With the current dynamics, local governments have limitations to make drastic changes as soon as possible in their own regions. Decision making must climb a bureaucratic process that takes a long time. This is evident from the status of the tradeoff that occurs in the
process of establishing the Large Scale Social Restrictions and Regional Quarantine which must await the approval of the Minister of Health in advance (1). Limited understanding also encourages policies designed at the center to be implemented uniformly in the regions.

COVID-19 IS A PUBLIC HEALTH AFFAIR: DECENTRALIZATION OF AUTHORITY TO THE REGIONS

Law No. 23 of 2014 concerning Regional Government states that all governance matters except foreign policy, defense, security, justice, national monetary and fiscal, religion, become the business of each local government.

In accordance with the mandate of the law, the health sector is one aspect that must become the authority of local governments. However, it was also said later in Article 13 that government affairs which cover cross-provincial or cross-country regions become the authority of the central government. Thus, the central government became the holder of control of the handling of the pandemic.

Through Circular Letter 440/2622 / Sj, the central government establishes the role of regional head as commander of the task force to accelerate the handling of COVID-19 in the regions. In the letter also, it was stated that the local government can determine the status of a COVID-19 disaster emergency, on condition that it gets a recommendation from the Regional Disaster Management Agency (BPBD) and the District Health Office (DHO). However, the central government still urges regional heads in setting policies in their regions to always pay attention to the synergy with the central policies.

There is no doubt that inequality in the implementation of health decentralization in Indonesia still occurs due to differences in capacity and leadership, unequal distribution of resources, and budgetary dependence on the central government. However, the current situation illustrates the centralization of policies in the handling of COVID-19 resulting in local governments not having the discretion in setting policies that need to be implemented immediately in the regions. In fact, the health decentralization policy gives the mandate to the regions to plan budget allocations and resources effectively and efficiently according to the target. This policy also allows the birth of innovation and local policies according to the needs of each region. The central government must be able to provide discretion to regional governments to determine the policies needed during the emergency phase as it is now.

ALTERNATIVE MANDATE DESIGN

The goal of COVID-19 pandemic handling in Indonesia clashed public health interests with the wheels of the economy, uncertainty about the benefits of available treatment options, and very fluid participation of actors. The third point of note also creates confusion regarding who the actors can be actively involved in, the political constellation of the actors involved, and the intentions behind their involvement.
In the context of decision making, this condition is analogous to “trash cans” in which the flow of actors, problems, solutions, and opportunity choices merged into one and ultimately produce outcomes that are difficult to predict (2).

The successful handling of COVID-19 will depend on the policies, resources and actors involved in implementing the micro level. Handling will vary in each region depending on local government perceptions of central government policy, available resources, and the flexibility of modifying regulations according to the local social context.

1. **The Dynamics of Central-Regional Leadership**

The division of authority and control of orders between the central and regional governments is a determining factor in the successful handling of a pandemic. In the situation of national disasters, the dynamics of central-regional and the clarity of the distribution of authority changes. The central government, in this case BNPB, holds the country’s main control for the coordination and integration of regulations, policies, guidelines and resource mobilization. This role should not need to limit the function of local governments in implementing the policies needed to handle pandemics in their regions. In emergency situations, local governments should be able to quickly follow the needs without many requirements and bureaucracy.

Policies cannot be designed uniformly in all regions which have different characteristics. The central government should focus on issuing national guidelines and strategies for regional governments, providing technical assistance as well as carrying out strict oversight of regional policies. The regulation provides flexibility for regional governments as executors and commanders to determine all the efforts needed in their regions.

In the dynamics above, the role and quality of central government leadership is important. In an ideal situation, the chief executive should have a technical understanding of the pandemic, such as the Minister of Health. So in the current situation, the appointed BNPB Chairperson must strengthen coordination and communication with cross ministries and institutions and a team of experts to determine the best policy. BNPB must continue to involve ministries and technical institutions, including the Ministry of Health and the Ministry of Villages, Disadvantaged Regions and Transmigration. This is unfortunately not yet reflected in BNPB Decree No. 2/2020 concerning the Technical Team for the Compilation of the COVID-19 Handling Protocol, which excludes the role and function of the Ministry of Health from the technical frame. The President, as the owner of the highest political power, is also expected to be more assertive in making decisions and setting priorities in order to protect his citizens.

2. **Financing**

In Law No. 24 of 2007 concerning Disaster Management said that disaster management funds are a joint responsibility between the central government and local government. In fact, many local governments find it difficult to handle pandemics
optimally due to budget constraints. Under normal circumstances, in 2017 alone there were only 177 out of 514 districts and cities that had regional health budgets with ideal standards (10%) (3).

The central government through the Ministry of Finance continues to encourage local governments to reallocate and refocus local budgets for the purpose of handling COVID-19. With declining regional own-source revenues (Pendapatan Asli Daerah / PAD) and limited regional fiscal capacity that is still very dependent on central financing, the speed of transfers from central government to regional government is crucial in emergency response situations. For example, if in a normal situation the Special Allocation Fund (DAK) is transferred four times a year, the central government can now transfer twice a year with the same nominal. Other financing allocations that can also be used in times of emergency are the General Allocation Fund (Dana Alokasi Umu / DAU), Special Allocation Fund (Dana Alokasi Khusus / DAK), Revenue Sharing Funds (Dana Bagi Hasil / DBH), Village Funds, Ready-to-Use Funds (Dana Siap Pakai / DSP) and Indirect Cost (Belanja Tidak Terduga / BTT). In addition, the central government must also encourage and assist regions to find other sources of funding creatively, such as mobilization of funds from the private sector or the community.

3. Test and Trace
Tests and trace are important components to break the transmission of infectious diseases. The government must have the ability to trace and find positive cases immediately before causing wider dissemination. So in this case, surveillance which includes monitoring and tracking cases is one of the keys to handling a pandemic. There are still many obstacles in the field that affect the quality of surveillance, including the limited number of Human Resources (HR) for conducting surveillance, the non-specific allocation of human resources, the limited means of supporting information and technology systems for recording and reporting, and the lack of a budget for surveillance. Surveillance is often only carried out by the central government and surveillance data are generally sent directly to the central level without prior analysis at the local level. This situation indicates the need to strengthen surveillance capacity by the central to the regions.

Data transparency to determine the distribution of cases, as well as laboratory access to find cases, is an important element in surveillance. At the beginning of the outbreak handling, the Health Research and Development Agency at the Ministry of Health of the Republic of Indonesia has full authority over data control and access to COVID-19 examination on the grounds as they fear of misuse of data or spreading fear in the community. The policy makes local governments unaware of the distribution data in their area and delays in finding cases. But now, the central government has implemented decentralized data processing and inspection access to the district and city level. Things that should have been done from the start.
4. Treat
To prepare regions for the possibility of an increase in cases, local governments need to immediately increase the capacity of beds and maintenance while ensuring other essential services continue to run. However, with changes to some rules and the issuance of the Omnibus Law, the government showed an intention to encourage a centralized approach to the health sector. For example, amendment to Law 44/2009 on granting permits for establishment and operation of hospitals, where the latest policy regulates the central government as the only party that can issue these permits through the OSS (Online Single Submission; or Electronically Integrated Business Licensing) license to bypass bureaucracy and making licensing easier (4). A similar licensing process is also applied to permits for the establishment and operation of all levels of health service facilities, to laboratories (5) (6). Regional and provincial governments can still provide health services, but all business and operational licenses must go through the central government. With a bureaucratic process and limited resources at the central level to process all regional licenses, this has the potential to hamper efforts needed at the local level to respond quickly to pandemic response needs. In a national disaster situation, again there should be an exception for regions to cut down on the bureaucratic process.

5. Isolate
In addition to test, trace and treat, isolation is an essential part to suppress the spread and break the chain of transmission of the epidemic COVID-19. This policy was submitted by the central government to become the full authority of the regional government. In practice, many regions have implemented independent isolation due to limited treatment capacity or centralized isolation. Independent isolation is carried out up to the community level because patients do isolation at home or village / village facilities facilitated by local authorities. For this reason, local governments play a very important role in conducting education, recording, supervision and enforcement for those who are not compliant in isolation. In this case, the central government can help the regions carry out supervision and technical direction to technological assistance to carry out monitoring.

SPEED AND AGILITY ARE KEY
There is one important question that must be answered together. What factor is more important in determining success: should the efforts to deal with a pandemic focus only on prescriptions designed by the central government or on the results of policy implementation that is carried out collectively involving the central and regional governments?

The iteration or mutation of national policy at the sub-national level can be seen as an experiment in natural implementation - rather than a struggle for territory. This indicates that the top-down perspective is more appropriate at the initial planning stage, but the bottom-up view is more effectively used in the subsequent stages of implementation and evaluation (2).
COVID-19 is a new disease. Naturally, any policies related to COVID-19 handling becomes a gray area where the availability of knowledge is still very limited in translating implementation or orchestrating interconnected policy elements. This ambiguity must be seen as an opportunity to implement new methods and objectives. It is important for policy designers to actively utilize this situation, especially in increasing their knowledge of the change process through the application of formative evaluation1.

Towards the peak of the pandemic, Indonesia must avoid two pitfalls of implementation. First, the process of implementing policies must not be forced into a restricted form. COVID-19 treatment programs that demand conformity will only be met with superficial compliance. Demanding uniformity means seizing important information and limiting the use of street-level bureaucrats knowledge2 as a resource.

Second, learning is key. If there are 514 cities and districts with 514 different outcomes, then information about what policies are effective or ineffective is difficult to collect and compare. Learning will occur in random patterns. Here is the importance of the same indicators or measures of success that can be used by various regions. Evaluation and feedback are vital components that will be the arena of Indonesia’s future battle.

Handling a pandemic requires speed in action, even with the risk of ‘falling’ if you take the wrong step. For this reason, it is important for the government to continue evaluating and learning so that it can be agile in adapting to changing needs during the pandemic. The speed and agility of the response was the key for a country as diverse and wide as Indonesia succeeded in ending the pandemic.

### See examples of handling pandemics in other countries

#### Centralized control of China
China received much praise for its response to the rapid pandemic response, such as the construction of two hospitals within two weeks, the lockdown policy and the rapid mobilization of resources to the affected areas. Within two months, China had reopened Wuhan City, which was originally the epicenter of the plague. However, China has also received criticism regarding centralized handling. This handling raises other problems such as the lack of transparency to the regional level and the slow pace of decisive efforts and the decision-making process from the regions to the center, especially the decision to restrain infection outside China given that control is controlled by the Central Government (7).

An example of a country that has centralized control but with a more ‘democratic’ approach is South Korea. The South Korean government approached prevention and detection through massive tests since the early discovery of the first case. Learning from the handling of SARS and MERS, the South Korean government has also implemented changes to public privacy data regulations for the purpose of tracking and tracing cases (9).

In an emergency situation, the Singaporean government has the authority to issue temporary emergency rules to be able to enforce all efforts needed for handling a pandemic (8).

#### Decentralized control
The country that has successfully implemented a decentralized system in handling COVID-19 outbreaks, especially in the case of health services, is Germany. Germany does not have a centralized diagnostic system, as previously implemented by the government through the Ministry of Health’s Research and Development Agency. The German government opens market access for laboratories. Private clinics that are capable and meet the standards can also conduct an examination. Affordable test access for German citizens is one of the strong reasons how the country can have a low case fatality rate despite having the fourth highest positive case in Europe (10).

Meanwhile, the United States government which has a decentralized system has difficulty coordinating integrated response and surveillance given that each state has its own surveillance and health system (11).

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1 Progress monitoring activities throughout the process / effort to provide feedback for improving learning
2 Bureaucratic apparatus that is in direct contact with the public or performs public services (Michael Lipsky, 2010)
References


5. Permenkes No 411 Tahun 2010 tentang Laboratorium Klinik.


