Australian National University

Clientelism and Public Health:

Explaining Variation in Healthcare Services in Three Indonesian Cities

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Declaration

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Abstract

What explains Indonesia's persistent regional disparities in healthcare delivery? This study argues that the answer lies not only in resources or capacity, but in politics, specifically, in how clientelism shapes the way health services are governed. Patronage, clientelism, rent-seeking, and informal political practices influence who gets appointed within the healthcare system, which programs are prioritised, and how budgets are allocated and used. Yet these dynamics have been largely overlooked in studies of Indonesia's health sector. By comparing three cities—Kupang, Makassar, and Semarang—this research shows that the political logic behind clientelism helps explain Indonesia's persistent regional inequalities in healthcare delivery.

A mixed-methods design underpins the analysis. Quantitative data from the Clientelism Perception Index (Berenschot, 2018b) helps identify cases with contrasting patterns of health-sector performance, while interviews, policy analysis, and process tracing reveal how clientelistic exchanges operate on the ground. Three questions guide my study: (1) How does variation in clientelism influence the delivery of healthcare services? (2) What contextual factors modify this relationship? And (3) Through what mechanisms does clientelism affect healthcare quality?

Five findings stand out. *First,* the intensity of clientelism shapes health sector performance. Cities with entrenched political clientelism, such as Kupang, tend to exhibit poor health outcomes, while cities with lower levels of clientelism, such as Semarang, perform better. Differences in fiscal capacity alone do not explain these disparities; instead, political incentives are more decisive. Makassar, however, presents an anomaly: despite high levels of clientelism, it achieves relatively strong healthcare outcomes, suggesting that intensity alone cannot account for variation.

Second, the form of clientelism matters. In Makassar, local leaders strategically insulate certain sectors—particularly healthcare—from excessive political interference while concentrating clientelistic practices in rent-rich areas such as infrastructure, land, and business licensing. This hybrid model of governance demonstrates how elites can

combine programmatic and clientelist approaches to maintain performance legitimacy while sustaining political networks.

Third, clientelism is not uniformly applied but sectorally differentiated. Local politicians often preserve service quality in highly visible sectors like health and education to demonstrate competence and maintain coalition stability while concentrating clientelist activities in less scrutinised, profitable domains. Effective healthcare thus functions as both a governance achievement and a political strategy for regime survival.

Fourth, four contextual factors shape the extent to which clientelism distorts healthcare governance: the size of the middle class, the strength of civil society, the degree of market competition, and the availability of alternative patronage sectors. Where civic oversight, healthcare market competition, and alternative rent channels are strong—as in Semarang and parts of Makassar—health systems are more insulated. Where these factors are weak, as in Kupang, clientelism permeates all levels of governance.

Fifth, clientelism distorts healthcare through two primary mechanisms: patronage and rent-seeking/corruption. Patronage operates when politicians make politically motivated appointments of health officials and target programs toward political allies or supporters, while rent-seeking involves the extraction of resources through procurement and budgeting. These mechanisms are pervasive in Kupang, concentrated in big-ticket projects in Makassar, and largely contained in Semarang.

This study offers three major contributions. It provides a framework for understanding how clientelism affects healthcare; it shows that governance often combines programmatic and clientelistic practices rather than fitting into either category; it explains why similar political systems can produce different outcomes. The policy implication is that improving healthcare in decentralised democracies requires more than technical fixes. Reform efforts must confront the political incentives that allow clientelism to thrive—by strengthening civic oversight, insulating key sectors from patronage and rent-seeking, and reducing politicians' dependence on public resources for electoral mobilisation.

In sum, Indonesia's uneven healthcare performance reflects the political logic that governs it. Recognising how clientelism works and how it can be constrained is essential for building more accountable health systems in Indonesia and beyond.

List of Abbreviations

AAS	Australia Awards Scholarship
ACC	Anti-Corruption Committee
Alkes	*Alat Kesehatan* (Medical Equipment)
AMDAL	*Analisa Mengenai Dampak Lingkungan* (Environmental Impact Assessment)
AMPI	*Angkatan Muda Pembaharuan Indonesia* is an Indonesian youth organisation affiliated with Golkar Party
ANC	Antenatal Care
APBD	*Anggaran Pendapatan dan Belanja Daerah* (Regional/Local Revenue and Expenditure Budget)—official annual budget at city or district or provincial level
APBN	*Anggaran Pendapatan dan Belanja Negara* (State Revenue and Expenditure Budget)—official state annual budget at the central government level
APSA	American Political Science Association
ASN	*Aparatur Sipil Negara* (Indonesia's Civil Service/ Civil Servants)
AUD	Australian Dollar
Babinsa	*Bintara Pembina Desa* (Village Supervisory Non-Commissioned Officer), a member of the Indonesian Army assigned to Village and Urban Village
Bapak	Literally means "Father" or in English can be translated as "Mister"—a formal and polite way to address a man who is older and/or in position of authority.
Bappenas	*Badan Perencanaan dan Pembangunan Nasional* (National Development and Planning Agency)
BAZNAS	*Badan Amil Zakat Nasional* (National Zakat Agency)
BCA	Bank Central Asia
BGD	*Burgerlijk Geneeskundige Dienst* (Civil Health Service in Dutch)
BKD	*Badan Kepegawaian Daerah* (District or Provincial Civil Service Agency)

BKN	*Badan Kepegawaian Negara* (National Civil Service Agency)
BKKBN	*Badan Koordinasi Keluarga Berencana Nasional* (National Family Planning Coordinating Board)
BKPPD	*Badan Kepegawaian, Pendidikan, dan Pelatihan Daerah* (Regional Civil Service Agency)
BLUD	*Badan Layanan Umum Daerah* (Regional Public Services Bureau), a subnational public service entity established by local/regional governments in Indonesia to deliver public goods and services using a more flexible financial management system than standard bureaucratic units
BOK	*Bantuan Operasional Kesehatan* (Health Operations Support Funds)
BPJS	*Badan Penyelenggara Jaminan Sosial* (Social Security Administrative Body)—an implementing agency responsible to manage national health insurance scheme (JKN)
BPS	*Badan Pusat Statistik* (Central Bureau of Statistics)
BSB	Bumi Semarang Baru
BSM	*Bantuan Siswa Miskin* (Poor Student Assistance), a national government program to provide educational subsidies for students from poor families
Caleg	*Calon legislatif* (Legislative Candidate)
COVID-19	Corona Virus Disease 2019
CPI	Clientelism Perception Index
CPI	Centre Point of Indonesia
CSO	Civil Service Organisation
CSR	Corporate Social Responsibility
DAK	*Dana Alokasi Khusus* (Special Allocation Grants)
DAU	*Dana Alokasi Umum* (General Allocation Fund)
DBH	*Dana Bagi Hasil* (Revenue Sharing Fund)
Dinkes	*Dinas Kesehatan* (Health Office)—a government department established in cities, districts, and provinces, responsible for healthcare services

DJSN	*Dewan Jaminan Sosial Nasional* (National Social Security Board)
DPD	*Dewan Perwakilan Daerah* (Regional Representative Council), similar to senators
DPR	*Dewan Perwakilan Rakyat* (People's Representative Council), national legislative body
DPRD	*Dewan Perwakilan Rakyat Daerah* (Regional People's Representative Council), legislative body (council) at the provincial and district/city level
Dr	Doctor (medical)
D.M.D	Doctor of Medicine in Dentistry (a professional degree in dentistry)
DTKS	*Data Terpadu Kesejahteraan Sosial* (Unified Database of Social Welfare)
Eiseikyoku	A Japanese term for Health Department
e-Katalog	e-Catalogue (electronic catalogue), an online procurement platform that lists goods and services that government agencies can purchase directly from verified suppliers at pre-approved prices, without undergoing a tender process
FKK	*Forum Kesehatan Kelurahan* (Urban Village Health Forum)
FKS	*Forum Kota Sehat* (Healthy City Forum)
Forwakot	*Forum Wartawan Balai Kota* (Forum for Journalists of the City Hall)
Gasurkes	*Tenaga Surveillans Kesehatan* (Health Surveillance Officer)
GDP	Gross Domestic Product
Germas	*Gerakan Masyarakat Hidup Sehat* (Community Movement for Healthy Living)
GMT	*Gowa-Maros-Takalar*
Golkar	*Golongan Karya* (a political party)
GP	General Practitioner
GRDP	Gross Regional Domestic Product
HB-0	Hepatitis B vaccine given to newborns, ideally within 24 hours of birth

HDI	Human Development Index
HMI	*Himpunan Mahasiswa Indonesia* (Indonesian Students Association)
HIPMI	*Himpunan Pengusaha Muda Indonesia* (Indonesian Young Entrepreneurs Association)
ICU	Intensive Care Unit
ICW	Indonesia Corruption Watch
IDI	*Ikatan Dokter Indonesia* (Indonesian Doctor Association)
IDR	Indonesian Rupiah
IMR	Infant Mortality Rate
INA-CBG	Indonesia Case-Based Groups, a hospital payment system under Indonesia's healthcare insurance scheme (JKN)
INDO-DAPOER	Indonesia Database for Policy and Economic Research, database managed by the World Bank
IPKM	*Indeks Pembangunan Kesehatan Masyarakat* (Public Health Development Index)
ISDV	*Indische Sociaal-Democratische Vereeniging* (a socialist organisation established in Dutch East Indies in the 20th century)
ISPA	*Infeksi Saluran Pernafasan Atas* (Upper Respiratory Infection)
Jamkesda	*Jaminan Kesehatan Daerah* (Regional Health Insurance)
Jamkesmas	*Jaminan Kesehatan Masyarakat* (Community Health Insurance)
JKN	*Jaminan Kesehatan Nasional,* lit. National Health Insurance
Jumantik	*Juru Pemantau Jentik* (Mosquito Larvae Inspectors)
K1	First semester antenatal care visit made by pregnant women to healthcare facility
K4	Fourth antenatal care visit, refers to a pregnant woman completing at least four antenatal care visits during her pregnancy
KADIN	*Kamar Dagang dan Industri* (Indonesian Chamber of Commerce)
KAHMI	*Keluarga Alumni Himpunan Mahasiswa Indonesia* (Family of the Alumnae of the Indonesian Students Association)
KASN	*Komisi Aparatur Sipil Negara* (Civil Service Commission)

KB	*Keluarga Berencana* (Family Planning)
Kemenpan&RB	*Kementerian Pendayagunaan Aparatur Negara dan Reformasi Birokrasi* (Ministry of Civil Service and Bureaucratic Reform)
KIM Plus	Koalisi Indonesia Maju Plus
KKI	*Konsil Kedokteran Indonesia* (Indonesian Medical Council)
KPBU	*Kerjasama Pemerintah dengan Badan Usaha* (Government and Business Cooperation)
KPK	*Komisi Pemberantasan Korupsi* (Corruption Eradication Commission)
KPPU	*Komisi Pengawas Persaingan Usaha* (Business Competition Supervisory Commission)
KPU	*Komisi Pemilihan Umum* (General Elections Commission)
KPUD	*Komisi Pemilihan Umum Daerah* (General Elections Commission at subnational level)
KRMT	*Kanjeng Raden Mas Tumenggung*, a Javanese nobleman title
LBH	*Lembaga Bantuan Hukum* (Legal Aid)
LKPP	*Lembaga Kebijakan Pengadaan Barang/Jasa Pemerintah* (National Public Procurement Agency)
LPSE	*Layanan Pengadaan Secara Electronic* (Electronic Procurement Services)
LSM	*Lembaga Swadaya Masyarakat* (refers to Civil Society Organisation and Non-Government Organisation)
Mantri cacar	Dutch colonial term used in Netherlands East Indies to refer to native male paramedics responsible for delivering vaccinations
Mantri-verplegers	Dutch colonial term used in Netherlands East Indies to refer to native male nurses, paramedics or caretakers
Mas	Lit. older brother in Javanese, a casual way to address a man in respectful way
Mbak	Lit. older sister in Javanese, a casual way to address a woman in respectful way
MCH	Maternal and Child Health
MGD	*Militair Geneeskundige Dienst* (Military Health Service)

MMR	Maternal Mortality Rate
MUI	*Majelis Ulama Indonesia,* lit. Indonesia Ulema Council
MSS	Minimum Service Standard
NAMRU-2	Naval Medical Research Unit Two, a United States Navy biomedical research laboratory
Nasdem	*Nasional Demokrat* (National Democrat Party)
NIAS	*Nederlandsch-Indische Artsen School* (Netherlands Indies School for Physicians)
NGO	Non-Government Organisation
NTT	Nusa Tenggara Timur
NU	Nahdlatul Ulama (an Islamic-based mass-based organisation)
ORI	Ombudsman of the Republic of Indonesia
P5L	*Paguyuban Pemberdayaan Pompanisasi dan Pengelolaan Lingkungan Panggung Lor* (Panggung Lor Association for Empowerment through Pump Irrigation and Environmental Management), a community-based organisation in Panggung Lor, Semarang Utara
PAD	*Pendapatan Asli Daerah* (Local Own-source Revenue)
PAN	*Partai Amanat Nasional* (National Mandate Party)
Pattiro	*Pusat Telaah dan Informasi Regional* (Center for Regional Information and Studies)
PBI	*Penerima Bantuan Iuran* (Contribution Assistance Recipients), recipients of National Health Insurance Contribution Subsidy
PBU	*Peserta Bukan Penerima Upah* (Self-paid Participants)
PCR	Polymerase Chain Reaction
PDAM	*Perusahaan Daerah Air Minum* (Regional Clean Water Supply Company)
PDI	Partai Demokrasi Indonesia (Indonesian Democratic Party), predecessor of PDI-P
PDI-P	*Partai Demokrasi Indonesia Perjuangan* (Indonesian Democratic Party of Struggle)

PDIB	*Perkumpulan Dokter Indonesia Bersatu* (United Indonesian Doctors Association), an alternative organisation for medical doctors to reduce IDI's dominant position, established in 2022
PDSI	*Perkumpulan Dokter Seluruh Indonesia* (All-Indonesian Doctors Association), a new doctors' association in Indonesia, established in 2022 to reduce IDI's dominant position
Permenkes	*Peraturan Menteri Kesehatan* (Health Minister Regulation)
Perda	*Peraturan Daerah* (Local/Regional Regulation)
Perwali	*Peraturan Walikota* (Mayor Regulation)
PETA	*Pembela Tanah Air* (Defenders of the Homeland), a military force established by the Japanese occupation government during World War II (1943).
Pilkada	*Pemilihan Kepala Daerah* (Head of Region Election)
PKI	*Partai Komunis Indonesia* (Indonesian Communist Party)
PKK	*Pembinaan Kesejahteraan Keluarga* (Family Welfare Development)
PKS	*Partai Keadilan Sejahtera* (Prosperous Justice Party)
PMII	*Pergerakan Mahasiswa Islam Indonesia* (Indonesian Islamic Student Movement)
PMKRI	*Perhimpunan Mahasiswa Katolik Republik Indonesia* (Union of Catholic University Students of the Republic of Indonesia)
PPE	Personal Protective Equipment
PPNI	*Persatuan Perawat Nasional Indonesia* (Indonesian National Association of Nurses)
PPP	Public-Private Partnership
Pokir	*Pokok-pokok Pikiran* (key considerations from DPRD's proposals)
Poskeskel	*Pos Kesehatan Keluarga* (Family Health Post)
Posyandu	*Pos Pelayanan Terpadu* (Integrated Service Post)
Posyandu Lansia	*Pos Pelayanan Terpadu Lanjut Usia* (Integrated Service Post for Elderly)
Posrem	*Pos Pelayanan Terpadu Remaja* (Integrated Service Post for Teenagers)

PPDS	*Program Pendidikan Dokter Spesialis* (Specialist Doctor/Medical Education Program)
PPPK	*Pegawai Pemerintah dengan Perjanjian Khusus* (Government Employees with Work Arrangements) or Non-Permanent Staff
PRI	Partido Revolucionario Institucional (Institutional Revolutionary Party), a party machine in Mexico
PTT	*Pegawai Tidak Tetap* (Non-Permanent Employee)
Puskesmas	*Pusat Kesehatan Masyarakat* (community health centre)
Pustu	*Puskesmas Pembantu* (satellite community health centre)
QR	Quick Response (a two-dimensional barcode) to be signed for quick access to digital information
RS	*Rumah Sakit* (hospital)
RSIA	*Rumah Sakit Ibu dan Anak* (Maternal and Children Hospital)
RSJ	*Rumah Sakit Jiwa* (mental health hospital)
RSU	*Rumah Sakit Umum* (general hospital)
RSUD	*Rumah Sakit Umum Daerah* (Local Public Hospital) at province or district and city level
RSUP	*Rumah Sakit Umum Pusat* (Central Public Hospital)
RSU PKU	*Rumah Sakit Umum Pembina Kesejahteraan Umat* (General Hospital of the Council for the Welfare of the People)
Muhammadiyah	Muhammadiyah
RSWN	Rumah Sakit Wongsonegoro, often to refer RSUD KRMT Wongsonegoro, a public hospital name in Semarang
RT	*Rukun Tetangga* refers to Household Association, consisting of several households in a neighbourhood
RW	*Rukun Warga* refers to Neighbourhood Association, consisting of several RTs in one RW
Satgas	*Satuan Tugas* (Taskforce)
SDOH	Social Determinants of Health
Sekda	*Sekretaris Daerah* (Secretary of the Region)
Semut	*Semarang Utara*
SI	*Sarekat Islam*

SIP	*Surat Ijin Praktek* (lit. for practice permit letter) refers to medical practice permit/license
SME	Small and Medium-size Enterprises
SPM	*Standar Pelayanan Minimal* (Minimum Service Standard)
SSBI	Self Service Business Intelligence
STOVIA	*School tot Opleiding van Inlandsche Artsen* (School for the Training of Native Doctors in Dutch language)
TB	*Tuberculosis*
TEPRA	*Tindak Lanjut Evaluasi Pelaksanaan Rencana Anggaran* (Follow-up on the Evaluation of Budget Execution)
TKDN	*Tingkat Komponen Dalam Negeri* (Domestic Component Level)—a government-regulated measure of the percentage of local content in a product or service used in government procurement projects
UCI	Universal Child Immunisation
UHC	Universal Health Coverage
Undana	*Universitas Nusa Cendana* (University of Nusa Cendana), a public university in Kupang
UNDIP	*Universitas Diponegoro* (University of Diponegoro), a public university in Semarang
UNHAS	*Universitas Hasanuddin* (University of Hasanuddin), a public university in Makassar
UNICEF	United Nations Children's Fund
UPTD	*Unit Pelaksana Teknis Daerah* (Regional Technical Implementing Unit)
U.S.	United States
VIA	*Vereeniging van Indische Artsen* (Association of Indies Doctors)
VOC	*Vereenigde Oostindische Compagnie* (Dutch East India Company)
Welvaartsdiensten	Lit. Ethical Policy (in Dutch)
WHO	World Health Organization
Zelfbesturen	A Dutch term of self-government or self-rule

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Chapter 1 Introduction

Research Background and Problem

Twenty-four years ago, as a junior accountant at a local medical equipment distributor's office in Jakarta, I stepped into a world where business was not just about selling products: it was also about leveraging political connections to secure sales. My boss, a formidable doctor with deep connections in the government, did not win contracts through competitive bidding; she secured them through dealings with high-level officials who expected something in return. That return came at a cost. Every month, she hosted provincial health officials in Jakarta, ensuring their visits were nothing short of luxurious. Flights, hotels, and extravagant dining were all covered—despite their already receiving government travel allowances. But the real spectacle happened behind closed doors. At the end of their stay, they left not just with handshakes and promises; they walked away with cheques ranging from IDR 50 million to 100 million (approximately equivalent to AUD 5,000 to 10,000). The largest sums were always reserved for officials from Indonesia's most remote regions—Nusa Tenggara Timur, Papua, and Maluku. Part of my job involved maintaining a ledger in which my boss disguised these payouts as "entertainment costs," or "facilitation costs," to keep them off the tax office's radar. I knew it was wrong, yet this was an expected part of my job, in a system where illicit payments were not just an open secret but were part of the normal cost of doing business. In my case, that business was the provision of medical equipment to public hospitals. These were critical supplies that directly impacted healthcare in these underserved regions. After three months, I walked away. But some questions lingered: What nurtured such corrupt practices? How did they take root? And what impact did they have on healthcare services across different regions?

Two decades later, my journey has come full circle. What began as a firsthand encounter with corruption in Indonesia's health sector has evolved into a deeper investigation into the hidden forces driving healthcare disparities across the country. While structural, socio-economic, and technical factors undoubtedly play a role, a more fundamental question emerges from my experience above: Are corruption and related

inadequacies in healthcare services rooted in the informal dynamics that suffuse Indonesian politics and state administration?

I embarked on fieldwork in 2022 (after a delay caused by the COVID-19 pandemic) to investigate healthcare disparities in my case study locations—three Indonesian cities selected through a correlation analysis of clientelistic politics and health sector performance (Chapter 2 discusses my case selection method in detail). As part of my research, I visited two city-run public hospitals (*Rumah Sakit Umum Daerah*, RSUD) where I observed a stark contrast in healthcare quality: RSUD SK Lerik in Kupang and RSUD KRMT Wongsonegoro in Semarang. To further capture patient experiences, I also analysed visitor reviews on Google Maps, which revealed similarly striking disparities in the perceived quality of care at the two hospitals.

Figure 1.1

Front View of SK Lerik in Kupang City

Source: Photo taken by the author, July 2022.

From the outside, RSUD SK Lerik in Kupang looks impressive. It is grand, modern structure with gleaming green tiles dominating its façade. The first hint that something

may be wrong is that a brand-new oxygen generator, located near the front side of the hospital, imported from the UK, stands idle. Step inside, and a starkly different reality unfolds. The corridors are eerily quiet, with barely any patients or visitors in sight. Several doctor's rooms in the polyclinic sit empty, their doors closed, as if abandoned. On the upper floor, a gaping hole in the ceiling—left unrepaired since tropical cyclone Seroja struck in May 2021—serves as a silent testament to neglect.

Although I was not able to directly interview patients and visitors in the hospital, I analysed feedback from Google Maps reviews. As of 16 May 2025, the hospital received an average rating of 3.7 out of 5 stars from 76 reviewers. One visitor, Djami (2025), shared her experience:

> The service here is absolutely appalling. I have visited this hospital twice—once with my mother and once with my niece—and on both occasions, they were outright dismissed without so much as an examination. Instead, they were simply told to go home and manage their conditions themselves. No care, no concern, just an immediate rejection. What, then, is the point of this building?

A particularly troubling account came from Tanaem (2024) who wrote: "Bad services, there was a patient who had just passed away, [but] the doctors and nurses [who] sat nearby were simply sitting, gossiping, and laughing."

Many reviews echo similar concerns, citing inconsistent treatment quality, poor service, and a lack of professionalism among healthcare workers. Patients and their families report confusing registration procedures, unclean rooms, slow service, and dismissive communication, raising serious doubts about the hospital's commitment to patient care. The dissatisfaction is so widespread that many compare RSUD SK Lerik unfavourably to other hospitals, highlighting a stark gap in service quality. As a result, despite recent renovations, the hospital remains noticeably underutilised.

In sharp contrast, RSUD KRMT Wongsonegoro in Semarang boasts an impressive rating of 4.9 out of 5 stars, based on a total of 7,096 reviews, reflecting the hospital's exceptional reputation. Typical is a review by a visitor, Bernadetta (2025), who praised the hospital:

The ICU 2 Team provided exceptional care—fast, efficient, and highly responsive—when treating my younger cousin, who was admitted to RSWN in a critical condition due to uncontrolled diabetes. Thanks to their expertise, his condition is now improving. Their communication with our family was outstanding; they explained his condition clearly, with patience, empathy, and professionalism. We are deeply grateful for their dedication. Thank you, ICU 2 Team, —please continue delivering this excellent service and stay committed to saving lives. With heartfelt appreciation, greetings from humanity!

Figure 1.2

Front View of RSUD KRMT Wongsonegoro in Semarang

Source: Photo taken by the author, July 2022.

Other reviews and high ratings on Google Maps commend the hospital's service, describing it as "the best hospital with excellent service," "comfortable," "beautiful and impeccably clean," and "efficient." Visitors frequently recommend it, praising the staff as friendly and professional. My visit to the hospital in July 2022 corroborated these reviews. The building was impressively grand and well-maintained, bustling with

numerous visitors. Clear signage guided guests effectively, and the information desk staff provided professional and helpful assistance.

Statistical data from the Ministry of Health and the Central Bureau of Statistics (*Badan Pusat Statistik,* BPS) further illustrate disparities in the distribution of healthcare personnel across Indonesia. In 2017, Java (Semarang is the capital of Central Java) and Bali had 0.39 general practitioners (GPs) per 1,000 residents, while the region where Kupang is located, Eastern Indonesia (Maluku, East Nusa Tenggara, and Papua) had only 0.03 GPs per 1,000 residents. Specialist doctors were even scarcer, with 0.20 specialists per 1,000 residents in Java and Bali compared to 0.01 in Eastern Indonesia (Mahendradhata et al., 2017, p. 122). The shortage of healthcare workers extends to community health centres (*puskesmas*). According to Gani and Budiharsana (2019, p. 23), on average 7.7% of *puskesmas* in Indonesia do not have GPs, 37.5% lack dentists, 30–32% lack pharmacists and environmental health officers, and 60% do not have medical laboratory technicians. But in the provinces of Eastern Indonesia the situation is worse: for example, 40% of *puskesmas* there do not have doctors and dentists (Gani & Budiharsana, 2019, p. 23).

Research Questions

Against this background, I have come to recognise the deep-rooted and persistent nature of healthcare disparities in Indonesia. These gaps, I argue, cannot be fully explained by structural weaknesses, technical limitations, economic disparities, or funding shortfalls alone. Instead, they are often symptoms of deeper political dynamics, especially the informal forces that shape how policies are made and how resources are distributed. Social and political factors play a crucial role in either enabling or obstructing the fair distribution of public resources.

In particular, my research focuses on the informal dimensions of politics, especially by using the lens of clientelism. By "informal politics," I refer to everyday political actions, strategies, and negotiations that occur outside formal legal structures (Schmidt, 2020, p. 436). Kerkvliet (2005, p. 3; 2009, p. 232) describes this as "everyday politics"—distinct from official, advocacy, or conventional forms of politics—and as being characterised by low-profile, unorganised actions carried out by individuals who

may not even view their behaviour as political. Yet, as Berenschot (2015a, p. Title Section) aptly states, "informal politics is real politics."

Building on this understanding, my research investigates how clientelism operates across different urban contexts, and how its various forms shape the delivery of healthcare services. I distil the focus of my study into three key research questions:

1. How does variation in the nature of clientelistic politics at the subnational level affect the delivery of healthcare services to citizens?
2. What contextual factors modify the relationship between clientelism and healthcare service delivery?
3. What are the chief mechanisms through which clientelistic politics affect healthcare quality?

To address these research questions, I draw on interdisciplinary literature at the intersection of public health and political science.

From the public health perspective, a robust body of work has highlighted the social determinants of health (SDOH)[1] and the global persistence of healthcare disparities[2] (Braveman, 2023; Cunningham, Polomano, Wood, & Aysola, 2022; Diaz, Thakur, & Celedón, 2023; Lavizzo-Mourey, Besser, & Williams, 2021; Solar & Irwin, 2010; Thakur, Lovinsky-Desir, Bime, Wisnivesky, & Celedón, 2020). Studies focusing on Indonesia have added important insights into structural challenges and access gaps in the health sector (Anderson, Meliala, Marzoeki, & Pambudi, 2014; Meliala & Rarasati, 2022; Paramita, Yamazaki, Setiawati, & Koyama, 2018). However, despite these

[1] Social determinants of health (SDOH) are: "the factors apart from health care that influence health and are shaped by social policies and forces; 'social' includes economic" (Braveman, 2023, p.1). A WHO commission (2008) defined the SDOH as the "circumstances in which we are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces such as economics, social policies and politics" (WHO CSDH, 2008, p. 1).

[2] According to Ndugga, Pillai, and Artiga (2024, p. Disparities in Health and Health Care: 5 Key Questions and Answers), "Health disparities include differences in health outcomes, such as life expectancy, mortality, health status, and prevalence of health conditions. Health care disparities include differences between groups in measures such as health insurance coverage, affordability, access to and use of care, and quality of care."

advances, there remains a limited understanding of how political dynamics shape these disparities (McCartney et al., 2019, p. e1).

To bridge this gap, some scholars have examined how various political factors—such as welfare regimes, political parties and traditions, power dynamics, political representation and social capital—affect health outcomes (Borrell, Espelt, Rodríguez-Sanz, & Navarro, 2007, p. 419; Coburn, 2000, p. 135; 2004, p. 41; Esping-Andersen, 1990, pp. 92–94; Kokkinen & Muntaner, 2016; Muntaner et al., 2011; Navarro et al., 2006; Navarro & Shi, 2001, p. 481; Quamruzzaman & Lange, 2016, p. 48; Wilkinson, 1996). The role of political will has also been acknowledged as central to shaping health outcomes (Chung & Muntaner, 2006, p. 829). Yet even these studies often stop short of fully unpacking the underlying political roots of health inequalities (Marmot, 2005, p. 1099). More recent contributions by Armingeon and Schädel (2015); Reeves and Mackenbach (2019) advance this work by showing how unequal political participation and representation drive social and health inequities. Dawes (2020, p. 77) further argues that political conditions themselves should be understood as fundamental determinants of health.

Meanwhile, the political science literature has primarily examined health policy through the lens of formal institutions and processes. In the Indonesian context, studies have linked the quality of health service delivery to leadership effectiveness (Rosser & Wilson, 2012, p. 608; Rosser, Wilson, & Sulistiyanto, 2011, p. 3), as well as electoral dynamics and policy innovation (Fossati, 2016c, p. 324; 2017, p. 178). Others have explored how democratisation, institutional quality, and coordination influence health outcomes (Aspinall, 2013b, 2014a; Brinkerhoff & Bossert, 2014; Fossati, 2016a, p. 291; 2018a, 2018b; M. Grindle, 2009; Kristiansen & Santoso, 2006; McCollum, Limato, Otiso, Theobald, & Taegtmeyer, 2018; Warburton & Aspinall, 2013).

However, a key limitation in both fields is the relative neglect of informal political practices—such as clientelism—that persist at the grassroots and often determine how health policies are implemented in practice. By focusing on these informal mechanisms, my research contributes to a more grounded and context-sensitive understanding of

how political dynamics influence health system and service delivery, especially in decentralised settings like Indonesia.

Clientelism—also referred to as clientelistic politics—is a form of everyday political practice that centres on the exchange of material benefits such as money, jobs, and services in return for political support and votes (Hicken, 2011, pp. 295–296; Kitschelt & Wilkinson, 2007b, p. 5; Piattoni, 2001; Stokes, 2009, p. 605). Closely related is the concept of patronage, which refers specifically to the "material resources" distributed through these exchanges (Hutchcroft, 2014, p. 54). While some scholars use the two terms interchangeably (Kitschelt & Wilkinson, 2007b; Piattoni, 2001, p. 6), others make a clearer distinction (Aspinall & Sukmajati, 2016, pp. 3–4; Hutchcroft, 2014, p. 56). This study adopts the latter view, understanding clientelism as a political strategy, and patronage as the tangible benefits—or "divisible benefits" (Shefter, 1977, p. 403)—that facilitate such strategies.

Globally, clientelism has been extensively studied in relation to electoral politics, governance, public service delivery, and social policy (e.g., Bardhan, 2022; Berenschot, 2015b, 2018b, 2019a, 2019b, 2020; Blunt, Turner, and Lindroth, 2012; Brun and Diamond, 2014; M. Grindle, 2016; Hicken, 2011; Hutchcroft, 2014; M. Lewis, 2006; Schaaf and Freedman, 2015; Stokes, 2005, 2011; Stokes, Dunning, Nazareno, and Brusco, 2013). This diverse literature includes rich case studies that analyse informal political arrangements in places like Mexico City (Schmidt, 2020, p. 437), "alternative politics" in Israel's health policies (Cohen, 2012, p. 285), and informal negotiations in health policy reforms (Waring et al., 2018, p. 1). Yet, despite this growing body of literature, relatively few studies have specifically linked clientelism to healthcare service delivery—especially in Indonesia.

Among the limited Indonesia-focused research, Berenschot and van Klinken (2018, p. 95) examine how social networks help citizens to navigate state institutions, while Berenschot, Hanani, and Sambodho (2018, p. 129) investigate the role of informal intermediaries in facilitating healthcare access. Such works, while insightful, are not plentiful. Meanwhile, a growing number of studies have made important strides in measuring and comparing clientelism across diverse settings. In Indonesia, key

contributions include Aspinall and Berenschot (2019); Berenschot (2018b, 2019a, 2020); Berenschot et al. (2018); Berenschot and Mulder (2019), all of which examine the broader impacts of clientelism on governance and public service outcomes. Comparative research has explored clientelism in Argentina and Chile (Calvo & Murillo, 2014), Kenya (Opalo, 2022), and Southeast Asia (Aspinall, Weiss, Hicken, & Hutchcroft, 2022), and in cross-national research (Kopecký et al., 2016). Scholars have also examined micro-level dynamics, such as how brokers mediate access to public services in India and Indonesia (Berenschot et al., 2018, p. 208), and how informal service delivery networks operate in Indian states (Berenschot, 2010, p. 457; Berenschot & Bagchi, 2020). Some scholars call for further macro-level analysis to better understand the systemic nature of informal politics (Brinkerhoff & Goldsmith, 2004, pp. 179–181).

Despite these significant contributions, there is relatively little research that systematically links clientelism to healthcare service delivery, particularly in comparative subnational contexts. Notable exceptions include Berenschot and van Klinken (2018, p. 129) and Blunt et al. (2012, p. 214) who explore the informal intermediaries and patronage dynamics affecting Indonesia's health services. Yet systematic analysis of this relationship remains limited. This research aims to fill that gap by analysing how variations in clientelism across Indonesia's urban settings shape the quality and equity of healthcare services, and by unpacking the political mechanisms that underpin the patterns I observe.

Research Objectives and Research Design

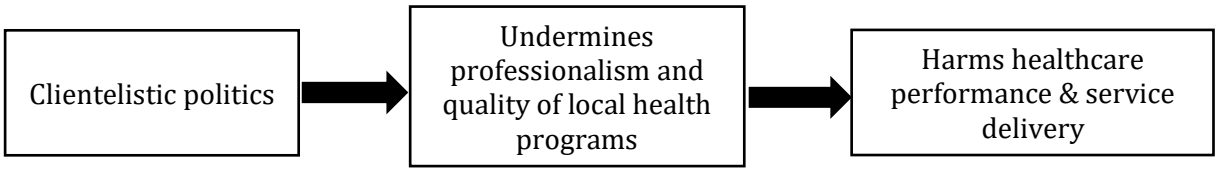
My thesis seeks to deepen the understanding of clientelism and of the politics of healthcare by introducing a comparative framework that examines how varying patterns of clientelistic politics at the subnational level in Indonesia influence the quality of healthcare services. At the heart of this inquiry is the core and *first research question*, already introduced above: *How does variation in the nature of clientelistic politics at the subnational level affect the delivery of healthcare services to citizens?*

This question stems from the assumption that informal political arrangements—such as clientelism—can undermine the performance of local health systems, resulting in lower service quality and poorer health outcomes. Building on this premise, the study

puts forward its first, and most basic, hypothesis: regions characterised by more intense clientelistic politics will tend to exhibit worse healthcare outcomes. This relationship is depicted in **Figure 1.3.**

Figure 1.3

Pathway Linking Clientelism to Health System Outcomes



To test the hypothesis, I selected three cities as the primary research sites. These were chosen based on a quantitative correlation analysis involving three variables: Clientelism Perception Index (CPI) scores of Indonesia's provincial towns, as studied by Berenschot (2018, p. 1580), these cities' performance on Minimum Health Service Standards or MSS (*Standard Pelayanan Minimal, SPM Kesehatan*), and their levels of government health spending—summarised in **Table 1.1** and explained in greater depth in Chapter 2. The SPM Kesehatan index used here draws on key indicators that reflect essential dimensions of public health service delivery at the city and district level: maternal and child health, access to universal healthcare coverage, child malnutrition rates, and the availability of referral healthcare services for the poor.

Table 1.1

Correlation Analysis: CPI, Health MSS, and Per Capita Health Spending, 2013–2018

Variables	CPI	Health MSS	Health Spending
CPI	1		
Health MSS	-0.3611	1	
Health Spending Per Capita	0.2661	-0.0077	1

Source: Author's analysis of data from the Ministry of National Planning/Bappenas (on MSS), Ministry of Finance (on health spending), and Berenschot (2018b, p. 1576) on CPI.

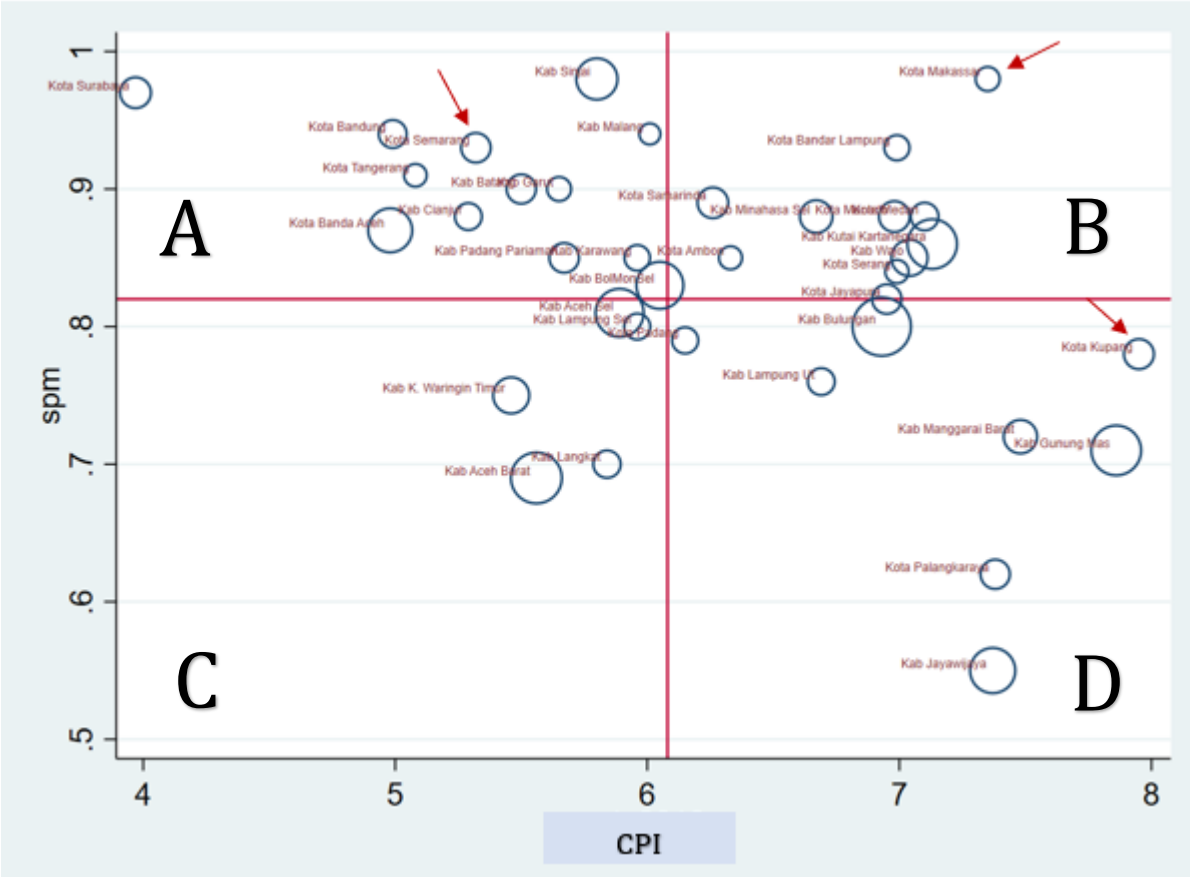
The correlation analysis supports the study's initial hypothesis, revealing a moderately strong negative association between CPI and MSS scores for the 2015–2018 period (correlation coefficient is -0.361). This suggests that higher levels of clientelism tend to be associated with lower health service performance. In contrast, the correlation between CPI and per capita government health spending is relatively weak (0.226), while the correlation between MSS and per capita health spending is negligible (-0.0077). Based on these results, per capita health spending is treated as a control variable during the case selection process, and cities were chosen with relatively similar levels of health expenditure to ensure comparability.

The findings are visually represented in the scatter plot shown in **Figure 1.4**. The diagram is divided into four quadrants (A, B, C, D), representing different combinations of clientelism intensity (CPI) and healthcare performance (SPM), with circles representing different cities and districts, and the sizes of these circles indicating relative levels of per capita health spending. From this exercise, I selected three case studies—each representing a distinct combination of clientelism and healthcare performance, while maintaining comparable health expenditure levels. The selected cities are:

- Quadrant A: Low clientelism, high healthcare performance – Semarang
- Quadrant B: High clientelism, high healthcare performance – Makassar
- Quadrant D: High clientelism, poor healthcare performance – Kupang

Figure 1.4

Scatter Plot of Correlation Analysis between SPM (MSS) and CPI



Source: Author's analysis of data from the Ministry of National Planning/Bappenas (on SPM/ the **y** axes) and Berenschot (2018b) on CPI/ the **x** axes). Data on healthcare spending per capita (size of the circles) is from Ministry of Finance's reports on local government spending.

Quadrant C (low clientelism, low healthcare performance) is not represented, as no city or provincial town fits this profile. Practical considerations also influenced the case selection: cities in Papua, Maluku, Kalimantan, and Sumatra were excluded due to accessibility constraints and logistical limitations.

Notably, two of the selected cities: Semarang (A) and Kupang (D) align with Hypothesis 1, which posits that more intense clientelistic politics are associated with weaker healthcare outcomes. However, Makassar (B) stands out as an anomalous case. It sits at a high level of clientelism while also demonstrating strong healthcare

performance.[3] Despite its high clientelism score, the city delivers relatively strong healthcare services. This challenges the assumption that the intensity of clientelism alone determines service quality.

The case of Makassar highlights the need to go beyond measuring intensity of clientelism. While the first hypothesis emphasises *intensity* of clientelism as a key factor, the second hypothesis builds on this by arguing that the *nature* of clientelistic politics also matters. Drawing on the framework developed by Berenschot and Aspinall (2020, p. 11) as summarised in **Table 1.2**, this study explores how organisational and strategic differences in clientelistic practices influence city governance, including in the health sector.

Table 1.2

Basic Typology of Patronage Democracies

	Control	**Networks**	**Resources**
Party-centred patronage democracy	Political parties control distribution of state resources	Exchanges organised by political parties and affiliated groups	Relational clientelism using public resources
Community-centred patronage democracy	Stronger control of non-party networks and/or limited availability of state resources	Exchanges organised through community leaders, family networks and other informal non-party networks	More one-off, retail clientelism, vote-buying and community gifts

Source: Berenschot and Aspinall (2020, p. 11).

Using these elements, I develop my conceptual framework, which I explain at a greater length in Chapter 2. This framework enables analysis of the programmatic and clientelistic/patronage flows that take place through the key components of the health system that are my research focus, i.e., personnel and programs (**Table 1.3**). This framework also allows me to identify two key modes or routes through which clientelistic politics affect the healthcare sector: a patronage route, in which jobs and resources in the sector are transformed into patronage and distributed to supporters of

[3] Although several cities and districts fall within Quadrant B, most cluster near the boundaries with Quadrants A and D. Makassar, however, sits at the far extreme of both CPI and SPM levels, standing apart from other jurisdictions in Quadrant B.

incumbent local politicians, and a resource extraction route, through which clientelistic politicians and their allies extract resources (typically in the form of corruption, i.e., kickbacks, bribery, extortion, project skimming, budget manipulation, etc.) from the sector in order to finance their clientelistic strategies. These modes of patronage politics are contrasted with programmatic or professional approaches in each part of the sector.

Table 1.3

Conceptual Framework of How Clientelism Affects Healthcare Performance

Components of health system	**Key activities**	**Clientelistic and patronage flows**		**Programmatic/ professional alternative**
		Patronage route	**Resource extraction route**	
Health workforce/ personnel	Promotion and selection of local health officials and public health provider executives, and temporary staff.	Patronage appointments for political supporters and people with political connections.	Bribery and illegal fees in exchange for promotion and selection of public officials.	Merit-based selection and promotion.
Healthcare programs and facilities (health services)	Primary and public healthcare programming, provision of key healthcare initiatives/programs, such as construction of primary healthcare centres and local hospitals, and provision of medicines and medical devices.	Healthcare programming is designed to allocate projects and government contracts to political supporters and persons with political connections.	Budget manipulation, mark-ups, illegal fees, and bribery extracted from procurement contracts. Sub-standard and/or counterfeit drugs and medical supplies.	Transparent, inclusive, universalistic health policies and programming; transparent health sector procurement.

Adopting this framework enables a deeper understanding of the distinctive features and dynamics of clientelism across three selected cities. It provides a valuable lens through which to explain why Makassar's health sector has remained relatively insulated from clientelistic interference and rent-seeking, despite a broad context of high clientelism in the city. At the same time, it allows for a systematic deconstruction of

the clientelistic practices observed in Kupang and Semarang—highlighting how their specific configurations shape the strategies used within both the health sector and broader local governance.

The unexpected case of Makassar, in particular, invites further inquiry into the factors that produce variation. This anomalous case—a highly clientelistic context with a relatively high-performing health sector—leads directly to the *second research question, which explores the contextual conditions that modify the relationship between clientelism and healthcare service delivery.* Building on my answers to this question, the study turns to a *third research question, which investigates the mechanisms through which clientelistic politics influence healthcare quality and outcomes*.

These questions build on each other, moving from identifying patterns, to understanding causes, to explaining consequences. The next section summarises the arguments I build in response, outlining how the analytical framework is applied across the case studies.

The Arguments

To summarise, this thesis advances five key arguments, each grounded in the research questions and hypotheses introduced above. These arguments are supported by both quantitative analysis and qualitative evidence drawn from the three case studies.

1. The intensity of clientelism shapes health sector performance

The first argument responds to the question on how variation in clientelistic politics at the subnational level affects the delivery of healthcare services to citizens. The data I provide show that, in general, the relationship between clientelism and healthcare delivery follows the expected pattern: regions with higher levels of clientelism tend to exhibit lower-quality healthcare, while those with lower clientelism show better outcomes. This pattern is evident in the statistical analysis presented in **Figure 1.4** Semarang (Quadrant A) exemplifies a low-clientelism, high-performance model, whereas Kupang (Quadrant D) illustrates the reverse—high clientelism and poor service quality. Most subnational regions in Indonesia in the figure are located in these two

quadrants, suggesting that clientelism distorts the health system by prioritising political and personal gain over public needs. It undermines merit-based recruitment, distorts resource allocation, and facilitates rent-seeking and corruption, especially in efforts to sustain political financing.

Government health spending per capita is used as a control variable in this analysis. While there is some association between healthcare performance and broader indicators like funding levels, the correlation is weak with a negative coefficient value. In the case study sites, Kupang, Semarang, and Makassar report comparable levels of per capita health spending, yet Kupang performs significantly worse, supporting the argument that the intensity of clientelism is a critical factor shaping healthcare outcomes. However, Makassar presents an anomaly: despite high levels of clientelism, it outperforms Kupang, suggesting that intensity of clientelism alone cannot fully account for variation. This points to the need to consider how political dynamics interact with the other contextual factors. Further details are provided in Figure 1.4 and expanded in Chapter 2. These findings build upon and extend Berenschot's (2018b, 2019a) work on the varying intensity of clientelism across Indonesia's subnational governments, and his observation that variation in the intensity of clientelism is significantly correlated with poor outcomes in major areas of public spending.

2. The nature of clientelism matters

As noted above, the case of Makassar, along with several other regions located in Quadrant B of Figure 1.4, is anomalous, combining high clientelism with relatively strong healthcare performance. This finding challenges the assumption that clientelism intensity alone determines outcomes and gives rise to Hypothesis 2: the *form or pattern* of clientelism also plays a decisive role in shaping health service delivery.

To explore this hypothesis, I draw on and adapt Berenschot and Aspinall's (2020, p. 11) analytical framework (**Table 1.2**), which identifies three key dimensions for assessing the nature of clientelism: (1) the degree of elite control over state resources, (2) the nature of the organisation of clientelistic networks, and (3) the mechanisms of distribution of state resources. Rather than treating clientelism as a binary condition,

the framework views it as a continuum, enabling a more nuanced comparison across contexts.

In Semarang, as I explain in Chapter 6, relatively strong party institutionalisation in the government and society under the long-standing rule of the Indonesian Democratic Party of Struggle (*Partai Demokrasi Indonesia-Perjuangan,* PDI-P) has fostered a stable system of long-term patron-client relationships. The party's dominance in both government and civil society—through key leadership roles held by cadres and sympathisers in public office and influential organisations, for example, Indonesian Chamber of Commerce and Industri (*Kamar Dagang dan Industri Indonesia,* KADIN), National Zakat Agency (*Badan Amil Zakat Nasional,* BAZNAS), Indonesia Ulama Council (*Majelis Ulama Indonesia, MUI*), and Indonesian Young Entrepreneurs Association (*Himpunan Pengusaha Muda Indonesia,* HIPMI)—allows it to demand accountability from its members and align political agendas with public needs, with the goal of maintaining local electoral dominance. The party also maintains relatively structured patronage networks, with party leaders actively mediating relationships with communities and civil society organisations. This concentration of power has made political relationships more institutionalised and interconnected, and rooted in society, enabling the party's central leadership to more effectively exert control, demand performance from local politicians, and implement key policies—many of which align with popular demands, including in the health sector. This logic is consistent with other analyses which point to the PDI-P having relatively strong societal roots that enables the party to impose its directives on local leaders (Mietzner, 2012, p. 511).

By contrast, in settings where political parties are weak and control over resources rests with individual elite actors—such as in Kupang—clientelism is more fragmented, transactional, and personalistic. Resource distribution is driven by immediate political interests rather than broader public priorities. The health sector becomes just another arena for rent extraction, with little incentive for reform. The case of Kupang (Chapter 4) represents the extreme end of the continuum of political control over state resources, with local politics based around personalised patronage networks. This dynamic fosters short-term clientelism, where building up one's political war chest by accumulating funds often takes priority over public service quality. There are few

brokers able to act as intermediaries between local communities and politicians on development issues; instead, most operate as vote-getters, engaging in transactions for personal material benefits. As a result, elites face little pressure to deliver public goods, and political survival depends more on maintaining informal and personal alliances than on performance. The absence of institutionalised networks or reformist brokers reinforces a governance model dominated by clientelism and minimal accountability.

Makassar, as previously discussed, occupies an intermediate position on the clientelism spectrum—situated between the two ends of the typology: my analysis in Chapter 5 shows it is neither governed by strong, centralised party control with tightly organised patronage networks, nor defined by entirely fragmented, individualised forms of clientelism. Instead, Makassar exhibits a hybrid configuration, where clientelistic practices remain pervasive, but are shaped by a distinctive political ecology. This includes features such as cartel-like politics, competitive patronage networks, weak party institutionalisation, and relatively robust level of civil society engagement. These dynamics create a political environment where civil society and patronage networks, when they find common ground with broader societal concerns, can exert pressure on elites to adopt more programmatic policies—not due to institutional constraints, but as a strategic response to reputational risks and the imperative to maintain elite coalitions.

In terms of elite control, political authority in Makassar is not consolidated within a single dominant party, as in Semarang. Rather, it is distributed across multiple elite coalitions that frequently compete for influence. This pattern is reinforced by the enduring role of the political culture associated with key local ethnic groups. For example, largely as a product of their history as a trading community, Bugis people are known for their strategic adaptability, ability to leverage informal alliances, their emphasis on economic influence, and traditions of negotiating power-sharing arrangements to sustain dominance (Pelras, 1996, pp. 184–185). Within this context, political parties in Makassar function primarily as vehicles for elite competition, while familial and local oligarchic networks dominate both politics and the local economy (Acciaioli, 2000; Haryanto, 2017; Haryanto, Sukmajati, & Lay, 2019; Yakub, Armunanto, & Haryanto, 2022, p. 303). This combination produces a fluid and shifting landscape,

where elite alliances are continuously reconfigured in response to emerging political opportunities.

This fragmented yet competitive environment results in loosely coordinated but dynamic patron-client relationships. As observed by Pelras (1996, p. 181), such relationships are rooted in hierarchical webs of loyalty and obligation that shift based on patron performance. These relationships are inherently unstable; loyalty can shift quickly when competing patrons offer better benefits or fail to meet expectations. Patadungan (2015, p. 100) characterises Makassar's local politics as oligarchic and cartel-like—dominated by dynastic elites but remaining open to contestation from rival factions. Importantly, the mechanism of resource distribution in Makassar reflects this decentralised competition. Without central party oversight, elites rely on their own networks to distribute state resources, as it is difficult to enforce uniform programmatic policy agendas or coordinate clientelist strategies across the board. Compared to Kupang, these networks in Makassar are more organised and assertive, often overlapping with civil society and student organisations that wield significant influence. These groups are capable of articulating demands and mobilising mass-based pressure, especially in sectors like healthcare and education, where citizen scrutiny is high. When their interests align with broader societal concerns, they can compel elites to adopt more programmatic policies.

In this context, the nature of clientelism in Makassar—competitive, dynamic, assertive, and selectively applied—helps explain why the health sector has performed relatively well despite the persistence of informal political practices. The interplay between rival patronage networks, weak party institutionalisation, and assertive civic engagement generates ongoing political pressure that incentivises elites to deliver visible improvements in public services. This pressure is especially pronounced in politically important sectors such as healthcare, where public expectations and scrutiny are high, and performance is closely tied to political legitimacy. This pattern reflects both public pressure and elite calculations. Thus, I show that clientelism's effects on service delivery are not uniformly detrimental (as the below argument will explain); in contexts like Makassar, where clientelism is competitive and exposed to civic pressure,

it can generate incentives for improved performance—particularly in politically salient sectors like healthcare.

3. Clientelism is not uniformly applied across all areas of governance

My research also demonstrates that, under particular enabling conditions—see the next point—clientelistic politicians have considerable leeway to target their clientelistic activities to particular areas. This discretion allows for the emergence of a *hybrid governance system* in which clientelistic exchanges are concentrated in select sectors—typically those that offer higher political returns or rent-seeking opportunities—while more programmatic approaches are pursued elsewhere. This argument builds on and extends Jennifer Bussel's work (2010, p. 1230; 2019), which shows that politicians in designing their political approaches strategically weigh the costs of losing access to bureaucratic rents against the political benefits of improved service delivery. While Bussell identifies the logic of selective reform, she does not fully theorise the conditions under which specific sectors become insulated from clientelist capture. My research addresses this gap by developing a sector-specific, comparative analysis of healthcare governance in Indonesian cities and by theorising how contextual factors—such as civic pressure, middle-class demands, market competition, and the availability alternative patronage arenas—mediate the application of clientelism.

This argument is exemplified in the case of Makassar, where high levels of clientelism coexist with relatively strong health sector performance. Here, clientelism remains a central organising principle but operates in a *sectorally differentiated* matter. Politicians concentrate informal exchanges in areas such as infrastructure, property development, business licensing, and land reclamation—domains characterised by high rent-extraction potential and relatively low public scrutiny. In contrast, the health sector has historically been more insulated from clientelism, owing to its visibility, electoral salience, and strong public expectations.

The hybrid strategy was evident under the leadership of Mayor Ilham Arief Sirajuddin (2003–2013), who framed his governance around two key priorities: delivering essential services—particularly healthcare and education—and promoting

economic growth. Ilham's emphasis on safeguarding essential public services reflected a deliberate political strategy: he wanted to maintain popular legitimacy by promoting better government performance in electorally salient sectors while accommodating clientelist demands in economically lucrative sectors that offered leeway for distribution of rents without significant public scrutiny. During his tenure, the health sector was managed in a relatively professional manner, whereas clientelistic exchanges were concentrated in areas tied to urban expansion and local revenue generation (see Chapter 5 on Makassar Case Study).

A comparative look at Semarang and Kupang further underscores this variation in clientelism sectoral application. Like Makassar, Semarang exhibits a hybrid pattern, but in an even more refined and subtle way. Despite its relatively programmatic politics compared to Makassar, clientelism persists in Semarang, especially in infrastructure, land use, and property development, while the health sector is relatively programmatic. Permana (2024, p. 210) notes the concentration of patronage in the city's land-use planning and development-related sectors. As I show in Chapter 6, some studies and informants in the city suggest that local elites often turn a blind eye to violations of land-use planning by business interests—particularly those that had sponsored their electoral campaigns. Large corporations involved in land clearing and property development were reported to have supported mayoral bids in exchange for regulatory leniency and legal protection. But the healthcare sector functions largely without such clientelist interventions.

In contrast, Kupang represents the opposite end of the spectrum. Here, clientelism is pervasive across nearly all domains, including healthcare. As I show in Chapter 4 and as other scholars have suggested, e.g., Tidey (2022, p. 56), the city's governance has long been shaped by intense, particularistic exchanges and weak institutional accountability. Structural constraints—including a more limited local economy and fewer alternative sectors for rent-seeking and patronage—further limit politicians' ability to strategically insulate high-risk sectors, resulting in clientelist saturation across the board.

Together, these cases show that while clientelism remains a defining feature of subnational politics in Indonesia, its form and sectoral application vary significantly. Political actors in cities like Makassar and Semarang strategically insulate high-profile sectors such as healthcare to preserve public legitimacy, while concentrating clientelism in less visible but more profitable areas. In doing so, they craft hybrid systems that balance the competing demands of performance, patronage, and political survival. In her important and distinctive contribution to the clientelism literature, Bussell (2010; 2019) has shown that politicians strategically limit reforms to protect rent-generating sectors: in effect, clientelism can be selectively withdrawn from politically salient services as part of an intentional governance strategy. Drawing on a comparable context, Manor's (2016, pp. 15–16) analysis of Indian state-level politics helps my thesis to find an important theoretical ground. My case studies in Makassar and Semarang resonate to his findings on the pattern of selective clientelism and hybrid governance strategy. He called this strategy "post-clientelist initiatives" (p. 16) to describe how chief ministers in many Indian states intentionally withdraw clientelist practices from high-profile, service-oriented sectors—such as health or education—in order to build performance legitimacy, while concentrating clientelism in less visible, rent-rich domains. This sectorally differentiated targeting of clientelist practices remains under-theorised in the wider clientelism literature, which has tended to treat informal exchange as either pervasive or absent, rather than as contingent, calibrated, and spatially uneven.

Delivering a baseline level of effective healthcare services, then, serves a dual purpose: *preserving public legitimacy* and *stabilising elite coalitions*. In this context, programmatic governance in the health sector functions not only as a reputational shield but also as a calculated political strategy to prevent fragmentation within patronage networks and avoid public backlash. By ensuring visible performance in a high-stakes sector, politicians can demonstrate competence to the electorate while simultaneously reducing internal dissent among coalition partners who rely on regime stability for continued access to patronage resources. This argument also extends previous findings that healthcare policy advancement in Indonesia's regions is often driven by political motives and leadership strategy rather than institutional strength alone (Luebke, 2009, p. 201; Rosser & Wilson, 2012, p. 608; Rosser et al., 2011, p. 3).

4. Four contextual factors enable and/or incentivise politicians to modify the relationship between clientelism and healthcare service delivery

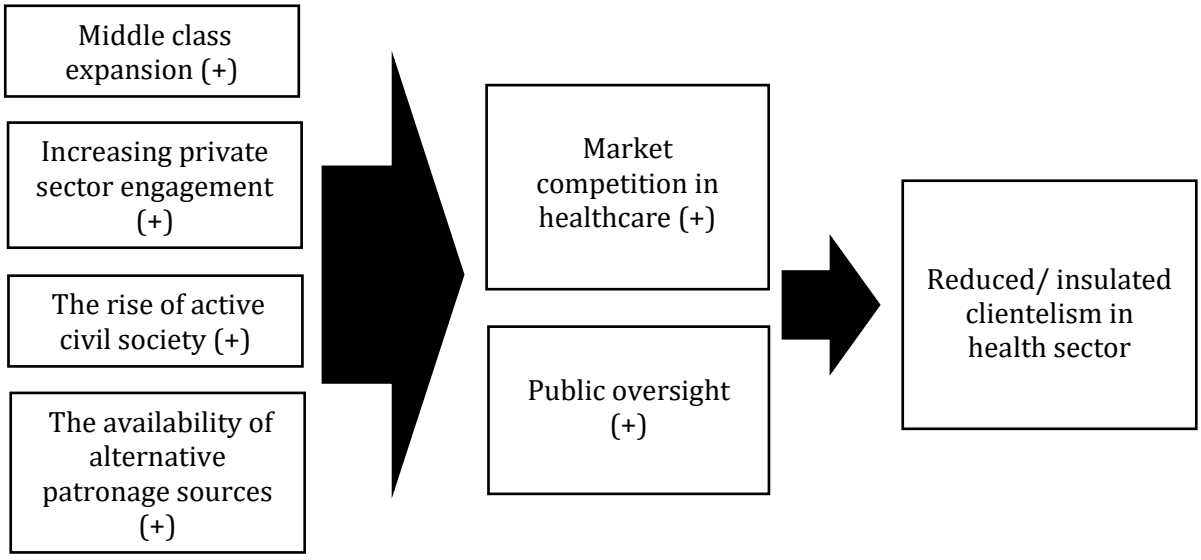
In observing that different mixes of programmatic and clientelistic politics are visible in different regions of Indonesia, my argument here differs from the standard argument in the clientelism literature, which posits that economic development simply weakens clientelism by making voters less dependent on patronage and more likely to punish clientelist politicians (see especially Weitz-Shapiro, 2009, 2012, 2014). While I emphasise that it can also simply *displace* clientelism, moving it to sectors less visible to the public eye, I do agree that economic development is important, but not necessarily in the way proposed in these standard accounts.

To explain why clientelism varies and anomalous mixtures occur, my thesis proposes a new analytical framework that considers both structural factors and agency. This framework identifies four key structural factors that moderate the negative effects of clientelism on the healthcare system, and all of which are associated with the level of economic development in a city: the availability of alternative sources and sites of patronage, the size of the middle class,[4] the nature of local civil society, and the degree of market competition in healthcare. These factors can create incentives for politicians to protect the healthcare system from clientelism or at least reduce its prevalence in the sector. **Figure 1.5** illustrates how these factors can modify clientelism in the health sector.

[4] Exact figures on city-level middle-class populations are not publicly available, but population size and economic indicators from BPS suggest that Semarang and Makassar likely have larger middle-class segments than Kupang. Both cities have higher GDP per capita and more diversified, formal service economies. In contrast, Kupang's smaller, less diversified economy—dominated by low- to mid-income service sectors—suggests a more limited middle class.

Figure 1.5

The Relationship between Contextual Factors and Clientelism in the Health Sector



The availability of alternative patronage sources refers to the extent to which political elites can access and distribute resources in sectors beyond the health sector—such as infrastructure, land, licensing, or commercial contracts—as a means of maintaining loyalty and consolidating power. Where such alternatives exist and are politically valuable, elites may divert clientelistic strategies away from politically sensitive sectors like health, allowing for greater space for programmatic governance. Conversely, in settings where alternative patronage channels are limited, health and education sectors often become primary arenas for distributing favours and extracting rents.

In Semarang, the presence of a relatively diverse economy, with robust manufacturing, trade, services, infrastructure, and property development, provides political elites with multiple avenues and sources to build and sustain patronage networks. Access to land, construction permits, and urban development projects serve as a key source of political leverage. The long-standing dominance of PDI-P further institutionalises the patronage flows through affiliated organisations such as KADIN, HIPMI, BAZNAS, and MUI, enabling a degree of insulation in the health sector. While clientelism persists, elites often prioritise sectors that offer more lucrative or flexible forms of political exchange.

Makassar also benefits from a range of alternative patronage sources due to its role as a regional economic hub in Eastern Indonesia. Political elites frequently channel patronage through large-scale infrastructure projects, property development, and procurement contracts. These avenues are especially attractive in a highly competitive political environment, where material resources are critical for building coalitions. As a result, while health sector appointments may still reflect clientelist logics, the intensity of political interference is moderated by the availability of more profitable or less publicly scrutinised alternatives.

In contrast, Kupang offers fewer alternative sites for patronage due to its smaller, less diversified economy and limited investment activity. With fewer opportunities in sectors like infrastructure or land development, political elites often rely more directly on state-funded services—including health—as key patronage arenas. In the absence of, or limited alternative patronage resources, everyday service delivery and government jobs become deeply entangled with political loyalty and resource extraction, making reforms more difficult to implement.

Middle class size and impact. In relatively prosperous cities like Makassar and Semarang, the rise of a middle class has placed new constraints on clientelist politicians. Middle-class voters tend to be more responsive to service quality, especially in essential sectors like healthcare, and often have access to alternative providers such as private, provincial, and national hospitals. Unlike lower-income constituents, they are generally unmoved by the small inducements typically used in clientelist exchanges, thereby weakening the effectiveness of such strategies. In this respect, my findings are in line with the comparative literature, and support the argument that economic development enlarges the middle class and reduces voters' tolerance for clientelism, thus raising its political and financial costs (Berenschot, 2018b, p. 1563; Magaloni, Diaz-Cayeros, & Estévez, 2007, p. 203). Extending this literature, I argue that, as far as healthcare goes, as individuals become wealthier, they can opt for private healthcare providers, reducing their dependence on state-run primary healthcare centres and hospitals. This shift erodes the political leverage that incumbents normally can extract from public resources, since fewer voters depend on them for essential care. This dynamic aligns with modernisation theory arguments suggesting that a wealthier electorate raises the

costs of clientelistic practices (Calvo & Murillo, 2004; Dixit & Londregan, 1996; Robinson & Verdier, 2013) or reduces public tolerance for such practices (Kitschelt & Wilkinson, 2007b; Weitz-Shapiro, 2014). Moreover, a wealthier and more informed electorate is harder to monitor and less likely to comply with clientelist exchange (Lehoucq, 2007a; Stokes et al., 2013).

However, as Weitz-Shapiro (2014, p. 5) note, a large middle class alone is insufficient. Political competition must also be present to incentivise politicians to abandon clientelism. This thesis builds on and refines that perspective by showing that even in highly competitive yet clientelistic environments, such as Makassar, politicians may not abandon clientelism entirely but instead shift their strategies. Rather than risking public backlash by engaging clientelism in political salient sectors like healthcare, they strategically insulate these domains to maintain legitimacy and appeal to middle-class and swing voters. At the same time, they continue to deploy clientelism in less visible, rent-rich sectors such as infrastructure, land, and spatial planning, where electoral costs are lower and opportunities for resource extraction remain high. This selective adaptation shows that political competition and a large middle class can reshape, but not necessarily eliminate, clientelism—facilitating hybrid governance strategies that blend programmatic delivery in select sectors with entrenched patronage and rent-seeking elsewhere.

Civil society and public accountability. It is thus not only a larger middle class that is important. An empowered civil society—often emerging alongside middle-class expansion—can curb the intensity, if not the presence, of clientelism. Economic growth enhances access to higher education and strengthens the organisational and advocacy capacities of civil society actors and assertive citizens. In addition to formal civil society organisations and non-government organisations (NGOs), informal networks such as student movements, alumni groups, and even vote brokers can serve as advocates for improved healthcare services. These groups heighten public scrutiny and increase reputational risks for political elites, incentivising them to adopt more programmatic policies in visible sectors like health, while potentially maintaining clientelistic ties in less scrutinised domains. Existing research has highlighted the role of civil society actors in influencing local politics, elections, and policy making in Indonesia (Antlöv,

Brinkerhoff, & Rapp, 2010; Aspinall, 2013b; Tans, 2012). M. Mustafa (2024, p. 131) further argues that the nature of interactions between civil society and local government significantly shapes the scope and impact of governance reforms.

Evidence from Semarang and Makassar illustrates how variations in civil society shape the functioning of clientelistic politics in the health sector. In Semarang, civil society has relatively strong capacity to represent community interests and engage with political elites. Community-based organisations and neighbourhood groups are deeply embedded in local governance structures and trusted by residents, making them active brokers in advancing public demands—particularly on health issues. These networks are closely connected to subdistrict (*kecamatan*) and ward or urban village (*kelurahan*) government units, often through community health centres (*puskesmas*), public health forums—e.g., *Forum Kota Sehat* at the city level and *Forum Kesehatan Kelurahan* at the ward level—and regular planning and budgeting forums at the local level. All of these mechanisms reinforce routine oversight and sustained public engagement in governance.

Makassar presents a different configuration. While civil society is less institutionalised than in Semarang, it remains politically salient. Advocacy groups, student associations, professional networks, and religious organisations continue to articulate public concerns. Their engagement is typically issue-specific and episodic, but they can exert influence—and act opportunistically—during periods of political contestation or elite rivalry. In contrast, grassroots community groups have less capacity and are often co-opted by political elites for electoral mobilisation. These groups tend to have limited influence within their own communities, except when they become instrumental to politicians seeking to expand or consolidate patronage networks. This dynamic is particularly evident in Makassar, where the mayor has strategically mobilised grassroots organisations (e.g., the household association or *Rukun Tetangga*, RT and neighbourhood groups or *Rukun Warga,* RW) to gain votes and maintain electoral dominance. Rather than serving as platforms for improving service delivery, public health forums were primarily instrumentalised for electoral purposes—mobilising voter support and reinforcing patronage networks—thereby limiting their potential to contribute meaningfully to public health.

In Kupang, civil society engagement is significantly weaker. Organised groups are fewer, under-resourced, and often disconnected from formal governance structures. The public health forums and community-based groups' connection with public health offices and *puskesmas* are very weak. While some faith-based and donor-supported organisations contribute to service delivery, their capacity to influence health governance or hold officials accountable is limited. Their community influence is also constrained. Instead, informal family-based and ethnic-based networks often compete for local resources and influence, but this competition rarely translates into collective civic engagement. As a result, civil society's role in shaping governance and demanding better services remains minimal, allowing clientelistic practices to persist with limited scrutiny or public pressure for accountability in the health sector.

Market competition and private sector dynamics. I also show in this thesis that the expansion of private healthcare under Indonesia's universal health coverage (*Jaminan Kesehatan Nasional,* JKN)[5] has introduced, or at least accelerated, market-based pressures that indirectly constrain clientelistic behaviour. Prior to JKN scale-up, government-run healthcare providers dominated the healthcare market for lower- to middle-income Indonesians. Public facilities were generally perceived as affordable but low in quality, while private providers offered better care at higher costs, limiting access (in most cases) to all but relatively wealthy Indonesians. This segmentation began to shift in 2014, when the national government mandated universal enrolment under the JKN and required private providers to participate in the scheme. The inclusion of private providers into the JKN system significantly transformed the healthcare landscape, increasing competition and raising expectations for service quality. As private facilities began offering free (JKN-covered) services, they quickly gained a share of the market once monopolised by public providers (see Chapter 3 for detailed analysis). This has placed both reputational and financial pressures on public health facilities—including *puskesmas* and city-run hospitals—as poor performance risks not only public trust but also the loss of JKN-generated revenue. For politicians, this shift undermines the effectiveness of using public healthcare as a patronage resource. Middle-class voters, in

[5] Also commonly referred to as *BPJS Kesehatan (Badan Penyelenggara Jaminan Sosial),* the agency responsible for managing the JKN.

particular, now have alternatives and are more likely to exit poor public care rather than remain dependent on clientelistic exchanges. As private healthcare becomes more accessible, these voters—less reliant on state services—are increasingly resistant to clientelistic inducements (Calvo & Murillo, 2004, p. 742).

This shift aligns with broader findings that liberalisation, economic development, institutional reform, and service pluralism can disrupt the development of clientelist networks (Berenschot, 2018b; Bobonis, Gertler, Gonzalez-Navarro, & Nichter, 2023; Bold, Molina, & Safir, 2018; Fujiwara & Wantchekon, 2013; Montambeault, 2011) by creating "pockets of alternatives," as Brinkerhoff and Goldsmith (2004, p. 164) put it. However, their effectiveness depends on how deeply clientelistic structures are embedded and whether competitive dynamics are institutionalised across sectors.

5. There are two primary pathways through which clientelism distorts healthcare performance: *rent-seeking* and *patronage*

Patronage and rent-seeking distort health sector governance in distinct but often overlapping ways. *Patronage* refers to the allocation of public positions, contracts, and services in exchange for political support. In healthcare, this includes politically motivated appointments, favouritism in promotions, and the use of programs like free care or vaccinations for electoral mobilisation—undermining competence, planning, and service delivery. *Rent-seeking* involves extracting resources through corrupt practices, such as kickbacks, inflated procurement, and the sale of government posts. While rent-seeking does not necessarily involve clientelism, it is often linked, especially when clientelistic politicians need to accumulate resources to fund their election campaigns. Both mechanisms thrive in settings with weak oversight, fragmented accountability, and high elite discretion over resources.

Across the three case studies, clientelism in the health sector consistently manifests through patronage in bureaucratic appointments, though its expression varies by subsector. Patronage is most evident in promotion and selection processes within city health offices (*dinas kesehatan*), RSUDs, and frontline units such as *puskesmas*.

In Semarang, key positions are typically awarded to loyalists or partisans of the ruling PDI-P. However, to maintain political coalitions and administrative stability, lower-level posts and smaller contracts are often shared with members of other parties. While patronage remains entrenched, it is moderated by performance expectations, with technically competent candidates preferred for strategic roles. Underperforming appointees are often replaced, and routine civil service recruitment tends to follow more transparent, merit-based procedures.

In both Makassar and Kupang, clientelism is characterised by the overlap of patronage and rent-seeking, though the intensity and scope differ. Appointments are shaped more by personal networks and campaign ties than formal party affiliation. In Makassar, patronage is used to reward supporters through strategic placements in health offices and service units, and the distribution of ad hoc programs for rewarding supporters. These appointments are often linked to rent-seeking, as political elites expect their appointees to facilitate access to public resources—particularly in high-value projects like hospital construction and medical equipment procurement. In Kupang, by contrast, opportunities for rent extraction are more pervasive. With weaker oversight and limited alternative patronage sectors, even routine and small-scale health projects become vehicles for political gain, making rent-seeking a more generalised feature of governance.

Contributions and Implications

My thesis makes contributions to three intersecting bodies of literature: those on clientelism, public service delivery, and subnational politics in Indonesia. By offering a sector-specific, subnational analysis of how patronage and rent-seeking shape healthcare governance, it brings fresh empirical and theoretical insights into how clientelism functions across different local contexts.

First, my thesis addresses a gap in the literature by focusing on the health sector—an area often overlooked in favour of more politically visible sectors such as infrastructure or social assistance. Through a comparative study of three Indonesian cities—Kupang, Makassar, and Semarang—it demonstrates that clientelist practices are not uniformly applied, even within the same country or administrative tier. Instead,

these practices vary in form, intensity, and purpose, in ways that are shaped by local political structures, economic conditions, and civic pressures.

Second, my study introduces an original analytical framework that identifies two core mechanisms—patronage and rent-seeking—through which clientelism influences health governance. It shows how political elites use public resources and bureaucratic appointments to maintain support networks, and how these practices often overlap. Patronage manifests through strategic placements in health offices, allocation of insurance subsidies, and distribution of contracts for facilities and medical supplies. Rent-seeking frequently emerges within these patronage networks, where appointees or contractors are expected to channel resources back to political actors to finance campaigns or maintain clientelist networks.

Third, my thesis demonstrates how these mechanisms play out differently across cities. In Kupang, rent-seeking and patronage are pervasive and highly visible across frontline services, programs, and procurement. In Makassar, clientelism is more selective, concentrated in high-value projects such as hospital construction and equipment procurement. Semarang, by contrast, exhibits a more institutionalised and restrained form of patronage, with key appointments are based on the partisanships and government contracts are controlled more by party structures rather than individualised networks, and little evidence of resource extraction from any subsystem of the health sector.

Fourth, my thesis advances the concept of hybrid governance, showing how clientelistic and programmatic practices coexist in the same sector. It challenges the binary framing of governance as either corrupt or institutionalised by revealing how political actors may strategically insulate certain sectors—such as health—from excessive clientelist interference. This insulation strategy is often driven by the need to preserve legitimacy, improve service delivery performance, or maintain political stability.

Fifth, the thesis identifies four modifying contextual factors—middle-class size, civil society strength, market competition, and the availability of alternative patronage

sectors—that shape how and to what extent clientelism impacts healthcare governance. This integrative framework helps explain why similar clientelist strategies produce divergent outcomes across different localities.

In terms of policy contribution, my thesis provides a more granular understanding of how and where governance reforms may succeed in curbing clientelist influence. It suggests that efforts to improve service delivery in decentralised settings must account for local political dynamics and focus on building institutional safeguards, enhancing civic oversight, and leveraging competitive pressures—particularly in sectors vulnerable to rent-seeking. The framework also offers practical entry points for donors and reform advocates to promote sectoral insulation, support merit-based appointments, and identify reform windows in politically sensitive environments.

Overall, my research advances a more nuanced understanding of how clientelism functions at the subnational level and its consequences for the quality of public services. It highlights both structural constraints and the strategic agency of political elites in shaping governance outcomes. Looking forward, the framework developed here can be applied to other policy sectors to assess which are more susceptible or resilient to clientelist pressures. Future research could further explore how civic mobilisation, private sector engagement, and institutional reform interact with these dynamics to either constrain or reinforce clientelism in contemporary urban governance.

Outline of the Thesis

In order to build a coherent and well-supported argument, this thesis is organised into three interconnected parts, each building progressively toward the central claims. The first part introduces the key concepts, analytical framework, and research design, establishing the foundations for the argument. The second part provides the historical and institutional context necessary to understand how clientelism has evolved and become embedded in Indonesia's health governance. The third part presents a comparative analysis of the three case studies—Kupang, Makassar, and Semarang—demonstrating how variations in clientelism, shaped by contextual factors, produce different governance and service delivery outcomes. This structure

ensures that each chapter advances the overall argument in a logical and cumulative manner.

Part I: Theoretical Framework and Research Design. Part I establishes the conceptual and methodological foundations of the study. **Chapter One** introduces the research problem and foregrounds the core argument, while **Chapter Two** reviews key literature on clientelism and public service delivery, defines core concepts, identifies gaps in understanding subnational variation, and outlines the study's comparative case study design—using correlation analysis, process tracing, and fieldwork across Kupang, Makassar, and Semarang. **Chapter Three** provides the historical, institutional, and political economy contexts of healthcare in Indonesia, with a particular focus on health sector staff, including doctors, medicines and medical equipment, healthcare facilities (community health centres and hospitals), and major health policies. It traces the evolution of patronage relations in the health sector from the colonial and post-colonial periods to the contemporary era, setting the groundwork for understanding clientelism in the case study cities of Kupang, Makassar, and Semarang.

Part II: Empirical Case Studies. Part II presents the empirical core of the thesis, with chapters organised on a city-by-city basis. **Chapter Four** explores Kupang, a city with pervasive clientelism and poor health service delivery performance. Kupang's weak economy, heavy reliance on state funding, and highly competitive political environment foster predatory and exclusionary clientelistic practices. The health sector, like other sectors, is extensively targeted for patronage, with elites prioritising self-enrichment and rewarding close allies. **Chapter Five** examines Makassar, an anomalous case where high levels of clientelism coexist with relatively good health services. The chapter explains how Makassar's dynamic economy, strong personal networks, and middle-class activism shape a clientelistic system where politicians prioritise performance in the health sector while redirecting more predatory practices to other sectors such as licensing, urban planning, property development, and infrastructure. **Chapter Six** explores Semarang, where low clientelism and strong health outcomes are supported by inclusive patronage networks, economic strength, and elite oversight. Patronage is institutionalised through PDI-P's party structures and extends to grassroots groups, enabling community input and service monitoring. While programmatic politics is more

prominent, patronage persists in high-rent sectors like land and infrastructure and is shared across party lines to sustain coalition stability.

Part III: Conclusion. **Chapter Seven** synthesises the empirical findings and draws broader conclusions. It compares the three case study cities, highlighting how variations in economic development, social structures, and political dynamics influence patterns of clientelism in the health sector. The chapter reflects on the implications of these findings for the study of clientelism in public sector and distributive politics. It also places my subnational case studies in dialogue with cross-national patterns by analogising them to the important findings of a cross-national study conducted by Aspinall et al. (2022) on the patronage democracy, thereby using the cross-national framework as a reference point for interpreting the Indonesian cases. This last chapter also outlines directions for future research.

Chapter 2
Locating and Designing the Study

This chapter establishes the conceptual foundation of my study by reviewing literature on clientelism, particularly its operation in urban contexts and its impact on the delivery of public services, with a focus on healthcare. Expanding on the framework briefly introduced in Chapter 1, it draws together theories of clientelism and patronage, analyses of structural and political determinants of healthcare outcomes, and comparative insights from global and Indonesian studies. Addressing how clientelism varies across urban settings, how these variations shape healthcare outcomes, and what contextual factors modify these relationships, are all central to answering the research questions that guide my thesis.

The chapter begins by situating my study within the broader literature on clientelism. It traces the conceptual evolution of the concept of clientelism, distinguishing it from related terms such as patronage and rent-seeking/corruption, and reviews contemporary scholarship that explains its variation across democratic polities and policy sectors—particularly in the context of healthcare. Special attention is given to urban settings, examining how the urban middle class, civil society activism and patterns of economic development influence the forms and consequences of clientelism. The subsequent section outlines the research of design of my study. The chapter concludes by identifying key gaps in the literature and positioning this research within ongoing debates on clientelism and healthcare services.

Locating the Study

Classical Foundations

The concept of clientelism originates from early sociological and political theory. In studies of agrarian politics in traditional societies, state offices and resources were distributed through personalised patron-client relations. Scott (1972, pp. 8–10) examined agrarian societies in Southeast Asia, describing patron-client relationships as

dyadic (between two actors), asymmetrical (reflecting social hierarchies), and reciprocal (mutually beneficial). Lemarchand and Legg (1972, p. 151) and Weingrod (1968, pp. 377–378) further framed political clientelism as a strategic exchange rooted in identity and social structure. They crucially extended earlier foundations by suggesting that such "mutual-aid dyads" may encrust, rather than replace, formal organisations. This institutional anchoring motivates the thesis' focus on healthcare bureaucracies—where informal ties attach to formal rules of staffing, procurement, and access—and justifies an institution-centred, meso-level research design.

Contemporary Definitions

Modern scholarship shifted clientelism into the context of democratic competition. Kitschelt (2000, pp. 846–849) conceptualised it as one type of linkage between citizens and politicians, alongside programmatic and charismatic modes. Kitschelt and Wilkinson (2007a, pp. 5–7) accordingly defined clientelism as *contingent exchanges* of material inducements for political support. Stokes (2009, p. 605) defined clientelism as the *strategic distribution* of material inducements to secure electoral support. Berenschot (2018b, p. 1564) similarly characterises clientelism as the *exchange of personal favours*—such as jobs, contracts, or welfare entitlements—for political loyalty. Reviewing what was already an extensive literature, Hicken (2011, pp. 290–292) distilled four elements of clientelism: dyadic personal ties, contingent reciprocity (quid pro quo), hierarchical asymmetry, and durability or ongoing relationships. In sum, while patronage refers to the allocation of resources, clientelism describes the relational and strategic logic that structures such exchanges (Hutchcroft, 2014, p. 177).

Varieties and Patterns of Clientelism

Comparative studies clarify how clientelism takes different forms across political systems and countries. In Latin America, clientelism is more durable, often institutionalised within party machines, such as the Peronists in Argentina or Institutional Revolutionary Party (*Partido Revolucionario Institucional,* PRI) in Mexico, which long coordinated the distribution of patronage through vertically integrated networks in low-income communities (Auyero, 2000; Nichter, 2010, pp. 1–2; 2014; Stokes, 2005, p. 315). In most countries in Africa, clientelism is organised through ethnic

identities and networks, especially in countries with low institutional capacity (Weghorst & Lindberg, 2011, p. 1193). It is strongly shaped by colonial legacies and neopatrimonial governance, where political authority is frequently mediated through kinship, ethnicity, and traditional leaders. In this context, brokers often include traditional chiefs and local elites of the ethnic groups and clans who mediate access to electoral favours and state resources, which are frequently allocated based on personal loyalty rather than merit (Baldwin, 2016, pp. 35–39; Bratton & van de Walle, 1994; 1997, pp. 61–89). Van de Walle (2013, p. 3) later revisits the characteristics of African clientelism by classifying three distinct forms constructing the pattern: tribute (traditional gift exchange), elite clientelism (prebendal access to office), and mass clientelism (party-based distribution of services to large constituencies).

In North America, clientelism in the United States transitioned from overt party machine politics in the late 19th and early 20th centuries to more institutionalised forms, such as pork-barrel spending, patronage-based appointments, and constituency service (Levitt & Snyder Jr, 1997, p. 30; Shefter, 1993, pp. 16–35). While mass-based patronage has significantly declined, elite-level clientelism persists through party-business linkages, wherein political parties exhibit selective responsiveness to organised business interests in exchange for campaign financing and political support (Kuo, 2018, pp. 56–57).

In Europe, clientelism varies markedly across regions, shaped by divergent historical trajectories, institutional capacities, and welfare regimes, as listed in the following accounts. Ferrera (1996, p. 17) characterises the “Southern Model” of welfare—found in Italy, Spain, Portugal, and Greece, or Southern Europe—by its distinctive institutional and political configurations, tracing its roots to historical cleavages and enduring political polarisation. In these contexts, clientelism remains deeply embedded within party systems. As Kopecký and Scherlis (2008, p. 355) and Piattoni (2001, pp. 4–12) observe, political elites in Southern Europe—notably Italy, Greece, and Spain—continue to allocate public sector jobs, contracts, and selective benefits through local brokers to secure electoral support. In Central and Eastern Europe, scholars such as Kitschelt and Wilkinson (2007a, pp. 39, 47) highlight how the post-communist created fertile ground for the re-emergence of clientelism, often

manifesting through the politicisation of privatisation, licensing, and bureaucratic appointments under weak institutional oversight and fragmented party systems. By contrast, Northern and Western European countries, such as Germany and the Nordic states, barely exhibit clientelism (Kopecký, Mair, & Spirova, 2012; Kopecký et al., 2016; Rothstein, 2011), a pattern attributed to strong bureaucratic institutions, universalistic welfare systems, and high level of public trust, which collectively reduce the reliance on intermediaries to access state services.

In Southeast Asia, the pattern of clientelism is varied. In Malaysia, clientelism is party-based, resembling that found in many Latin American countries (Aspinall et al., 2022, pp. 77–84). In Indonesia and the Philippines, it assumes a decentralised, highly personalised form, with political parties playing a relatively weak role. In both countries subnational clientelistic networks have flourished in the wake of decentralisation reforms. A key difference between the Philippines and Indonesia lies in the nature of their clientelistic systems. In the Philippines, clientelism is more entrenched and oligarchic, particularly at the central level, where powerful dynastic families dominate—a pattern that Hutchcroft (1998, p. 52) characterises as a "patrimonial oligarchic state."

In contrast, Indonesia's clientelism has become more fragmented and localised post-decentralisation reform (Aspinall & Sukmajati, 2016, pp. 4–6). Clientelistic networks here are typically mediated by local bureaucrats, village heads, and informal power holders such as local strongmen, rather than cohesive party organisations, resulting in complex local patronage arenas. As I further elaborate below, in the Indonesian context, scholars argue that decentralisation and elite competition have given rise to fragmented clientelism, where local elites vie for control over resources and political support (Aspinall, 2013a, pp. 29–33; Berenschot, 2018b, pp. 1569–1570). Berenschot and van Klinken (2018, p. 102) further observe that decentralisation has both preserved traditional patron-client ties and facilitated the emergence of new forms of urban brokerage in competitive local arenas. This shift represents a transition from centralised authoritarian patronage to a more dispersed, locally embedded, and competitive form of clientelism, shaped by varied subnational political economies. It also illustrates how patronage networks adapt to institutional reforms to maintain their influence.

Viewed in comparative perspective, these cases underscore the varied and adaptive nature of clientelism. Following Yıldırım and Kitschelt (2020, pp. 21–25), my study conceptualises clientelism not as a binary—personalised versus institutionalised—but as a continuum of exchange strategies. While its forms differ across polities—from ethnic brokerage in Africa, to machine politics in Latin America, decentralised personalism in Indonesia and the Philippines, and elite patronage in the United States—the core logic of contingent exchange and political loyalty remains fundamental. Drawing on these diverse expressions, clientelistic strategies have evolved further under conditions for electoral competition, leading to increasingly sophisticated and targeted modes of exchange. These include vote-buying (Aspinall, Rohman, Hamdi, Rubaidi, & Triantini, 2017; Stokes, 2005, pp. 318–321), abstention buying (Cox & Kousser, 1981, p. 646), turnout buying (Nichter, 2008, p. 19), ticket buying (Aspinall & Sukmajati, 2016), and broker buying (Hicken, Aspinall, Weiss, & Muhtadi, 2022, p. 77). In Indonesia, such practices are frequently mediated by brokers who operate through informal associations, religious networks, and even gambling syndicates or *botoh* (Abbiyyu, 2020, pp. 68–70). As Ravanilla, Haim, and Hicken (2022, p. 795) aptly observe, clientelistic methods typically rely on intermediaries—brokers—who mediate exchanges between political elites and constituents, distribute benefits, and manage expectations of reciprocity.

Brokers' Roles and Influence: From Vote Mobilisation to Service Delivery

My thesis foregrounds the role of brokers as part of wider patronage networks in shaping clientelistic politics in Indonesia's sector and local politics in general. While early models portrayed brokers as passive conduits operating within a triadic model of clientelism— "client-broker-patron," where patrons allocate benefits, brokers distribute them, and clients reciprocate with loyalty and political support (Kitschelt & Wilkinson, 2007a, pp. 8–9)—more recent scholarship has highlighted brokers as strategic actors. Far from being mere conduits, brokers are increasingly recognised as political entrepreneurs, who exercise agency, mobilise social capital and navigate complex local landscapes to sustain reciprocal exchanges (Berenschot & Aspinall, 2020, p. 11; Stokes et al., 2013, p. 138). By centring analysis on these actors and the networks they cultivate, one purpose of this study is to explore how brokers mediate patronage flows, enforce

political loyalty, and influence service delivery outcomes in subnational healthcare governance.

Across countries, brokers are known by localised terminologies—*fixers* in India who navigate bureaucratic access (Berenschot, 2011, p. 382), *punteros* in Argentina who manage electoral mobilisations (Auyero, 2001, p. 3), and *community leaders* acting as brokers in Brazil (Koster, 2012, pp. 484–485)—reflecting their embedded relational character. Lisoni (2017, p. 126) further classifies brokers into two ideal types: *dirigente* broker, who retain partial autonomy, and *puntero* broker, who act as loyal delegates of patrons. In Latin American contexts, Holland and Palmer-Rubin (2015, p. 1186) make different classification by distinguishing them into four types: *organisational* brokers, *hybrid* brokers, *party* brokers, and *independent* brokers, based on their findings that many politicians in fact outsource their vote mobilisation to interest organisations. In Indonesia, brokers are also diverse. One way of classifying them suggests they come in three types: *activist* brokers who are driven by ideology, *clientelist* brokers who are seeking durable ties, and *opportunist* brokers who are driven by short-term rewards (Aspinall, 2014b, p. 548); but in fact the types are extremely diverse—even *botoh* or gamblers in some regions in Java can operate as electoral brokers (Abbiyyu, 2020, pp. 68–70) (candidates engage *botoh* because of their deep-rooted knowledge of local constituencies and their ability to mobilise votes effectively through informal networks and to influence voters).

Brokers' influence can extend beyond elections into governance and service delivery. In Indonesia and India, brokers—typically but not necessarily the same individuals who mobilise votes—can mediate citizen access to healthcare, education, and licensing, politicising bureaucratic entitlements (Berenschot, 2019b, p. 208; J. Bussell, 2019, p. 8). McLoughlin and Batley (2012, pp. 11–12) argue that brokers politicise bureaucratic processes, distorting formal accountability. Auyero's ethnographic study offers a particularly vivid portrayal, describing brokers as "problem-solvers" whose legitimacy stems from their ability to navigate bureaucracy on behalf of the poor (Auyero, 2000, p. 55).

Comparative studies show that brokers' strategies vary depending on the density of civil society and media scrutiny (Mares & Young, 2019, p. 218). Where oversight is strong, brokerage is constrained; where weak, it thrives. Thus, contemporary studies highlight that brokers are not mere intermediaries but often autonomous agents who mediate, negotiate, and shape political and governance outcomes.

As political entrepreneurs, brokers' behaviour can be difficult to manage. Indeed, ensuring broker loyalty is a persistent challenge, yet little evidence is found by Hicken et al. (2022, p. 77) that politicians in Indonesia deploy effective mechanisms to monitor brokers' loyalties. Candidates must not only recruit brokers but manage, incentivise, and control them to prevent predation and defection (Aspinall, 2014b, pp. 552–553). Field studies overseen by Aspinall and Sukmajati (2016, pp. 5–6) provide empirical depth that demonstrates how brokers and campaign teams (*tim sukses*) play a pivotal role in connecting candidates to voters but are also prone to leaking funds or betraying trust, making vote-buying an inherently uncertain and costly strategy. Indeed, as Aspinall and As'ad (2015, pp. 174–176) show, election outcomes often hinge more on the quality of recruited brokers—particularly state-linked brokers such as village heads—than on direct candidate appeals.

My thesis highlights the central role of brokers in shaping clientelistic politics in Indonesia's health sector. Moving beyond early views of brokers as passive intermediaries (Kitschelt & Wilkinson, 2007a), I follow recent work that sees them as strategic actors who mobilise networks and navigate local power structures (Berenschot, 2020; Stokes et al., 2013). In Indonesia, brokers vary widely—from ideologically driven activists to opportunists, even including *botoh* or gamblers in some regions (Abbiyyu, 2020; Aspinall, 2014b). Their influence extends beyond elections, mediating access to healthcare and politicising public services (Auyero, 2000; Berenschot et al., 2018). By tracing their role in subnational governance, my study shows how brokers sustain clientelism not just at the ballot box, but in everyday service delivery.

Clientelism, Patronage, and Rent-seeking/Corruption

Clientelism, patronage, and rent-seeking/corruption are deeply interconnected, yet analytically distinct dimensions of informal politics. While patronage is often used interchangeably with clientelism (Kitschelt & Wilkinson, 2007a, p. 7; Piattoni, 2001, p. 4; Van de Walle, 2007, p. 51), some scholars have drawn important distinctions. In one perspective, which I adopt in this thesis, *patronage* refers broadly to the distribution of resources—or material flows such as jobs, contracts, or services—for political gain (Hutchcroft, 2014, p. 177), whereas *clientelism* structures these exchanges within contingent, reciprocal relationships, between patrons, brokers, and clients. A key conceptual differentiation is that patronage pertains to the resources, while clientelism refers to the nature of relationships; the presence of one does not necessarily imply the other, e.g., as noted above, patron-client ties such as between landlord and tenant may not have electoral purpose, and patronage dispersal may not be personalistic. Importantly, not all patronage is contingent (Aspinall et al., 2022, pp. 6–7). As Aspinall et al. (2022, p. 238) demonstrate with empirical evidence from Southeast Asia, much patronage serves broader strategic purposes—such *as credibility signalling, turf protection,* or *brand-building*—beyond *vote-buying* alone. *Rent-seeking*, on the other hand, occurs when political actors exploit these or similar distributional mechanisms, or simply their dominance of the state, to extract economic rents without contributing to productive outcomes, often diverting resources away from public goods (Krueger, 1974, p. 291; Pasour, 1987, p. 137; Tollison, 1982, p. 578; 2012, pp. 3–6).

These conceptual boundaries are often blurred in practice. Building on earlier discussions, Carroll and Lyne (2007, pp. 5–8) argue that rent-seeking becomes clientelistic when the subsequent allocation of those rents is politically contingent, that is, when political loyalty conditions their distribution. They draw analytical boundaries between *clientelism*, *pork-barrelling*, and *rent-seeking,* viewing them as overlapping but analytically separate strategies of distributive politics grounded in selective exchange and informal rules. While rent-seeking refers primarily to the extraction of rents, it acquires a clientelistic character when those rents are later distributed selectively to supporters, thereby prioritising narrow political interests over the equitable delivery of public goods. While there is a temporal disjunction between the extraction of rents and

their later redistribution, in practice these can be closely linked, blurring the line between rent-seeking and clientelistic behaviour and contributing to conceptual complexity.

Building on these foundations, Robinson and Verdier (2013, p. 264) demonstrate that clientelistic networks create constant demands for political financing and resources, while rent-seeking often serves as a key mechanism for providing those finances and resources. Rent-seeking is likely to be especially important to clientelistic politics when a large proportion of the material resources distributed to voters or other clients are distributed privately—e.g., in the form of vote-buying—rather than in the form of public resources, such as in the form the form of preferential access to welfare programs. In such cases, clientelistic politicians need to divert resources out of the public system.

The imperative to remain in power intensifies resource extraction, reinforcing the diversion of public goods for partisan purposes. Bardhan (2022, p. 2) similarly notes that electoral strategies like vote-buying tend to institutionalise corruption over time. Keefer and Vlaicu (2008, pp. 375–380) argue that in low-credibility democracies, where politicians cannot credibly commit to programmatic platforms, clientelism and patronage become rational strategies, exacerbating corruption, inefficiency, and rent-seeking. Tollison (2012, pp. 3–6) and Krueger (1974, p. 77) further demonstrate that rent-seeking imposes significant societal costs by diverting substantial portions of gross domestic product (GDP) to non-productive activity.

Before extending these insights, it is important to clarify the definition of key forms of resource extraction—namely rent-seeking, corruption, and clientelism. Hutchcroft (1997, pp. 640–641) lends a useful reference for *rent-seeking* as "directly unproductive profit-seeking" activities, which can be legal (such as lobbying) or illegal (e.g., bribery). Such activities are typically inefficient and have been argued to reduce the role of the state in favour of markets. Unlike rent-seeking, which emphasises how states distort markets, *corruption* shifts the focus to how markets may, in turn, distort states (p. 642). Drawing on Joseph Nye's classic formulation, Hutchcroft highlights that:

> Corruption is behaviour which deviates from the formal duties of a public role because private-regarding (personal, close family, private clique) pecuniary or status gains; or violates rules against the exercise of certain types of private-regarding influence. (Nye, cited in Hutchcroft, 1997, p. 643)

Lambsdorff (2002) offers a critical refinement: corruption not only exploits but also creates rents, as political and bureaucratic actors deliberately engineer regulations—such as licensing barriers and procurement discretion—to extract bribes (pp. 113–115). This is particularly relevant to Indonesia, where local elites manipulate health procurement rules and medical licenses to sustain patronage networks. Lambsdorff further argues that corruption constitues a monopolistic and exclusionary form of rent-seeking, reinforcing elite control and undermining public accountability (p. 121). These dynamics clarify how political contingent rent distribution—central to clientelism and patronage—can distort institutional performance, generate corruption, and thus deepen service inequities. Hutchcroft (1997, pp. 645–646) emphasises how rent-seeking and corruption practices intersect with clientelism. It is when patrons occupy or influence public office that clientelism and corruption overlap, embedding rent distribution in personalised power relations. Unlike impersonal "market corruption," clientelism embeds rent distribution in enduring social relations, further distorting institutional performance and deepening service inequities.

In addition to being a source of rents, politicians can also distribute healthcare services, as with other public resources, directly to their clients, effectively turning healthcare into a patronage resource. This pattern is evident in various contexts where healthcare programs, aid, and jobs can be allocated selectively in exchange for political support. In Brazil, Nichter (2011, pp. 7–15) shows that politicians strategically distribute healthcare and sterilisation benefits as a means of electoral mobilisation among urban poor populations. Similar dynamics are evident in Lebanon, where informal political networks condition healthcare access—individuals with higher levels of political activism are significantly more likely to receive financial health aid, disproportionately affecting marginalised communities (Chen & Cammett, 2012, p. 2). In Indonesia during the COVID-19 pandemic, political parties and their affiliated politicians were reported to prioritise vaccine distribution for their supporters, illustrating how public health

services—especially in times of crisis—can be instrumentalised as patronage (Sari, 2021a, 2021b; Sari, Aspinall, Haryanto, & Armunanto, 2023, p. 1).

To deepen the understanding of how corruption manifests in health systems, Sommersguter-Reichmann, Wild, Stepan, Reichmann, and Fried (2018, p. 293) offer a more nuanced typology of corruption in the health sector by distinguishing between individual and institutional corruption. *Individual corruption* involves illicit acts such as embezzlement, bribery, and fraud committed for personal enrichment. In contrast, *institutional corruption* stems from structural incentives, organisational norms, and institutional arrangements that systematically divert public services from their intended purpose. This broader analytical perspective highlights how health systems can be distorted in ways that undermine the public interest—even when actors operate within the formal boundaries of legality. Such a typology is especially valuable for analysing contexts where corruption is not confined to discrete acts of misconduct but is embedded in routine institutional practices. It also provides a critical lens through which to examine the intersection and institutionalisation of clientelism and rent-seeking in the health sector.

This typology is particularly useful in understanding the Indonesian context, where institutional corruption is often reinforced by the decentralised governance system, which facilitates the proliferation of patronage networks at the local level. As Tomsa (2015, p. 197) and Buehler, Nataatmadja, and Anugrah (2021, p. 389) observe, decentralisation has empowered local elites—the so-called "little kings or raja kecil"—to exploit devolved authority to entrench clientelism and expand rent-seeking in their regions. Rather than improving accountability, decentralisation has in many cases created new arenas for localised corruption. Empirical evidence from Indonesia's Corruption Eradication Commission (*Komisi Pemberantasan Korupsi*, KPK), illustrates the extent of the problem, revealing persistent corruption in key sectors such as health, in addition to other sectors like infrastructure and procurement at the subnational level (Anggraeni, Primayogha, Rachman, & Alamsyah, 2020; Erdianto, 2018; Indonesia Corruption Watch, 2013, 2017, 2020; Irawan, 2018; Manurung, 2018; Ni'am & Asril, 2023; Noorca, 2022; Rico, 2023; Setiyono, 2017; *Tempo*, 2001, 2019; Trijono, 2006).

Importantly, the persistence of institutional corruption at the subnational level often intersects with broader, cross-sectoral governance failures, compounding its impact on service delivery. This overlap between sector-specific and systemic corruption illustrates how misconduct in areas like infrastructure, education, or licensing can severely undermine essential services. Cross-sectoral corruption, therefore, emerges as a key driver of healthcare inequality and inefficiency. This argument is reinforced by Bukari, Seth, and Yalonetkzy (2024, p. 1), whose study of 29 Sub-Saharan African countries highlights how multi-sectoral corruption erodes the broader governance environment in which health systems operate. In Indonesia, sectors such as public infrastructure procurement and land reclamation are especially vulnerable. In such sectors collusion between politicians, bureaucrats and contractors enables rent extraction through project skimming, inflated budgets, and selective tendering (Boas, Hidalgo, & Richardson, 2014; S. Hidayat, Tambunan, & Haning, 2024; Tambunan, 2023).

These patterns reveal a critical lesson: decentralised governance, in the absence of strong institutional oversight, can deepen rather than mitigate the systemic problems of clientelism and corruption. As Bukari et al. (2024, p. 1) argue, efforts to curb corruption within a single sector—such as health—are unlikely to succeed without broader reforms that strengthen institutional integrity. This insight underscores the need to analyse health-related corruption not in isolation, but within a wider political and governance context—an approach that this study adopts. As Aspinall et al. (2022, pp. 250–251) further remind us, patronage regimes rooted in long historical legacies, make reform arduous but possible—most promising when crisis-driven openings align with institutional redesigns that constrain discretionary patronage and foster bureaucratic autonomy.

While rent-seeking dominates discussions of governance failures, the role of patronage is equally harmful—and too often overlooked—when it comes to healthcare. Far from being a secondary concern, patronage undermines professionalism, distorts merit-based recruitment, can divert resources and treatments away from those who need them most, and weakens the institutions meant to deliver essential services. Around the world, the impacts are clear: in the Dominican Republic, for example,

political connections inflated staffing levels in the health system, filling roles with poorly qualified candidates, while promotions often went to those with ties to politicians or the military rather than those with the right skills (M. Lewis, 2006). In Ethiopia, health officials described how nepotism and favouritism shaped hiring processes, reinforcing inequality and undermining performance (M. Lewis, 2006, p. 20). Indonesia is no exception, though patronage in the healthcare system has so far been little researched. One of the closest accounts is provided by Blunt et al. (2012, pp. 216–218), who document how patronage-driven appointments in the health sector compromise staffing decisions, erode bureaucratic integrity, and ultimately impede the health sector's ability to function effectively.

In sum, as I introduced earlier as my research framework, clientelism can undermine healthcare delivery through two primary pathways. *First, a rent-seeking route*—manifested in corruption in elements of the management of the health sector, such as procurement, distribution of resources, and personnel selection (where it can involve sale of positions). These practices compromise service quality through the appointment of unskilled staff, reducing accountability, fostering informal payments, and, most importantly, diverting funds away from healthcare provision as politicians take funds out of the system. These practices directly harm patients by lowering care standards, demotivating qualified health workers, and limiting access for the poor (M. Lewis, 2006, p. 20). *Second, the patronage route* involves the allocation of services and jobs with the health sector as political rewards. This distorts resource distribution, by prioritising political loyalty over need and thus weakens institutional capacity, entrenches inequities, and erodes the impartiality of healthcare provision. Extending this line of analysis, Berenschot et al. (2018, p. 130) demonstrate how the institutional weakening so generated provides openings for brokers and intermediaries to manipulate access to public services, including national health insurance and referral systems, thereby reinforcing informal hierarchies and perpetuating inequalities in healthcare delivery.

Understanding clientelism, patronage, and rent-seeking/corruption is not merely an academic exercise—it is central to unpacking the political logic that underpins healthcare governance. Mapping how these interconnected practices operate in

everyday institutional life can reveal how political incentives and informal exchanges influence who gets what, when, and how in the delivery of public health services. In contexts like Indonesia, where decentralisation has layered new institutions over long-standing informal networks, grasping these dynamics is key to explaining why well-intentioned reforms often falter. This conceptual framing thus provides both a sharper explanation of persistent governance failures and a more grounded path toward equitable and effective healthcare provision.

Factors that Modify the Relationship between Clientelism and Service Delivery

Several factors can mitigate the negative effects of clientelism, according to the scholarly literature. *First,* it is especially well established that socioeconomic development and middle-class expansion can pressure elites to adopt more programmatic governance (Berenschot, 2019a, p. 1568; Weitz-Shapiro, 2014). Brinkerhoff and Bossert (2014, p. 687) likewise observe that rising citizen expectations, especially from a politically aware and aspirational middle class, tend to reduce tolerance for clientelistic exchanges. Berens and Ruth-Lovell (2021, p. 711) add that processes such as urbanisation and increased education attainment further moderate clientelism's appeal. Among these trends, the emergence of a politically conscious middle class is particularly consequential. This group is more likely to favour universalistic policies over discretionary benefits and to resist the transactional logic of clientelism (Kitschelt & Wilkinson, 2007a, pp. 22–23; Weitz-Shapiro, 2014, p. 13).

Second, a robust civil society can constrain clientelism by promoting accountability and limiting the space for clientelistic exchange. The active involvement of progressive civil society actors and organisations in local politics, combined with broader societal mobilisation, has been shown to reduce opportunities for clientelism and improve good governance (Antlöv et al., 2010, p. 417; Kitschelt & Wilkinson, 2007a, p. 27; Mares & Young, 2019, p. 216; M. Mustafa, 2024; Tans, 2012). Even in authoritarian settings, civil society, in forms of social organisations, can foster more accountable service delivery, as Tsai (2007, pp. 355–357) demonstrates. However, civil society is not inherently anti-clientelistic; it can also be a vector through which clientelistic exchange is organised. The critical issue is the degree to which civil society groups are

organisationally and financially independent from political elites—only autonomous civil society groups are likely to constrain, rather than reinforce, clientelistic practices.

Third, and related to both of these factors, economic development, a robust private sector, and market competition can also reduce clientelism. Many studies suggest that economic development and modernisation can weaken the foundations of clientelism by reshaping the incentives for both politicians and voters. As incomes rise and the middle class expands, the marginal benefits of engaging in clientelistic exchanges tend to decline, while the costs—both financial and reputational—increase (Bustikova & Corduneanu-Huci, 2017; Calvo & Murillo, 2004; Dixit & Londregan, 1996; Hicken, 2011; Kitschelt & Wilkinson, 2007a; Magaloni et al., 2007; Robinson & Verdier, 2013). Additionally, as electoral competition intensifies in more developed settings, clientelistic strategies become harder to monitor and enforce, further disincentivising their use by political elites (Lehoucq, 2007b; Stokes et al., 2013).

Fourth, a combination of institutional reform and enhanced political credibility on the part of politicians can play a critical role in reducing clientelism and rent-seeking practices (Bobonis et al., 2023; Montambeault, 2011; Rose-Ackerman, 1999). Keefer and Vlaicu (2008, p. 371) highlight that when politicians are perceived as credible and likely to deliver on programmatic policies, the attractiveness of clientelistic appeals diminishes. It can thus be important to develop institutional reforms that enhance politician credibility, for example by removing the distance between politicians and voters through decentralisation. Nonetheless, Buehler (2014, p. 161) cautions, decentralisation reform on its own does not necessarily reduce clientelism; without accompanying institutional reforms, it may instead foster proliferation of local patronage networks and the "little kings" noted above. Buehler et al. (2021, p. 381) demonstrate that Indonesia's decentralised yet rigid unitary state, coupled with the relatively high economic autonomy of voters, can inhibit the consolidation of enduring local patronage networks. Conversely, stronger democratic institutions—marked by independent judiciaries and media freedom—create a less permissive environment for clientelistic and illicit political behaviour (Lo Bue, Sen, & Lindberg, 2021, p. 9). The obvious challenge, however, is to develop such strong institutions out of an environment in which clientelism undermines them from within.

When examined together, these four sets of factors—middle class development, civil society strength, market dynamics, and institutional reform—serve not merely as abstract variables, but as concrete forces that shape how clientelism unfolds on the ground. In this thesis, I examine how these factors interact in three Indonesian cities—Semarang, Makassar, and Kupang—each representing a distinct constellation of political competition, civic engagement, and economic opportunity. Rather than asking whether clientelism exists, I ask *what* form it takes, and *how* and *under what conditions* it influences the distribution of healthcare resources. In doing so, I move beyond framing clientelism as a static pathology. Instead, I demonstrate how its effects can be moderated by the presence—or absence—of civic voice, middle-class demands for better governance and quality of services. Ultimately, this study contributes to a deeper understanding of clientelism—not only as a mechanism of political exchange, but as a governance practice with tangible implications for the quality of life, equity, and health outcomes for citizens across Indonesia.

Clientelism in Indonesia

Indonesia exhibits a distinct pattern of what Aspinall (2013a, pp. 34–37) describes as "fragmented" or "decentred" clientelism, and what he and Berenschot later term as "freewheeling clientelism" (Aspinall & Berenschot, 2019, p. 65). In this configuration, clientelistic exchanges are highly decentralised and loosely organised, with numerous brokers operating semi-independently rather than being centrally coordinated by political parties or elite patronage networks. This diffusion of brokerage allows for more fluid, opportunistic forms of exchange, which are shaped by local political and social dynamics. Berenschot (2018b, p. 1564) further notes that the intensity and visibility of clientelistic practices vary geographically—with such exchanges perceived to be less pervasive in urban Java compared to in cities in Eastern Indonesia, where local capacity is weaker, economies are more monopolistic, and informal brokerage is more entrenched.

This fragmentation stems from Indonesia's post-1999 decentralisation reforms which, rather than reducing clientelistic practices, multiplied local opportunities for brokerage and personalised patronage. As Buehler (2010, pp. 273–274) argues,

decentralisation empowered local elites, often operating through informal networks and loosely structured political parties, to capture new arenas of subnational electoral competition. Van Klinken (2009, p. 12) similarly characterises Indonesia's provincial politics as a "patronage democracy," where political success increasingly depends on managing fragmented, overlapping networks of personal loyalty rather than programmatic platforms. Robison and Hadiz (2004) contend that the endurance of patronage systems following democratisation and decentralisation reflects the adaptation of oligarchic structures inherited from the New Order. The predatory control over state resources and public institutions that powerful actors inherited from the previous regime enabled them to reorganise their networks and consolidate their influence at the regional level, allowing entrenched elites to dominate local political economies (Hadiz & Robison, 2005, p. 232).

This fragmented and brokered nature of clientelism is particularly visible in healthcare service delivery. As Berenschot et al. (2018, p. 130) observe, access to healthcare in many Indonesian cities is often mediated through personal networks rather than being determined by formal eligibility or need. Ironically, the expansion of subsidised health insurance coverage under Indonesia's new universal healthcare system has intensified reliance on intermediaries, as complex procedures and inadequate government funding mean that everyday access to healthcare has remained a highly negotiated affair. Poor citizens frequently turn to influential intermediaries to arrange hospital admission or access to subsidised care.

Further evidence of this pattern is provided by Nugroho, Handayani, and Effendi (2021, p. 292), whose ethnographic study in West Java also demonstrates that despite the establishment of a national health insurance system (JKN), access to healthcare services for the poor remains heavily brokered. Their findings confirm the persistence of what Berenschot et al. (2018, p. 130) call "brokered citizenship," where formal entitlements are effectively mediated through informal actors. Although not all brokerage is inherently clientelistic, much of it operates within relationships marked by moral indebtedness (*hutang budi*) and expectations of reciprocity. The support provided by brokers is often not unconditional; clients are expected to return favours, particularly

during elections. As one broker candidly put it: “From whom did you get these programs and handouts? From me, right? So now vote for my candidate” (p. 139).

This pattern of interaction reveals that brokers are not simply facilitators of service access, but strategic political actors who transform public goods into conditional rewards—reshaping healthcare access through the lens of clientelistic exchange. While often framed in the language of care, solidarity, or community service, such interventions mask transactional relationships grounded in political loyalty. Berenschot (2019, p. 208–210) and Berenschot et al. (2018, p. 139) contend that this mode reflects a deeper trend: the logic of clientelism is not only confined to elections but has become embedded in the everyday functioning of welfare distribution, including access to health services.

This entrenchment of informal practices signals deeper institutional weaknesses in Indonesia’s post-decentralisation governance. The slow—or in some areas, stagnating or even regressing—development of effective bureaucratic systems has left local governments fragmented and ill-equipped to manage complex service delivery. These administrative gaps have created fertile ground for clientelism and patronage to persist, even within ostensibly programmatic initiatives like universal healthcare. Rather than displacing informal access, such reforms are often co-opted by local elites who exploit bureaucratic inefficiencies to sustain patronage through informal channels. As Blunt et al. (2012, p. 216) observe, formal bureaucratic rules often function as a veneer, concealing the opportunistic behaviour of patrons and their networks.

These patterns of elite co-optation are reinforced from within bureaucracy itself, echoing the classical concept of “goal displacement” developed by Merton (1940, pp. 562–563), whereby rigid adherence to procedures comes to overshadow substantive outcomes. In sectors such as healthcare, where discretion and responsiveness are vital, such formalism—particularly when coupled with weak technical capacity—can generate deep inefficiencies (p. 562). As Merton (1940, p. 567) further noted, tensions emerge when the demand for impersonal treatment clashes with citizens’ expectations for personalised care. These bureaucratic shortcomings open the door for informal brokers

to mediate access, further entrenching non-programmatic practices in everyday governance.

These conditions help explain how clientelistic practices persist and adapt within Indonesia's urban settings. While urbanisation, modernisation, and economic development, as noted above, are often assumed to weaken traditional patron-client relations, their effects have been uneven. Van Klinken (2009, p. 25) argues that urbanisation may reduce the salience of primordial ties but does not eliminate clientelism; instead, it transforms into more monetised and transactional forms of money politics, shaped by enduring structural problems of poverty gaps and inequality. Heath and Tillin (2018, p. 90) suggest that expansion of universalistic and impartial health programs—such as the JKN health insurance scheme—should reduce citizens' dependence on clientelistic exchanges in health services. Yet the reality is far more complex. The tension between these reform expectations and the persistence of informal practices is particularly evident in Makassar. As Berenschot (2018b, p. 1563) observes, while economic diversification and the dispersion of economic power can constrain clientelism by empowering civil society and increasing political accountability, such outcomes are not automatic. Despite Makassar's economic vibrancy and middle-class growth—as I will show in this study—clientelistic practices continue to thrive, underscoring how structural inequalities and institutional deficits sustain informal politics.

In sum, the existing literature on Indonesia offers important insights into how political clientelism evolves and endures within a decentralised democratic context. Rather than being displaced by urbanisation, economic growth, or programmatic reforms like JKN, clientelism often adapts—manifesting in more monetised, bureaucratically embedded, and sector-specific forms. These studies provide important clues to how patronage networks influence bureaucratic appointments, how rent-seeking distorts resource allocation, and how informal intermediaries continue to shape citizens' access to public services. Building on these insights, this study examines how clientelism operates in the health sector across three urban contexts—Kupang, Makassar, and Semarang—each marked by different combinations of contextual factors and agencies. By tracing how patronage and rent-seeking mechanisms affect healthcare

delivery, the study contributes to a deeper understanding of the political conditions that reproduce inequality and institutional dysfunction in Indonesia's health governance.

Gaps in the Literature and Contribution of this Study

While considerable research has illuminated the mechanisms, variations, and persistence of clientelism, important gaps remain, particularly concerning its sector-specific effects on public service delivery. Notably, few studies have systematically explored how clientelism influences healthcare outcomes at the subnational level. Much of the existing scholarship remains either focused on national-level generalisations or clustered around infrastructure and welfare sectors, leaving the interplay of clientelism and healthcare relatively understudied (with a few exceptions, including Berenschot et al. (2018, p. 129) and Blunt et al. (2012, pp. 217–218)).

Within this context, it is not surprising that there has been limited attention paid to how sectoral characteristics within healthcare—such as the partial privatisation of healthcare, the professionalisation of health workers, or the regulatory complexity of health services—might mediate the impact of clientelistic strategies. While national-level studies in India and Lebanon by Bussell (2019), Chen & Cammett (2012), and Manor (2016) offer valuable insights into the selective and hybrid clientelism application in some specific sectors, there remains a need for deeper subnational comparative analysis, particularly in decentralised systems like Indonesia's, where local variations in governance and service delivery are pronounced.

Another gap concerns the modifying role of urban socio-economic change. While scholars such as Berenschot (2019a, p. 233), Brinkerhoff (2004, p. 371), Chen and Cammett (2012, p. 6), Kitschelt (2007), Kitschelt and Wilkinson (2007a, pp. 24–27), Magaloni et al. (2007, p. 7), Montambeault (2011), Robinson and Verdier (2013), Stokes et al. (2013), Tans (2012), and Weitz-Shapiro (2014) have highlighted the potential of middle-class expansion and civil society activism to constrain clientelism, empirical testing of these relationships at the urban and sectoral level—especially in relation to healthcare—remain rare.

This study contributes to filling these gaps by providing a comparative analysis of how variations in clientelistic patterns across Indonesian cities shape healthcare outcomes. It especially examines the mechanisms through which clientelism influences healthcare access and quality and investigates contextual factors—such as middle-class growth, privatisation, and elite competition—that might moderate these effects.

Designing the Study

Research Strategy and Design

As briefly indicated in the introduction chapter, in this thesis I adopt a comparative case study strategy to investigate how varying forms of clientelistic politics shape the delivery of healthcare services in different urban contexts in Indonesia. As noted by George and Bennett (2005, p. 84) and Gerring (2007, pp. 37–38), comparative case studies are particularly suited for uncovering causal mechanisms, especially where the processes of interest—such as clientelistic practices—are context-dependent and not easily observable through quantitative means alone.

To set the scene, four initial criteria guided the case selection for this study: the unit of analysis, time period, theoretical relevance (Levy, 2008, p. 2), and accessibility or expediency. The primary unit of analysis is the city-level administrative territory (*kota*) which has become a key locus of governance under Indonesia's decentralisation framework. Following the implementation of decentralisation laws, significant public responsibilities and fiscal resources have been devolved to this level (Kristiansen & Santoso, 2006; McCollum et al., 2018; Pal & Wahhaj, 2017). This administrative layer, situated below the provincial level, is illustrated in Chapter 3, Figure 3.1. To ensure comparability, cities of Jakarta and Yogyakarta were excluded due to their status as special administrative regions. Likewise, all cities in provinces with special autonomy status including those in Aceh, Papua, West Papua, South Papua, Central Papua, Highland Papua and Southwest Papua were also excluded from consideration. Within each selected case, the analysis focuses on the distribution of healthcare programs and public sector employment in healthcare, applying the conceptual framework outlined in Table 1.3 of Chapter 1, which identifies the key subsystems and mechanisms through which

clientelism shapes health service delivery. A more detailed explanation of the case study selection follows in the next section.

The timeframe of this study spans the post-decentralisation period, beginning around 2001 and extending through to at least 2023. This period captures the full arc of significant institutional transformations following the enactment of Indonesia's decentralisation laws in 1999. Key developments include the shift in local executive elections—from indirect mayoral selection by local parliaments in the early 2000s to the adoption of direct local elections (*pilkada*) in 2005. The selected timeframe also ensures that each case covers at least three electoral cycles, allowing the study to examine political transitions and the competitive dynamics that shape changes in leadership. This longitudinal scope is critical for tracing how shifts in political power affect patterns of clientelism and their impact on healthcare governance over time.

To construct the analytical framework for comparing clientelism in the selected case studies, as explained in Chapter 1, I draw on the clientelism and patronage typology developed by Berenschot and Aspinall (2020, p. 11), which captures not only the nature of clientelistic practices but also their linkage to patronage and rent-seeking. In analysing the determinants and intensity of clientelism, I rely on the conceptual and empirical contributions of such as Berenschot (2018b, 2019a), who offers the most robust subnational framework developed so far for measuring clientelism in Indonesia.

Research Focus

Returning to the core of this study design, these following questions guide the design of this study:

1. How does variation in the nature of clientelistic politics at the subnational level affect the delivery of healthcare services to citizens?
2. What contextual factors modify the relationship between clientelism and healthcare service delivery?
3. What are the chief mechanisms through which clientelistic politics affect healthcare quality?

To address these research questions, I begin by outlining an initial assumption about the pathways by which clientelism may affect healthcare performance (Chapter 1, Figure 1.1). This is refined further as a conceptual framework in Table 1.3 of Chapter 1. To recap briefly: clientelistic politics can undermine the professionalism and effectiveness of the health system, ultimately impairing healthcare performance and service delivery. This occurs through two main pathways: the patronage route and the resource extraction (or rent-seeking) route. In the patronage route, health sector jobs and resources are allocated as rewards to political supporters—typically of incumbent local leaders—rather than based on merit or need. In the resource extraction route, clientelistic politicians and their allies divert resources from the health sector—often through corrupt practices—to fund their political operations and sustain clientelistic networks. To test this assumption, I employ a mixed-methods approach. This integrates cross-sectoral quantitative analysis to inform case selection with qualitative methods—such as document analysis, semi-structured and in-depth interviews, and field observation—to examine causal mechanisms and contextual variations in greater depth. In line with Lieberman's (2005, pp. 435–437) "nested analysis" model, this combination enables large-N data to guide the choice of small-N case studies, while within-case process tracing strengthens both internal and external validity.

This approach is particularly appropriate given the challenges of studying clientelism, a phenomenon often characterised by informal, opaque exchanges that elude direct measurement (Denzin, 2017, p. 98). Triangulating multiple sources—interviews, observations, and documents—serves to mitigate bias and enhance the robustness of causal inference (Denzin, 2017, p. 27). The aim is not only to detect whether clientelism affects healthcare outcomes but to understand how and under what conditions these effects manifest across different institutional, political, and socio-economic contexts (Brinkerhoff & Bossert, 2014, p. 685; Brinkerhoff & Goldsmith, 2002, p. 50; M. S. Grindle, 2012, p. 14).

This research is further strengthened by the use of ethnographic techniques, particularly in Semarang, where the researcher's positionality as a local resident enabled deeper immersion. The COVID-19 pandemic constrained opportunities for similar immersion in Makassar and Kupang, limiting fieldwork to two weeks in each location.

Nevertheless, this was supplemented by the support of local research assistants, who played a key role in facilitating access to informants, conducting observations and tracking political dynamics, particularly during the period of travel bans (when my fieldwork had been scheduled) between 2020 and 2022.

Case Selection

Based on the criteria developed for case study selection, as introduced in Chapter 1, I employ a two-stage case selection strategy designed to ensure both empirical relevance and analytical rigour—I have also briefly introduced this in Chapter 1. The first stage involves a quantitative correlation analysis using secondary data to examine the relationships between subnational variations in clientelism intensity and healthcare performance across Indonesian cities. To measure clientelism, I use the *Clientelism Perception Index* (CPI) developed by Berenschot (2018b, p. 1580), which scores the prevalence of clientelistic practices across 53 regions, including provinces, provincial capitals, smaller cities, and rural districts. This dataset offers a rare and robust subnational indicator of clientelism intensity. **Table 2.1** shows the list of provinces, cities, and districts that became the samples of CPI work (Aspinall & Berenschot, 2019, pp. 275–276).

Table 2.1

List of Provinces, Cities, and Districts Measured in CPI

Provinces	Cities (*Kota*)	Districts (*Kabupaten*)
DKI Jakarta	-	-
West Java	Bandung	Karawang
		Garut
		Cianjur
Central Java	Semarang	Batang
East Java	Surabaya	Malang
Banten	Tangerang	-
	Serang	
Aceh	Banda Aceh	Aceh Selatan
		Aceh Barat

Lampung	Bandar Lampung	Lampung Selatan
		Lampung Utara
West Sumatera	Padang	Padang Pariaman
North Sumatera	Medan	Langkat
Central Kalimantan	Palangkaraya	Gunung Mas
		Kota Waringin Timur
East Kalimantan	Samarinda	Kutai Kartanegara
		Bulungan
South Sulawesi	Makassar	Wajo
		Sinjai
North Sulawesi	Manado	Minahasa Selatan
		Bolaang Mongondow Selatan
NTT (East Nusa Tenggara)	Kupang	Manggarai Barat
Maluku	Ambon	-
Papua	Jayapura	Jayawijaya

Source: Adapted from (Aspinall & Berenschot, 2019, pp. 275–276).

Health system performance is assessed using the *Minimum Health Service Standard* (MSS or SPM-*Standar Pelayanan Minimal*) dataset, compiled by the Ministry of National Development Planning/Bappenas and the Ministry of Health. MSS scores are derived from key indicators of basic health services that fall under the responsibility of city governments. These include skilled birth attendance, maternal and child healthcare, tuberculosis control, care for malnourished children, universal immunisation coverage, and extent of JKN coverage.

To account for fiscal variation across districts and cities, per capita city government health expenditure—sourced from the Ministry of Finance—are also incorporated into the analysis. Although the CPI data is limited to 2014, the MSS indicators are available from 2005 to 2018, enabling a broader assessment of local government performance in delivering primary healthcare services. While local reporting quality can vary, regular monitoring and validation by the central government enhances the reliability of these indicators, which remain the most consistent measure of subnational

health governance in Indonesia. The results of the correlation analysis are presented in Table 1.1 of Chapter 1 (page 11) and repeated here for ease of reading (**Table 2.2**).

Table 2.2

Correlation Analysis between CPI, Health MSS, and per Capita Health Spending, 2013-2018

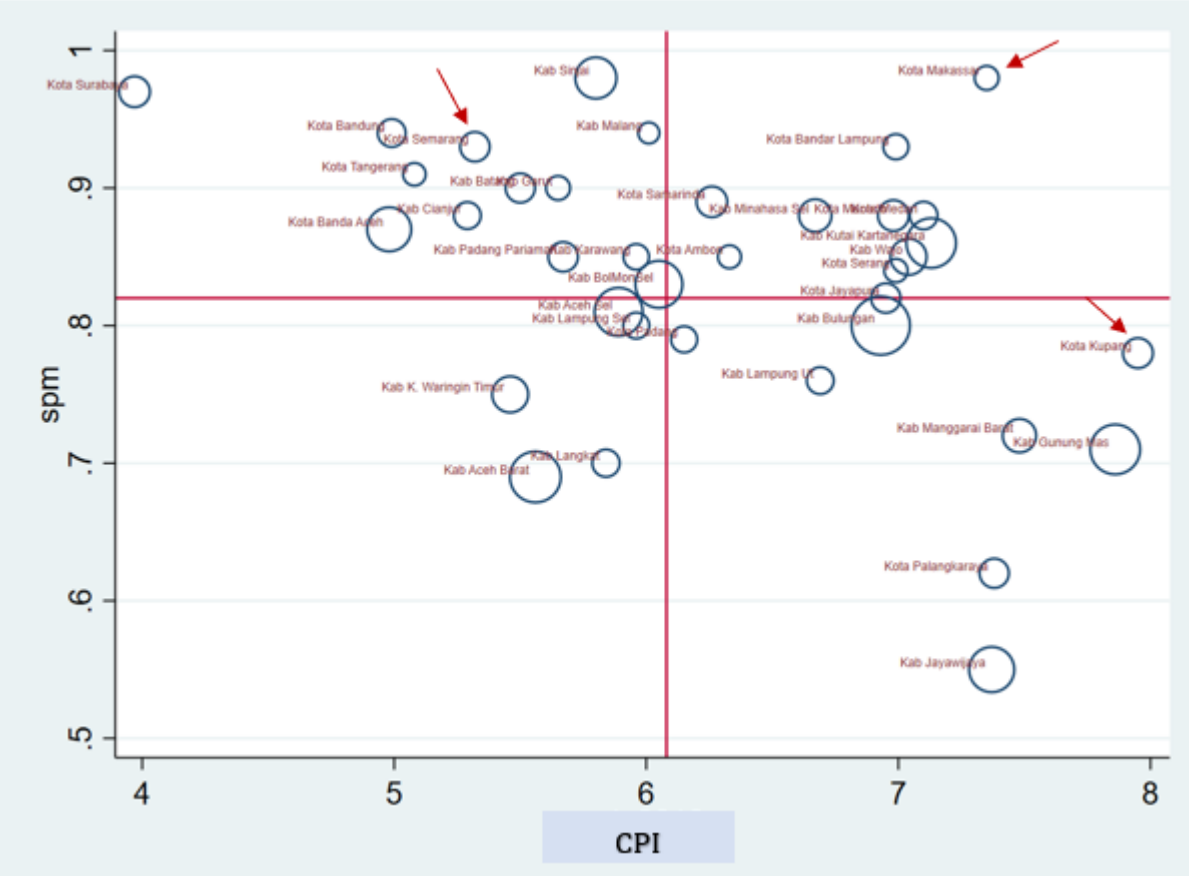
Variables	CPI	Health MSS	Health Spending
CPI	1		
Health MSS	-0.3611	1	
Health Spending	0.2661	-0.0077	1

Source: Author's analysis of data from the Ministry of National Planning/Bappenas (MSS), Ministry of Finance (on health spending), and Berenschot (2018b, p. 1576) (on CPI).

The second stage applies a scatter plot quadrant framework based on the correlation between CPI scores and MSS outcomes (see Chapter 1, Table 1.1, p. 11 and Figure 1.4, p. 12), repeated here in **Figure 2.3.**

Figure 2.1

Scatter Plot of Correlation Analysis between SPM (MSS) and CPI

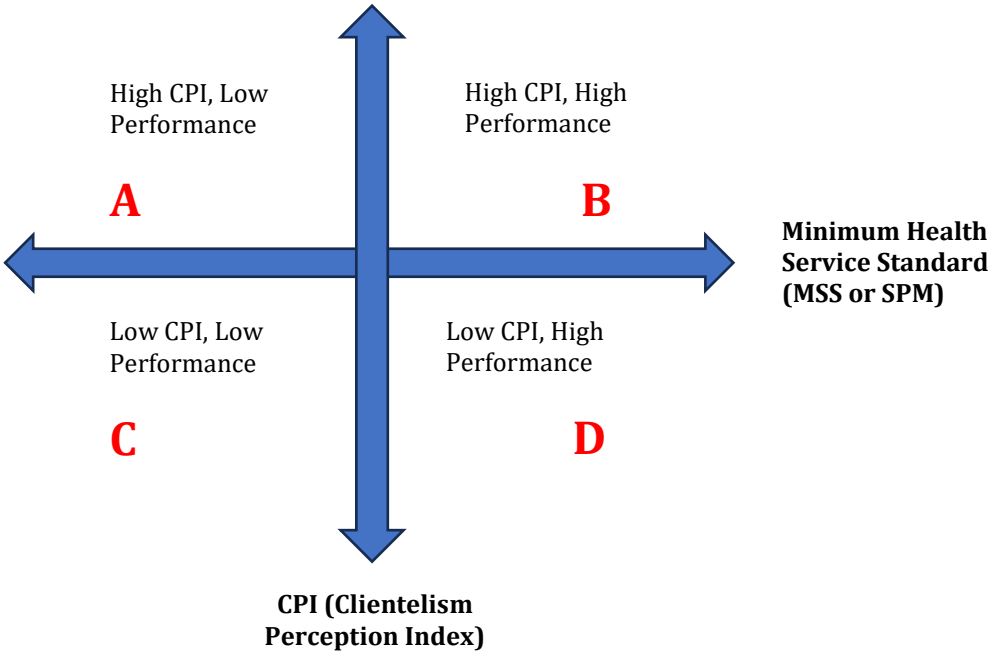


Source: Author's analysis of data from Berenschot (2018b) on CPI, Ministry of National Planning/Bappenas (on SPM/MSS), and Ministry of Finance (on health spending per capita), in circles.

This framework enables a purposive selection of three urban case studies that represent distinct combinations of clientelism intensity and healthcare performance. The cases are: Semarang (low clientelism, high healthcare performance—Quadrant A), Makassar (high clientelism, high healthcare performance—Quadrant B), and Kupang (high clientelism, low healthcare performance—Quadrant C). These cases were selected to maximise analytical contrast and provide insight into the conditions under which clientelism undermines—or coexists with—effective service delivery. The selection criteria and typological matrix is illustrated in **Figure 2.4** (which corresponds to Figure 1.4 in Chapter 1).

Figure 2.2

Selection Criteria Matrix



This case selection strategy follows Seawright and Gerring's (2008, p. 1) recommendation to combine both "typical" and "diverse" cases in order to maximise explanatory leverage. By controlling for health spending and sticking to provincial cities, the design helps ensure that observed differences in service delivery are more likely attributable to political-institutional variation rather than resource disparities or different administrative settings.

The inclusion of both confirming and disconfirming cases is intentional. Rather than selecting only cities that align with the expected pattern—where high clientelism correlates with poor healthcare performance, or low clientelism correlates with better performance—the study also includes an outlier to interrogate unexpected outcomes. How can a highly clientelistic city like Makassar perform relatively well in healthcare?[6]

[6] The correlation analysis did not find a case of low level of clientelism and poor healthcare performance among provincial cities/towns. It only found some rural districts in this category, but I decided to confine my research design to urban centres.

These puzzles justify a most-different case logic, while analytical consistency is maintained by situating all cases within a shared institutional framework.

A case-based approach is chosen over purely statistical modelling for two main reasons. First, causal inference in complex governance contexts—particularly those involving informal institutions like clientelism—requires tracing political processes and identifying how outcomes unfold over time, rather than relying solely on statistical associations (Gerring, 2009, p. 2). Second, this study aims to uncover the causal mechanisms that link clientelism to sector-specific outcomes in healthcare—an objective more appropriately addressed through process tracing and qualitative within-case analysis than through cross-sectional regression alone.

As Blatter and Haverland (2012, p. 19) argue, case study research represents a non-experimental approach that differs fundamentally from large N-studies. It is characterised by a small number of cases, a high density and diversity of empirical observations within each case, and a strong emphasis on the iterative relationship between concrete empirical data and abstract theoretical concepts. This approach is particularly well suited for investigating how and why particular governance configurations produce divergent outcomes across different subnational contexts.

Figure 2.3 visually presents the case study locations on the map of Indonesia (highlighted with red circles). The three cities—Semarang (Java), Makassar (Sulawesi), and Kupang (Timor)—are strategically situated across different islands, offering geographic and sociopolitical diversity that enriches the analysis of local political dynamics and patterns of clientelism.

Figure 2.3

The Case Study Locations in the Map of Indonesia

Source: Data are from https://commons.wikimedia.org/wiki/File:Indonesia_provinces_2022_-_id.png.

Within-Case Analysis and Process Tracing

To explain the varied effects of clientelism on healthcare services across regions, the study adopts a within-case analysis approach using the commonly applied tool of process tracing. These methods allow the research to move beyond surface-level correlations and investigate the specific causal mechanisms through which clientelism operates and affects healthcare. As George and Bennett (2005, pp. 206–207) emphasise, process tracing is essential for identifying the sequences, actors, and contextual conditions that produce political outcomes—particularly when informal dynamics such as patronage or rent-seeking are involved.

The central objective is to uncover how different forms of clientelism influence health sector outcomes, through what mechanisms, and under which enabling or constraining conditions. Given Indonesia's regional diversity—including variations in administrative capacity, elite configurations, and political culture—it is unlikely that a single causal pathway will account for all observed patterns. Instead, my study aims to identify multiple, possibly overlapping mechanisms that mediate the relationships between clientelism and health governance.

Each case study traces the ways in which informal political arrangements—particularly patronage relations and broker networks—intersect with the delivery of healthcare services. The analysis centres on two key subsystems of the health sector:

a. Health personnel management, encompassing recruitment, rotation, promotion, and the appointment of both frontline and managerial staff under the authority of mayors/city government leaders.
b. Public healthcare delivery, with a focus on services provided by local public hospitals (*Rumah Sakit Umum Daerah, RSUD*) and community health centres (*puskesmas*), including governance processes, local health policies, allocation of healthcare resources, and access to the health service facilities and implementation of key health programs under the responsibility of city government.

Additional attention is given to healthcare governance and leadership, as well as to procurement-related processes, particularly the acquisition of pharmaceuticals, medical equipment, and infrastructure that support service delivery in *puskesmas* and public hospitals (*RSUD*). Where data access permits—acknowledging the constraints posed by confidentiality—these areas are examined as they are often highly vulnerable to rent-seeking practices and discretionary budget manipulation.

To unpack causal complexity, the study adopts Beach and Pedersen's (2013, pp. 14–19) distinction between theory-centric and case-centric process tracing. While one objective is to test existing theoretical expectations—particularly hypotheses related to patronage and rent-seeking routes of clientelism affecting healthcare outcomes—the inclusion of "deviant" or anomalous cases like Makassar necessitates a more exploratory, case-centric approach. This dual orientation enables the research both to assess the applicability of established theories and to inductively generate new propositions about how informal institutions shape public service delivery.

The use of process tracing is justified on several grounds: first, it allows for the identification of causal mechanisms—such as whether personnel appointments are politically motivated or whether service programs are strategically allocated to reward brokers, and how the effects flow through to personnel quality. Second, it enables

refinement of hypotheses through detailed, time-sequenced evidence linking political decisions to outcomes. Third, it supports cross-case generalisation by allowing me to compare how politics intersects with healthcare provision across the three cities to identify which mechanisms recur and which are contingent on local context.

In line with the method's logic, each process trace is constructed using triangulated evidence, including: interviews with key stakeholders (such as mayors, vice mayors and former mayors/vice mayors, local parliamentarians/city councils, health sector officials, party cadres, NGO activists, local experts, brokers, business actors, healthcare professionals and users); document analysis (e.g., mayoral decrees, city government regulations, plans and budget expenditure reports); and field observations of both service delivery and electoral campaign activities. The aim is to generate causal process observations that support inferences about both structural factors (e.g., elite configurations and patronage networks) and agency (e.g., patron-client relations, brokers' roles, capacities, and constraints). Importantly, the analysis is not limited to confirming established theories—such as the detrimental effects of patronage on bureaucratic performance—but also seeks to explore conditions under which such effects may be mitigated, moderated, or even reversed.

Ultimately, this process-tracing approach provides the analytical backbone for developing a comparative framework capable of explaining observed variation in health sector outcomes. It supports both fine-grained empirical analysis and broader theoretical generalisation by identifying shared mechanisms across cases, as well as the contextual factors that enable or constrain them.

Data Collection Methods

To investigate the relationship between clientelism and healthcare service delivery, this study employs a combination of primary and secondary data collection methods, guided by the logic of methodological triangulation (Bowen, 2009, p. 28; Denzin, 2017, p. 297). This multi-source strategy strengthens the rigour of the research by enabling cross-validation of findings and reducing the risk of bias associated with reliance on a single method or data source.

Primary Data Collection

I used two main methods to collect primary data:

Semi-structured and in-depth interviews. The core of the fieldwork consisted of over 100 semi-structured interviews with a diverse range of stakeholders across the three case study cities and at the national level. Respondents included former and current mayors and vice mayors, a provincial governor, local parliamentarians (i.e., *Dewan Perwakilan Rakyat Daerah*, DPRD members), health sector officials, civil servants from various sectors, hospital administrators, frontline healthcare workers, civil society activists, political party cadres, brokers, businesspeople, journalists, local ombudsmen, members of civil society commissions and community organisations, members of campaign teams, and local policy experts. Interviews were conducted in multiple phases between 2020 and 2023, using a flexible format that adapted to evolving COVID-19 restrictions: online platforms (e.g., Zoom, WhatsApp calls), phone interviews, and face-to-face meetings once travel restrictions were lifted in 2022. The interview design followed Rubin and Rubin's (2004, pp. 171–175) responsive interviewing model, which is particularly suited to exploring politically sensitive topics. This approach prioritised building trust and encouraging open dialogue, enabling the researcher to gather nuanced, direct insights into the informal workings of clientelism and healthcare governance.

Informants were selected using a combination of purposive and snowball sampling. Selection was guided by the individuals' institutional roles, their knowledge of local political dynamics, and their proximity to healthcare governance, local government affairs, or electoral processes. In several instances, interviews were preceded or supplemented by exploratory conversations with community members, neighbourhood representatives, or local ombudsman and watchdog organisations. These preliminary engagements helped refine research questions and sharpen lines of inquiry during the formal interviews.

Field observation and participant observation. Where access and time allowed—particularly in Semarang and Makassar—I conducted ethnographic-style participant observation in both healthcare settings and political environments. This included observation at hospitals, *puskesmas* (community health centres), campaign posts, party

offices, parliamentary recess meetings, and electoral campaign events. These observations focused on informal practices related to service access, staff conduct, patient interactions, and local narratives concerning political influence over health governance. While time constraints and COVID-19 restrictions limited the scope of direct observation in Kupang, I collaborated with local research assistants to carry out structured observations there, especially in healthcare facilities and during campaign periods. These assistants were trained to document relevant practices and interactions systematically. Additionally, fieldwork included monitoring online platforms—such as Google Maps reviews, Instagram accounts, and local Facebook groups—to triangulate public perceptions of service delivery quality and political interference in health facilities.

Secondary Data Collection

Document and policy analysis. The study draws on a wide range of official documents, including local government regulations, mayoral decrees, planning and budget documents, public procurement reports, audit findings, case reports from the Corruption Eradication Commission (KPK), and annual health sector performance reports. Analysis of these materials was guided by Bowen's (2009, p. 33) method of thematic coding, enabling the identification of recurring patterns in decision-making processes, discretionary practices in service provision, and indicators of institutional accountability. This documentary evidence complemented interview and observational data, offering a broader institutional context for understanding how clientelism operates within the health governance system.

Statistical and media data. To supplement primary findings and support contextual analysis, I examined a range of statistical datasets related to health service delivery. These included indicators on maternal and child health, universal health coverage rates, and other Minimum Health Service Standards (MSS) metrics from 2001–2020, sourced from Bappenas. Additional data were drawn from BPJS health insurance statistics on service coverage and utilisation, health expenditure figures from the Ministry of Finance, and broader healthcare and statistical data from the World Bank's INDO-Dapoer database. To assess levels of clientelism, as already explained, I used CPI scores

developed by Berenschot (2018b), which provide a comparative measure of clientelistic intensity across Indonesian regions. To contextualise local political dynamics, I also reviewed local election results, public procurement records, investigative journalism, and monitoring reports from NGOs. In cases where access to high-level informants was limited—particularly during COVID-19 travel restrictions—I consulted publicly available sources such as interviews, podcasts, and media commentary from credible outlets to capture elite perspectives. All secondary data were cross-validated and interpreted with caution, particularly when used to corroborate primary evidence or support inferential claims.

Ethical and Logistical Considerations

This research was conducted in full compliance with ethical standards set by the Australian National University's Human Research Ethics Committee, as well as relevant Indonesian research regulations. It also followed the general principles outlined by the American Political Science Association (2020) and adhered to best practices for qualitative political inquiry in healthcare as outlined by Pyo, Lee, Choi, Jang, and Ock (2023, pp. 15–18). Informed consent was obtained in all cases, with participants clearly informed about the voluntary and confidential nature of their participation. Given the sensitivity of discussing informal political practices and potential rent-seeking/corruption, particular care was taken to ensure respondent anonymity and confidentiality. All data were securely stored and handled according to ethical research protocols.

Due to COVID-19 and some institutional constraints, research was conducted in multiple phases:

- Remote interviews conducted with limited support from one local research assistant in each city during the period of travel restrictions (January 2020–April 2022).
- After travel restrictions were lifted, a three-week field visit was conducted in Kupang, Makassar, and Semarang (June–July 2022).
- In 2023, as part of an effort to deepen my understanding of the economic dimensions relevant to the Makassar case study, I conducted research on major reclamation projects in Makassar and South Sulawesi and produced an academic article based on

this work (Sari, 2024), published in early 2024. A follow-up visit to Makassar took place in October 2024 during a work-related trip, providing an opportunity to reconnect with informants and observe ongoing developments, including reclamation projects and healthcare facilities. Together, these activities strengthened my understanding of the region's economic landscape and sharpened my analysis of clientelistic patterns involving political-business networks.

- Semarang: Fieldwork was conducted through multiple site visits between 2022–2025, benefiting from my positionality as a native of the city, which enabled extended engagement and informal access to key local actors and institutions.

COVID-19-related international restrictions prevented fieldwork travel to Indonesia from early 2020 to mid-2022. Nonetheless, to remain productive during this period, I conducted remote research and authored one journal article and two articles in New Mandala examining the politicisation of COVID-19 vaccine delivery by politicians in Indonesia. This research drew on online interviews, media reporting, and social media analysis to explore patronage practices during a national health emergency. These articles (Sari, 2021a, 2021b; Sari et al., 2023) contribute to the broader analysis of clientelism in Indonesia's healthcare sector during a period of pandemic emergency.

Process Tracing, Theory Contribution, and Comparative Ambition

The final stage of the research strategy applies process tracing to investigate the causal pathways through which clientelistic practices influence health sector outcomes. This method is especially well-suited for analysing informal political dynamics—such as discretionary authority, personalised relationships, and rule-bending behaviour—that operate outside formal institutional frameworks (Beach & Pedersen, 2013, pp. 14–19; George & Bennett, 2005, p. 211).

My study focuses on three interrelated domains of causal influence, asking three key questions:

1. Patronage and rent-seeking in staffing: Are positions in public hospitals (RSUD), *puskesmas*, or local health offices (*Dinas Kesehatan*) allocated to political loyalists, and whether staffing is affected by rent-seeking, i.e., sale of office?

2. Patronage and rent-seeking in procurement: Are procurement processes for medical supplies and device, or health construction projects manipulated and inflated for political or personal gain?
3. Service access and broker mediation: Do informal brokers or political intermediaries condition access to healthcare based on political loyalty and/or personal connections?

Within each case, process tracing reconstructs sequences of decision-making, institutional shifts, and policy implementation. The analysis examines how actors apply—or bypass—formal rules, identifies key points of discretion, and evaluates how informal norms, incentives, and accountability pressures shape outcomes. Empirical evidence from interviews, public records, and field observations is matched to hypothesised mechanisms, such as patronage, brokerage, and rent-seeking. Table 1.5 in Chapter 1 provides a conceptual framework that guides the examination and analysis of my research data.

The research combines two orientations of process tracing. A theory-centric approach draws on established frameworks in governance and informal institutions (Berenschot & Aspinall, 2020, p. 11; Brinkerhoff & Goldsmith, 2002; M. S. Grindle, 2012) to test existing hypotheses. A case-centric approach is used where anomalies—such as Makassar's relatively strong health performance despite high clientelism—warrant theory refinement or extension (Beach & Pedersen, 2013, pp. 117–120).

By tracing both expected and unexpected outcomes, the study aims to refine understanding of when and how clientelism undermines, bypasses, or coexists with effective service delivery. It also explores the moderating effects of institutional or political configurations—such as bureaucratic insulation, elite pacts, or civil society engagement.

While the study is not intended for statistical generalisation, its comparative case logic supports analytical generalisation. It contributes to theory-building by developing a middle-range framework that explains how clientelism affects health governance across varied subnational contexts. The inclusion of both "typical" and "anomalous"

cases enhances its relevance for future research on decentralised service delivery and informal politics.

Ultimately, the study aims to generate insights with practical relevance for policy reform—particularly in designing institutional safeguards that insulate essential services from political interference, while recognising the persistent role of informal practices in democratising systems.

Conclusion

This chapter situates the study within the broader scholarship on clientelism and patronage, focusing on the distinct clientelistic patterns in each case study and their effects on healthcare service delivery in three Indonesian cities—Kupang, Makassar, and Semarang. It integrates classical perspectives on patron–client relations with contemporary analyses linking clientelism to democratic competition, governance, and service provision. While drawing on cross-regional studies, the analysis is grounded in Indonesian scholarship, enabling a nuanced understanding of the country's distinctive forms of clientelism.

The study advances existing debates in three ways. *First*, it clarifies the conceptual boundaries between clientelism, patronage, rent-seeking, and corruption, and identifies the mechanisms through which these practices affect staffing, procurement, and access to healthcare. *Second*, it demonstrates how contextual factors—middle-class growth, civil society strength, and market competition, institutional reform—shape patterns ranging from predatory to selective or hybrid clientelism. *Third,* it introduces an additional explanatory factor: the presence of alternative patronage arenas that can redirect political incentives away from health and toward other sectors.

Methodologically, my research applies a mixed-methods, comparative case design. A quantitative correlation between clientelism intensity and health service performance guided the selection of cases, followed by qualitative fieldwork and process tracing to examine causal pathways. Three interrelated domains were analysed: patronage and rent-seeking in staffing, procurement, and access to health services.

The thesis contributes to the study of informal politics by offering a middle-range framework that explains how clientelism shapes healthcare governance under decentralisation, and why its effects vary across contexts. It shows that clientelism is not inherently uniform or wholly detrimental but contingent on the interaction between political incentives and institutional safeguards—such as bureaucratic insulation, transparent procurement systems, smart governance tools, public oversight, and performance-based evaluation. The findings clarify the mechanisms through which clientelism operates and demonstrate how social, political, and economic conditions can moderate its impact. In doing so, the study bridges theory and practice, providing analytical tools for understanding the health–clientelism nexus and actionable insights for strengthening governance systems to protect essential services from political capture while acknowledging the resilience of informal practices in democratic life.

Ultimately, this study is designed to uncover how and why clientelism shapes healthcare governance in distinct ways across Indonesian cities, and to offer a framework and practical insights for building safeguards that protect essential services from political capture while acknowledging the enduring role of informal practices in democratic systems.

Chapter 3
Setting the Scene: Historical Background and Context of the Indonesian Health Sector

This chapter examines the historical and institutional foundations that have shaped healthcare in Indonesia, situating them within broader patterns of political development and informal politics, particularly those related to political clientelism. It traces the evolution of the health sector from the colonial and early post-independence periods, through the centralised developmentalism of the New Order, to the country's post-decentralisation reforms[7] and the 2023–2025 period when I was writing this thesis. While observers have noted persistent disparities in healthcare provision, and attributed them to uneven state capacity or the quality of local political leadership, such accounts often stop short of explaining *why* capacity and leadership vary so significantly across regions. This chapter contributes to a deeper political explanation by exploring how clientelistic structures and incentives have shaped institutional legacies and contemporary governance outcomes. It also highlights two major health service reforms initiated during New Order ('Family Planning', *Keluarga Berencana*, KB) and the expansion of the primary healthcare system throught the community health centres (*Pusat Kesehatan Masyarakat, Puskesmas*)) and a more recent reform in 2014, namely the consolidation of multiple health insurance schemes into the single-payer National Health Insurance (*Jaminan Kesehatan Nasional*, JKN). It uses these examples to illustrate both the potentials and the limitations of centralised health policy when implemented within subnational political economies structured by informal power relations and political clientelism. Anchored in the broader analytical framework of this thesis, the chapter lays the foundation for the case studies that follow, demonstrating how historical legacies, institutional arrangements, and evolving state-society relations condition the ways in which clientelism interacts with healthcare delivery across Indonesian cities.

[7] Following the collapse of President Suharto's New Order regime in 1998—an era that triggered democratic and decentralisation reforms—commonly referred to as *Reformasi*.

Organised into four sections, the chapter first reviews the colonial and early post-independence foundations of Indonesia's health system. It then examines the New Order's centralised expansion, especially through family planning and the *puskesmas* network. The third section turns to the post-*Reformasi* era, analysing how decentralisation reshaped healthcare delivery, with emphasis on primary care, referral systems, national health insurance, pharmaceuticals, and the COVID-19 response. The final section reflects on how these institutional and political shifts have reconfigured the incentives and constraints that shape subnational clientelism in healthcare, setting the stage for the case studies that follow.

Medical Legacies: From Colonial Rule to the New Order

Colonial Medical Foundations and Hierarchies

Indonesia's contemporary healthcare system is deeply rooted in a layered history of fragmented state building, colonial governance, centralised planning, and military-led development. The Indonesian state as it is known today did not emerge merely as a product of the declaration of independence on 17 August 1945. Rather, it evolved through centuries of shifting political authority—from precolonial kingdoms and sultanates to layered systems of indirect and direct colonial rule. Before its unification as a republic, the region that became Indonesia was not governed as a single territorial or administrative entity. Instead, it consisted of a patchwork of indigenous polities, gradually brought under foreign control—first by the Dutch East India Company (*Vereenigde Oostindische Compagnie,* VOC) from the early 17th century, and later by the Dutch colonial state after the VOC's collapse in 1799.

This colonial transition was pivotal in shaping the foundations of the modern health system. The VOC, motivated primarily by commercial gain and military security, introduced only limited healthcare infrastructure to serve European needs, particularly in port cities and garrison towns (Adams, 1996, p. 13; Schoute, 1937, pp. 85–90; Uddin, 2005, pp. 5–7). From the 17th to the 18th century, a racially segmented and geographically uneven system developed: Western medicine was largely reserved for Europeans, while the indigenous population relied on missionary clinics or traditional treatments administered by local healers. Hospitals and medical posts were

concentrated in Java and strategic ports, while in rural areas only religious missions provided some measure of basic care (Furnivall, 1939, p. 280; Schoute, 1937; Sciortino, 1996). The shift to formal Dutch colonial state administration in the 19th century maintained this focus, with limited investment in indigenous health (De Jong, 1984, pp. 56–58; Departemen Kesehatan, 1980a, 1980b; Sciortino, 1996, p. 24). Both systems were heavily militarised and racially stratified, with the latter dominated by the Military Health *Service* (*Militair Geneeskundige Dienst,* MGD) and the Civil Health Service (*Burgerlijk Geneeskundige Dienst,* BGD), which prioritised the needs of Europeans (Hesselink, 2018, p. 146; Sciortino, 1996, pp. 28–30), and operated on the basis of the colonial logic of segregation and administrative control.

The establishment of preventive and curative care during Dutch rule reflected the administrative priorities of a colonial state concerned more with protecting European health and economic productivity than advancing equitable public welfare. Major investments were chanelled into laboratories for tropical disease research and hospitals serving urban elites, while rural and indigenous populations were still largely left to missionary clinics or rudimentary services provided by penal or military institutions (Boomgaard, 1993; Departemen Kesehatan, 1980b; Pols, 2018; Schoute, 1937). Health provision was divided institutionally between research and treatment (Boekholt, 1992; Boomgaard, 1993; De Jong, 1984; Departemen Kesehatan, 1980b; Pols, 2018; Schoute, 1937; Sciortino, 1996; Van Heteren, 1996), and geographically between Java and the outer islands—reinforcing administrative fragmentation and deepening urban-rural disparities (Departemen Kesehatan, 1980b, pp. 88–89).

Public health priorities shifted during periods of political instability and prolonged wars against indigenous resistance in the mid-19th century. The colonial government, facing financial strain, cut back on rural medical budgets and closed hospital in smaller towns, concentrating care in urban centres like Batavia (now Jakarta), Semarang, and Surabaya (Schoute in Sciortino, 1996, p. 27). These cuts contributed to the spread of infectious diseases—such as smallpox, cholera, and tuberculosis—which disproportionately affected indigenous communities and prompted the state to experiment with low-cost strategies, including training indigenous health workers in the late 19th to early 20th century (De Jong, 1984, pp. 171–173).

In part as a response to the parlous living conditions of local people, which generated public health crises in the form of recurring epidemics, the Dutch colonial government in 1901 introduced the 'Ethical Policy' (*welvaartsdiensten*). Positioned as a civilising mission, the policy aimed to improve indigenous welfare by making expanded investments in health, education, and irrigation. In practice, however, the Ethical Policy served political functions alongside its humanitarian goals: containing unrest, legitimising colonial rule, and extending the reach of the state into rural areas. In healthcare, for example, the indigenous populations remained marginalised, and generally received only minimal care, often restricted to epidemic control or penal institutions (Hesselink, 2018; Pols, 2018, p. 164).

Medical training for indigenous populations, however, became more prominent under the Ethical Policy. Key institutions such as the School of Javanese Physicians or *Dokter Djawa School* in Batavia (established in 1851) (Hanifah, 1949), STOVIA (*School tot Opleiding van Inlandsche Artsen*) in Batavia and NIAS (*Nederlandsch-Indische Artsen School*) in Surabaya (established in the 1920s) were designed to produce trained indigenous physicians who could be deployed to underserved areas as vaccinators, rural doctors, and disease control officers (Hanifah, 1949; Pols, 2024, pp. 163–168; Sciortino, 1996, pp. 30–31). These initiatives remained embedded in a rigidly racialised hierarchy. Indigenous doctors were systematically confined to subordinate roles, often in lower status rural positions under the supervision of European counterparts (Pols, 2024, pp. 170–171). Alongside them, medical auxiliaries such as *mantri-verplegers*, village doctors or *dokter desa*, and *mantri cacar* (smallpox workers) formed the backbone of disease control and outreach. Despite their crucial contributions, they remained underpaid, under-resourced, and institutionally marginalised (Boekholt, 1992, pp. 83–84; Departemen Kesehatan, 1980a).

The expansion of health services under the Ethical Policy also reshaped nursing in the colony, albeit within tightly constrained cultural and institutional limits. Before 1900, nursing was not recognised as a formal profession in the Dutch East Indies. Patient care was largely handled by *chirurgijns* (surgeons), a class of low-ranking, informally trained male attendants tasked with wound care, basic diagnoses and prescriptions (Sciortino, 1996, pp. 24–26). Although the Dutch colonial administration had brought in

European nurses, their numbers were small, and many struggled with the tropical climate and language barriers (Hesselink, 2018, pp. 145–149). Despite their essential role, these nurses were undervalued and were often scapegoats for poor health outcomes (Schoute, 1937, p. 43; Sciortino, 1996, p. 27).

Nursing training programs for indigenous nurses were gradually introduced, but the role remained auxiliary and subject to European oversight (Hesselink, 2011, p. 159). Moreover, nursing and midwivery were perceived as low-status and morally inappropriate careers for native women, which further limited their participation (Hesselink, 2018, p. 152). Missionary institutions, such as those in Mojowarno and Yogyakarta, played a pioneering role in recruiting and training Indo-European and indigenous men and women. However, their contributions were rarely integrated into the formal colonial system (Hesselink, 2018, p. 152).

This colonial dualism also produced growing frustration and political consciousness. The founding of the Association of Indigenous Doctors (*Vereeniging van Indische Artsen,* VIA) in 1912 reflected the frustration of native doctors over unequal pay and status. Many members of this emerging medical elite later aligned themselves with nationalist movements in the 1920s and 1930s, transforming their professional grievances into broader critiques of colonial rule (Pols, 2024, pp. 170–172). Nevertheless, access to advanced training remained highly limited. While a small number of Indies physicians studied in the Netherlands, most continued to serve in poorly funded, rural and peripheral areas. These enduring inequities not only stoked anti-colonial sentiment but also entrenched patterns of elitism and patron-client ties in the medical profession that persisted after independence. Contemporary evidence shows that these patterns continue to shape professional trajectories and access to opportunities. Interviews with medical worker in Semarang reveal persistent barriers to specialist training, with recommendation letters from the Indonesian Doctors Association (*Ikatan Dokter Indonesia*, IDI) often influenced by personal connections rather than solely merit. Practitioners without family ties (and powerful background) to established specialists face greater difficulties, indicating that informal networks mediate career advancement (Anonymous, personal communication, August 1, 2022). Public testimonies further corroborate this pattern: discussions on YouTube, including

those by Dr. Tony Setiobudi, highlight how access to residencies and institutional support often depends on alignment with influential figures rather than meritocratic criteria (Setiobudi, 2022a, 2022b, 2022c).

By the 1930s, the colonial health system had expanded in administrative reach but it remained fragmented, urban-centric, and deeply unequal. While the Ethical Policy increased training and outreach through village doctors, chicken pox vaccination paramedics (*mantri cacar*) and midwives, these services were chronically underfunded and structurally marginalised—particularly outside Java (Boekholt, 1992; Departemen Kesehatan, 1980b, pp. 88–89). By the 1940s, only 1,483 doctors served a population of 70 million, with more than 80% of healthcare workers based in Java (Vandenbosch, 1943, p. 1). In the outer islands, self-governing native states or *Zelfbesturen* nominally managed health provision but lacked fiscal or administrative capacity (Vandenbosch, 1943, p. 147). This reliance on underpaid intermediaries—rural doctors, nurses, and medical auxiliaries—extended the colonial state's reach but embedded a model of decentralised, informal governance reliant on local discretion and patronage (Pols, 2024, p. 165).

Japan's occupation of the Dutch East Indies in March 1942 marked a rupture in colonial governance but not a transformation in health system equity. The Japanese military dissolved Dutch colonial institutions and centralised healthcare under the health department (*Eiseikyoku*), prioritising military needs over public welfare. The exodus or imprisonment of many European doctors, nurses, and pharmacists created a severe shortage of medical personnel, and healthcare services rapidly deteriorated. Indigenous doctors were conscripted into 'Defenders of the Homeland' (*Pembela Tanah Air,* PETA) to treat Japanese soldiers—a role that, while coercive, later positioned them as central actors in post-independence health leadership (Departemen Kesehatan, 1980b, p. 84).

After the proclamation of independence in 1945, the newly formed Ministry of Health of the Republic of Indonesia inherited a fractured, under-resourced system marked by colonial and wartime legacies. Former STOVIA and NIAS graduates assumed leadership roles, yet the institutional culture they carried forward retained strong

echoes of racial hierarchy, urban bias, and technocratic elitism. As Shields and Hartati (2003, p. 25) note, the system remained "structured by colonial ideologies, privileging curative over preventive care and sustaining exclusive professional networks." Rather than a clean break, the early postcolonial period reproduced many of the colonial-era structures of exclusion and centralised control—setting the stage for the uneven health governance that would persist through the New Order and into the era of decentralisation.

Postcolonial Health Governance and the New Order Regime

Following independence, Indonesia's healthcare system developed within a fragmented and politically constrained environment—shaped as much by colonial legacies as by new state-building imperatives. The postcolonial state inherited a racially stratified, urban-centric health infrastructure from the Dutch, which offered limited reach and resources. In early 1945, the Ministry of Health[8] had only 1,200 doctors, 150 dentists, 650 pharmacists, and 3,500 nurses for a population of 70 million (*Berita Kementerian Kesehatan RI*, 1956, p. 8). The country operated 680 hospitals with just 62,428 beds—equating to only eight beds per 10,000 people (Leimena, 1955, pp. 25–26).

Despite these constraints, modest reforms were initiated in 1950–1951 to lay the foundation for basic healthcare provision. These included the deployment of health workers, expansion of medical education and training, the construction of public health centres (*puskesmas*) and their networks, and a shift toward preventive and community-based health services. Nevertheless, the broader health bureaucracy in the 1950s and 1960s remained structurally conservative. Colonial-era hierarchies persisted, with administrative appointment often reflecting the Javanese aristocratic (*priyayi*) traditions that reinforced patrimonial norms, and social and political hierarchies (Kartodirdjo, 1984, p. 192; Sutherland, 1979, pp. 22–24, 26–30). Access to training, specialisation, and professional advancement was shaped by these embedded social hierarchies.

[8] The agency was initially known as *Kementerian Kesehatan* (Ministry of Health) but was renamed *Departemen Kesehatan* (Department of Health) during the New Order period. The name was changed back to *Kementerian Kesehatan* in 2009.

The institutional logic of Indonesia's health governance was significantly shaped under Suharto's New Order (1966–1998), which adopted a technocratic, yet authoritarian model aimed at aligning the health sector with national development goals. Through the military's *dwifungsi* (dual function) doctrine, the military extended its influence across civilian ministries, including health (Departemen Kesehatan, 1980b, pp. 110–115). Many key ministerial and bureaucratic positions—including in the Ministry of Health and the national coordinating agency for family planning (*Badan Koordinasi Keluarga Berencana Nasional*, BKKBN), were occupied by retired officers, entrenching a centralised, hierarchical bureaucracy, as noted in *Directory of Government of the Republic of Indonesia 1998* (1998); Matanasi (2018, p. 137). Bureaucrats were evaluated primarily on their ability to meet centrally determined numerical targets, tied to promotion and disciplinary systems. This approach yielded measurable outcomes: fertility rates fell from 5.6 in 1971 to 2.4 in 2017 (BPS, BKKBN, Kemenkes, & USAID, 2018; Singarimbun, 1991, p. 15). Even so, this model also reinforced rigid hierarchies and obscured structural deficiencies.

A core component of this development approach was the expansion of primary healthcare structure. The government prioritised the construction of community health centres (*puskesmas*) and their satellite units (*puskesmas pembantu, pustu*) as the backbone of rural primary healthcare delivery. Following the Presidential Instruction No. 5/1974, the number of *puskesmas* increased from 1,227 in 1967 to 2,000 in 1979 (Departemen Kesehatan, 1980b, pp. 61, 131). These efforts were heavily supported by international donors and multilateral institutions, such as the World Health Organisation (WHO), United Nations Children's Fund (UNICEF), and the U.S. Naval Medical Research Unit Two (NAMRU-2) contributed to maternal and child programs, infectious disease control, and biomedical research, while the World Bank and bilateral donors financed physical infrastructure and medical training (Departemen Kesehatan, 1980b, pp. 61–75; Mahendradhata et al., 2017, pp. 90–95).

However, while infrastructure expanded, equity and workforce distribution lagged behind. Despite improvements in aggregate indicators—such as the doctor-to-population ratio improving from 1:20,900 in 1971 to 1:7,100 in 1990 (Ricklefs, 2005, pp. 600–601)—urban-rural disparities remain stark. The government introduced the

compulsory service scheme (*wajib kerja sarjana*) in 1974 to address urban-rural disparities by mandating new medical graduates to serve in underserved areas for a fixed term, typically three years, before qualifying for specialist training or full licensing. Yet weak enforcement mechanisms and poor incentives limited its effectiveness (Rokx, 2010, pp. 33–34). By the late 1990s, it was gradually replaced by contractual staffing schemes—*Pegawai Tidak Tetap* (*PTT*)–and later *Nusantara Sehat* (Healthy Nusantara)—which deployed short-term teams to underserved areas (Mahendradhata et al., 2017, pp. 104–106; Rokx, 2010, pp. 33–34, 38–39).

Notwithstanding these reforms, critical gaps in human resource development persisted—driven not only by structural inequalities but also by internal dynamics within the medical profession itself. In the nursing sector, most practitioners continued to receive only secondary or diploma level education, with minimal clinical exposure (Shields & Hartati, 2003, pp. 211–212). The profession remained heavily gendered, subordinated to doctors, and largely excluded from decision-making and leadership roles—limiting its contribution to a more equitable and resilient health system (Shields & Hartati, 2003, pp. 213–214). Similar patterns of exclusion were evident in the training of medical doctors, particularly at the specialist level. As Pols (2024, pp. 170–172) notes, elite structures embedded in colonial institutions like STOVIA continue to shape the stratification of medical education until the present time. These institutional barriers are sustained by informal norms and practices—particularly "feudal" norms of seniority-based deference, and patron-client ties—that operate across nearly all subsectors of the medical profession. As former IDI chair Dr Kartono Mohamad acknowledged, an informal class hierarchy continues to shape the medical profession in Indonesia, positioning general practitioners (GPs) at the base, specialists in the middle, and subspecialists at the top—a stratification that persists into the present day (Mohamad, 2016).

During the New Order period, corruption and rent-seeking were pervasive in the public health system, with public sector jobs and promotions typically secured through personal connections rather than merit. McLeod (2010, p. 45) describes this system—the New Order's corruption model—as a "franchise-style," in which lower-level officials paid "franchising fees" to superiors in exchange for the right to extract resources. In the

health sector, as in many others, it was common to provide bribes or gifts to senior officials as a sign of gratitude for being selected, promoted, or granted government contracts. As discussed in Chapter 1, such practices became routine and were widely accepted as part of the prevailing bureaucratic culture under the New Order.

In summary, the post-independence and New Order periods saw significant expansion of Indonesia's healthcare infrastructure, largely driven by authoritarian and centralised governance. Initiatives such as the *puskesmas* and national family planning (*Keluarga Berencana*, KB) program improved access and outcomes across the archipelago. However, these gains were built on hierarchical and centralised patronage-based systems. Bureaucratic appointments, medical training opportunities, and public contracts were frequently allocated through informal networks and on the basis of political connections, consolidating elite control and constraining the development of a merit-based, responsive health system. Corruption, rent-seeking, unequal workforce distribution, and exclusionary gatekeeping were all widespread, contributing to persistent disparities in access and service quality. These historical dynamics are important to grasping the argument developed in this study: contemporary clientelistic politics and institutional weaknesses at the subnational level must be situated within a broad legacy of historical and structural constraints. The following section explores how these dynamics evolved in the post-*Reformas*i era of democratic decentralisation, and how they continue to shape the variegated landscape of clientelism and healthcare delivery across Indonesian regions today.

Healthcare in the *Reformasi* Era: Decentralisation and the Reconfiguration of Health Governance

The decentralisation of Indonesia's government system, formally enacted in 2001 under Law No. 11/1999 on Regional Administration (later refined by Law No. 32/2004), marked a fundamental transformation in governance structure. This reform, consistent with global trends promoting devolution and local autonomy, was designed to enhance administrative efficiency, foster democratic responsiveness, and address long-standing regional disparities (Falleti, 2005, p. 327). In principle, decentralisation would bring government "closer to the people," fostering accountability and more locally attuned

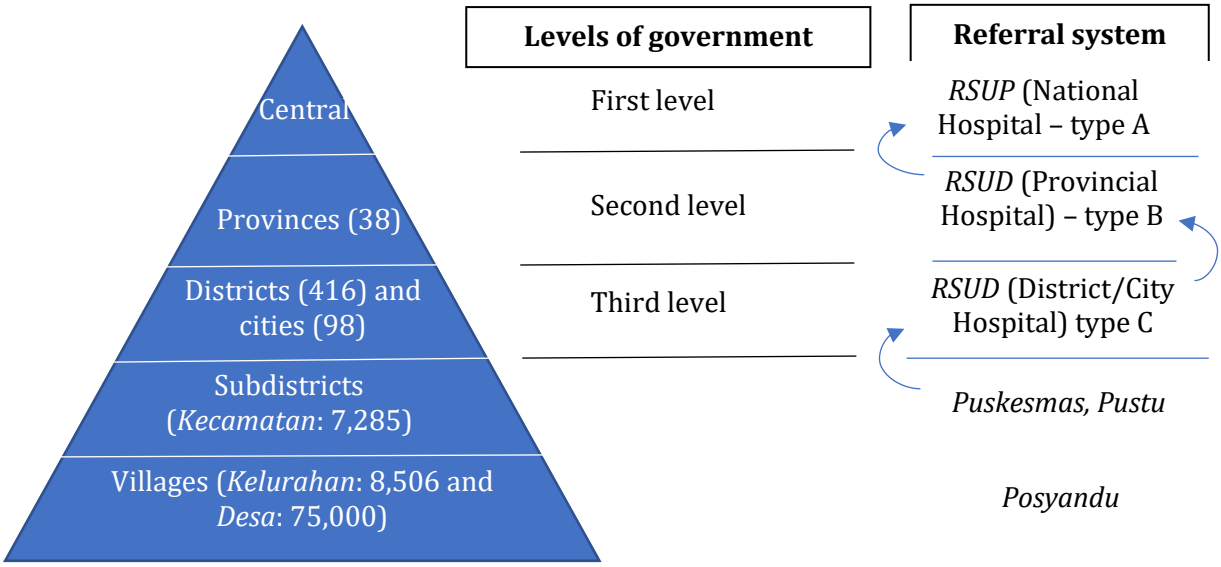
service delivery. Yet in practice, Indonesia's experience reflects broader international findings that decentralisation often yields uneven outcomes—particularly in settings where subnational institutions are underdeveloped or co-opted by local elites (Hadiz, 2004; Talitha, Firman, & Hudalah, 2020).

Health sector reforms under decentralisation introduced significant changes in institutional arrangements. While the central government retained control over national policy, standard-setting, strategic planning, and the management of top-tier referral hospitals (*Rumah Sakit Umum Pusat*, RSUP), key operational responsibilities—including planning, budgeting, staffing, and procurement for most public health services, primary healthcare and third-tier of referral government-run hospitals (*Rumah Sakit Umum Daerah,* RSUD)—were devolved to district and city governments (Mahendradhata et al., 2017, p. 134).

Figure 3.1 outlines Indonesia's decentralised, multi-tiered referral system, which begins at the primary level with *puskesmas*, moves through secondary-level district/city public hospitals (RSUD *Kabupaten/Kota*), secondary-level public hospitals (*RSUD Provinsi*), and culminates in national-level referral hospitals (RSUP) managed by the Ministry of Health.

Figure 3.1

Indonesia's Levels of Government and Healthcare Referral System



Source: Adapted from Rakmawati, Hinchcliff, and Pardosi (2019, p. e1028) and Ministry of Home Affairs Regulation No. 300.2.2-2430/2015.

This restructuring was intended to empower local governments to tailor health interventions to local contexts. In some districts, this shift has facilitated more responsive service delivery and policy innovation. However, the overall impact has been highly uneven. Outcomes vary depending on local bureaucratic capacity, fiscal resources, and the presence of active civil society. In many cases, decentralisation has widened governance disparities—deepening fragmentation, weakening intergovernmental coordination, and exacerbating inequities in health service quality and access.

Parallel to decentralisation, Indonesia also underwent a democratisation of the political system that reshaped political representation and accountability at the subnational level. This included open elections for local legislative bodies (DPRD) and, from 2005 onwards, the direct election of local executive leaders[9]—governors, mayors, and district heads—who were now made accountable to voters who directly voted for

[9] Law No. 32 of 2004 on Local Government, along with its derivative Government Regulation *(Peraturan Pemerintah)* No. 6 of 2005 on the Selection, Inauguration, and Termination of Heads and Deputy Heads of Local Governments, introduced the system of direct elections for subnational executive leaders in Indonesia.

them, rather than to central authorities ("Peraturan Pemerintah Republik Indonesia Nomor 6 Tahun 2005 tentang Pemilihan, Pengesahan, Pengangkatan, dan Pemberhentian Kepala Daerah dan Wakil Kepala Daerah," 2005; "Undang-Undang Republik Indonesia tentang Pemerintahan Daerah," 2004). This dual process of political and administrative decentralisation fundamentally altered the nature of democratic accountability in local governance.

Crucially, the decentralisation of authority over key public services, including health, coincided with the democratisation of political competition. As explored in Chapters 1, 2, 4, 5, and 6, Indonesian elections at the subnational level have often been characterised by highly clientelistic features, including vote-buying, patronage distribution of public resources, and the mobilisation of personal networks. This development provided incentives to many local politicians to view the health sector as a potential source of rents and patronage, as we examine through much of this thesis. Health programs, health infrastructure projects, medical equipment and medicine supplies, and bureaucratic appointments offered opportunities not only to deliver tangible benefits to constituents but also to build patronage networks, reward political supporters, and extract rents from procurement processes.

Decentralised Health Governance and Staffing

The move from a centralised to a decentralised health system, as well as the wider political shifts, fundamentally reshaped power relations in Indonesia's public health governance. Local heads of executive governments (mayors and district heads), alongside members of DPRD, became the principal decision-makers in healthcare, tasked with tailoring health services to local needs and enhancing public accountability. However, this transition unfolded rapidly and without a coherent sectoral blueprint. Driven by a mix of donor pressure and ad hoc experimentation, the decentralisation process introduced institutional fragmentation, weakened central oversight, and left many subnational governments unprepared to manage complex health mandates. Crucially, democratic decentralisation also enabled the diffusion of patronage and rent-seeking of public resources. Direct local elections created new pathways for local elites to access power and assert control over health governance—shaping staffing, programming, and budgetary decisions. Yet accountability and oversight mechanisms

failed to keep pace with this redistribution of authority. In this context, health resources were frequently captured by local elites, national initiatives lost coherence, and service delivery became increasingly dependent on the capacity, priorities, and political incentives of subnational actors—leading to wide disparities in implementation across regions.

One of the most consequential effects of this fragmentation has been on the governance of health human resources. During the New Order, staffing decisions were deeply embedded in patronage networks, with appointments often driven by loyalty and personal connections rather than merit or professional competence. This politicised approach to personnel management laid the foundation for practices that persisted—and in many cases deepened—following the shift to decentralised governance. Although the central government, through the Ministry of Civil Service and Bureaucratic Reform (*KemenPAN-RB*), continues to define qualification standards and oversee training and recruitment, decentralisation delegated critical functions such as deployment, promotion, disciplinary oversight, and contract-based hiring to provincial and district governments. This devolution has enabled staffing decisions to be shaped by informal politics.

Workforce planning remains rigid, often reliant on outdated staffing formulas that fail to reflect local realities, resulting in inefficiencies and degraded quality of care. Following decentralisation, nearly three-quarters of all civil servants—including health workers—were reclassified as subnational employees (Heywood & Harahap, 2009, p. 2). Numerous observers have pointed out that this shift complicated coordination across levels of government, weakened national health surveillance systems, disrupted the equitable distribution of medicines and medical equipment, and impaired the coherence of public health delivery (Hayes & Harahap, 2011; Mahendradhata et al., 2017, pp. 206–207; Pisani, 2013; Rakmawati et al., 2019).

Efforts to curb politically motivated staffing through civil service reform have had limited and short-lived impact. The Civil Service Commission (*Komisi Aparatur Sipil Negara,* KASN), established in 2014 under the Law No. 5/2014 on State Civil Apparatus, aimed to promote meritocracy and insulate the bureaucracy from political

interference—especially during the local election cycles when incumbents often exploit bureaucratic appointments to mobilise electoral support. However, the Commission's authority was progressively undermined, and in 2023, its oversight role was ended through Law No. 20 of 2023, endorsed under President Joko Widodo's administration. This rollback of safeguards signalled a renewed vulnerability of the civil service—including the health sector bureaucracy—to political capture, reinforcing the persistence of patronage and rent-seeking in staffing practices at the subnational level (Indonesia Corruption Watch, 2023).

These challenges are compounded by the widespread use of temporary and contract-based staffing schemes, such as the *honorer* (casual) workers or non-civil service (*non-Aparatur Sipil Negara,* ASN) arrangements. These positions often become vehicles for patronage: they are used to reward political allies or generate illicit income, with promises of permanent status tied to electoral outcomes. The central government's authority to approve conversion to permanent ASN status has become a source of lobbying pressures and fiscal strain (@SitiFadilahSupariChannel, 2022; Tamsir, 2022). In practice, many contract workers—especially those stationed in rural *puskesmas*—lack job descriptions, proper supervision, and performance evaluation. As a result, absenteeism, skill mismatches, and weakened service delivery occurs in many regions (Efendi, 2012, pp. 37–38; Rokx, 2010, pp. 33–34; Rokx, Schieber, Tandon, Harimurti, & Somanathan, 2009; Suryanto, Boyle, & Plummer, 2017).

Political capture extends beyond recruitment into the management of career advancement, especially with the effective dismantling of the Civil Service Commission, as noted above. In its absence, in the districts, local elites now wield virtually unchecked control over promotions and rotations (*mutasi*), often prioritising loyalty over competence. As Rosser et al. (2011, p. 9) observe, in a study written shortly before the introduction of the short-lived Civil Service Commission, in patronage-driven political environments, public sector appointments—including in healthcare—are routinely used to consolidate political support, undermining professionalism and institutional accountability.

The weakening of civil service safeguards has not only entrenched patronage in general bureaucratic staffing but has also amplified similar dynamics within the medical profession. A major obstacle to equitable health workforce development and distribution is the fragmented and hierarchical governance of medical professions. As outlined in **Table 3.1**, the division of authority among the Ministry of Health, professional councils, and associations like the IDI has generated bureaucratic friction, regulatory inconsistencies, and opportunities for exclusionary practices.

Table 3.1

Institutions and Associations Responsible for Human Resources in the Health Sector (*2022)*

Central Government Institutions	**Roles and Responsibilities**
Directorate General of Health Workforce, Ministry of Health	Formulates policies on health workforce planning, distribution, and quality improvement.
Ministry of Administrative and Bureaucratic Reform (KemenPAN&RB)	Oversees planning, recruitment and placement of civil servants.
Ministry of Home Affairs	Formulates guidelines for medical professionals engaged as regional civil servants in provincial and district or city governments.
Ministry of Finance	Formulates policies on regional fiscal capacity and transfers and overall state finances, for paying civil servants in the health sector.
Ministry of Education, Culture, Research and Technology	Manages and oversee policy for tertiary education, including medical faculties in the universities, medical residency requirements, and teaching hospitals.
National Civil Service Agency (BKN)	Registration and administration for civil servants (including medical staff).
Professional Associations	
Indonesian Doctors Association (IDI)	At the moment, it is the only professional medical association recognised in Indonesia. It provides recommendation for medical permit registrations and extensions, and for specialised medical trainings.
Medical Specialist Collegiums (around 38, as of 2016).	Each collegium designs, for its field, national medical education and competency standards, and oversees quality assurance of medical specialist and subspecialist professional education (examinations, certification, accreditation, and monitoring of the medical professional education providers).
Indonesian Medical Council (*Konsil Kedokteran Indonesia,* KKI)	Medical professional registration and regulatory body, with authority over issuing licenses to practice (*Surat Ijin Praktek,* SIP), ratifying/determining the standard of medical education, and supervision of medical practice quality.

Local Governments	
District and city government (local health offices, mayors/heads of regions)	Works with the regional civil service agency (*Badan Kepegawaian Daerah,* BKD) in planning for the health sector human resources, manages promotions, selection and movements of senior staff, and recruits and manages temporary or casual staff (non-civil servants) in the health sector (in health offices, *puskesmas*, and local hospitals or RSUD), issues licenses to practice to general practitioners and dentists.
Provincial government (provincial health offices, governors)	Issues licenses to practice for medical specialists, works with BKD in health sector planning, manages promotions, selection and movements of provincial level senior level staff, and recruits and manages temporary or casual staff (non-civil servants) in the health sector at the provincial level (health offices, and local hospitals or RSUD).

Source: Adapted from Meliala and Rarasati (2022, pp. 76–78).

The professional association for doctors, the IDI, has significantly expanded its authority in the post-*Reformasi* era. Democratic reforms not only decentralised governance but also extended a degree of democratisation to professional bodies like IDI, allowing it to operate with greater autonomy as a non-governmental organisation. These changes repositioned IDI as a dominant actor in the regulation of the medical profession, with the body gaining considerable influence over who gets trained, where doctors are deployed, and how careers progress. Founded in 1950 to represent the interests of doctors, IDI's informal authority grew substantially following the enactment of the Medical Practice Law (Law No. 29/2004). Although the law aimed to professionalise and standardise medical governance, in practice it entrenched IDI's control over nearly all aspects of the profession—from specialist education and certification to licensing and disciplinary processes (@2045TV, 2022; @DrTonySetiobudi, 2022b; Kumparan, 2022a; Mahkamah Konstitusi Republik Indonesia, 2017; Prabukusumo, 2018; Ramadhan, 2018; Rarasati, 2020).

The collegiums (*kolegium*), which were originally intended to function independently, have gradually been incorporated into IDI's organisational structure. Meanwhile, the Indonesian Medical Council (*Konsil Kedokteran Indonesia, KKI*)—which should provide external oversight—has become heavily influenced by IDI appointees (Trisnantoro, 2023). This consolidation of authority has turned IDI into a powerful gatekeeper, particularly in regulating access to specialist medical training and licensing.

Admission to such programs often hinges on IDI-issued recommendations, a process frequently shaped by opaque criteria, personal networks and affiliations with senior doctors or elites. This structure disadvantages candidates from peripheral regions or who lack the backing of senior doctors or elites (Arlinta, 2022; Konsil Kedokteran Indonesia, 2012, 2017). My fieldwork further confirms that IDI continues to exercise strong influence, including through informal norms and practices, in the case study cities. This system reproduces exclusion and perpetuates elite dominance, often under the guise of maintaining quality standards.

A recent bullying scandal at a public university in Semarang, *Universitas Diponegoro* (UNDIP), in 2024, exemplifies how internal cultures of seniority and hierarchy within specialist training environments can legitimise abusive practices and obstruct reform (Tempo, 2024a). In a case that attracted considerable public attention, a specialist medical trainee took her own life after being unable to endure sustained bullying and abuse from her senior colleagues and supervisors. While recent interventions—such as the Omnibus Law on Health (Law No. 17/2023) and the assertive stance of Health Minister Budi Gunadi Sadikin—aim to curtail IDI's monopolistic influence, their practical impact remains limited (@DrTonySetiobudi, 2022a, 2022b, 2022c; @KOMPASTV, 2022; Arlinta, 2022; Mahkamah Konstitusi Republik Indonesia, 2017; Mohamad, 2016; Pahlevi, 2023; Pinandhita, 2022; Prabukusumo, 2018; L. P. Putri, 2019; Saptohutomo, 2022; Susianto, 2022).

Though IDI is not a major focus of my own research, existing literature and commentary on it suggest that, in the absence of stronger regulatory oversight, it continues to exert significant control over the medical profession, shaping pathways of training, licensing, and promotion in ways that prioritise elite networks over merit and inclusivity.

Health Sector Funding under Decentralisation

Regardless of decentralisation, health financing in Indonesia continues to rely heavily on central government transfers, primarily through the General Allocation Fund (*Dana Alokasi Umum*, DAU), and the Revenue Sharing Fund (*Dana Bagi Hasil*, DBH). Law No. 36 of 2009 on Health further obliges regional governments to allocate at least 5% of

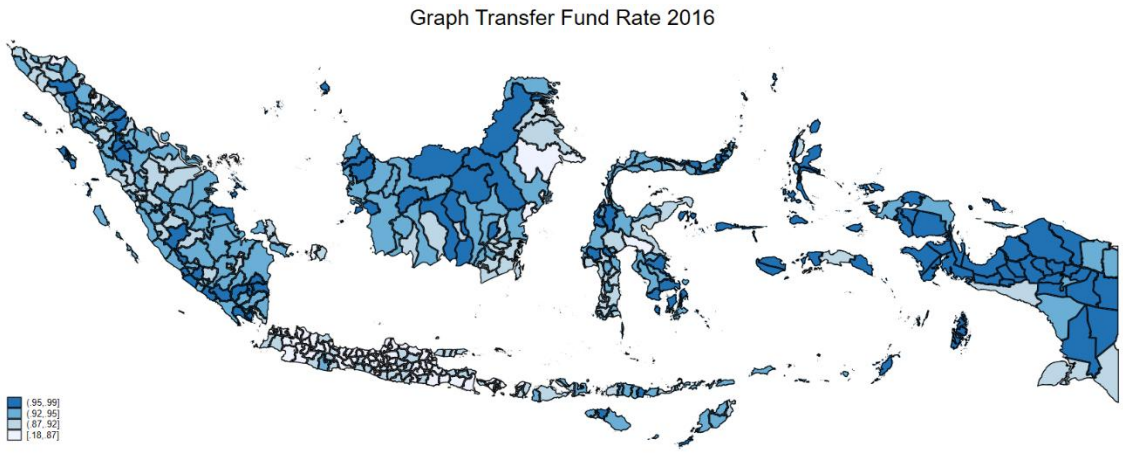
their regional budgets (*Anggaran Pendapatan dan Belanja Daerah*, APBD) to the health sector ("Undang Undang Republik Indonesia Nomor 36 Tahun 2009 tentang Kesehatan," 2009). Yet, the dependence on central transfers varies; districts with limited fiscal capacity remain highly reliant on DAU and DBH, while wealthier districts with stronger revenue bases are less dependent. The DAU is distributed through a formula-based mechanism to support routine regional expenditures, whereas the DBH redistributes revenues from natural resource exploitation.

Despite these redistributive mechanisms, stark disparities in fiscal capacity persist. Resource-rich regions and those with robust local revenues enjoy far greater fiscal flexibility, enabling greater investment in health infrastructure and services, while poorer regions struggle to uphold minimum health standards (*Investing in Indonesia's health: Challenges and opportunities for future public spending*, 2008). To address such disparities, the central government supplements health financing through Special Allocation Grants (*Dana Alokasi Khusus,* DAK), which are targeted at supporting essential sectoral programs in under-resourced regions.

In theory, this combination of fiscal instruments—particularly the equalising role of the Special Allocation Fund (DAK)—should enable districts with greater financial resources to deliver better healthcare. However, **Figures 3.2** and **3.3** illustrate a disconnect between fiscal transfers and actual health budget allocations in 2016. Districts receiving larger fiscal transfers often allocated a smaller proportion of their budgets to health compared to districts with more limited transfers.

Figure 3.2

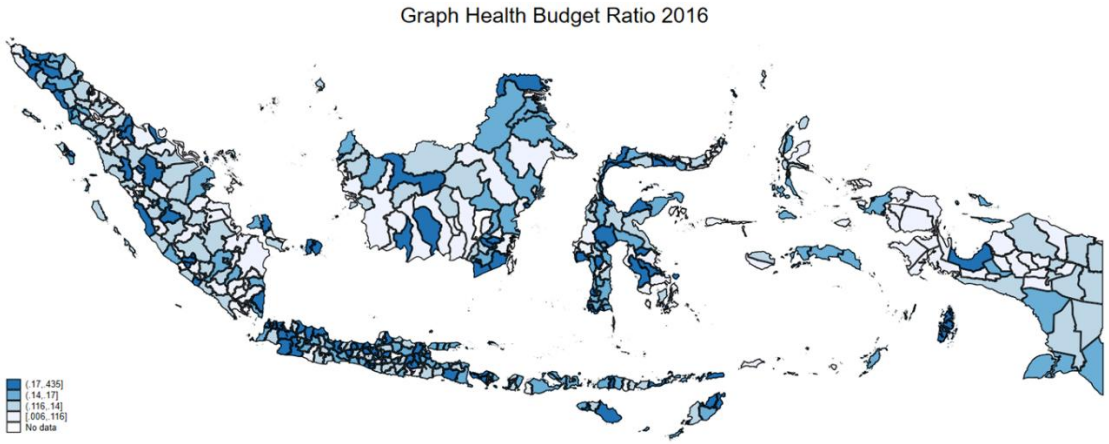
Spatial Variation in Transfer Fund Rate (Central Government's Transfer to Total Revenue), 2016



Source: Author's analysis from Directorate General of Fiscal Balance, Ministry of Finance (2016).

Figure 3.3

Spatial Variation in Health Budget Ratio (Budget for Health per Total Budget), 2016



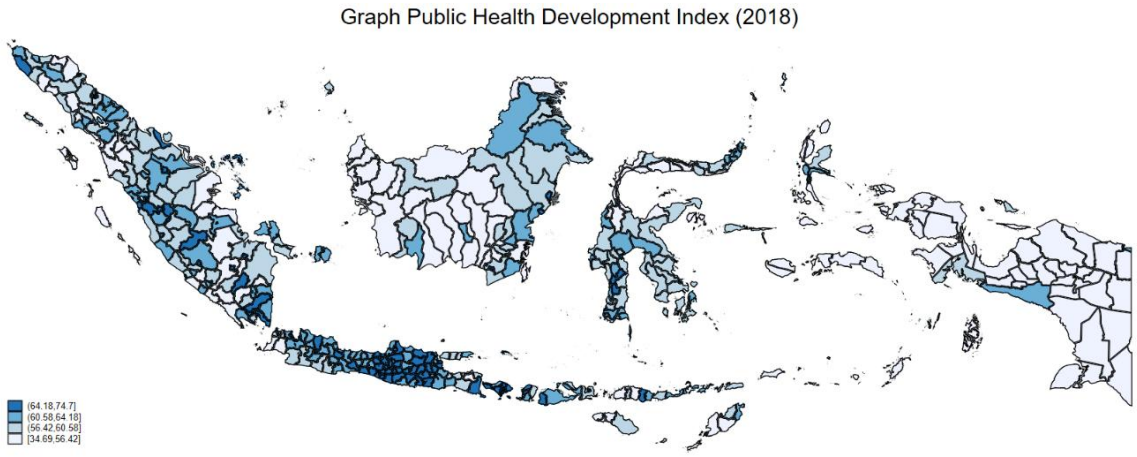
Source: Author's analysis from Directorate General of Fiscal Balance, Ministry of Finance (2016).

When these allocations are compared with health outcomes two years later, as reflected in the Public Health Development Index (*Indeks Pembangunan Kesehatan Masyarakat, IPKM*) in 2018 (**Figure 3.4** that shows spatial disparities in health outcomes

of IPKM),[10] a misalignment becomes evident: districts with greater fiscal support do not always translate that advantage into better health outcomes.

Figure 3.4

Public Health Development Index, Indonesia (2018)



Source: Author's data analysis from the Ministry of Health (2018).

This observation is further supported by the correlation analysis presented in **Table 3.2**, which examines the relationship between IPKM (for 2013 and 2018), district-level fiscal dependency on central government transfers, and per capita health spending. The analysis finds a weak negative correlation between IPKM and health spending per capita (-0.2586), indicating that higher spending per person does not necessarily correspond with improved public health outcomes. In contrast, the analysis reveals a stronger negative correlation between IPKM and fiscal dependency, suggesting that districts more reliant on central government transfers tend to perform worse in health outcomes. In other words, a higher level of fiscal dependency is associated with weaker healthcare performance—highlighting the limits of funding alone and pointing to the importance of political factors that shape governance quality in the healthcare sector.

[10] Regions like Java and Bali perform significantly better than provinces in Eastern Indonesia—such as those in Kalimantan, Sulawesi, Nusa Tenggara, Maluku, and Papua. These findings align with previous assessments by World Health Organization (2017a), which emphasise the uneven distribution of healthcare progress across the country. Eastern regions such as Nusa Tenggara Timur (NTT), Maluku, and Papua consistently lag behind on indicators like maternal mortality, child immunisation, and skilled birth attendance.

Table 3.2

Correlation Analysis between Health Performance (IPKM), Health Funding per Capita, and Fiscal Transfer Dependency Rate

Variable	IPKM 2013, 2018	Health Spending per capita	Fiscal Transfer Dependency Rate	Mean
IPKM 2013, 2018	1			0.561
Health Spending per capita	-0.2586	1		534673.6
Fiscal Transfer Dependency Rate	-0.5609	0.2882	1	0.904

Source: Author's analysis using Ministry of Finance and Ministry of Health data 2015–2018.

Political factors also affect funding flows. Regions vary in their ability to attract additional central government support through lobbying by regional executives and legislative actors. Members of DPRDs and the national parliament (*Dewan Perwakilan Rakyat*, DPR) often facilitate healthcare allocations for their electoral constituencies, including earmarks for DAK and the Ministry of Health's initiatives under its Community Movement for Healthy Living (*Gerakan Masyarakat Hidup Sehat, Germas*). Although DAK funding is centrally determined in terms of amount, category (physical or non-physical), and designated programs, regional leaders actively lobby the central ministries and national parliament for large allocations. These funds are not transferred as flexible cash grants but rather programmed through centrally managed procurement processes. Although DAK is formally determined by central government, its actual distribution and amount allocated is often influenced by informal negotiations and political networks. In particular, DPR members who sit in the national parliament's Commission IX,[11] play a powerful role in brokering where DAK and *Germas* funds are directed.

A revealing example of patronage is played out in *Germas.* While *Germas* is officially intended as a preventative healthcare promotion scheme at the local level and

[11] The DPR uses a commission system, in which members are allocated to commissions which provide oversight over the work of various ministries. Commission IX oversees health and labour (manpower) affairs.

budgeted under the Ministry of Health, its roll out has become highly politicised. Allocation decisions are frequently brokered within the DPR's Commission IX and among dominant party factions (*Fraksi DPR*), transforming what is intended as a public health initiative into a form of club goods and pork-barrel politics. Instead of being distributed based on public health needs, *Germas* allocations are channelled to legislators' constituencies through informal networks and loyal party operatives.

These brokers—often members of legislators' success teams (personal vote brokers and political supporters)—are tasked with organising events, managing procurement for snacks and lunches, and receiving honorariums. In this way, *Germas* serves as a patronage source and a mechanism designed to reward political supporters while claiming credit for public service delivery. This deeply undermines the program's intended function as a universal health initiative, instead reinforcing patron-client relations and prioritising political loyalty over equitable access.

The politicisation of health programs—such as *Germas*—helps explain the pattern in which increased spending fails to yield improved outcomes. When governance is shaped by clientelistic incentives, spending often goes to activities that promote political over healthcare outcomes. Thus, under decentralisation, many districts prioritise politically visible infrastructure and inflated staffing expenditures over less electorally rewarding but essential public health outreach, such as *puskesmas* and integrated healthcare service posts (*pos pelayanan terpadu, posyandu*) programs. As B. Utomo, Sucahya, and Utami (2011, pp. 8–9) argue, decentralisation and intensified local electoral competition have fuelled short-term, vote-maximising strategies over sustained investment in health system strengthening: a dynamic I seek to investigate deeply in this thesis.

Empirical evidence from my case study cities (Chapters 4, 5 and 6), show that health budgets can be relatively easily diverted toward politically visible infrastructure or personnel expenditure, while essential public health programs, medicines procurement, and outreach programs remain underfunded (see also Ahsan, Kramer, Adani, Muhammad, and Amalia, 2021 and Lewis, 2006, pp. 8–9).

Building on the preceding analysis of decentralised health governance and resourcing—particularly in relation to staffing and funding—the next section turns to four key pillars of Indonesia's local health service delivery. While some of these elements originated under earlier regimes, they have become central to the functioning of the decentralised health system. They are: the primary healthcare network built around *puskesmas*, the national family planning program, the hospital governance and referral system, and the national health insurance scheme (*Jaminan Kesehatan Nasional,* JKN).

Healthcare Services: *Puskesmas* and *Posyandu* under Decentralisation

The uneven distribution of healthcare outcomes across Indonesian districts is shaped not only by fiscal disparities and resource availability but also by the informal political dynamics that influence how local elites mobilise and exploit the health sector. In particular, *puskesmas*—Indonesia's primary healthcare centres—serve as frontline institutions where health budgets and policies are translated into actual care, and as strategic arenas where political actors compete to build popularity and legitimacy. As decentralisation deepened, *puskesmas* and community-based facilities such as *posyandu* became the primary interface between the state and citizens in the health sector. However, their performance varies widely (Mahendradhata et al., 2017, pp. 136–139)—shaped not just by administrative and financial capacity but increasingly by local political incentives and clientelist logics.

This section examines the evolving role of *puskesmas* and *posyandu* under decentralised governance, showing how their institutional configuration and local implementation reflect broader tensions between equity, efficiency, and political capture. *Puskesmas* have long served as the institutional backbone of Indonesia's primary healthcare system. They were originally established in 1970s to provide subdistrict-level care focused on disease surveillance and basic treatment. Over time, their mandate has expanded to include promotive, preventive, and basic curative services, especially in maternal and child health, immunisation, and infectious disease control. Under decentralisation, their management was devolved to district and city governments—making their resourcing and performance directly contingent on the political priorities of elected local executives. As such, *puskesmas* now serve not only as

service delivery units but also as tools through which political elites cultivate legitimacy, reward loyalty, and consolidate electoral support.

This politicisation is especially evident in the composition and governance of the health workforce. Contract-based positions—particularly temporary staff (*honorer*) and contracted/non-ASN employees (*Pegawai Pemerintah dengan Perjanjian Kerja*, PPPK), comprise a significant portion of *puskesmas* staff, especially in remote areas. These staff typically face job insecurity, poor remuneration, and limited career development pathways. Recruitment can also be politicised and can be used for patronage and rent-seeking purposes (see the section on Health Sector Staffing above). Commodification of staffing for patronage can undermine technical competence, create mismatches between skills and assignments, and divert limited resources away from essential supplies such as medicines and equipment. Such practices contribute to absenteeism, misaligned staffing, and reduced technical competence—diverting resources from essential services and reflecting the subordination of health governance to political consolidation. In more entrenched cases, positions are reportedly sold to finance political operations—blurring the lines between patronage and outright rent-seeking. I examine such phenomena in my case study chapters (Chapters 4–6).

Closely linked to *puskesmas* operations are the *pos pelayanan terpadu* or *posyandu* (community-led integrated health posts). Originally conceptualised as a mechanism for community participation in maternal and child health, *posyandu* were institutionalised under the New Order; from the start they worked closely with *puskesmas* and also the state-sponsored Family Welfare Movement (*Pemberdayaan dan Kesejahteraan Keluarga*, PKK)[12] (Sciortino, 1996, pp. 97–98). While the model succeeded in mobilising women as health volunteers, it also embedded community health within patronage-based governance networks. In the contemporary period, following the pattern established in the New Order, wives of village heads and district heads often assumed leadership roles in PKK and local health forums, turning these institutions into

[12] PKK *(Pemberdayaan dan Kesejahteraan Keluarga),* translated as Family Empowerment and Welfare Movement, is a nationwide women's organisation established under the New Order to promote family welfare through health, education, and community programs. Structured from neighbourhood (*RT/RW*) to national levels and led by the wives of local government heads, the PKK mirrors the state bureaucracy and functions as a semi-official link between women's groups and governmental authority.

vehicles for political influence (Adzmy & Disyacitta, 2018; Aspinall, White, & Savirani, 2021; Ichsan Kabullah & Fajri, 2021). Health cadres increasingly act as intermediaries not only between healthcare workers and the community but also between citizens and political elites (Adzmy & Disyacitta, 2018, pp. 3–8; Aspinall et al., 2021, pp. 15–18; Ichsan Kabullah & Fajri, 2021, pp. 140–145). Research shows that in several districts, they also function as brokers during elections—mobilising votes, distributing aid, and claiming credit for public services (Adzmy & Disyacitta, 2018, pp. 20–28; Berenschot et al., 2018).

Figure 3.5

Picture of Mothers and Their Babies in A Typical Posyandu

Source: Author's photograph, taken in a village in Ende District, NTT, circa 2009.

My fieldwork in Makassar and Semarang corroborates these findings (see Chapters 5 and 6), revealing close ties between health cadres and both political actors and health bureaucracies. Community health cadres can be co-opted by local politicians and repurposed as brokers—mobilising electoral support in exchange for cash, gifts, job promises or increased operational funding. In Kupang, by contrast, the *posyandu* system has weakened due to limited local leadership, lack of interest, and declining cadre engagement—driven by the mayor's disinterest in community-based initiatives. Instead,

local budgets have been channelled into constituency-building projects such as city parks and housing renovations for the poor, while health funds are diverted to hiring contract-based staff and purchasing high-cost equipment like oxygen generators, with minimal impact on frontline service delivery (see Chapter 4).

The case of *puskesmas* and *posyandu* illustrates how decentralised primary healthcare institutions and the supporting community-based health initiatives—originally designed to promote grassroots participation and outreach to urban and remote areas—can become embedded in local patronage networks. Though there is doubtlessly considerable local variation, often these platforms, rather than serving as neutral sites of public service provision, are instead politicised: jobs and resources tied to *puskesmas* are used to reward loyalty, while *posyandu* cadres are mobilised as informal brokers in electoral cycles. These dynamics exemplify a broader pattern explored throughout this thesis—where democratic decentralisation, in the absence of robust accountability, not only facilitates more localised governance but also opens new spaces for clientelistic appropriation.

Health Services: Family Planning (KB) under Decentralisation

Beyond *puskesmas* and *posyandu,* Indonesia's family planning program represents a critical—yet distinct—pillar of the country's health governance architecture. The KB program under the New Order was a centralised intervention tightly embedded in the regime's developmentalist agenda. Framed as both a patriotic duty and a tool for economic growth, fertility control was institutionalised through slogans like *dua anak cukup* ('two children are enough') and enforced through bureaucratic discipline and ideological conformity.

Established in the 1970s, the National Family Planning Coordinating Board (*Badan Koordinasi Keluarga Berencana Nasional,* BKKBN) functioned as a powerful, centralised agency reporting directly to the president. With strong donor backing and military oversight, it deployed a vast network of field officers, clinics, trained midwives, and volunteer cadres. This structure enabled Indonesia to reduce its total fertility rate from 5.6 in 1971 to 2.6 by 2017 (BPS et al., 2018; Hull, 2003, p. 3). At its peak, the KB

program was internationally lauded as a technocratic success (Hull, 2007; I. D. Utomo, Arsyad, & Hasmi, 2006).

However, the 2001 decentralisation reforms fundamentally restructured this apparatus. While BKKBN formally retained a national mandate, operational authority shifted to district and city governments. This transition, as in other parts of the health sector, disrupted central coordination, introduced uneven local prioritisation, and fragmented service delivery—especially in areas with weak institutional capacity or low political commitment (Hull & Mosley, 2009; B. Utomo et al., 2021, p. 4). Local governments, now balancing multiple responsibilities, often deprioritised family planning, contributing to widening subnational disparities. The program's post-2001 fragmentation underscores how shifts in formal institutional authority have exposed public health interventions to local political discretion. As operational control moved to district and city governments, program coherence weakened, and service quality diverged sharply across regions—particularly in areas with limited bureaucratic capacity or low political prioritisation. These developments reflect the broader patterns examined in this thesis, namely of how clientelism and subnational political incentives shape the implementation and performance of health services. Although BKKBN has sought to revitalise the program—reframing its mission from population control to 'family development' (*pembangunan keluarga*) and promoting integrated social services—long-standing problems of fragmentation, uneven funding, and weak political incentives continue to constrain progress (B. Setiyono, personal communications, April 14, 2025).

Variation across the case study cities illustrates how these dynamics play out in practice. In Semarang, where bureaucratic coherence and political support for public health have remained relatively strong, contraceptive coverage reached 77.73% in 2024. This reflects a slight but consistent improvement from 76.88% in 2016 (*Pemerintah Kota Semarang,* 2025). Between 2012 and 2016, the average number of children per family was maintained in the range of 1–2 children per family. In contrast, Kupang—where clientelistic pressures are more entrenched and institutional capacity weaker—recorded a much lower contraceptive coverage of just 39.7% in 2022, with the average number of children per family still ranging from 3 to 4 children per family. Similarly, Makassar

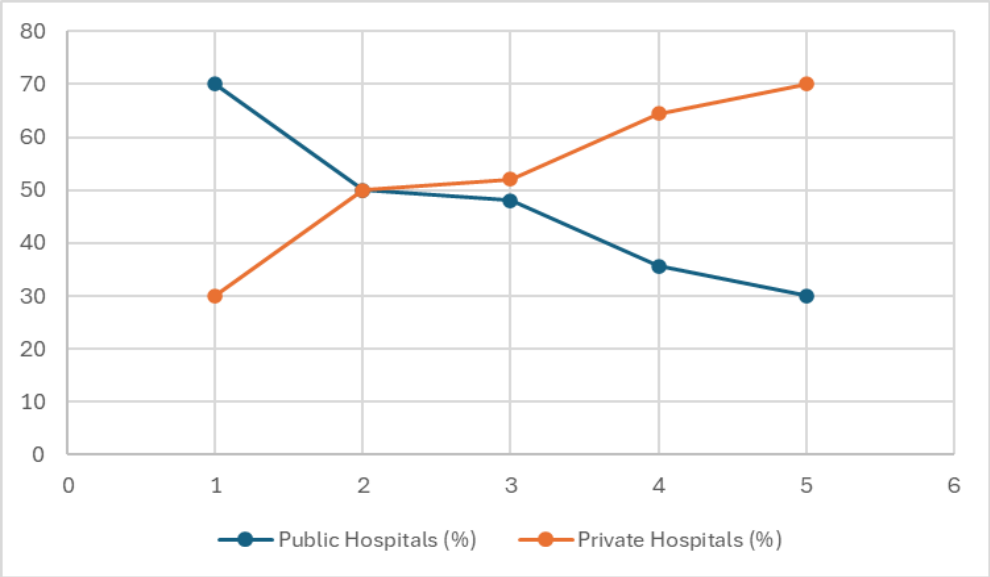
reported a coverage rate of 49.77% in 2022, with 56.35% of women of reproductive age not using contraception in 2022 (Mappong, 2022). These figures suggest that in cities where local elites lack incentives to invest in reproductive health—often prioritising politically strategic sectors instead—family planning is deprioritised, with direct implications for women's health and broader demographic outcomes. As such, the evolution and uneven performance of the KB program exemplify the argument I propose in this thesis: that the interaction between decentralised authority, clientelistic political interests, and local institutional context fundamentally shapes the delivery and equity of healthcare services in Indonesia.

Healthcare Referrals and Hospital Governance

While the family planning (KB) program illustrates how decentralisation exposed community-level health initiatives to local elite interests, Indonesia's healthcare referral system reveals a different yet complementary form of fragmentation that is driven not only by decentralisation but also by market liberalisation and elite capture. Unlike the highly centralised public health model of the New Order, the referral sector has followed a progressively liberalised trajectory since the 1980s, shaped by investment incentives, economic deregulation and selective state disengagement (Kementerian Perindustrian, 2021). Statistical trends reflect this shift. Before 1984, government hospitals made up 70% of all hospitals in Indonesia (Sulastomo, 1988). By early 2000, nearly half of Indonesia's hospitals were privately operated (Departemen Kesehatan, 2007, p. 96), and by 2015, private hospitals accounted for 64.4% of all hospitals and provided 46.4% of all hospital beds (Mahendradhata et al., 2017, p. 107). Between 1996 and 2005, private hospital numbers grew by 30.15%, compared to just 6.88% growth in public hospitals (Departemen Kesehatan, 2007, p. 97). The total number of hospitals tripled from 1,111 in 1999 to 3,016 in 2020, with private hospitals accounting for roughly 63% (1,895 facilities). **Figure 3.6** visualises these trends.

Figure 3.6

Hospital Ownership (Public vs Private) Trends



Source: Author's analysis using data from Mahendradhata et al. (2017) and Departemen Kesehatan (2007). Axis x represents year 1984 (1), 2001 (2), 2003 (3), 2005 (4) and 2015 (5), while axis y represents percentage.

The expansion of the private healthcare sector was paralleled by significant shifts in the governance of public hospitals. Under public sector reform policies in the 1990s, government-run hospitals were granted fiscal autonomy and encouraged to adopt more entrepreneurial practices (Gani, 1996, pp. 295–297). These changes blurred the line between public service and profit-seeking, introducing commercial logics into what had previously been a state-dominated domain. Following decentralisation in 2001, hospital governance became even more fragmented. Type C and D hospitals were transferred to district governments, Type B to provinces, and only Type A facilities remained under central control. In theory, this multi-level governance structure was intended to improve responsiveness; in practice, it exacerbated coordination failures and created jurisdictional ambiguities—particularly in the management of referrals and resource allocation.

These institutional changes occurred without corresponding increases in subnational capacity, and referral coordination suffered as a result. The launch of *Jaminan Kesehatan Nasional* (JKN) in 2014 sought to formalise a three-tiered system of

care, anchored in a structured referral mechanism. Yet enforcement remains uneven, especially in urban and politically competitive areas, where local elites and private providers frequently circumvent referral protocols to maximise financial gains or secure political advantage (Mahendradhata et al., 2017, pp. 71–74). Geographic disparities compound the problem. Java and Bali account for over 60% of Type A and B hospitals, while remote regions like Papua and Maluku remain critically underserved. In 2019, Jakarta had 1.8 hospital beds per 1,000 people, compared to just 0.5 in many eastern provinces (Booth, Purnagunawan, & Satriawan, 2019, p. 145). These inequalities not only reflect enduring developmental imbalances but also incentivise patients to bypass primary and secondary care facilities—further weakening the referral system and overburdening tertiary hospitals.

Concurrently, the hospital sector has become increasingly dominated by politically connected corporate actors. Large conglomerates have expanded their presence through strategies of vertical integration, selective participation in *Jaminan Kesehatan Nasional* (JKN), and control over referral pathways. **Table 3.3** summarises the major corporate hospital chains and their political affiliations. The distribution of private hospitals, although they are part of Indonesia's national healthcare insurance network, is heavily concentrated in urban centres.

Table 3.3

Large Corporate Hospitals Associated with Indonesian Conglomerates

No	Hospital Chain Name	Corporate	Founders and Affiliations
1	Siloam Hospitals	Lippo Group	*Mochtar Riady* (a major national oligarch) and his family. One of the commissioners is *Kartini Sjahrir*, sister of *Luhut Binsar Pangaribuan* (*LBP*), an influential minister during President Joko Widodo and Prabowo's presidency.
2	Mayapada Hospitals	Mayapada Group	*Dato Sri Tahir*, a national oligarch, and his family. He is also son-in-law of *Mochtar Riady*. One commissioner is former Indonesia National Police Chief, *General Da'i Bachtiar.*
3	Mitra Keluarga	Kalbe Farma Group	Founded by *Boenjamin Setiawan*, a national oligarch. He was also the founder of Kalbe Farma Group, a pharmaceutical company.

4	Primaya Hospitals	Formerly Awal Bros Group, now Saratoga Group	*Sandiaga Uno* (major oligarch). He previously served as Vice Governor of Jakarta Province then as Minister of Tourism and Creative Economy under President Joko Widodo in 2020–2024.
5	Pondok Indah Hospitals	Salim Group	*Anthoni Salim,* a national oligarch (son of *Sudono Salim*, founder of Salim Group, Indonesia's largest conglomerate with a long history of connections to the former Suharto regime).
6	Ciputra Hospitals	Ciputra Group	*Ciputra* and his family. Ciputra was another major national oligarch, with close regime connections dating back to the New Order period.
7	Eka Hospitals	Sinarmas Group	*Eka Tjipta Widjaja,* likewise a leading oligarch with regime connections dating back to the New Order.

Source: Various sources (Andrian, 2022; *Angkaberita*, 2021; Fadillah, 2019; *Fajar*, 2022; Hema, 2022; Jelita, 2020; *Jurnal Asia*, 2017; *Koran-Jakarta*, 2017; *Kumparan*, 2022b; A. Putri, 2022; Simamora, 2017).

Business players increasingly view the healthcare sector as a strategic and profitable domain—particularly in urban areas where economic growth and middle-class expansion have boosted demand for higher-quality services. This commercial potential has driven many diversified conglomerates to integrate healthcare into their portfolios, targeting segments of the population willing and able to pay for private hospital care. Participation in JKN has further incentivised this expansion. Despite relatively low reimbursement rates through the INA-CBG (Indonesia Case-Based Group) payment system, informants suggest that participation in BPJS Health or JKN remains profitable, not only due to high patient volumes but also through supplementary income from the sale of medicines and medical supplies not covered by the scheme or unavailable in public facilities.

Many private hospitals, including major corporate chains, have formally partnered with BPJS Kesehatan as JKN providers to access this insured patient base while consolidating market power. Notable examples include Primaya Hospitals and Siloam Hospitals. Their advantage is reinforced through selective participation in the JKN and vertical integration with pharmaceutical suppliers. A central strategy involves controlling referral pathways: since JKN requires referrals from primary care providers, company-owned primary care clinics are often used to channel patients directly into affiliated secondary and tertiary hospitals. This allows corporate groups to maintain

patient flow within their own networks, effectively expanding market share through internal referral loops.

The Indonesia Competition Commission (Komisi Pengawas Persaingan Usaha, 2020, pp. 7–9) has flagged such practices—including exclusive procurement arrangements and closed referral systems—as anti-competitive and potentially monopolistic. In addition, many of these hospitals restrict the number of JKN patients they accept or impose unofficial charges, citing low INA-CBG reimbursement rates and frequent unavailability of covered medications (Banerjee et al., 2021, p. 3041). These manoeuvres illustrate how private providers exploit structural weaknesses in the JKN system to maximise profits—undermining the scheme's goals of equity, accessibility, and integrated public service delivery.

In some cases, these large providers have reportedly acquired financially distressed smaller hospitals by exploiting rigid and costly accreditation standards—where failure to comply can result in the loss of JKN provider status under BPJS, which is subject to annual review, thereby threatening a clinic or hospital's viability (Arief, 2019; Gunawan, 2019). Many smaller hospitals struggle to meet these accreditation criteria due to bureaucratic inefficiencies, limited resources, and costly compliance demands. Civil society groups, including Lokataru, have criticised this regulatory framework, arguing that it enables predatory consolidation while undermining equitable service delivery (Lamboka, 2019; *Lokataru*, 2019). This mode of market expansion points to broader concerns about monopolistic practices, regulatory asymmetry, and the erosion of public oversight—raising critical questions about the role of the state in ensuring access, fairness, and accountability within Indonesia's increasingly market-driven health system.

Crucially, the market power of these hospital groups is often reinforced by clientelist linkages to political elites. Many corporate health providers are owned or backed by influential business families with long-standing ties to national and local political actors. In some instances, according to an informant, an economist and local experts in political economy suggest, politically connected firms have acquired distressed hospitals by exploiting accreditation delays that result in the loss of JKN

status—effectively monopolising regional service delivery (Anonymous, personal communication, November 27, 2023). Several major hospital groups illustrate the convergence between business and political power. For example, *Siloam Hospitals*, owned by the Lippo Group, includes on its board Kartini Sjahrir, sister of senior minister Luhut Binsar Pandjaitan, a key political figure under both the Jokowi and Prabowo administrations (Jelita, 2020). Similarly, Primaya Hospitals, formerly known as Awal Bros Group, is now affiliated with Saratoga Investama, the investment firm linked to Sandiaga Uno, a prominent businessman-turned-politician and minister (*Kumparan*, 2022b; A. Putri, 2022).

Political ties offer key advantages to oligarchs, including privileged access to capital, preferential treatment in navigating regulatory hurdles, discretions to bypass due diligence procedures, and leverage in lobbying to shape health sector policy in ways that entrench their dominance over healthcare markets. In such cases, patronage relationships extend beyond electoral mobilisation to encompass policy influence, licensing privileges, and procurement access, and help to insulate corporate providers from meaningful oversight. For instance, in South Sulawesi, businesswoman Imelda Obey leveraged her close ties to political elites and law enforcement officials to secure routine government contracts in the medical equipment sector. Through these connections, she came to dominate regional (Sulawesi)-level supply chains for medical supplies and equipment. Despite her entanglement in the corruption case involving Governor Nurdin Abdullah in 2019, she largely evaded serious legal consequences (Ali, 2021; *Transsulawesi*, 2019). Not only did she evade the accountability, but in 2024 President Joko Widodo, through the Ministry of Industry, even awarded her company (Akbar, 2024)—turning a problematic business actor into a celebrated entrepreneur. As Sari (2024, pp. 204–205) demonstrates in Makassar, and as Setiyono (2011, p. 220; 2017, p. 33) notes more broadly, such networks of political and law enforcement ties enable business elites to manipulate regulations and escape accountability.

As I elaborate in later chapters, procurement remains one of the most vulnerable arenas for clientelistic capture. Between 2014 and 2015, approximately 39% of hospitals struggled to access the national e-purchasing system, complicating the acquisition of essential medical supplies and enabling irregular practices (Djasri, Rahma, & Hasri,

2016, p. 114). Investigations by the Corruption Eradication Commission (KPK) have exposed cases of fraudulent BPJS Health claims and manipulated contracts—highlighting how actors exploit regulatory loopholes to extract rents and divert public resources (CNN Indonesia, 2020).

Taken together, these dynamics show how decentralisation, market liberalisation, and elite networks have reshaped hospital and referral governance, often privileging politically connected providers. Procurement lies at the heart of this transformation, linking hospital operations to broader patterns of clientelism and resource extraction. These shifts became even more consequential with the launch of the national health insurance scheme (*Jaminan Kesehatan Nasional,* JKN), which absorbed many former local schemes (*Jaminan Kesehatan Daerah, Jamkesda*) and formalised referral mechanisms in an effort to integrate providers into a single framework—yet in practice also opened new arenas of discretion, political influence, and market competition that continue to shape access and service quality.

The National Health Insurance Scheme (*Jaminan Kesehatan Nasional,* JKN)

In 2014, Indonesia launched the national health insurance program—*Jaminan Kesehatan Nasional*, JKN, with the aim of unifying service access and financing across all levels of care while consolidating the diverse local schemes (*Jaminan Kesehatan Daerah, Jamkesda*) that had already emerged in many districts and cities. The JKN is not simply a technical health financing reform, and an attempt to provide universal health coverage, but also a sectoral governance arrangement that is shaped, informally, by the broader logic of Indonesia's patronage democracy. As argued previously in Chapter 2, the decentralised political context creates uneven incentives for local politicians to adopt programmatic policies, and opens space for rent-seeking, elite capture, and politically mediated access to services in at least some regions. JKN offers a critical lens through which to observe how formal universalist policies can be filtered through informal power networks at the local level. As a state-led reform designed to universalise healthcare access through a single-payer system, JKN exemplifies both the promise and the limitations of technocratic solutions in a fragmented patronage democracy such as Indonesia. Its implementation reveals how health entitlements are subject not only to

bureaucratic and fiscal constraints, but also, at least to some extent, to the patterns of political discretion, brokerage, and institutional unevenness found in other parts of the healthcare system. The following analysis shows that while JKN has expanded coverage nationally, its equity and effectiveness remain contingent on local political configurations, bureaucratic capacity, and the strength of informal institutions and civic engagement.

Launched in 2014, JKN was conceived as a single-payer national health insurance system to consolidate previously fragmented insurance programs and expand equitable access to healthcare across public and private providers. Although initiated by the national government, JKN is administered by Social Security Administrative Body on Health Insurance (*Badan Penyelenggara Jaminan Sosial, BPJS Kesehatan*)—a vertically structured institution reporting directly to the president. Its legal basis is established under Law No. 24 of 2011 on BPJS. The broader governance of the national social security system is coordinated by the Council of Social Insurance (*Dewan Jaminan Sosial Nasional*, DJSN), established under Law No. 40 of 2004 and Law No. 2 of 2018. DJSN advises the president on social security policy, oversees BPJS operations, determines contribution rates, and supports efforts to expand coverage. This dual institutional arrangement reflects a highly centralised architecture at the national level—yet, as this thesis argues, the effectiveness of JKN remains contingent on how these national frameworks interact with subnational implementation dynamics, local political interests, and clientelist governance structures.

JKN represented a major institutional shift, consolidating previously disparate healthcare arrangements into a more unified and inclusive framework. It consolidated multiple legacy schemes at the national and subnational level: the civil servants scheme (*Asuransi Kesehatan, Askes*), the military and police scheme (*Asuransi Angkatan Bersenjata Republik Indonesia, Asabri*), the scheme for formal private-sector employees (*Jaminan Sosial Tenaga Kerja, Jamsostek*), the program for the poor (*Jamkesmas*), along with the diverse local health insurance schemes (*Jamkesda*) developed by district and municipal governments (see also in Aspinall, 2014a, pp. 4–7; Fossati, 2016a, p. 291; 2016b, p. 307; 2017, pp. 185–189; and Rosser and Wilson, 2012, p. 608; and Rosser et al., 2011, pp. 17–26). This integration extended coverage to informal and unemployed

populations previously excluded from state health protection. Its core ambition is to provide equitable access to healthcare for all Indonesians, regardless of income level or employment status. This transformation also intensified interactions between public and private healthcare providers, particularly in the domain of the primary care and healthcare referral systems, where private doctors, clinics, and hospitals now play an increasingly important role in serving JKN-covered patients.

By 2021, JKN had enrolled over 222 million people—roughly 82% of the population—making it one of the world's largest Universal Health Coverage (UHC) programs (Nundy & Bhatt, 2022, p. 26). Yet despite this impressive reach, the program continues to grapple with systemic structural and operational challenges that threaten its goals of equitable and sustainable healthcare access. Foremost among these challenges is chronic underfunding. The government's contributions for subsidised beneficiaries (*Penerima Bantuan Iuran,* PBI) have not kept pace with rising healthcare costs, leading to cumulative deficits of over IDR 28 trillion between 2014 and 2019 (Ahsan et al., 2021, p. 357). In an effort to control spending, the government introduced the INA-CBG payment system. While intended to enhance cost-efficiency, this model has had unintended consequences, as some healthcare providers now avoid complex or costly cases that fall outside reimbursement thresholds (Banerjee et al., 2021, p. 3041).

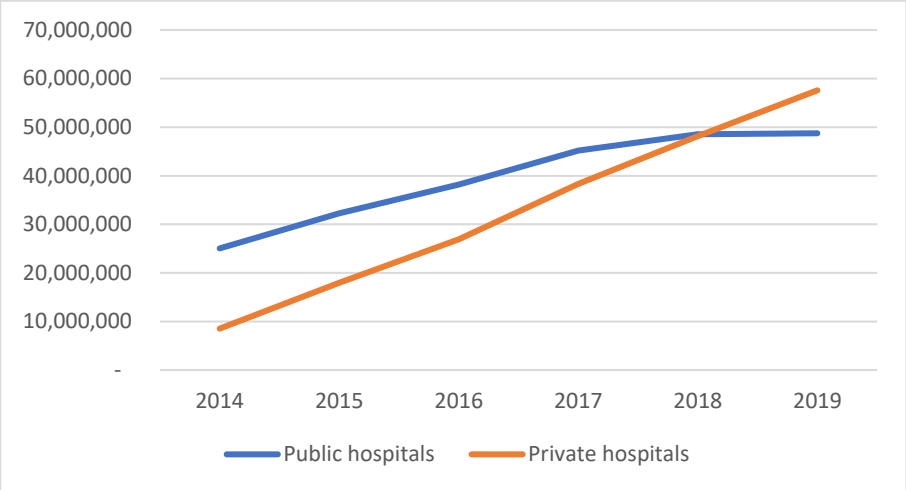
Equally concerning are the persistent disparities in service utilisation. Although enrolment figures are high, access to care remains uneven—especially in rural and underdeveloped regions. These areas often suffer from limited infrastructure, severe provider shortages, and cumbersome bureaucratic processes (Nugroho et al., 2021, pp. 283–285). As a result, patients frequently face long travel distances and confusing referral pathways, deterring them from using JKN services. Some ultimately opt to pay out-of-pocket rather than navigate the system's complexities. In Eastern Indonesia and remote islands, structural barriers such as poor transport, digital illiteracy, and limited administrative capacity exacerbate these gaps (Booth, Purnagunawan, & Satriawan, 2019, pp. 142–146; Nugroho et al., 2021, p. 288).

Private sector engagement introduces another layer of complexity. While JKN sought to integrate public and private providers, participation by private hospitals and

clinics remains selective. Many limit JKN patient intake or restrict the range of services offered, citing inadequate INA-CBG rates, reimbursement delays, and administrative burdens (Nundy & Bhatt, 2022, p. 28). This reinforces dependence on overstretched public facilities. However, in certain domains—particularly in urban areas—private utilisation under JKN now surpasses public sector figures: see **Figure 3.7** which compares numbers of cases treated in public and private hospitals using the JKN scheme at the aggregate, national level.

Figure 3.7

Number of Cases Treated in Public and Private Hospitals (Using JKN), Indonesia (2014–2019)



Source: Author's analysis based on raw data provided by Badan Penyelenggara Jaminan Sosial Kesehatan (2021).

At the same time, JKN faces persistent coverage gaps among informal workers. Unlike formal employees, informal workers—who constitute over half of Indonesia's labour force—must enrol voluntarily. As of 2020, more than 60% of non-poor informal sector workers remained outside the system (Banerjee et al., 2021, p. 3041), undermining the risk pool and threatening JKN's financial sustainability. The financial viability of JKN thus hinges on broad-based enrolment and an inclusive risk pool.

Related to the enrolment coverage, one of the scheme's structural weaknesses lies in its dependence on targeted premium subsidies (*Penerima Bantuan Iuran,* PBI),

which are vulnerable to political manipulation. Officially, PBI recipients are selected based on poverty data of the unified database on social welfare (*Data Terpadu Kesejahteraan Sosial,* DTKS) compiled by the Ministry of Social Affairs, but this data must be verified and updated by local governments. This opens space for distortion, as local officials can direct subsidies toward politically connected individuals, campaign supporters, or members of their personal networks rather than those with the greatest need. Such practices are emblematic of how clientelistic incentives can subvert national policy objectives. More broadly, to address coverage gaps—particularly for the near-poor—the central government has encouraged districts and cities to establish local subsidies through the targeted premium subsidies paid by local government funding (*PBI APBD* or *Penerima Bantuan Iuran Pemda*, recently renamed *PBU Pemda*). While this mechanism offers flexibility, it also reinforces the role of subnational elites in determining access, as I explore in my thesis.

In some cases, my findings suggest these schemes are used programmatically to enhance service equity—as in Semarang, where the local government extended JKN coverage to all residents regardless of socioeconomic status. This universalist policy not only expanded coverage but also strengthened public trust and reinforced the city's reputation for service delivery integrity—demonstrating how programmatic policies can be politically rewarding in competitive and civically engaged contexts (see Chapter 6).

By contrast, in Kupang—where resources are limited and clientelistic politics remain entrenched—the allocation of JKN subsidies is more fragmented and discretionary. Local officials reportedly use access to PBI APBD as a form of patronage, distributing health entitlements selectively to consolidate support (see Chapter 4). Makassar presents a mixed case. While the city has stronger fiscal capacity and more developed infrastructure than Kupang, JKN access continues to reflect the strategic calculations of political elites, particularly during electoral periods. Rather than advancing universal entitlements, the selective expansion of coverage is often channelled toward loyal supporters and family networks of ruling elites.

Beyond issues of politicised targeting, access to healthcare services under JKN is frequently mediated by informal actors—such as brokers, village heads, and

neighbourhood elites—particularly in areas where state capacity is weak or fragmented. This politicisation of access aligns with what Berenschot et al. (2018) describe as "brokered citizenship," in which eligibility for state entitlements is filtered through informal relationships rather than being extended on the basis of formal criteria. In such settings, health coverage becomes contingent on political proximity rather than need, undermining the universality of JKN. Citizens outside dominant patronage networks might face delays and bureaucratic exclusion or often resort to out-of-pocket payment despite formal enrolment. JKN, despite its universalist aims, is embedded in this broader political economy of mediated care. The ability to access healthcare is not solely a function of enrolment but often depends on one's connections within local patronage networks.

City and district governments vary significantly in addressing healthcare access constraints. As we shall see in greater detail in Chapter 6, among my case studies, Semarang stands out as a positive case: the city introduced "Ambulans Semarang HEBAT," a free ambulance service for all residents, supported by real-time hospital bed availability and mobile-based registration. Local leaders also monitored service quality, renovated *puskesmas* and public hospitals, and upgraded medical equipment—reflecting a programmatic commitment to reducing access barriers. Makassar implemented similar measures, including free ambulance services and the upgrade of a *puskesmas* into a local hospital. However, as detailed in Chapter 5, infrastructure improvements were tainted by corruption and rent-seeking in construction and procurement processes. Kupang, by contrast, demonstrates how limited fiscal capacity and entrenched clientelism undermine access. Despite JKN membership, poor residents often face logistical barriers due to the absence of transport services, digital tools, or intermediaries. Although the SK Lerik Hospital was physically expanded, it remained under-equipped, with frequent staff absences. The mayor reportedly prioritised high-cost equipment imports over essential infrastructure, such as staffing, basic medical tools, and clean water access. These cases illustrate a core finding of this thesis: formal JKN enrolment does not guarantee meaningful access, particularly where political incentives favour visibility over functionality, and clientelism distorts local healthcare governance.

The experience of JKN reveals a broader insight central to this thesis: efforts to universalise healthcare in Indonesia are inseparable from the political and institutional dynamics of a decentralised patronage system. Although the scheme has significantly expanded formal coverage and introduced a unified platform for public and private provision, its outcomes remain uneven and are conditioned by subnational variations in political will, administrative capacity, and informal power structures. Where political incentives align with programmatic governance, as in Semarang, JKN can support inclusive and reliable service delivery. However, in settings where clientelist politics dominate, access to healthcare continues to be shaped by selective targeting, elite brokerage, and performative infrastructure investments. Rather than operating outside the political system, JKN is embedded within it—its implementation is filtered through the same networks and discretionary practices that characterise local governance more broadly. To fully understand the effectiveness and limitations of Indonesia's universal health insurance, one must look beyond formal policy frameworks to the informal political incentives and practices that govern access on the ground.

Pharmaceuticals, Medical Devices, and Supply Chain Inequalities

While JKN has expanded healthcare coverage and standardised many aspects of service financing, access to treatment ultimately depends on the availability of essential medical inputs—particularly pharmaceuticals, devices, and supporting infrastructure. Yet, as this section demonstrates, the procurement and distribution of these medical goods is deeply embedded in the political economy of Indonesia's health system. Rather than functioning as a neutral or technocratic domain, the supply chain for medicines and equipment is a critical site where clientelist practices, elite networks, and bureaucratic discretion intersect—shaping both the quality of care and the equity of health outcomes.

Access to affordable, safe, and effective medicines and devices is foundational to any health system's credibility and efficacy. This is especially true under JKN, where the reliability of care is closely tied to the availability of generic drugs and functioning equipment across Indonesia's vast and unequal geography. As the World Health Organization (World Health Organization, 2017b, pp. 18–19) notes, disruptions in medical supply chains undermine public trust, reduce adherence to treatment, and can

therefore undercut the goals of universal health coverage. Yet in Indonesia, the pharmaceutical and medical device sectors have been consistently ranked among the most corruption-prone domains of public procurement, as reported in Anti-corruption Eradication Commission (*Komisi Pemberantasan Korupsi*, KPK), Indonesia Corruption Watch (ICW)'s reports and local newspapers (Erdianto, 2018; Indonesia Corruption Watch, 2013, 2017; Komisi Pemberantasan Korupsi, 2018).

Despite sectoral growth, governance in these sectors remains fragile. ICW reported that between 2010 and 2016, medical equipment procurement generated 107 documented corruption cases, with estimated losses of IDR 543.1 billion (Indonesia Corruption Watch, 2017). Indonesia's pharmaceutical and medical device industries remain vulnerable to governance failures, including regulatory fragmentation, rent-seeking, and market capture by politically connected conglomerates (Laras, 2022). Rather than being driven by need or public interest, procurement processes are often shaped by rent-seeking and electoral calculations.

Indonesia's pharmaceutical industry includes over 230 manufacturers, but the sector remains import-dependent: over 90% of raw materials are sourced internationally (Hermansyah, Wulandari, Kristina, & Meilianti, 2020, p. 4; Meilianti et al., 2022, p. 2). This dependence exposes the system to global supply shocks and price volatility. While post-COVID efforts have encouraged domestic self-sufficiency (Ariana, Prihadyanti, Maulana, & Alamsyah, 2015, p. 41), progress has been very limited due to underinvestment in research and development and high entry barriers.

The procurement of pharmaceuticals under JKN operates primarily through the *National Formulary* (*Formularium Nasional, Fornas*) and the *e-Katalog* platform—centralised mechanisms intended to standardise prices and supply for essential medicines, enforce price ceilings and improve affordability. The National Formulary is an official list of medicines that are approved for use and covered under the JKN scheme. It was first introduced in 2013 by the Ministry of Health and includes generic and selected branded drugs deemed essential, cost-effective, and clinically appropriate for treating health conditions commonly found in Indonesia. The National Formulary standardise what medicines the BPJS Health will reimburse, helping ensure consistency

across public and private providers (*Kemkes*, 2013). The *e-Katalog* is an online procurement platform managed by the National Public Procurement Agency (*Lembaga Kebijakan Pengadaan Barang/Jasa Pemerintah,* LKPP). It was introduced in 2012 and lists pre-approved medical products, including medicines, medical supplies, and medical equipment, along with their fixed prices, suppliers, and specifications (Kurnia, 2024). The *e-Katalog* is intended to enable transparency and standardised procurement at national and subnational levels. It lists price ceilings for each product, which public agencies and hospitals must adhere to, reduces the needs for repeated tenders by allowing direct purchasing from the catalogue, and is therefore intended to reduce corruption and collusion in procurement by fixing prices and supplier eligibility.

While these reforms were technocratic efforts to enhance transparency and equity, in practice they can operate within—and are often undermined by—the same fragmented governance arrangements and informal political incentives that characterise Indonesia's decentralised health system. Crucially, the responsibility for procuring medicines and medical equipment for government-run hospitals and *puskesmas* remains with city and district governments. This institutional setup reintroduces local discretion into what is ostensibly a centralised system, creating multiple points where patronage, collusion, and rent-seeking can infiltrate procurement processes. In Makassar and Kupang, as later chapters elaborate, my fieldwork revealed arranged tenders, monopolistic practices, and preferential access for politically connected business elites. Often linked to political parties and law enforcement, these actors operated within protective networks that shielded procurement abuses from scrutiny. These patterns expose weaknesses in the *e-Katalog* system—gaps in monitoring, elite discretion, supply shortages, and enforcement loopholes—that are readily exploited through informal politics. Instead of curbing clientelism, centralised procurement frameworks risk being reabsorbed into it when implemented in politically saturated subnational contexts.

Another factor hampering the equitable distribution of medicines and equipment is the high logistical and transportation costs, which discourage many *e-Katalog* suppliers from fulfilling orders to rural and remote health facilities. As a result, local authorities in these areas often revert to conventional public procurement (tender) methods instead of using the *e-Katalog* system. As Suryanto, Plummer, and Boyle (2017,

p. 261) note, procurement reforms have not been matched by robust monitoring systems, leading to quality inconsistencies, supplier opportunism, and persistent geographic disparities.

Procurement in Indonesia's health sector has become a strategic site of rent extraction and political capture. Despite the centralised, technocratic design of mechanisms like the National Formulary and *e-Katalog*, which are designed to reduce these problems, these tools remain deeply embedded in Indonesia's patronage-based political economy. Moreover, according to Saraswati and Zulfa (2023, pp. 20–23), post-New Order liberalisation has enabled politically connected conglomerates to dominate the supply chain—from licensing and production to distribution—facilitating inflated pricing, non-competitive tenders, and opaque regulatory deals.

Civil society investigations confirm these dynamics. Indonesia Corruption Watch (Indonesia Corruption Watch, 2017) documented 219 corruption cases in the health sector between 2010 and 2016, involving 519 perpetrators and state losses of IDR 890.1 billion—of which 107 cases related to pharmaceutical and medical equipment procurement accounted for IDR 543.1 billion (approximately AUD54,000). These included cases of inflated prices for basic equipment such as ambulances and hospital beds, fictitious projects for medicine distribution, and collusion in tenders for medical devices. The industry insiders warn of entrenched cartels—the so-called "medical devices mafia"—that continue to manipulate post-2014 procurement reforms (Teguh, 2022). One emblematic case involved former Banten Governor Ratu Atut Chosiyah and her brother Tubagus Chaeri Wardana, who captured procurement contracts across Banten Province and South Tangerang City through familial and political connections (*Tempo*, 2017).

Fieldwork in Kupang and Makassar revealed similar patterns. In both cities, procurement tenders were widely reported to be dominated by networks of local business elites with close ties to politicians and law enforcement. Through collusion, these actors secured major contracts—particularly for expensive medical equipment and hospital construction—turning procurement into a key arena of political influence and rent-seeking. While difficult to verify due to risks faced by whistleblowers and weak

transparency, these accounts reflect a broader pattern of decentralised clientelism, where tenders serve political consolidation rather than public service delivery.

The medical devices sector reflects comparable vulnerabilities. While basic supplies are produced domestically, high-value imports dominate, and oversight remains weak. In 2021, reforms such as the Domestic Component Level (*Tingkat Komponen Dalam Negeri,* TKDN) and segmented *e-Katalog* were introduced to reduce dependency and promote competition. TKDN, codified in Ministry of Industry Regulation No. 16/2020, specifies the percentage of local content in goods or services produced domestically and has been promoted as an industrial policy tool to strengthen local manufacturing and reduce reliance on imports. Yet political pressure—particularly from President Joko Widodo's push to raise TKDN targets and drive state-owned enterprises to meet ambitious sales goals—has produced unintended consequences. In 2024, executives at the state-owned company Indofarma were exposed for falsifying financial and engineering reports to conceal underperformance (Binekasri, 2024; Trikarinaputri, 2024). Interviews with my informants, including a top executive and a commissioner at Indofarma, confirmed that such practices were driven by strong political pressure to demonstrate compliance with TKDN targets (Anonymous, personal communications, August 4, 2022). The implementation of TKDN in health procurement also opens new arenas of discretionary governance and political brokerage, where local elites and connected business actors can leverage certification and compliance processes as instruments of patronage and rent-seeking/corruption.

These developments underscore a broader pattern: although procurement and production reforms were designed to expand access, ensure affordability, and curb corruption, their effectiveness is repeatedly compromised by informal political imperatives. Though designed to serve public health goals, these technocratic tools are often distorted by patronage politics—reinforcing the central argument of this thesis on the persistence of informal political pressures in Indonesia's health sector.

These distortions are not isolated incidents but part of a deeper systemic feature of procurement in Indonesia's health sector. As this thesis argues, the political utility of procurement—both as a funding source and a patronage mechanism—means that even

well-designed reforms are filtered through informal networks and electoral calculations. In Makassar, as detailed in Chapter 5, hospital procurement projects at Batua and Daya hospitals were riddled with inflated costs and collusive tendering, resulting in convictions of senior officials (Fatir, 2023; Mappiwali, 2022; F. Mustafa, 2021; Rico, 2023). In South Tangerang, as noted above, Tubagus Chaeri Wardana used his influence as the mayor's spouse to manipulate medical tenders for personal gain, with KPK later recovering IDR 58 billion in illicit proceeds (Antara, 2014; VOI, 2022).

This politicisation extends deeply into frontline practices. In the high-profile "Interbat bribery scandal," pharmaceutical company PT Interbat disbursed over IDR 131 billion in illicit incentives to more than 2,000 doctors and 151 hospitals between 2013 and 2015, encouraging them to prescribe Interbat's branded drugs over generics (Silalahi, Pramono, & Paraqbueq, 2015). A former pharmaceutical sales manager from a different company, interviewed in Semarang, confirmed the systemic nature of such tactics: "The company allowed me to allocate up to 15% of sales for gifts, overseas trips, seminars, cash—whatever I needed to build relationships with doctors and hospitals" (Anonymous, personal communication, August 1, 2022).

Corruption in health procurement tends to intensify around election cycles. Data from ICW and the KPK show notable spikes in corruption cases during the lead-up to the 2009 and 2014 national elections. In both cycles, the number and total value of cases surged significantly in the year prior—particularly in 2008 and 2013—suggesting that procurement channels were systematically exploited to finance campaigns and reward loyalists (Indonesia Corruption Watch, 2013). These schemes often involved local elites—including district heads, health officials, hospital directors, and *puskesmas* managers—working in tandem with favoured contractors (Indonesia Corruption Watch, 2013, 2017; Irawan, 2018; Komisi Pemberantasan Korupsi, 2017; Purnamasari, 2021).

Rather than addressing these vulnerabilities, recent reforms appear to have deepened them. Presidential Instruction No. 2/2022 and LKPP Decision No. 166/2022, which aimed to expand supplier participation and promote inclusion of small and medium-size enterprises (SME), removed key verification procedures in the *e-Katalog* procurement system. This deregulation created new openings for abuse. As a former

senior LKPP official observed, these changes effectively "legalised and legitimised" corruption by aligning regulatory adjustments with the interests of political elites. Procurement thus becomes not only a tool for rent-seeking, but a means to reward supporters, finance patronage networks, and consolidate political dynasties.

These developments reinforce a central claim of this thesis: the governance of essential healthcare inputs—medicines, equipment, and procurement systems—is far from a neutral or technical matter. It is embedded in a broader political economy of clientelism, where formal rules are routinely subverted by informal power relations and elite incentives. Even when reforms are introduced with the goal of enhancing transparency or efficiency, their implementation is shaped by the same discretionary and politicised logic that undermines equity and institutional accountability across Indonesia's healthcare system.

In sum, reforms such as the National Formulary, *e-Katalog,* and TKDN have mixed results; to some extent it has helped to expand access and standardise procedures, yet procurement remains a key arena for rent-seeking/corruption, patronage, and political bargaining. This duality—programmatic progress alongside informal captures—underscores the concern of this thesis and will be explored further in the following case study chapters on Kupang, Makassar, and Semarang.

COVID-19 Response: Vaccine Distribution, and Political Capture

The COVID-19 pandemic laid bare the fragility of pharmaceutical and medical equipment governance, showing how public health emergencies can be exploited through informal politics and elite capture. The case of former Social Affairs Minister Juliari Batubara illustrates this vividly. In 2020, he was arrested and later sentenced to 12 years in prison for taking bribery payments—estimated at IDR 32.4 billion (approximately AUD3 billion)—for manipulating the procurement process for COVID-19 social assistance packages (Da Costa, 2021).

Another example I have analysed elsewhere (see Sari, 2021a, 2021b, and Sari, Aspinall, Haryanto, and Armunanto, 2023) shows that national-level political elites and political party networks, often cooperating with local government heads, used vaccine

distribution as patronage resource, providing preferential access to loyalists and constituents. In numerous districts and cities, informal negotiations shaped vaccination distribution, reinforcing pre-existing patronage structures under the guise of public health delivery.

Political manipulation in the health sector has also been evident at the highest levels of government. During the COVID-19 pandemic, scrutiny intensified around two senior ministers in President Joko Widodo's administration—*Luhut Binsar Pandjaitan* and *Erick Thohir*—due to their alleged business ties with companies dominating Indonesia's lucrative PCR testing market (CNN Indonesia, 2021b; Dongoran, 2021; Indonesia Corruption Watch, 2021; Santia, 2021). Pandjaitan, who was appointed to lead the pandemic response, and Thohir, who oversaw state-owned enterprises (including pharmaceutical SOEs), were both criticised for potential conflicts of interest and the opaque boundary between public duty and private gain. These concerns were heightened by reports that Pandjaitan's family has affiliations with the Lippo Group—a major hospital and healthcare conglomerate—where his sister serves as Commissioner (see **Table 3.3** above). Although both ministers denied wrongdoing, the episode illustrates how Indonesia's health governance—even in times of crisis—is susceptible to elite collusion, blurred public-private roles, and the instrumentalisation of public health for political and financial advantage.

Such crisis-era dynamics underscore the central argument of this thesis: that health sector governance in Indonesia—whether in routine service delivery or emergency response—is shaped less by formal institutions or technocratic design than by the enduring logic of clientelism and elite incentives. Even in moments of crisis, the distribution of essential health resources reflects political calculations, institutional fragmentation, and the embedded influence of informal power networks. As the following case studies show, the intensity and effects of these dynamics vary across cities, producing divergent patterns of health governance and service outcomes.

Conclusion

This chapter has traced the evolution of Indonesia's health sector from the colonial period through the New Order and into the post-decentralisation democratic

era, showing how institutional legacies, political transitions, and market reforms have shaped healthcare governance. Colonial rule produced an urban-biased, stratified system centred on curative care and a hybrid health structure. The New Order expanded access through the establishment of *puskesmas* and family planning programs but did so under an authoritarian regime that emphasised demographic control and bureaucratic discipline rather than participatory accountability. With democratic reforms, decentralisation in 2001 formally shifted authority to district and municipal governments. Rather than dismantling informal politics, however, this shift redistributed opportunities for clientelism, as local elites, party brokers, and informal networks came to mediate access to services such as JKN, *posyandu*, ambulance assistance, and even COVID-19 vaccination—often reinforcing political loyalties.

At the same time, Indonesia has seen significant programmatic advances. The launch of JKN, the modernisation of health infrastructure, and the integration of private providers into the national insurance system reflect ambitious policy efforts to improve both quality and reach. Market liberalisation and privatisation have introduced new actors and resources into the sector, generating opportunities for innovation and expanded access while also creating new vulnerabilities to elite capture. Procurement reforms, digital platforms, and price regulation have enhanced affordability and transparency in certain areas, yet these gains remain uneven, often offset by political manipulation, patronage-based tendering, and rent-seeking—particularly in pharmaceuticals, medical supplies, medical equipment, and hospital governance.

This review suggests that Indonesia's health sector has been shaped by both institutional reforms that broadened access and by informal politics that continue to structure the delivery of services. The coexistence of programmatic expansion and clientelistic practices underscores the central question of this thesis: not whether reforms matter, but how their outcomes are mediated by local political dynamics. The remainder of the study examines this variation in depth, comparing Kupang, Makassar, and Semarang to show how different configurations of clientelism and programmatic governance produce distinct health outcomes across Indonesian cities.

Chapter 4
All the Way Down:
The Deep Roots of Patronage in Kupang City

Kupang City offers a revealing case of how clientelism takes root and thrives in fragile institutional soil. As Van Klinken (2014) explains, 'Middle Indonesia'—consisting of provincial towns like Kupang—was historically shaped by a "fragile middle class whose power and livelihood depended heavily on access to state resources" (pp. 5–7). In this setting, local elites "looked to bureaucratic superiors rather than to mass constituents" and their politics was "factional rather than mobilisational," operating through "the modalities of a patrimonial authority achieved by operating through the bureaucracy (pp. 105–106). In Kupang, this legacy of elite brokerage and reliance on bureaucratic patrons rather than programmatic mobilisation entrenched highly personalised networks of loyalty and competition. Faced with limited economic resources and intense political rivalry, local elites depend on fragmented patronage structures to secure political support. The consequences are profound for public service delivery—nowhere more so than in the health sector, where institutional weakness is reinforced by political interference, rent-seeking, and resource misallocation.

As a **Quadrant D** city—marked by intense clientelism and poor healthcare performance—Kupang provides a stark counterpoint to the less intense and more institutionalised clientelism seen in Semarang or the more elite-contested patterns in Makassar. In Kupang, patronage and rent-seeking are not simply political strategies—they are the dominant modes of governing. Politicians draw on ethnic and familial networks to staff key posts, allocate contracts, and extract rents from even small-scale procurement and service initiatives. The result is a system where incumbents struggle to retain office, voters become increasingly disillusioned, and policy instability becomes the norm.

To systematically examine how clientelism shapes healthcare governance in Kupang, this chapter is organised into four main sections. The first section situates the analysis within Kupang's broad political and economic context and explains how that

context shapes the characteristics of clientelism there. It highlights key features such as the pattern of clientelistic exchange, capacity of patronage networks, political competitiveness, and absence of strong countervailing forces like an assertive middle class and vibrant civil society. The second section explores clientelism in practice, emphasising how clientelism is embedded in and plays out within the local health bureaucracy, provision of health programs and budgeting, and delivery of primary healthcare services at the *puskesmas* and of healthcare referrals at the city-run hospital (RSUD). The third section analyses the frontline implications of these clientelistic dynamics, assessing their impact on health service delivery quality, and noting how contextual factors—such as weak civic oversight, low market competition, and limited alternative patronage sectors—have amplified the effects of clientelism in Kupang's health sector. The fourth section concludes and summarises key finding and situates Kupang's case within the broader comparative framework of this study. Throughout this chapter, attention is given to how the patterns observed in Kupang compare with those identified in Makassar and Semarang, allowing for cross-city comparison of the mechanisms and contextual conditions through which clientelism affects healthcare provision.

Dry Soil, Deep Roots: Elite Strategies Behind Entrenched Clientelism

Kupang City, the capital of East Nusa Tenggara (*Nusa Tenggara Timur,* NTT) Province, lies on the western part of Timor Island. It stands out as the most economically developed and culturally diverse urban centre in a relatively poor province. Historically, it served as a trading post that attracted traders from China, the Arab world, and neighbouring islands, such as Rote, Sabu, and Flores. During the colonial era of the 16th to 19th centuries, it served as a trading centre and military outpost.

Figure 4.1

Kupang City in the Nusa Tenggara Timur (NTT) Province Map

Source: Online map produced using CartoGIS CAP, Australian National University.

Contemporary Kupang now has a demographically mixed population, with the local Timorese being the largest group, and with strong Protestant and Catholic communities (Arsip Nasional Republik Indonesia, 2018; van Klinken, 2014; Badan Pusat Statistik Kota Kupang, 2021a, 2025; Universitas Nusa Cendana, 2025; Hägerdal, 2008; Hägerdal, 2012). Between 2006 and 2020, the city's population increased from approximately 275,000 to 443,000, reflecting a cumulative growth of over 60% (Badan Pusat Statistik Kota Kupang, 2021a, p. 2). Kupang ranks highest in human development index (83.21% in 2024) and lowest in the percentage of poor people (8.24% in 2024) compared to other regions in NTT (Badan Pusat Statistik Kota Kupang, 2025, p. 371), but this comparison mostly underlines how NTT is a relatively deprived province.

Despite its status as the economic centre of NTT, Kupang continues to lag behind cities such as Makassar and Semarang in terms of infrastructure and diversification. The city's limited economic base has struggled to keep pace with rapid population growth,

exacerbating persistent socio-economic challenges. Poverty levels in Kupang remain significantly higher than in its comparator cities: in 2015 the poverty rate stood at 10.21%, compared to 4.38% in Makassar and 4.97% in Semarang. By 2020, the gap persisted, with Kupang recording 8.96% against 4.54% in Makassar and 4.34% in Semarang (World Bank, 2022). Kupang 's rocky terrain and scarce water resources limit private sector interest and hinder economic diversification. Demand for commercial and service activities from surrounding rural districts is relatively weak, further constraining growth. With a fragile private sector, many residents rely heavily on government employment or low-value service work—sectors that together contribute nearly half (48%) of the city's gross regional product (Badan Pusat Statistik Kota Kupang, 2021a, p. 18).

Fiscal capacity further illustrates these disparities. Like other Indonesian cities, Kupang relies heavily on transfers from the central government, with the largest share coming from the general allocation fund (*Dana Alokasi Umum,* DAU)*.* In Kupang, DAU accounts for 55–65% of annual transfers and is used primarily to cover civil servant salaries and basic capital expenditure. Although the DAU is alloated by the central government, its allocation/spending requires approval from the local council (*Dewan Perwakilan Rakyat Daerah*, DPRD), making it subject to political bargaining. Compared to Kupang, both Makassar and Semarang benefit from having a stronger local revenue base, which reduces their relative dependence on DAU transfers and provides greater fiscal room for programmatic development. This structural difference reinforces Kupang's fiscal vulnerability and limits its ability to invest in broader infrastructure or diversify its economic activities (Badan Pusat Statistik Kota Kupang, 2021a, pp. 24–25). In addition to the DAU, Kupang also receives tied funding through the special allocation fund (*Dana Alokasi Khusus*, DAK). Unlike the DAU, these transfers are earmarked for nationally determined priority projects and are tightly controlled by the central government. In 2024, the DAK accounted for roughly 20% of Kupang's total revenue, with the majority of this funding directed toward sectors such as education and health (Kementerian Keuangan, 2024).

Kupang's heavy reliance on fiscal transfers—driven by its limited economic base—has reinforced a deep dependence on government activity, not only within the

public sector but also across the local private sector. With few alternatives for autonomous income generation, both citizens and business rely heavily on state-funded employment, contracts, and services. In this context, the city's budget (and, to a lesser extent, the provincial budget) becomes a major site of political contestation. Public sector jobs, promotions, and procurement contracts are tightly embedded in elite patronage networks, while private sector actors—particularly in hospitality, construction, and trade—depend on government-driven expenditure to sustain operations. These dynamics exemplify what Berenschot (2018b, p. 1567) describes as the "constraint perspective," where clientelism is not merely a consequence of poverty but thrives in settings where economic opportunities are concentrated around the state, and where social actors lack the capacity to hold elites accountable (p. 1567). In these settings, political elites consolidate power and secure loyalty chiefly by controlling access to public resources, while limited economic diversification and widespread dependence on state-linked livelihoods reduce the ability of civil society and business groups to monitor or challenge their dominance. As Berenschot (2018b, p. 1568) observes, "the concentration of control over economic activities fosters clientelism because it stifles the public sphere and inhibits effective scrutiny and disciplining of politico-business elites."

Tidey's ethnographic research in Kupang further illustrates how these structural dependencies manifest in everyday governance. She shows how public servants often operate within a system that conflates bureaucratic obligation with moral and kinship obligations, blurring the lines between administrative function and personal loyalty (Tidey, 2012, pp. 7–9; 2018, pp. 94–95). This convergence of institutional and affective ties reinforces patronage dynamics, as public sector actors participate in what Tidey calls "ethical civilities" to navigate job security and fulfill reciprocal obligations. These practices are sustained by the scarcity of alternative livelihoods and the centrality of the state as the main distributor of economic opportunity. Taken together, these insights from Berenschot and Tidey underscore the rentier character of Kupang's political economy and help explain the persistence and social embeddedness of clientelism in the governance of public services, including health.

Political Contestations and the Pattern of Clientelism

Kupang's entrenched clientelism is thus not merely the result of local elite preferences, it is structurally reinforced by its fragmented political landscape and constrained economic base. With nearly 90% of government revenue deriving from central transfers and the majority of employment tied, directly or indirectly, to the public sector, political power hinges on access to and control over state resources (Badan Pusat Statistik Kota Kupang, 2021a, 2021b, 2024, 2025). This context both enables and incentivises political actors to use public office as a mechanism for distributing jobs, contracts, and benefits to consolidate their support networks.

Elections in Kupang City are shaped by strong identity-based mobilisation. Candidates often form pairs (i.e., a mayoral candidate alongside a deputy) based on Protestant-Catholic and Rotenese-Floresian-Timorese[13] alignments to appeal to dominant demographic blocs. As confirmed by Tokan's (2019) survey, electoral preferences remain strongly influenced by religion, ethnicity, kinship, and regional origin. Mayors and elites mobilise these networks during campaigns, yet upon assuming office, they typically narrow their distributive coalitions, concentrating patronage on family members and close supporters. This exclusionary tendency often breeds intra-group fragmentation and dissatisfaction, particularly among those from a candidate's ethnic or religious backgrounds who are sidelined after elections.

Kupang's political trajectory since 2007 reveals a cyclical pattern of elite turnover and the persistent instrumentalisation of the bureaucracy as a tool for political consolidation. Each successive mayor—Daniel Adoe (2007–2012), Jonas Salean (2012–2017), and Jeffirstson Riwu Kore (commonly known as Jefri or Jeriko) (2017–2022)—entered office with promises of reform or administrative modernisation, yet each ultimately perpetuated clientelistic governance. Adoe, elected as a reformist outsider, failed to deliver substantive institutional change and was later convicted of corruption related to education procurement (Adrianus, 2014). Salean, a former bureaucrat and regional secretary under the New Order regime, mobilised his entrenched bureaucratic

[13] Rotenese (ethnic group from Rote Island), Floresian (ethnic group from Flores Island), and Timorese (ethnic group from Timor Island).

networks to gain political power (Dama, 2012). Once in office, he orchestrated mass civil servant rotations (*mutasi*) to reward loyalists (Lewanmeru, 2014), recruited contract staff and granted promotions to civil servants drawn from his family and political supporters, and allegedly allocated 24.2 hectares of public land to 152 individuals—primarily his relatives, political allies, and bureaucratic loyalists (Ama, 2020; R. Hidayat, 2012). Reflecting the logic of patronage-based governance, Salean explained in an interview:

> Like other regional heads, we have to accommodate their needs. If they're contractors, we try to help them secure work packages [contracts]—even if that means splitting large procurement projects into smaller ones so we can use the direct appointment method. Some do go through the tender process, but they usually come from more experienced companies. (Interview with former mayor, Jonas Salean, Kupang, June 1, 2021; author's translation)

When asked whether he had ever received a gift in return for the positions he granted, Salean denied the allegation, stating that he did not seek money or illicit favours, but only expected loyalty and professionalism in return for public service (J. Salean, personal communication, June 1, 2021). When further questioned about the informal practice among politicians of 'slipping in' (*menyelipkan*) or 'entrusting' (*menitipkan*)[14] favoured projects and activities into health sector programs or other sectoral budget lines, he claimed to have no knowledge of such practices.

Jefri's rise to the mayoralty in 2017 underscores how national political access and personal wealth can serve as crucial sources of local power. Before entering local politics, he served two terms in the national legislature (DPR) (2009–2014; 2015–2019), following earlier careers as a lecturer, finance professional, and entrepreneur, with declared assets exceeding IDR 167.4 billion (approximately AUD 16 million) (Evanda, 2021; Jaya, 2025). He resigned from parliament in 2017 to contest—and ultimately

[14] The terms *menyelipkan* ('to slip in') or *menitipkan* ('to entrust') refer to the informal practice of inserting items or projects serving personal or political interests into public programs—particularly during negotiations between the mayor and the local legislature (DPRD) over the annual budget and development plan. These dealings often involve mutual agreements on which projects to prioritise, and which companies or contractors should be selected or awarded contracts, effectively turning budget deliberations into arenas for patronage exchange.

win—the mayoral election (Mima, 2025). As a member of the DPR's education committee, he had previously leveraged the Poor Student Assistance (*Bantuan Siswa Miskin,* BSM) program to build a voter base in NTT by channelling educational subsidies to loyalists (Rohi, 2018, p. 371). Jefri also came from a politico-military family background. His former wife was the sister of Yakobus Jacky Ully and the daughter of Titus Ully, both high-ranking police generals, while his current wife, Hilda, is the daughter of a senior military officer and Golkar leader.

Once elected, Jefri Riwu Kore's administration was characterised by an emphasis on infrastructure as both a development agenda and a political strategy. He mobilised national resources to secure large-scale projects for Kupang, while simultaneously channelling city budgets into small, individualised initiatives designed to cultivate grassroots loyalty. In an interview, Jefri defended his approach of consolidating support through project distribution, stating, "Kupang has long suffered from slum conditions, poor infrastructure, and inadequate lighting. By improving infrastructure, we can stimulate economic activity" (Interview with former mayor, J. Riwu Kore, Jakarta, February 2, 2025; author's translation). His flagship *bedah rumah* (house renovation) program—launched in 2020 to upgrade 2,000 homes for low-income residents (Fajar, 2024) —was complemented by highly visible projects such as the city lights initiative and the creation of urban parks. Together, these initiatives exemplified his dual strategy of combining targeted patronage, which delivered tangible benefits to selected constituents, with cosmetic projects designed to boost his public image and political brand.

Budget data underscores this pattern: from 2018, at least 10% of the city's funds were allocated to infrastructure, with substantial spending on roads, pedestrian crossings, drainage, schools, and hospital construction. While framed as urban improvement, these allocations also functioned as instruments of patronage and, allegedly, channels of rent-seeking for his supporters. Critics argued that such investments prioritised political branding and the consolidation of familial influence over substantive improvements in human development and public services, such as access to clean water and the reduction of child malnutrition (ExpoNTT, 2021; Goti, 2020; KompasTV, 2021; RakyatNTT, 2021; Salmon, 2021). Reports and informant

testimonies reinforced these criticisms, pointing to nepotistic appointments of underqualified allies to key bureaucratic posts and the diversion of municipal resources to support his brother's controversial candidacy in Sabu Raijua District (Mahkamah Konstitusi Republik Indonesia, 2021; Paat, 2021; Taolin, 2021). As one informant—a local broker and contractor who had previously supported Jefri—observed, his leadership marked a shift in how patronage was distributed compared to his predecessor:

> If we compare the two leaders, the difference is quite clear. During Salean's time, even though the bureaucracy was largely dominated by his relatives, they generally had backgrounds in public administration. Because of that, rules were still followed. So even if there was some nepotism, the people appointed usually had the skills and qualifications needed for their roles, which made their positions justifiable. Jeriko [Jefri] was a different story. He didn't really understand how the bureaucracy worked, so he was easily influenced by his campaign team. They felt entitled to decide who got what positions in the bureaucracy, and Jeriko went along with their suggestions when making appointments. There were even a couple of serious rule violations. First, he appointed people with known issues in their records to key positions. Second, he skipped over proper rank progression—there was a case where someone jumped straight from echelon IV to echelon IIIA, skipping echelon IIIB altogether. This actually happened. I might have been the only person brave enough to speak out against the city government at the time. And everyone knew that I used to be one of the core members of his team. (Interview with Smith Terik, local broker, Kupang, October 9, 2021; author's translation)

A core area of contention during Jefri's tenure (2017–2022) was the breakdown of traditional clientelist bargaining between the executive (mayor) and DPRD. Unlike his predecessors, who routinely accommodated the "key considerations" (*pokok-pokok pikiran, pokir*)—i.e., constituency development and infrastructure projects proposed by DPRD members—to secure smooth budget approval, Jefri argued that he rejected these informal insertions. In an interview, he denied allocating projects in response to requests by legislators, stating that he preferred transparent, technocratic processes in

line with national procurement rules (Interview with J. Riwu Kore, Jakarta, February 2, 2025; author's translation).

Figure 4.2

A Photograph of the Front Page of a Local Newspaper Describing DPRD Members' Request for 669 Projects

Musrenbang 2021 Tingkat Kota Kupang

Dewan Titip 669 Pokir

Wawali Harap Diakomodir

KUPANG, TIMEX—Wakil Wali Kota Kupang, dr. Hermanus Man membuka kegiatan Musyawarah Perencanaan Pembangunan dalam rangka penyusunan Rencana Kerja Pemerintah Daerah (RKPD) Kota Kupang tahun 2022, Selasa (27/4).

Dalam arahannya, Herman Man menyinggung program-program yang telah diusulkan, baik melalui kelurahan yang disampaikan secara berjenjang melalui kecamatan, maupun pokok-pokok pikiran dari Anggota DPRD Kota Kupang.

Kepada para pimpinan perangkat daerah, Herman Man minta agar dalam RKA yang disusun, mampu menampung pokok-pokok pikiran (Pokira) dari DPRD yang jumlahnya mencapai 669 Pokir.

Baca WARGA ... Hal 10

MUSREMBANG. Wakil Wali Kota Kupang, dr. Hermanus Man membuka kegiatan Musyawarah Perencanaan Pembangunan dalam rangka penyusunan Rencana Kerja Pemerintah Daerah Kota Kupang tahun 2022, Selasa (27/4)

Samsung Dual Camera

Source: Timex (2021), April 27, 2021.

However, his refusal to allocate such projects—which legislators see as necessary to reward their own supporters and secure re-election—sparked sustained political backlash. **Figure 4.2** captures a headline report from a local newspaper in 2021 indicating that DPRD members submitted 669 *pokir* proposals, demanding the executive accomodate them—a sign of the institutionalised nature of such expectations. The refusal delayed city budget approvals and led to protests both within the legislature and in public forums (Jahang, 2020; Rambu, 2021; Salmon, 2021).

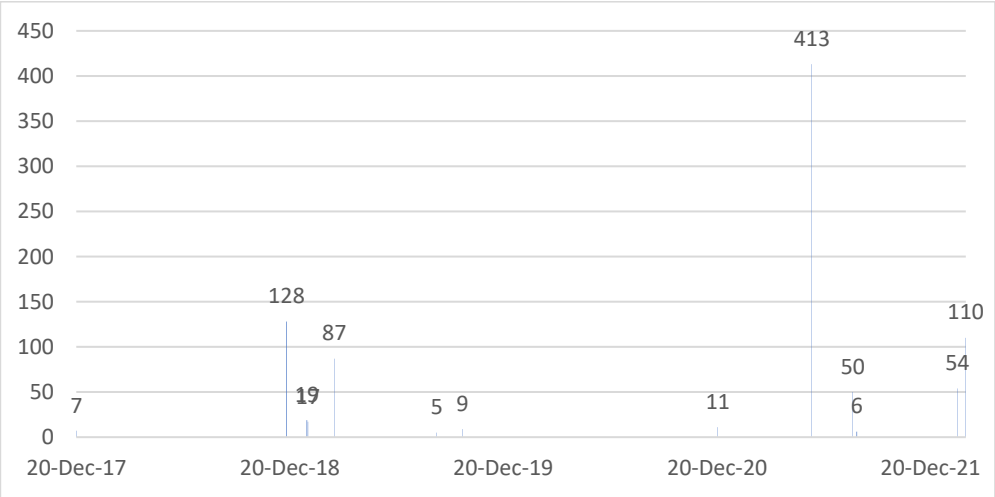
Yet, while Jefri positioned himself as a reformist resisting calls to share the spoils of government to other members of the elite, and defending due process, informants from the DPRD and local experts argued that he had merely re-centralised access to state resources within his own network. Several informants reported that under his government contracts and procurement packages were disproportionately awarded to Jefri's business associates and relatives, including his brother-in-law, Adi Manafe, who

was controversially appointed as head of the City Civil Service Office despite lacking qualifications. Informants alleged that Jefri used loyal bureaucrats to "secure" projects for his networks, raise political funds, and finance his personal and familial political ambitions (Anonymous, personal communication, April 30, 2021).

Job promotions, transfers, and *mutasi* (staff rotations) were also deployed extensively as tools for political consolidation. Jefri ordered at least 13 separate rounds of *mutasi* during his five years in office—far exceeding the frequency under his predecessors—with each rotation serving to reinforce loyalty and marginalise dissent within the bureaucracy. **Figure 4.3** illustrates the cumulative number of staff rotations during this period, reflecting how personnel management was used as a political tool. Although regulatory reforms such as Law No. 5/2014 on Civil Service and Law No. 10/2016 on Regional Elections attempted to restrict the arbitrary reshuffling of civil servants—particularly within six months of elections—their reinforcement remained weak and inconsistently applied, especially in contexts where political incentives to retain control were high.

Figure 4.3

Staff Rotations (Mutasi) in Kupang City (2017–2022)



Source: Author's analysis from various local newspapers online, 2017–2022.

Jefri's approach to political clientelism also differed in form and orientation from that of his predecessors Adoe and Salean. Whereas these previous leaders had relied on broad coalitions and distributed access across political elites, Jefri's pattern was more exclusive, and profit-driven. Observation from newspapers, social media groups, and interviews suggest he granted positions and contracts to individuals who could provide the greatest financial or strategic returns (Interview with DPRD member, Kupang, May 4, 2020, and with a local expert, Kupang, April 30, 2021; author's own translation). Informants alleged that temporary contract positions (*honorer* staff) were monetised under his administration, with candidates paying IDR 10–15 million (or around AUD 1,000–1,500) to secure placements with a monthly salary of IDR 2.5 million (approximately AUD 250) (Interview with a temporary/*honorer* staff, Kupang, May 4, 2020; author's own translation). Salary deductions were common, and those unable to pay were replaced. Between 2020 and 2022, Kupang maintained roughly 3,000 such contract positions—providing ample room for rent extraction and patronage distribution.

The distribution of patronage jobs—particularly temporary staff and senior-level positions within the city administration—followed a familiar pattern observed across many mayoralties, in which key elites, such as the mayor, the DPRD chairperson, and senior party figures, were said to control the largest quotas (*jatah*) of positions. These positions were strategically allocated to embed loyalists within the bureaucracy and sustain clientelistic networks. Under Jefri's administration, however, control over such allocations was concentrated within his inner circle. Intermediaries closely tied to him, including managers of local *rumah aspirasi* (lit. "aspiration houses"),[15] frequently managed these arrangements, ensuring that recruitment and promotion served his own political interests. which were constituency service offices run by Jefri's team and linked to his party, the Democratic Party (*Partai Demokrat*). Informants identified specific individuals tasked with handling staff recruitment and promotion processes with the bureaucracy; these individuals effectively operated as political gatekeepers, controlling access to city government jobs (Anonymous, personal communication, April 30, 2021).

[15] Constituency service offices run by Jefri's team and linked to his party, the Democratic Party *(Partai Demokrat).*

This pattern of control was further exemplified by the appointment of his brother-in-law, Adi Manafe, to the strategic position of Head of the City Civil Service Agency (*Badan Kepegawaian, Pendidikan dan Pelatihan Daerah*, BKPPD), as mentioned previously, underscoring how Jefri consolidated authority over bureaucratic appointments.

In Kupang, for much of the post-Suharto period government procurement typically followed a pattern of strategic allocation, closely tied to patronage distribution. To ensure benefits were shared among political elites in both the DPRD and the executive, tenders were often fragmented into smaller "packages." Projects were deliberately broken down into contracts valued below the IDR 200 million procurement threshold, enabling direct appointments and circumventing competitive bidding requirements (Interview with Jonas Salean, Kupang, June 1, 2021; author's translation). These allocations were usually overseen by trusted relatives, close associates, or staff who controlled financial flows while formally adhering to procurement regulations (Interview with local expert, Kupang, April 30, 2021; author's translation).

Under Jefri, however, informants emphasised that this system became more exclusive, as he concentrated patronage within his immediate family. High-value projects (over IDR 1 billion, or approximately AUD 100,000) were reportedly negotiated directly between his relatives and contractors, often in private meetings held at the residences of senior officials (Interview with local expert, Kupang, April 30, 2021; author's translation). Tensions over the unbalanced distribution of these resources were a recurring source of intra-elite conflict in Kupang. Disappointed DPRD members—excluded from patronage channels or who experienced reduced allocations—resisted mayoral initiatives, refused to endorse their accountability reports, and accused Jefri of undermining the political equilibrium needed to sustain governance (Rambu, 2021).

The broader context here is important: Kupang's limited economic diversity greatly constrained the scope of patronage, encouraging local leaders to concentrate on a relatively narrow range of benefits, primarily those that flowed directly from the city budget, and to share them within a relatively narrow inner circle rather than distributing them across broader support networks. Jefri's tenure exemplifies how the

refusal—or strategic failure—to accommodate these wider demands routinely disrupted governmental stability in the city and fuelled political fragmentation.

Between 2017 and 2022, it became increasingly evident that Jefri Riwu Kore was seeking to establish a local political dynasty in NTT. His wife, Hilda Manafe, was elected as a member of the Regional Representative Council (*Dewan Perwakilan Daerah,* DPD) for the 2019–2024 term and was re-elected for the 2025–2030 term (Alex, 2019; "Hilda Manafe, S.E., M.M," 2025), and his younger brother, Krisman Bernard Riwu Kore, became Head of Sabu Raijua District in 2024 with Jefri's political backing (I. Lay, 2025). Informants claimed that city government staff were asked to contribute financially to those campaigns and that city resources were subtly redirected to build the family's regional influence. Although Jefri publicly denied these allegations, independent reports noted a substantial increase in his personal wealth during his term, making him one of the richest regional heads—which was all the more striking given that he governed in one of Indonesia's poorest provincial capitals (Evanda, 2021; Jaya, 2025).

However, this dynastic project subsequently began to face significant headwinds. In 2022, Jefri lost his position as Chairperson of the Democratic Party's provincial board in NTT, a development that effectively severed his access to the party's nomination channels, campaign infrastructure, and patronage-based electoral machinery (Bere & Agriesta, 2022). The selection of the Chairperson was influenced by the national leadership, then held by Agus Harimurti Yudhoyono. When asked why he did not secure the position, Jefri offered little detail, noting only that he lacked support at the national level. Without institutional backing, elites must fund campaigns independently and mobilise brokers and grassroots support from personal networks—an expensive and politically risky undertaking.

This dynamic contrasts with patterns observed in Makassar and Semarang (see Chapter 5 and 6). In Makassar, although personal networks still dominate, party branches help channel patronage through business associations and development projects, offering more structured avenues of distribution. In Semarang, the Indonesia Democratic Party Struggle (PDI-P)'s institutional strength allows for a more coordinated and party-mediated form of clientelism, with benefits channelled through formalised

partisan networks and civic associations. These differences illustrate the varying roles of parties in mediating patronage across Indonesia's decentralised governance landscape.

Such variation resonates with broader scholarly analyses of Indonesia's political system. Berenschot and Aspinall (2020, pp. 2, 5) argue that Indonesian political parties are typically decentralised and fragmented, functioning as arenas for elite brokerage rather than programmatic policymaking. Clientelism, in this context, is mediated by networks of local brokers who exchange access to state resources for political support. While party centralisation is weak, access to party machinery still matters, particularly for candidates seeking to consolidate long-term influence.

In sum, the patterns of clientelism in Kupang are characterised by a highly individualised and exclusionary form of patronage, concentrated within the personal networks of the mayor and his close family and allies. Rather than being mediated through strong party institutions or broader coalition-building, access to state resources is tightly controlled by the ruling elite. This has fostered a political environment in which bureaucratic appointments, government contracts and jobs, resource allocation, and electoral strategies are driven by familial ties, transactional loyalty, and selective reward mechanisms. Although the role of political parties remains marginal in everyday governance, party endorsement remains a critical asset for electoral success, as illustrated by the political decline that followed Jefri Riwu Kore's loss of support from the Democratic Party.

The next section turns to explore how these broader patterns of elite-driven clientelism manifest within the health sector. Focusing on key institutions such as the *Dinas Kesehatan*, the RSUD, and *puskesmas,* it examines how patronage shapes recruitment, resource allocation and programming on health, and service delivery—highlighting the consequences for bureaucratic capacity and healthcare performance and outcomes in Kupang.

Clientelism in Practice: Governing Health Services in Kupang

This section examines how political clientelism and patronage have shaped the governance and delivery of healthcare services in Kupang. While national reforms—such

as the Civil Service Law[16] (Law No. 5 of 2014), which introduced meritocratic principles, and the Public Service Law (Law No. 25 of 2009), aimed at enhancing accountability and the quality of public services—were designed to depoliticise the bureaucracy, their impact has been uneven across subnational contexts. In Kupang, persistent patterns of elite-driven appointments, resource capture, and rent-seeking continue to characterise the health sector, as in other areas of government. These practices routinely undermine bureaucratic professionalism and weaken the effectiveness, equity, and responsiveness of healthcare service delivery. As the preceding section has shown, these practices permeate key domains of governance—including staff appointments and budget allocations—where discretionary power is routinely exploited to serve political and personal interests rather than public policy objectives.

This analysis is organised around five key aspects. It begins with an overview of Kupang's health system—its institutional structure, sources of funding, and strategic position within local governance. It then examines, through three parts, how clientelistic practices have shaped three core subsystems: health sector staffing, budgeting/spending, and the procurement of medicines and equipment. The discussion in these sections traces how these patterns evolved under successive mayors, with particular emphasis on the intensification of clientelist control during Jefri Riwu Kore's administration. These sections also assess how the COVID-19 pandemic created new opportunities for politicised budgeting and discretionary resource allocation. Fifth and finally, the analysis evaluates the broader consequences of clientelism for the quality, equity, and responsiveness of healthcare provision in Kupang, while drawing comparative insights from the experiences of Makassar and Semarang. By disaggregating how clientelism operates in specific domains of the health sector, this section contributes to a more granular understanding of how political clientelism permeates service delivery, and how these affect healthcare outcomes at the subnational level.

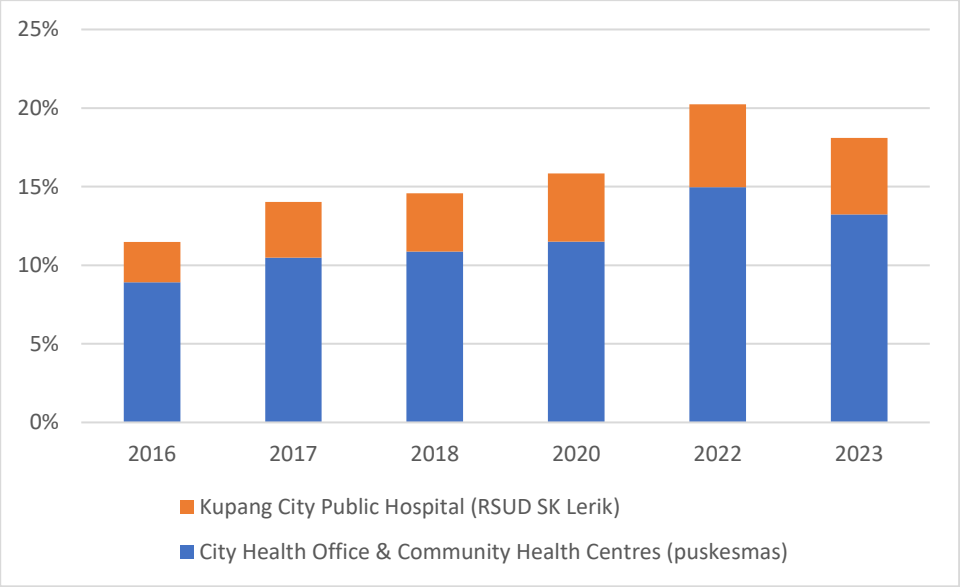
[16] Law No. 5/2014 was later moderated by national political elites, culminating in the abolition of the Civil Service Commission (*Komisi Aparatur Sipil Negara,* KASN) in 2023—through its revision (Law No. 20 of 2023), thereby weakening the institutional framework for depoliticising bureaucratic appointments nationwide.

Overview of the Health Sector in Kupang: Strategic Importance and Political Relevance

The health sector in Kupang City occupies a strategically significant position in the local governance landscape, both as a major domain of public service delivery and as a potential site of political patronage. In 2018, 764 of the city's 5,240 civil servants—or approximately 15%—were employed in the health sector, including 570 in the City Health Office (*Dinas Kesehatan, Dinkes*) and *puskesmas* network and 194 at the city-run hospital, RSUD SK Lerik (Badan Pusat Statistik Kota Kupang, 2024). This figure grew steadily, reaching 20% of the city's civil service workforce by 2022 (see **Figure 4.4**). These numbers exclude the considerable number of contract and temporary staff, which brought the total number of health personnel to over 800 in 2018 alone (Badan Pusat Statistik Kota Kupang, 2024; Dinas Kesehatan Kota Kupang, 2018, p. 122).

Figure 4.4

Proportion of Civil Servants Employed in Kupang's Health Sector between 2018 and 2022



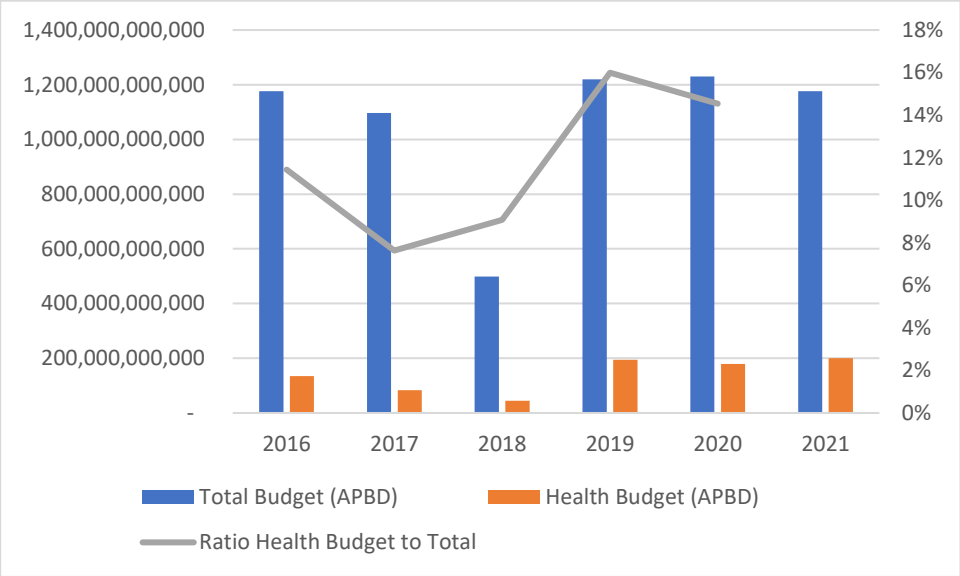
Source: Author's analysis from BPS Kota Kupang website (Badan Pusat Statistik Kota Kupang, 2024).

From a fiscal perspective, budget allocations to the health sector have been fluctuating. In 2016, health accounted for 11% of the city budget, but this share declined to 8% in 2017 and 9% in 2018. The proportion then rose sharply to 16% in 2020 and 15% in 2021, largely driven by COVID-19-related expenditures. **Figure 4.5** illustrates

the trend in health sector allocations relative to the total city budget during the period 2016–2021.

Figure 4.5

Health Budget Allocation to Total Budget in Kupang City, 2016–2021



Source: Author's analysis from Dinas Kesehatan Kota Kupang (2016–2019, 2021–2022).

As with other sectors, the source of health funding in Kupang relies heavily on intergovernmental (central government) transfers, with 75% sourced from the general allocation fund (*Dana Alokasi Umum*, DAU), 18% from the Physical Specific Allocation Fund (*Dana Alokasi Khusus, DAK Fisik*), which covers physical construction, and 7% from the Non-Physical Specific Allocation Fund (*DAK Non-Fisik*) (Dinas Kesehatan Kota Kupang, 2021, pp. 132–133).

Budget documents from 2011 to 2018 show a consistent pattern: the DAU is the largest source (70–80%) and provides routine expenditure coverage—including civil servant salaries and operational costs—while the DAK contributes the rest (20–30%) and supports national programmatic priorities such as *puskesmas* infrastructure, maternal and child health, BPJS premium subsidies, *puskesmas* operations (*Bantuan Operasional Kesehatan, BOK*), and health facility accreditation (Dinas Kesehatan Kota Kupang, 2012; 2017; 2018a; 2018b).

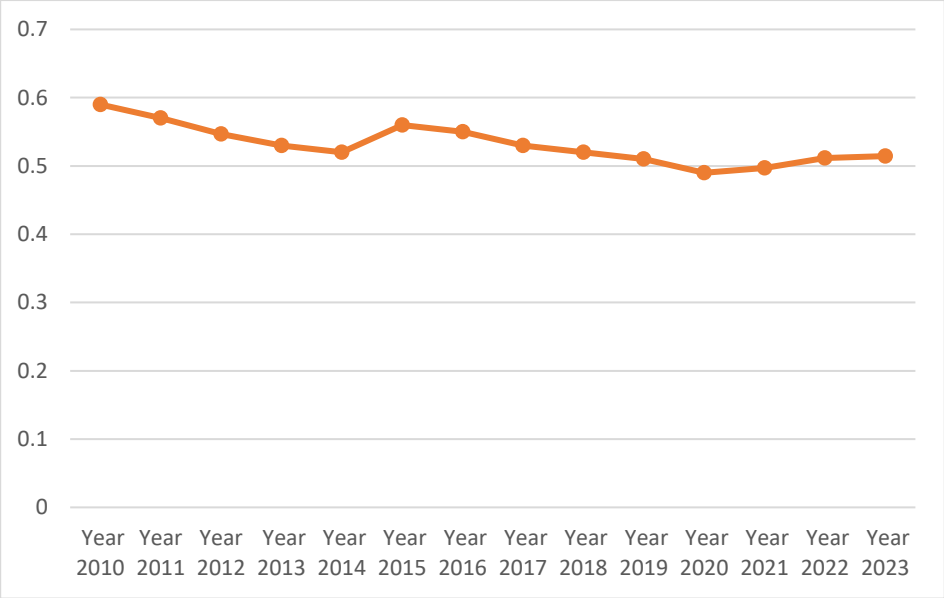
Despite its developmental importance, the health sector is also politically attractive because of its scale, complexity, and flexible budget flows. With extensive contract-based staffing, large procurement allocations, and weak oversight mechanisms, it offers opportunities for rent-seeking and discretionary appointments. Successive mayors have exploited these features to consolidate political control.

Health services in Kupang are delivered through a network of 11 community health centres (*puskesmas*), 35 *pustu*, five ward-level health posts (*pos kesehatan keluarga or poskeskel*), the city-run hospital (RSUD) SK Lerik, and the City Health Office (*Dinas Kesehatan*). Each subdistrict (*kecamatan*) is served by at least one *puskesmas*, while roughly half of the city's urban villages or wards (*kelurahan*) have access to a *pustu*. The City Health Office manages a broad array of functions—including primary care operations, equipment procurement and maintenance, infrastructure development, and health promotion—making it the institutional backbone of Kupang's health system (Dinas Kesehatan Kota Kupang, 2009; 2010; and 2021).

However, **Figure 4.6** shows that between 2016 and 2023 the ratio of *puskesmas* per 20,000 residents remained below one and exhibited a stagnant or declining trend, indicating that infrastructure development has not kept pace with population growth. This shortfall constrains access to basic healthcare and undermines service equity. Furthermore, the city government's own targets require at least one inpatient *puskesmas* per subdistrict, yet as of 2019, only four of Kupang's six subdistricts met this requirement (Badan Pusat Statistik Kota Kupang, 2021a; 2025; Dinas Kesehatan Kota Kupang 2013, 2016, 2018, 2019, and 2021).

Figure 4.6

Ratio of Puskesmas per 20,000 Population (2010–2023)



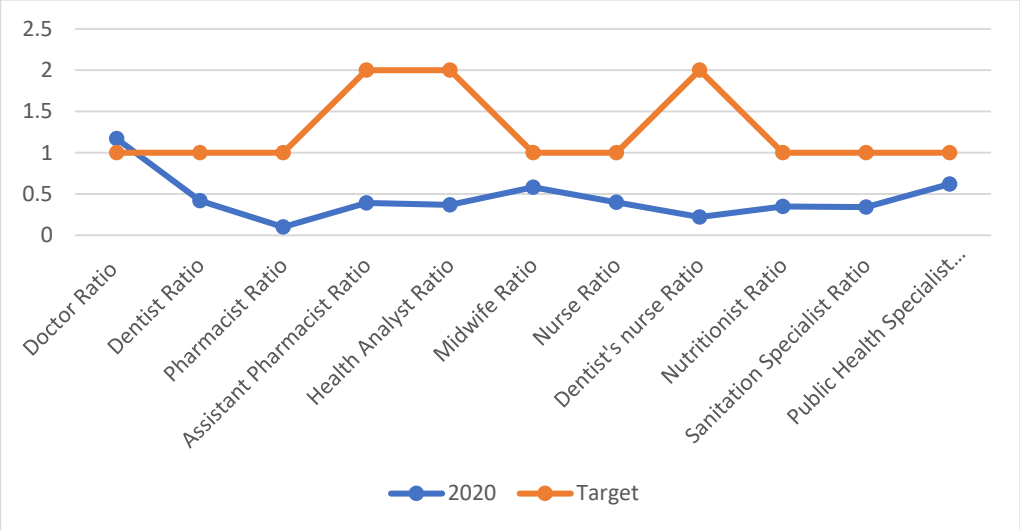
Source: Kupang's health profile and statistics (Dinas Kesehatan Kota Kupang, 2009; 2010; 2012; 2013; 2016; 2017; 2018a; 2018b; 2019; 2021; Badan Pusat Statistik Kota Kupang, 2021a; 2025).

To support service delivery, the city government employed 619 medical professionals across public health facilities in 2020 (Dinas Kesehatan Kota Kupang, 2021, p. 129). This included doctors, nurses, midwives, pharmacists, sanitarians, and public health specialists.

Nonetheless, as shown in **Figure 4.7**, the ratio of health workers per 100,000 population in that year remained well below the city's strategic plan targets (Dinas Kesehatan Kota Kupang, 2021, p. 129).

Figure 4.7

Ratio of Healthcare Workers per 100,000 Population Compared to City Government Targets (2020)



Source: Kupang Health Profile 2020 (Dinas Kesehatan Kota Kupang, 2021, p. 130).

This staffing shortfall hampers service quality and generates systemic limitations in aligning workforce development with healthcare needs. This was evident in the low proportion of active *posyandu*: only 36.8% of 315 posts were operational in 2018, rising to 53.7% in 2020, despite the city reporting an overall increase in the health budgets (Dinas Kesehatan Kota Kupang, 2018, p. 135; Dinas Kesehatan Kota Kupang, 2021, p. 127). My reviews of the city health profile reports from 2008 to 2023 suggests that only the 2018 and 2021 reports explicitly analysed the extent to which *posyandu* were actively functioning.

As the following sections will show, these structural and institutional constraints, while limiting the scale of patronage, do not eliminate elite intervention. Unlike Semarang and Makassar—where broader political dynamics and more institutionalised patterns of clientelism temper direct interference—Kupang's greater scope for personalistic discretion has enabled clientelism to continue shaping the distribution of health resources, staffing, and services.

A Prescription for Loyalty: The Reach of Patronage in Health Staffing

While Kupang's health sector is one of the city's largest public employers and budget users, the scope for clientelistic control in staffing is structurally constrained. Unlike in the education sector or village administration—where the mayor and other senior officials have greater leeway to manipulate appointments by using political or kinship networks—the health sector is governed by rigid technical standards and a limited supply of qualified personnel. Kupang's tertiary education institutions, particularly in medicine and pharmacy, have not produced enough doctors, specialists, and pharmacists to meet local demand. As of 2018, more than 800 staff were employed in the sector, yet chronic shortages of medical professionals and trained managerial staff significantly narrowed the space for discretionary appointments (Dinas Kesehatan Kota Kupang, 2016; 2017; 2018a; 2018b; 2019; 2020). This scarcity is compounded by national regulations, such as Minister of Health Regulation (*Peraturan Menteri Kesehatan, Permenkes*) No. 10 of 2010 on competency standards and Law No. 23 of 2014 on local governance, which impose strict eligibility requirements for leadership positions in public health facilities—particularly for heads of *puskesmas* and the *Dinas Kesehatan.*

The combined effect is a shallow pool of qualified health civil servants, limiting the supply of capable bureaucrats. This scarcity makes promotions and leadership appointments easily manipulated for patronage, while non-technical and contract staff hiring offers further opportunities for political control. Unlike Semarang's stronger professional bureaucracy or Makassar's more competitive clientelist environment, Kupang's weak professional pipeline has left the health sector especially vulnerable to personalised elite intervention.

This institutional rigidity helps explain the unusual continuity in Kupang's health leadership, where appointments have been less tied to local kinship than in other departments. Between 2011 and 2022, the position of Head of the *Dinas Kesehatan* changed only twice. Dr. Wayan Ari Wijana, a Balinese-Hindu physician, held the post (under Mayor Salean) before being reassigned in 2019 (Sergap, 2019). His successor, Dr. Retnowati, D.M.D., a Javanese Muslim also without a strong local kinship base, was widely perceived as Mayor Riwu Kore's personal aide. Dr. Wayan was reassigned to the

treasury department, well outside his professional expertise, while Dr. Retnowati's appointment—which contrasted with appointments to other offices which were dominated by family networks—was seen as being based on personal loyalty to the mayor. Local actors told me her role was instrumental in facilitating Jefri's access to health-sector rents. As one informant remarked: "The head of the health office was appointed primarily to secure access to health resources, including orchestrated tender projects that generated rents for the mayor's campaign team and supported his brother's election bid in Sabu Raijua" (Interview with local broker, December 30, 2021; author's translation). My interlocutor—who worked as an expert staff to a senior DPRD member —shed further light on what he meant by this:

> I once had a conversation with a visibly distressed Secretary of the Health Office. He explained that when the mayor and deputy mayor requested funds for personal use, he had to identify which pots within the Health Office's budget could be used. The mayor [Jefri] regularly travelled for what he called 'official' trips almost every week. The sources for these trips came from departments with large allocations. He would just command, "Prepare this and that, I'm going on a trip," and then the secretary and treasurer of the department would scramble to find the money. That's why many temporary/contract workers—like pallbearers during COVID-19—had their payments delayed. Even doctors' allowances were cut [to fund his personal travels]. (Interview, October 7, 2021; author's translation)

Another informant, who worked within the DPRD, expressed a similar view:

> In order to get the money to meet these requests, bureaucrats not only have to divert allowances such as honoraria and per diems paid to staff, but they also have to secure financial kickbacks through procurement processes or sell access to temporary staff positions. (Interview, October 7, 2021; author's translation)

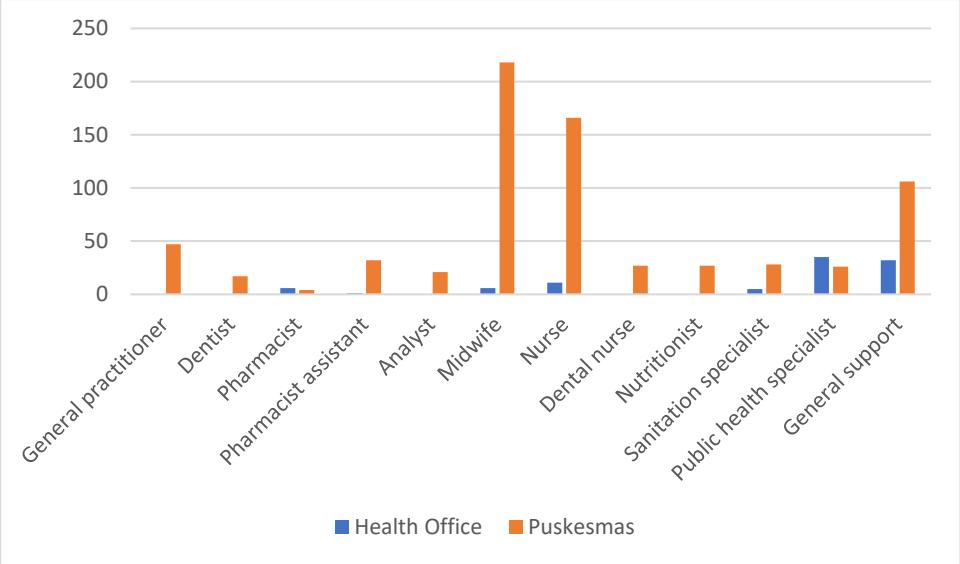
As previously discussed, senior positions in health staffing—such as the heads of the *Dinas Kesehatan* and RSUD—are formally restricted by regulation. Yet even within this narrow pool, appointments are often based less on performance than on loyalty, with elites selecting individuals willing to serve their interests. A member of the

Indonesian Independent Journalist Alliance (*Aliansi Jurnalis Independen, AJI*) in Kupang explained that the former Head of Dinas Kesehatan, Wayan Ari Wijana, was replaced because "he could not be controlled by the mayor for a big project" (Interview, June 29, 2021; author's translation).

At the lower level—where the pool of positions is larger, particularly among contracted nurses, midwives, and other non-permanent staff—health staffing becomes a key arena of patronage and rent-seeking. Data from the 2018 City Health Profile as presented in **Figure 4.8** illustrates this dynamic, highlighting the disproportionately high number of midwives and nurses at *puskesmas*, which underscores the value of these positions as instruments of political distribution.

Figure 4.8

Health Staff Distribution, Kupang City, 2018



Source: Dinas Kesehatan Kota Kupang (2018b, p. 137).

While the proliferation of nurse and midwife posts could be seen as an investment in grassroots healthcare capacity, these positions were especially vulnerable to political rotation and clientelist appointment, as confirmed by a local political broker I interviewed:

> I personally have handled the recruitment of temporary staff, and even then, in less than one year [contract term] there have already been four rounds of reshuffling [of the non-permanent staff]. It's become quite a serious issue. And it's just the campaign team doing the hiring. Technically, they're supposed to be on annual contracts, with official appointment letters valid from January 1st to December 31st. But in reality, reshuffles often happen just three or four months in. Some people get dismissed mid-contract and are replaced with new hires. (Interview, October 9, 2021; author's translation)

He added:

> There have been cuts and delays in the payment of honoraria, which has triggered multiple protests by temporary workers, including those in the health sector. Even healthcare workers have voiced complaints—especially regarding COVID-related funds. They were unhappy about deductions from their allowances. In some cases, they only received partial payments, with monthly cuts ranging from IDR 250,000 to 500,000 [AUD 25–50, appoximately].

Such problems point to the fact that political elites, especially mayors, tend to target the more discretionary edges of the health bureaucracy in Kupang. Permanent mid- and lower-level positions—such as *puskesmas* heads, clerical staff, and non-permanent outreach workers—are frequently filled by people connected to the mayor through informal networks, those who pay facilitation fees, or who are willing to make demonstrations of loyalty. These roles, often unprotected by the formal civil service system, provide fertile ground for patronage. Informants reported that political supporters and family members of DPRD members and senior bureaucrats played a role distributing these positions. An informant, a temporary or contract staff in a *puskesmas* explained:

> It was hard for me to find a job, but since my relative is close to the mayor, I was brought in as an honorary [temporary/contract-based] staff member rather than staying unemployed. At the office, most of the time we just show up to clock in, sit around and chat, then clock out—unless the budget for activities has been

> disbursed, then we start working. We were hired through an interview test, but without an insider—someone in the office or a known connection—it's nearly impossible to be accepted as an honorary staffer. Most of the positions are political placements from the mayor and DPRD members. Each DPRD member gets a quota of at least 10 people. From what I know, there are around 3,000 honorary staff in total, most of them backed by the mayor and deputy mayor. (Interview, May 4, 2020; author's translation)

When asked whether political elites charged individuals for such jobs, multiple sources mentioned the standard price was about IDR 10–15 million (approximately AUD 1,000–1,500) to secure low-level temporary staff positions (*tenaga honorer*), which came with a monthly salary of around IDR 2.5 million (AUD 250). Those unable to pay were simply replaced by others willing to meet the price—explaining the frequent reshuffles mentioned above. Furthermore, salary deductions were commonplace—temporary staff often stated they received only IDR 2 million per month instead of the full amount. Between 2020 and 2022, Kupang City employed roughly 3,000 temporary staff, making these positions a lucrative source of both patronage distribution and budgetary skim-offs. According to informants, the proceeds were channelled to political elites—including DPRD members and the mayor's success teams—to build up their political war chests.

Informal distribution of these positions was orchestrated, in part, through the City's Civil Service Agency (*Badan Kepegawaian, Pendidikan dan Pelatihan,* BKPPD), which was headed by Mayor Jefri's cousin-in-law, in 2019–2022 (Penatimor, 2019; Woso, 2022). This allowed for quiet but systematic politicisation of lower tier staffing across the health sector and other departments. As one informant, a local journalist, explained:

> When his wife [Hilda Manafe] ran as a DPD member representing NTT, Jefri instructed all city employees to return to their hometowns and gather votes on her behalf. Similarly, during the Sabu Raijua district head election, he directed ward heads (*lurah*) to mobilise support for his younger brother [Orient Riwu Kore]. At the same time, he appointed his cousin-in-law, Ade Manafe, as head of

> the BKPPD, while many of the newly hired contract staff were drawn from his own relatives. (Interview, February 3, 2022; author's translation)

This selective politicisation reflected what we might think of as a pattern of 'peripheral clientelism'—where elites preserve a technocratic façade at the top, and especially in specialty and professional posts, while exerting control over marginal or informal entry points. The result is a fragmented landscape in which merit-based appointments coexist with politically engineered placements, often within the same institutional framework.

This situation contrasts with the dynamics in Semarang and Makassar. Both cities possess a deeper pool of health professionals, which allows greater flexibility in appointments and even some elite interference without undermining the overall quality of the health bureaucracy. In Semarang, performance-oriented mayoral leadership has enabled reshuffles framed as meritocratic reforms, though at times used to reward loyalists. In Makassar, a more competitive political environment has fostered internal jockeying within the bureaucracy, particularly in high-value sectors such as hospitals. At the level of honorary or contract-based staff, all three cities reveal similar patronage-driven practices. The key difference is that in Kupang these posts function as lucrative instruments of rent-seeking, while in Semarang and Makassar they are used primarily for distributing patronage.

In conclusion, while Kupang's health staffing regime imposes technical and regulatory limits on top-level clientelism, elites still extract resources through senior officials and by manipulating non-permanent staff positions. Unlike Semarang and Makassar—where stronger bureaucracies and deeper professional pools constrain such practices—Kupang's weaker institutions leave its health sector especially vulnerable to personalised patronage.

From Healing to Hustling: How Clientelism Hollowed Out Kupang's Health Governance

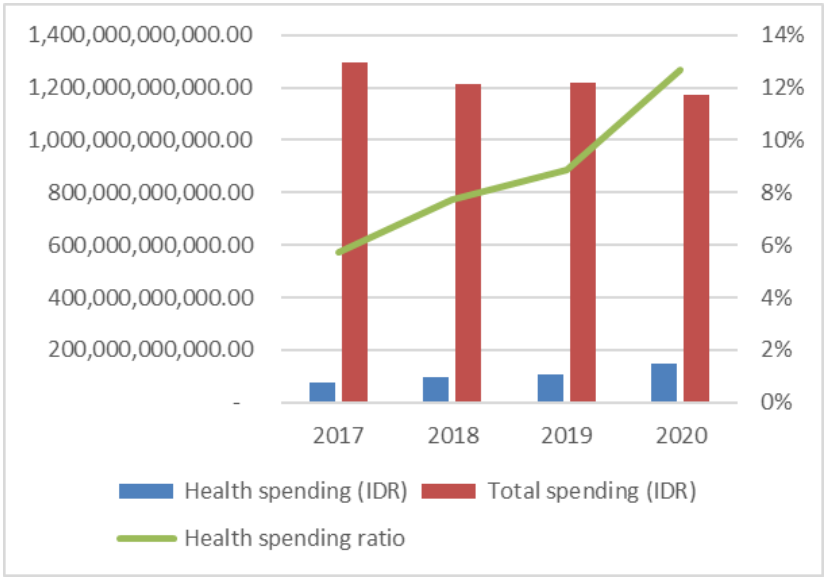
While Kupang City has steadily increased its health budget—surpassing 12% of its total APBD in 2020 and thus nominally fulfilling the 10% mandate under Law No. 36/2009—closer scrutiny reveals systemic mismanagement and clientelistic misuse. As

Berenschot (2018b, p. 1593) argues, discretionary governance in Indonesia allows political elites to exploit sectors where spending is opaque and oversight is weak. The health sector in Kupang City exemplifies this pattern. Though health funding rose significantly in nominal terms, a large share of this budget—especially for goods, services, and infrastructure—was vulnerable to elite capture.

Overspending has become a structural feature of Kupang's health budgeting. Between 2017 and 2019, the variance between planned and actual expenditure consistently exceeded 106%, with a dramatic spike to 129% in 2020. While the COVID-19 emergency partly explains this, the trend began earlier, indicating deeper institutional weaknesses and elite abuse. **Figure 4.9** and **Figure 4.10** illustrate Kupang's health budget allocations against total budget and the overspending trend measured by deviations between planned and realised expenditures. Crucially, spending surges were concentrated in discretionary budget lines—such as goods procurement, honoraria, and minor infrastructure—areas that are difficult to audit and therefore more easily manipulated for patronage purposes. (Interview with expert staff to the DPRD Chairperson, Kupang, October 7, 2021; author's translation)

Figure 4.9

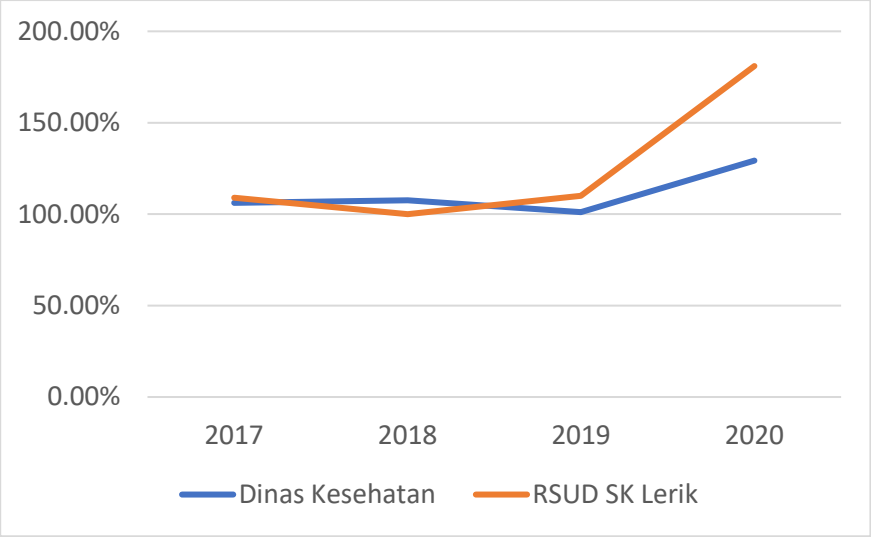
Health Spending (Excluding Salaries) as Proportion of Kupang City Budget (APBD), 2017–2020



Source: Author's analysis based on Kupang City APBDs, 2017–2020.

Figure 4.10

Spending Against Budget Variations at Health Office and RSUD SK Lerik (2017–2020)



Source: Author's analysis based on APBD Dinas Kesehatan Kupang City and RSUD SK Lerik, 2017–2020.

In fact, getting access to the budget documents to make these analyses was very difficult, and would likely have been impossible without the help of an insider (a staff member in the Kupang City DPRD) and a research assistant in Kupang. With their support, I was able to collect the reports and interviewed informants in Kupang during the COVID-19 global pandemic. Informants spoke candidly—albeit anonymously—about how inflated allocations were often driven by elites' habitual use of public funds to provide *hadiah* (gifts) for key political supporters or to build personal war chests ahead of elections (Interviews, Kupang, October 7, 2021; author's translation). I was unable to obtain comparable access to budget data in Semarang and Makassar and therefore could not conduct the same level of detailed budget analysis in these cities as in Kupang.

Public procurement in Kupang's health sector functions as a key mechanism through which political elites convert administrative authority into material and electoral resources. Rather than operating as a neutral, rules-based process, procurement is a transactional site where contracts are allocated not on the basis of efficiency or public need, but through informal negotiations, elite brokerage, and rent-seeking arrangements. These dynamics are especially pronounced in the health sector due to its combination of high expenditure, technical opacity, and urgent service

demands—features that make it both lucrative and difficult to monitor. In this sense, procurement serves as another "patronage enclave" within the broader bureaucratic apparatus: a zone of concentrated discretion where formal regulations coexist with informal political bargains, and where public health spending is routinely redirected to serve private and political interests.

Both official data and informant interviews demonstrate the persistence of clientelism in public procurement within the health sector. Official records between 2017 and 2020 show that spending variances in *Dinas Kesehatan* and RSUD SK Lerik frequently exceeded 100%, peaking at 129% in 2020—well above the 10% limit for acceptable budgetary deviation (see **Figure 4.10**). This overspending was especially pronounced in RSUD SK Lerik, which reached a staggering 180% budget variation during the COVID-19 pandemic, justified by emergency facility expansion. While some of this may have reflected legitimate needs and also reflected the hospital's position as semi-autonomous public entity under the mayor (Mayor Regulation or *Peraturan Walikota* No. 89 of 2020), the scale and lack of transparency of this expenditure as well as data received from local media and informants suggest that some of this expenditure was exploited for political purposes. An informant who worked for a local politician said:

> Everyone knew procurement was controlled by Jefri's inner circle. The bids might have been submitted by companies from Jakarta, but when it came to the actual work, it was his campaign team and even his son who handled it. Every tender had to go through the mayor. He was the one who decided who got the contracts. (Interview, Kupang, April 30, 2021; author's translation)

According to multiple informants, it was an open secret that two central actors during 2017–2022—referred to here as Mr A and Mr B—acted as the *de facto* gatekeepers of government contracts. Both had close affiliations with Mayor Jefri's campaign team: one with a political party background, the other with contracting experience (Interview, October 7, 2021, confirmed by another informant on March 3, 2022; author's translation). They operated as intermediaries for senior elites, orchestrating the allocation of tenders in the health sector and beyond. Their influence extended across multiple sectors, with them allegedly extracting rents from every

awarded contract, a portion of which was redirected to their political patron, Jefri.[17] His gatekeepers also included his very close family members, whom my informant, a local journalist, said were put in charge of controlling major government contracts valued at one billion rupiah (about AUD 100,000) or more (Interview, March 4, 2022; author's translation).

Meanwhile, according to these informants, the mayor selected heads of key departments, including *Dinas Kesehatan*, in part for their willingness to cooperate with these intermediaries, ensuring continued access to public resources. As one local informant explained, these bureaucrat-cum-intermediaries routinely demanded "fees" from contractors, which were then channelled to serve their patron's interests—financing personal travel or political campaigns (Interview with a local broker, Kupang, March 3, 2022; author's translation).

As one informant put it, this arrangement inverted normal procurement logic, such that "Only in Kupang do the highest bids tend to win" (Interview with a local journalist, Kupang, March 4, 2022; author's translation); this informant also pointed to the exclusion of local contractors and the dominance in public tenders of Jakarta-based companies, allegedly connected to the mayor's family. Procurement records from the Indonesian government's e-procurement system (*Layanan Pengadaan Secara Elektronik*, LPSE) support this analysis, showing repeated use of identical authorised representatives (*kuasa direktur*) across supposedly distinct companies. These entities were often proxies linked to local and national elites—including the mayor, governor, and DPR members from NTT. Some informants estimated that roughly 80% of health procurement in Kupang was controlled by this network (Interview with expert staff to DPRD Chairperson, Kupang, June 1, 2021; author's translation).

Kickback schemes were a routine feature of this system. Interviews with contractors and civil servants indicate that a 10–15% fee was typically demanded as a condition of winning tenders. These illicit payments financed mayoral patronage, campaign war chests, and the political operations of local elites. RSUD SK Lerik,

[17] Such patterns under Jefri echoed practices seen under previous mayors, reflecting continuity in Kupang's procurement politics.

operating under Mayor Regulation (Perwali) No. 89 of 2020 as a semi-autonomous institution or *Badan Layanan Umum Daerah* (BLUD), with minimal DPRD oversight, served as a primary locus for high-value procurement in the healthcare sector. Its autonomy provided a buffer from legislative scrutiny, allowing the mayor's office to centralise control over hospital-related expenditures—including contracts for medical infrastructure and equipment—beyond the reach of competing political factions. In 2020, the hospital recorded a dramatic budget variance of 180%, ostensibly due to emergency infrastructure expansion during the COVID-19 pandemic. Yet this budgetary spike also coincided with intensified rent-seeking, as the hospital's newly granted autonomy that year enabled swift, unaccountable allocation of lucrative projects (see Figure 4.10).

In contrast, procurement under the City Health Office was more constrained by legislative involvement, with legislators also demanding or expecting a share. Here, budget allocations were distributed to DPRD members through informal arrangements, often agreed upon in "half-chamber" (*setengah kamar*) meetings between the mayor, vice mayor, and legislators (Interview with expert staff to DPRD Chairperson, Kupang, October 7, 2021; author's translation). These patronage bargains determined the results of both open tenders and direct appointments before these arrangements formally entered the LPSE/e-procurement system. To accommodate DPRD members' patronage shares or "quotas," projects were frequently fragmented into smaller packages that fell below procurement thresholds, allowing direct appointments. These smaller contracts were typically channelled to companies favoured by individual legislators, while high-value projects remained under mayoral control. In effect, lucrative projects (i.e., hospital and *puskesmas* constructions, medical equipment) were monopolised by the executive, whereas lower-value ones were ceded to DPRD members (Interview with expert staff to DPRD Chairperson, April 30, 2021; author's translation).

Even the national electronic-based catalogue (*e-Katalog*) system failed to neutralise elite manipulation in procurement. When items were unavailable or deemed unsuitable in the catalogue, procurement reverted to conventional tenders—processes that were more easily dominated through elite orchestration. Contractors frequently used multiple or borrowed company names to obscure their affiliations, enabling them

to dominate the market without leaving clear traces. An analysis of procurement winners from 2017–2018 shows that most maintained direct or indirect ties to the mayor's inner circle or allied legislators (Interview with city government official, Kupang, October 7, 2021; author's translation).

This system ensured that both executive and legislative elites in Kupang could benefit from the distribution of patronage. However, when this balance faltered, DPRD members often retaliated by delaying budget deliberations, rejecting budget proposals, or withholding their approval from accountability reports—moves driven not only by institutional tensions but also by pressure from their own broker networks. This persistent contestation over the spoils of office helps explain a notable pattern: since 2007, no incumbent mayor in Kupang has secured re-election. Here, electoral turnover reflects not only voter dissatisfaction but also fractured elite coalitions and unfulfilled patronage expectations.

By contrast, Semarang and Makassar exhibit greater political continuity and elite coordination. In Semarang, long-standing PDI-P dominance has enabled more cohesive patronage arrangements, whereby intra-party discipline helps stabilise elite expectations and align legislative and executive interests. This stability allows mayors to consolidate support across multiple terms while selectively accommodating broker networks without provoking intra-elite conflict. Makassar, though characterised by intense political competition, has developed a form of selective patronage that focuses patronage politics on high-value sectors like health infrastructure while, relatively speaking, insulating programmatic service delivery. Although rivalries remain sharp, successive administrations have maintained a degree of continuity through negotiated settlements among elites. Unlike Kupang, where fragmented authority and weak party discipline produce unstable patronage bargains, Semarang and Makassar show how elite alignment—whether through party machinery or negotiated competition—can temper the disruptive effects of clientelism on governance and electoral survival.

Patronage politics—particularly in the procurement of medicines and medical devices—had tangible consequences for healthcare outcomes in Kupang. Stockouts of essential medicines and vaccines were frequent, and the overall quality of

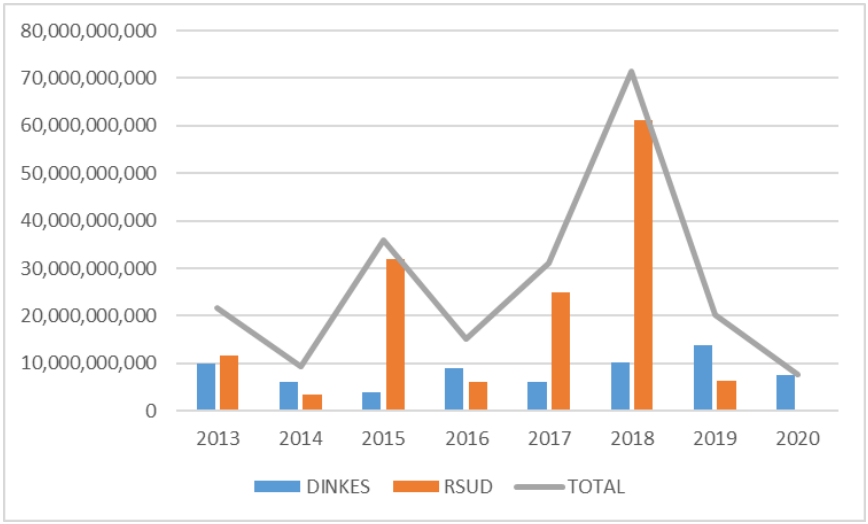
pharmaceutical services was compromised. In 2018, only eight of the city's eleven *puskesmas* met the national benchmark of 80% medicine availability, and none employed a qualified pharmacist (Dinas Kesehatan Kota Kupang, 2018, p. Tabel 9). This fell short of the requirements set out in Minister of Health Regulation No. 74/2016, which mandates one pharmacist per 50 patient visits and the use of both consumption- and morbidity-based forecasting methods for pharmaceutical planning. At the time, the City Health Office employed just six pharmacists—two stationed at *puskesmas* and four at RSUD SK Lerik (Dinas Kesehatan Kota Kupang, 2018, p. Tabel 15). In practice, these underqualified pharmacists oversaw procurement processes, relying on outdated consumption-based planning, which further undermined rational pharmaceutical management and exacerbated supply shortages.

Procurement manipulation intensified during the COVID-19 pandemic, as emergency allocations totalling IDR 48 billion (approximately AUD 4.8 million) were designated for medical equipment, PPE, and the recruitment of temporary workers in Kupang. However, both investigative reports and informant testimonies documented severe delays in disbursing honoraria for pallbearers and frontline health workers (CNN Indonesia, 2021a; Penatimor, 2021). In several cases, payments were not only delayed but also arbitrarily reduced, sparking public protests. Informants alleged that portions of these emergency funds were illicitly redirected to finance electoral campaigns in Sabu Raijua (where it will be recalled the mayor's brother was standing) and to generate interest income by holding balances in city government's bank accounts. Such practices exemplify how budget authority in Kupang's health sector was weaponised not to respond to a public health emergency, but to consolidate political dominance and fund political networks.

Figure 4.11 visualises the volatility of public procurement in RSUD SK Lerik and highlights the stark contrast with *Dinas Kesehatan* in 2015, 2017, and 2018 (Indonesia Corruption Watch, 2022).

Figure 4.11

Value of Public Procurement in City Health Office and RSUD, 2013–2020



Source: Author's analysis based on data from OpenTender.net (Indonesia Corruption Watch, 2022).

This disparity reflects the health office's smaller budget and DPRD patronage, with contracts fragmented into small packages for direct allocation, as mentioned earlier. Procurement there served executives and legislators, while RSUD procurement was more directly controlled by the mayor.

The analysis of Kupang's health budgeting and procurement presented here reveals how increases in public health spending can mask deep-rooted practices of clientelism. While nominally fulfilling legal mandates and responding to public health needs, budget allocations have disproportionately flowed into opaque and easily manipulated expenditure lines. Procurement, in particular, emerges as a key site for political transactions, where elites convert administrative authority into campaign resources, loyalty networks, and private enrichment. Actors close to the mayor's circle dominate contract distribution, often at the expense of local contractors and public accountability. The system operates through both formal mechanisms, like e-catalogue and open tenders, and informal arrangements, such as informal "half-chamber" meetings and fragmented budget packages, enabling both executive and legislative elites to share the spoils, but with the mayor emerging as the dominant actor.

Selective Delivery and Uneven Outcomes: Clientelism in Primary and Referral Healthcare Services

The distortions introduced by clientelism are not confined to budget allocations and procurement processes. They also manifest clearly in how healthcare services are delivered on the ground. This section turns to the outcomes of this politicised governance, showing how frontline service provision—both in primary care and referral systems—is uneven, selective, and often shaped by political proximity rather than public health priorities. The analysis reveals the everyday consequences of clientelistic rule, where access to care is not merely a matter of policy design but also an outcome of political intervention in, and extraction from, the healthcare system.

Primary Care and Public Health Services Analysis

Beyond public budgets and procurement, the clientelistic logic shaping Kupang's health sector is also evident in the uneven provision of primary healthcare and of public health programs generally, and in patchy access to essential services. Over the past decade, the city introduced several programmatic expansions to improve access—most notably the payment of JKN premiums for low-income residents and the launch of *Brigade Kupang Sehat* (Healthy Kupang Brigade) in 2014 to provide 24/7 mobile health services. However, these initiatives were poorly maintained and became vulnerable to the same logic of political clientelism that structure governance more broadly. Short-term political visibility was prioritised over institutionalisation, budgets were often diverted to patronage-driven expenditures, and frontline services lacked sustained monitoring. As a result, the expansions of the JKN and the free mobile health services failed to produce lasting improvements in service quality or healthcare outcomes. A persistent tension remains between formal service provision and informal political incentives. While some headline indicators suggest modest progress, a closer examination reveals deep inequalities, discretionary resource allocation, and selective focus—patterns shaped more by political priorities than by public health needs. These dynamics are particularly evident in the distribution of health infrastructure, insurance coverage, and maternal and child health services.

In Kupang, the delivery of frontline public healthcare reflects both infrastructural constraints and political selectivity. The city operates a relatively compact network of 11 *puskesmas*, each tasked with delivering outpatient care, health promotion, disease prevention, and supervision of *pustu* and *poskeskel*, as well as coordinating community-level initiatives such as *posyandu*. Of these 11 facilities, only four have been upgraded to provide inpatient services. With a population exceeding 500,000, this equates to one *puskesmas* for every 45,000 residents—well below the national service coverage benchmark. The ratio of general practitioners per 100,000 was 1.17 in 2018, slightly exceeding the target (1 per 100,000), but the ratio of other healthcare professionals (e.g., dentist, pharmacist, midwife, and specialist doctors) to 100,000 population was less than 1—far below the ratios in Makassar and Semarang (Badan Pusat Statistik Kota Makassar, 2020; Badan Pusat Statistik Kota Semarang, 2020a; Dinas Kesehatan Kota Makassar, 2021; Dinas Kesehatan Kota Kupang, 2021). This limited footprint not only restricts access but also enhances the strategic and political value of each facility, making them key arenas for patronage-based staff placements and contractor competition (Dinas Kesehatan Kota Kupang, 2018, p. 131).

Among the most visible consequences of this constrained and politicised infrastructure is the decline in Kupang of *posyandu*—Indonesia's emblematic model of community-based health participation. Designed to deliver maternal and child healthcare, nutrition, immunisation, and family planning services, *posyandu* are operated by community health volunteers/cadres (*kader kesehatan*) and family welfare (PKK) cadres, both groups being typically made up of respected women volunteers in their communities. As the frontline of Indonesia's promotive-preventive care system, their effectiveness depends not only on technical support from *puskesmas* but also on consistent political and financial backing. Across interviews, informants consistently confirmed that Kupang's mayors paid little attention to the community's role in public health. For example, an informant who had worked with the DPRD chairperson noted that Jefri's wife was rarely present in Kupang and offered little support for *posyandu* or PKK activities, despite this being a standard role for female spouses of regional

government heads in Indonesia.[18] (Interview, October 7, 2021; author's translation). Former mayor Yonas Salean, when interviewed, likewise dismissed the agency of *posyandu* and PKK cadres, in contrast to their recognition in Semarang. He asked: "What kind of intervention could we possibly make for *posyandu* cadres?" (Interview, June 1, 2021; author's translation).

In Kupang, this community health infrastructure has withered. Of the 315 *posyandu* registered only 116 (36.8%) remained active in 2018, meaning an averaging of just two of six *posyandu* registered were active per urban ward (Dinas Kesehatan Kota Kupang, 2018, p. 133). In 2023, the percentage of active *posyandu* was not much improved, at only 40.09% (Dinas Kesehatan Kota Kupang, 2023). This high rate of attrition signals not merely a decline in volunteerism, but systemic neglect, as the city government provided basic operational needs—transport allowances, equipment maintenance, and incentives for *kader*—only irregularly. As a senior bureaucrat noted, *Dinas Kesehatan* staff were routinely expected to generate money for the mayor, and budget allocations for public health—such as *posyandu*—were among the first to be sacrificed by the city government (Interview, October 7, 2021; author's translation).

From the above accounts, it becomes clear that neither Mayor Jonas Salean nor his successor, Jeffirstson Riwu Kore, made meaningful efforts to revitalise *posyandu* networks. Even minimal needs—such as transport stipends and equipment—were often neglected, and unlike in Semarang or Makassar, the mayor's wife played no visible role in health advocacy or cadre coordination. In Kupang, community health cadres were often excluded from politicians' mobilisation strategies, whether electoral or developmental, leaving them marginalised. Interviews with both former mayors—Salean and Riwu Kore—and also two local journalists, and a local political intermediary suggest limited recognition of the *posyandus'* political agency, alongside a stronger interest in the pay-offs and rent-seeking opportunities linked to larger-scale procurement.

[18] Typically, leadership of PKK and *Posyandu* at each administrative level—village, district/city, and province—is held by the wives of village heads, regents/mayors, and governors, respectively, reflecting the gendered and hierarchical nature of community health governance in Indonesia.

Budgetary data from Kupang's 2017–2020 APBD substantiate this pattern of neglect. Funding for *posyandu*-related programs—including public health promotion, nutrition improvement, immunisation, and maternal-child outreach—was consistently low and erratic (see **Table 4.1**). Only in 2019, when stunting became a national development priority, did allocations for nutrition programs increase substantially, suggesting that local elites were responding to top-down directives rather than committing to long-term, locally driven public health planning and community healthcare.

Table 4.1

Public Health Programs Related to Posyandu Activities, 2017–2020

Programs	2017	2018	2019	2020
Public health promotion and participation	221,821,900	439,362,600	419,882,500	65,033,410
Public nutrition improvement	78,464,800	498,916,600	1,215,128,500	906,771,750
U-5 and school children vaccination	35,462,900	345,435,350	45,265,600	27,101,900
Children and U-5 healthcare services	81,498,500	375,015,000	287,836,000	32,757,400
Health information dissemination for pregnant mothers and poor families	50,087,800	30,928,200	70,963,700	26,209,000

Source: Author's analysis from Dinas Kesehatan Kupang City budget realisation documents, 2017–2020.

The situation of *posyandu* in Kupang stands in marked contrast to Semarang, where *posyandu* are embedded in institutional structures such as the Healthy City Forum (*Forum Kota Sehat,* FKS) and Ward Health Forum (*Forum Kesehatan Kelurahan,* FKK) (see Chapter 6). In Semarang, these forums integrate *puskesmas*, *posyandu*, NGOs, and government agencies in the delivery of community-level healthcare, enabling bottom-up planning and accountability. Mayor Hendrar Prihadi revitalised and politically supported Semarang's *posyandu*; his wife was particularly active in supporting the PKK. The city provided its healthcare cadres with regular training, recognition, and financial incentives. It was not just Semarang's health office which provided such support, so did the mayoral office and party structures. While these efforts were not politically neutral, they did institutionalise community participation and enhance the delivery of promotive-preventive health services.

In Makassar, a different but equally strategic approach to grassroots mobilisation took shape (see Chapter 5 for more detail). Rather than formalising participation through city-wide forums as in Semarang, Mayor Danny Pomanto cultivated hyper-local networks anchored in the neighbourhood unit (*Rukun Tetangga/Rukun Warga*, RT/RW)[19] system. In this context, Danny Pomanto replaced nearly all RW heads with individuals loyal to his administration. Community health volunteers/cadres (*kader kesehatan*) were frequently the wives of RT and RW heads, creating overlapping roles between neighbourhood leadership and community health provision. This arrangement enabled the establishment of a vertically integrated patronage network operating at the neighbourhood level, which mobilised community volunteers not only for service delivery but also for political consolidation (i.e. these community volunteers were used to promote the mayor, as well as promoting healthcare). As a result, Makassar's *posyandu* and health outreach structures became embedded within a broader project to construct a durable, grassroots-based electoral machinery.

In contrast, Kupang's elites showed neither the institutional ambition of Semarang nor the political creativity of Makassar. Instead of harnessing the *posyandu* network for either participatory governance or local political control, they largely ignored it—leaving the program to deteriorate. Budget data from Kupang's 2017–2020 APBD confirm this neglect (as discussed previously, see **Table 4.1).** Without local leadership or political incentives to sustain grassroots health engagement, *posyandu* became functionally residual.

These contrasts highlight how community health participation is not shaped solely by national policy or even by the design of decentralisation, but by differing subnational political logics. In Semarang, *posyandu* were aligned with participatory planning and party-based social programs. In Makassar, they were instrumentalised into a personalistic grassroots machine. In Kupang, by contrast, their political and service value was largely disregarded because local political elites were more likely to focus on the health sector as a source of patronage and rent-seeking. This conclusion confirms the

[19] *Rukun Tetangga* (RT) or neighbourhood association usually consists of around 10–a20 houses in a neighbourhood, while *Rukun Warga* is a community association consisting of some *Rukun Tetangga.*

broader argument that clientelist governance not only distorts how resources are allocated but also determines which parts of the health system are activated, neglected, or repurposed for political gain.

Referral Healthcare Services, the Private Sector Engagement, and Healthcare Insurance (*Jaminan Kesehatan Nasional*, JKN)

While the politicisation of primary healthcare and community-based services reveals how clientelism distorts frontline health delivery, these dynamics are equally evident—but take a different form—in Kupang's healthcare referral system and its private health sector. Rather than fostering competitive pressure or driving improvements in public facilities, the presence of private hospitals and clinics has done little to enhance service quality at RSUD SK Lerik or in the *puskesmas* network. Instead, dual practice by health workers, limited middle-class uptake, and elite-linked private providers have contributed to a fragmented and unequal system. What follows is an examination of how Kupang's referral services and private healthcare landscape reflect a failure in the city to translate market pluralism into improved public sector performance or equitable access.

Table 4.2 presents the distribution of referral healthcare facilities in Kupang, encompassing institutions operated by various levels and government institutions—including the city, province, Ministry of Health, and other national agencies—as well as the private sector. In addition to RSUD SK Lerik and the *puskesmas* network, which form the core of city-run health services, several other hospitals operate within Kupang's jurisdiction. In principle, this pluralistic landscape should create competitive pressure on the municipal government to enhance service quality, as in the other cities covered in this thesis. However, as subsequent analysis will show, such pressure has been largely absent. **Figure 4.12** complements this overview by providing a spatial representation of healthcare facility locations across the city, showing their distribution and relative proximity.

Table 4.2

List of Hospitals in Kupang, 2025

No	Hospital Name	Hospital management	Type of Hospital
1	RSUD SK Lerik	City-run public hospital	C
2	RS Prof. Dr. WZ Johanes	Province-run public hospital	B
3	RS Jiwa Naimata	Province-run mental health hospital	C
4	RS Dr. Ben Mboi Kupang	Ministry of Health-run public hospital	A
5	RSU Undana Kupang	University/education hospital	C
6	RS El-Tari Kupang	Airforce (TNI AU)-run public hospital	D
7	Wirasakti Hospital	Military-run hospital	
8	RS Samuel J Moeda	Navy (TNI-AL)-run public hospital	C
9	RS Bhayangkara Drs. Titus Uly	Police-run hospital	C
10	RS St Santo Carrolus Boromeus	Catholic-based foundation run by the Carrolus Boromeus nuns, public hospital	C
11	RS Kartini Kupang	Private hospital	D
12	RS Leona	Private hospital	C
13	RS Mamami	Private hospital	D
14	RSIA Dedari	Private hospital, women and children hospital	C
15	RS Kupang Graha Medika	Private run hospital	D
16	Siloam Hospital	Private hospital, run by Lippo Group (national conglomerate)	B

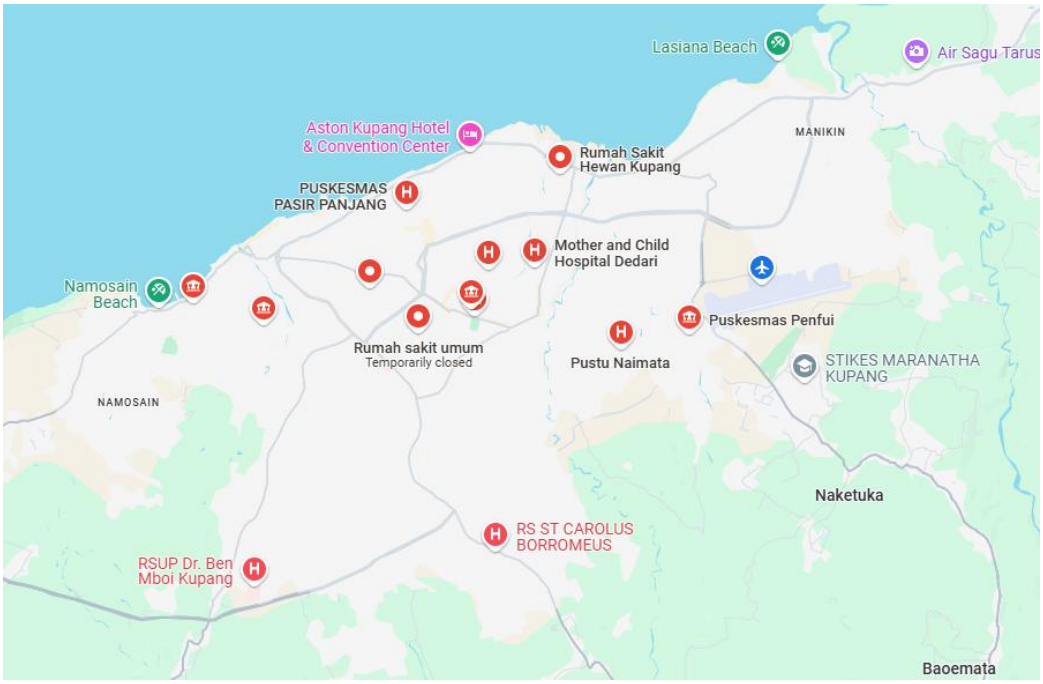
Source: Author's analysis based on field observations, cross-referenced with Google Maps and verified through individual hospital websites, completed on June 20, 2025.

Table 4.2 shows that Kupang City hosts 16 hospitals: one city-run, two province-run, one Ministry of Health-run, several Indonesian armed-forces-run, and seven private company-run, including Siloam Hospital Kupang, operated by Lippo Group. Numerous smaller private clinics also operate across the city, many of which are owned and run by medical professionals who simultaneously work in public facilities, particularly *puskesmas* and RSUD SK Lerik. The fact that Siloam Hospital—established in 2014—remains the only major private hospital in the city highlights the relatively limited

development of Kupang's private sector. The widespread dual-practice arrangement, while officially permitted, significantly reduces healthcare personnel availability in the public sector. Higher remuneration and greater autonomy in private practice draw doctors, nurses, and midwives away from their public posts, diluting the capacity of government-funded health services—especially in preventive and promotive care. A local informant from the Ombudsman of the Republic of Indonesia noted, "There are even some doctors who practice in seven different places" (Interview, June 29, 2021; author's translation).

Figure 4.12

Map of Healthcare Facilities (Clinics, Puskesmas, Hospitals) in Kupang, 2025

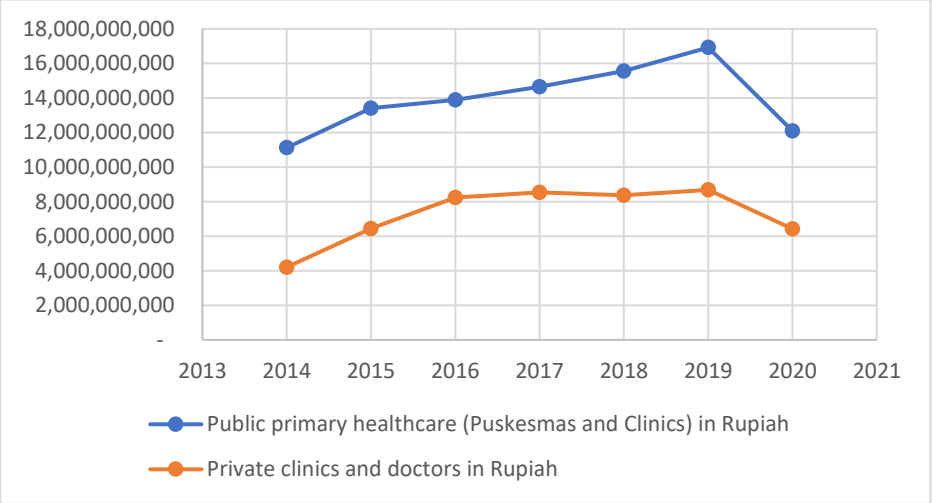


Source: Screen shot from Google Maps, accessed on June 20, 2025. The red circles indicate healthcare facilities (hospitals and *puskesmas*). Other private healthcare providers, such as private general practitioners and clinics are not captured.

Moreover, while Kupang's middle class is gradually expanding with urbanisation, this shift has not translated into greater demand for higher-quality public healthcare. At the primary care level, many residents continue to rely on *puskesmas* and other public facilities rather than private clinics and doctors (**Figure 4.13**).

Figure 4.13

Public Primary Healthcare vs Private Primary Care Capitation in Kupang under JKN, 2014–2020

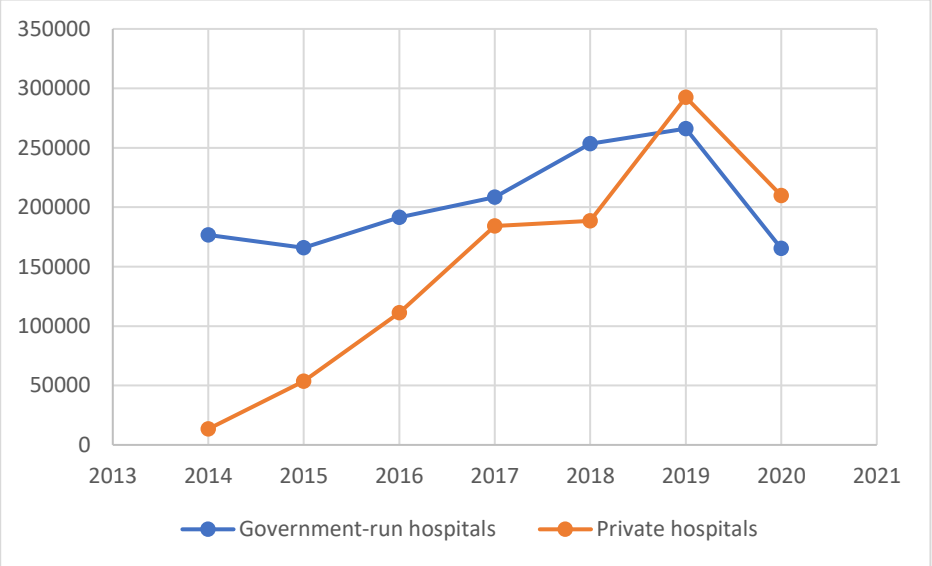


Source: Author's analysis from Self Service Business Intelligence (SSBI), December 9, 2020 (Badan Penyelenggara Jaminan Sosial Kesehatan, 2020).

The picture changes at the referral level, where by 2019 private hospitals were treating more healthcare insurance scheme participants (*Jaminan Kesehatan Nasional*, JKN) cases than government-run hospitals (**Figure 4.14**). Yet the growth of JKN utilisation in private hospitals has been slower in Kupang than in Makassar and Semarang, where private providers had already overtaken public facilities before 2019. This trend suggests both an expansion of private providers joining JKN and a growing preference among Kupang residents for private hospitals over RSUD SK Lerik, albeit with these trends lagging far behind Makassar and Semarang.

Figure 4.14

Number of Cases for Inpatient and Outpatient Treated in Government and Private Hospitals under JKN, 2014–2020

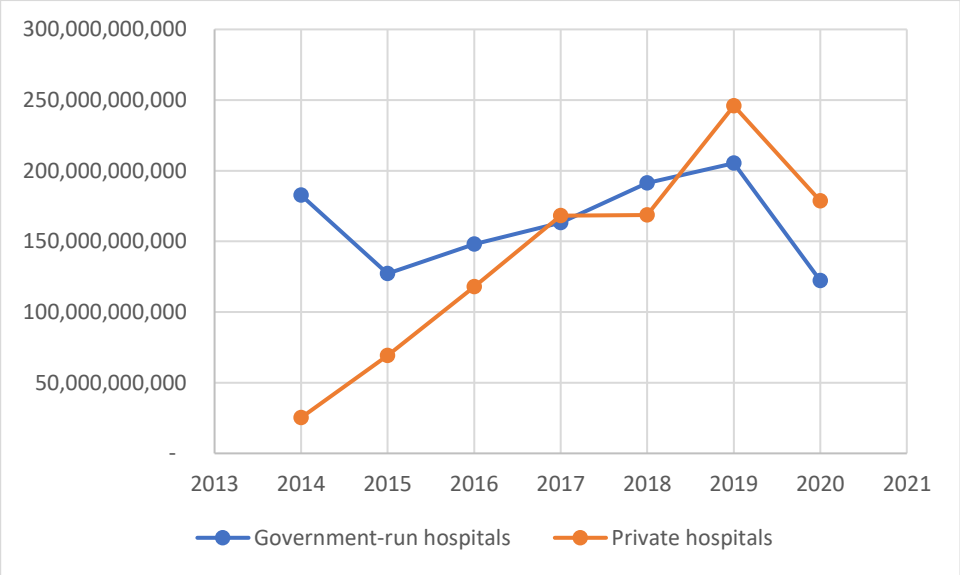


Source: Author's analysis from Self Service Business Intelligence (SSBI), December 9, 2020 (Badan Penyelenggara Jaminan Sosial Kesehatan, 2020).

In terms of total costs reimbursed, **Figure 4.15** shows a similar trend: JKN claims for private hospitals have surpassed those for government-run hospitals, signalling not only increased reliance on private care by Kupang residents but also a broader erosion of trust in the public sector. This shift highlights how weak service quality and governance at government-run hospitals created opportunities for private providers to capture a growing share of JKN funds. It also points to mounting pressure on the city government to raise the quality of public services—a challenge it has so far failed to meet.

Figure 4.15

Inpatients and Outpatients Claimed Costs in Referral Care, Kupang, 2014–2020



Source: Author's analysis from Self Service Business Intelligence (SSBI), December 9, 2020 (Badan Penyelenggara Jaminan Sosial Kesehatan, 2020).

Figures on primary care, referral care, and claim values (2014–2018) show that Kupang's middle class shifted to private providers later than in Makassar and Semarang. Many residents hesitated due to limited information on using JKN in private hospitals, fears of out-of-pocket costs, and providers' selective acceptance of only profitable cases. The coordination and communication between public and private healthcare providers were also weak (Interview with a nurse working for RSUD, Kupang, October 7, 2021; author's translation). Slower growth of private JKN partners—reflecting Kupang's smaller, less lucrative market—also delayed the shift. By 2019, however, private hospitals began treating more cases than public facilities, marking a turning point. In the early JKN years, the public sector faced little competitive pressure, but this changed as more residents turned to private hospitals, reflecting dissatisfaction with RSUD SK Lerik.

The weakness of community intermediaries in facilitating residents' access to quality healthcare—unlike the active brokering seen in Semarang and Makassar—and the absence of an organised, service-demanding middle class, combined with pervasive elite capture of the health sector, meant that the growth of private healthcare in Kupang failed to spur reform and instead reinforced existing inequalities while entrenching

clientelist control over health governance. My observations of civil society activism in Kupang show that criticism of healthcare governance and service quality was largely confined to Facebook discussions and rarely translated into concrete action. Civil society organisations were scarce, and community groups fragmented, leaving residents with weak political agency to demand better healthcare.

The rollout of the JKN healthcare insurance scheme in 2014 was intended to provide universal access to healthcare across Indonesia. However, Kupang's experience reveals a fragmented and politically mediated implementation. By 2017, only 47.7% of the city's population was covered by JKN, with one-third classified as subsidised members (*Penerima Bantuan Iuran,* PBI). Meanwhile, over 217,000 residents remained on the legacy municipal insurance scheme (*Jaminan Kesehatan Daerah, Jamkesda*), which operated outside the national risk pool. This dual-track system preserved inefficiencies, sustained opaque fiscal flows, and created space for elite brokerage in enrolment decisions, where access to subsidised healthcare could be granted or denied based on political alignment rather than need. In 2021, the coverage of universal health coverage increased to 75.1% and in 2023 it was reported that the coverage has achieved 93% (Dinas Kesehatan Kota Kupang, 2023), achievements that looked good but were left behind compared to Makassar and Semarang.

An analysis by Perkumpulan Prakarsa (Djamhari et al., 2020, pp. 21–26) documents widespread weaknesses in the verification of subsidised recipients, the use of outdated beneficiary databases, and the discretionary role of local actors in determining eligibility. They also highlight recurring delays in JKN reimbursements, which strained hospital finances and undermined service delivery—especially at RSUD SK Lerik. Despite nominal expansions in insurance coverage, these governance failures blunted JKN's impact.

Taken together, these dynamics show how Kupang's pluralistic healthcare landscape—marked by multiple hospitals, an expanding private sector, and the rollout of JKN—has struggled to generate competition or meaningful improvements in public provision. Weak community intermediaries, the absence of organised middle-class demand, and entrenched elite capture have allowed private providers to expand without

compelling RSUD SK Lerik or the *puskesmas* network to reform. Unlike in Semarang, where civic activism and community cadres pressed for accountability, or in Makassar, where a larger middle class and stronger private market created competitive pressures, Kupang's fragmented insurance schemes and governance shortcomings have blunted JKN's potential, leaving inequalities in healthcare access largely unresolved.

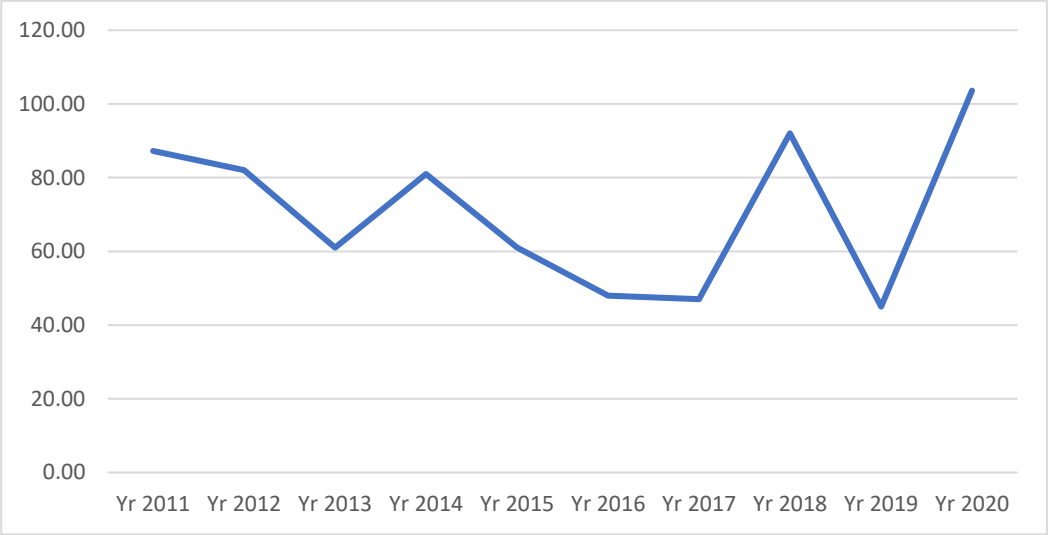
From Coverage to Consequences: Healthcare Outcomes Under Political Constraints

Despite the formal expansion of health financing, Kupang's health outcomes reveal limited progress and persistent inequality. Input indicators appear encouraging on the surface. Antenatal care (K1) exceeded 91% between 2016 and 2018, and skilled birth attendance reached 93% in 2018 (Dinas Kesehatan Kota Kupang, 2018, p. 117) remaining above the national average of 90% at 90.9% in 2021 (Dinas Kesehatan Kota Kupang, 2021).

Yet these apparent gains did not translate into safer maternal outcomes. Maternal mortality fell from 61 per 100,000 live births in 2015 to 47 in 2017, but then doubled to 92 in 2018, dropped again to 45 in 2019, and spiked to 103.6 in 2021 (**Figure 4.16**).

Figure 4.16

Maternal Mortality Rate (per 100,000 live births) in Kupang, 2011–2020

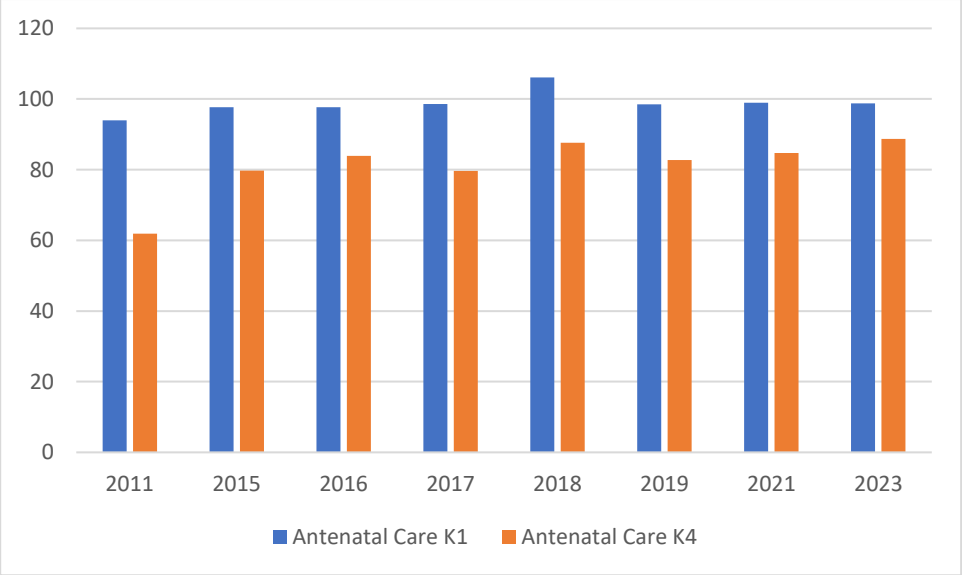


Source: Kupang City Health Profiles (2011, 2016, 2018, and 2021).

This volatility underscores a central argument of the thesis, that input improvements—financing, antenatal coverage, skilled birth attendance—were blunted by governance weaknesses shaped by clientelism and rent-seeking. Referral pathways for high-risk pregnancies remained inconsistent, emergency obstetric care was weak, and low community participation (as reflected in declining *posyandu* activity) further limited effective prevention. As shown in **Figure 4.17**, the gap between first trimester visits (K1) and complete four antenatal care visits (K4) illustrates how incomplete care heightened risks of obstetric emergencies. Combined with fragile insurance coverage for referral services, these gaps explain why maternal mortality in Kupang remained more volatile and higher on average than in Makassar or Semarang.

Figure 4.17

Antenatal Care (K1 and K4) Coverage in Kupang, 2011–2023



Source: Kupang City Health Profiles (2011, 2016, 2018, and 2021).

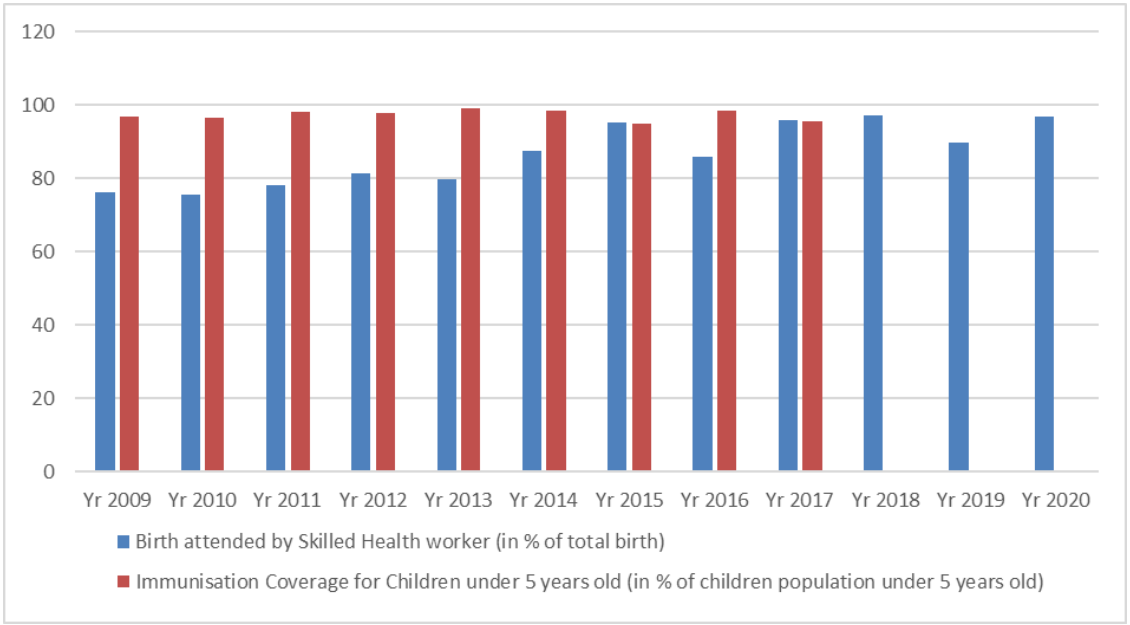
A similar disjuncture appears in immunisation outcomes. Full-course immunisation for children under five reached 90.6% in 2018, but the timely delivery of the critical HB-0 dose remained at just 75%, reflecting barriers to facility-based delivery (Word Bank, 2022). At the community level, only 64.7% of *kelurahan* achieved universal child immunisation in 2021 (Dinas Kesehatan Kota Kupang, 2021). These gaps were not simply technical but stemmed from uneven cold-chain infrastructure, inadequate cadre

transport allowances, and the discretionary allocation of resources. As a result, even where headline coverage appeared high, effective and timely delivery of vaccines was undermined—revealing governance shortcomings rather than input shortages.

Figure 4.18 illustrates trends in two key healthcare outcomes central to my thesis: *births attended by skilled health worker* and *immunisation coverage for children under 5 years old* (Dinas Kesehatan Kota Kupang, 2018, pp. 123–125). Both serve as critical indicators of the effectiveness of health governance (in maternal and child health) in the city.

Figure 4.18

Trends in Skilled Birth Attendance and Full Immunisation Coverage in Kupang, 2009–2020



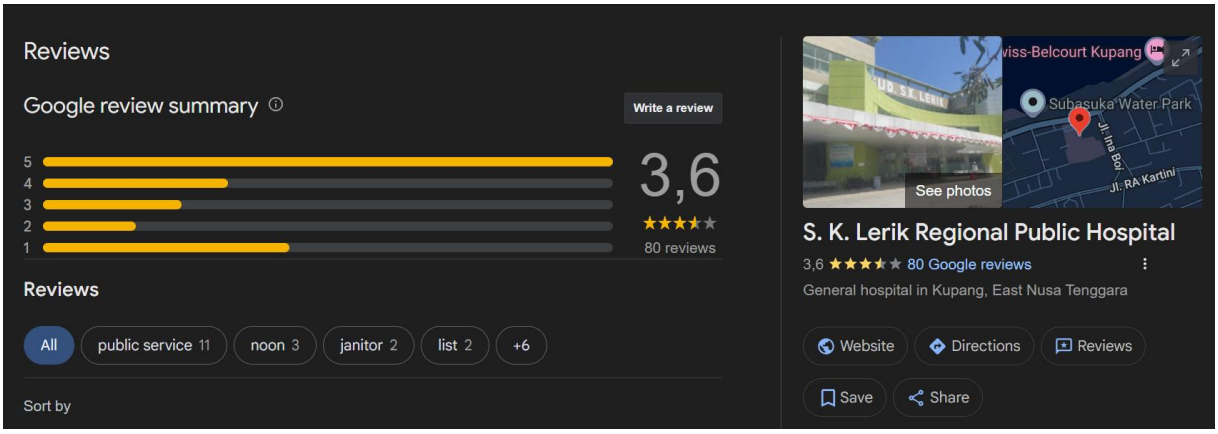
Source: Author's analysis drawing on data from Indo DAPOER (Indonesia Database for Policy and Economic Research), last updated November 8, 2020.

This thesis does not examine in detail other outcome areas, such as reproductive health or epidemiological trends. Even so, the evidence presented here is sufficient to demonstrate a consistent pattern: health financing and service inputs in Kupang have failed to deliver stable or equitable outcomes, largely because of the distorting effects of clientelism in healthcare governance.

This conclusion is reinforced by perspectives beyond the statistical record. Interviews, field observations, local media reports, social media commentary, and even Google Maps reviews all point to widespread dissatisfaction with both the quality of and access to healthcare services (see Chapter 1). **Figure 4.19** illustrates this vividly: as of 7 September 2025, 80 user reviews of RSUD SK Lerik yielded an average rating of just 3.6 out of 5 stars, with many comments directly criticising the hospital's poor service quality and inefficiency.

Figure 4.19

Google Map Reviews of RSUD SK Lerik



Source: Google Map review accessed on September 7, 2025.

In sum, Kupang's experience underscores how expanded health financing and improved input indicators do not necessarily translate into better outcomes. Maternal mortality remained volatile and ultimately worsened, immunisation coverage showed persistent gaps, and citizen dissatisfaction with service quality remained widespread. The problem lay less in the absence of resources than in the governance environment: weak institutions, clientelistic incentives, and entrenched rent-seeking practices consistently undermined the effectiveness of investments.

Civil society actors and community organisations in Kupang have not provided a strong counterweight to these dynamics. Unlike Semarang, where NGOs and civic forums are more institutionalised, or Makassar, where student groups and watchdog organisations frequently pressure local government, Kupang's civic sphere remains

fragmented and under-resourced. Informal community activism—through churches, neighbourhood groups, or health cadres—has limited capacity to demand accountability or resist the co-optation of health resources. As a result, frontline community structures such as *posyandu* atrophied rather than becoming platforms for mobilisation or oversight. Kupang's fragile and factionalised governance blunted the impact of reforms, leaving inequality and poor health outcomes deeply entrenched.

Pandemic Politics: COVID-19 as a Moment of Fiscal Exception and Patronage Expansion

Building on the earlier discussion of clientelistic governance and weak health outcomes, the COVID-19 pandemic offers a critical lens to examine how moments of crisis can reinforce rather than disrupt prevailing practices. In Kupang, the pandemic widened the discretionary use of city budgets and further weakened accountability, transforming emergency health spending into an extension of the patronage system.

The onset of the pandemic in 2020–2021 prompted significant reallocations of funding toward healthcare, and of movements within the healthcare budget, justified by the urgent need to implement rapid and adaptive response measures. In 2020, the Kupang city government redirected approximately IDR 48 billion (around AUD 4.8 million) to support COVID-19-related expenditures. As one local expert in Kupang explained:

> However, in practice, hospitals across the city experienced severe oxygen shortages. At the same time, payments for medical workers and burial teams were left unpaid, leading to public protests against the mayor in March 2021. In 2021, the budget was refocused, and according to the Deputy Mayor, IDR 52 billion [approximately AUD 5 million] was allocated for COVID-19 efforts. Yet records from the DPRD showed the figure had reached IDR 70 billion [approximately AUD 6.5 million]. This discrepancy raised serious suspicions of corruption, with allegations pointing to collusion between executive and legislative actors in manipulating the pandemic budget. (Interview, April 30, 2021; author's translation)

This emergency budget, earmarked for personal protective equipment (PPE), medical supplies, temporary infrastructure, and honoraria for frontline workers, marked a dramatic shift in fiscal priorities. Yet this shift was not accompanied by strengthened oversight or transparency. Instead, the extraordinary circumstances of the pandemic loosened procedural guardrails, offering local elites expanded room to manoeuvre. While similar patterns emerged across all three cities, their expression diverged. In Kupang, the mayor exercised full authority to prioritise costly medical devices and supplies, often at the expense of payments for honorary and contracted staff, with patronage and rent-seeking practices especially visible. In Makassar, discretionary funds were channelled into the creation of temporary patronage jobs. Semarang, by contrast, the mayor adopted a more inclusive approach, with resources planned through participatory mechanisms involving civil society and distributed via community groups.

Reports of financial mismanagement quickly emerged in Kupang. As mentioned earlier, pallbearers and temporary COVID-19 taskforce members protested over delayed and reduced payments, some receiving only a fraction of their promised honoraria. Protests occurred in 2021, with pallbearers staging demonstrations at the mayor's residence after months of unpaid wages (CNN Indonesia, 2021a; Penatimor, 2021). Meanwhile, health workers similarly reported non-payment of pandemic-related incentives—further eroding morale in a health system already strained by weak governance and low trust (Interview with local journalist, December 3, 2021; author's translation).

Compounding these issues were allegations of illicit fund diversion. In 2021, delays in disbursing natural disaster assistance for Seroja Cyclone (*Bantuan Seroja*) to poor residents led to accusations that key officials had redirected funds to support the mayor's brother, Orient P. Riwu Kore,[20] during his campaign in Sabu Raijua District (Mahkamah Konstitusi Republik Indonesia, 2021; Paat, 2021). Although difficult to verify, this suspicion aligns with long-standing practices of using public resources for

[20] Ironically, although Orient was disqualified in the 2021 election, Jefri's other younger brother, Krisman Riwu Kore, went on to win the 2024 Sabu Raijua election, paired with his former brother-in-law, Thobias Uly. This outcome illustrates the persistence of dynastic politics and the strength of Jefri's family network, showing how kinship ties and patronage alliances continue to shape electoral outcomes in NTT province.

electoral advantage. Delays in fund disbursement reportedly served another purpose: allowing interest to accumulate in government accounts before the funds were eventually released—a tactic commonly used by local governments to extract rents from public budget flows. According to one local expert, such delays were thus not accidental (Interview, April 30, 2021; author's own translation).

These episodes underscore a central finding of this thesis: crisis politics in Kupang did not break with established patterns of clientelism but rather deepened them. Emergency health financing under COVID-19 followed the same discretionary logic that had long governed routine health budgets—only now with fewer constraints and higher stakes. Far from catalysing systemic reform, the pandemic became a fiscal exception that reaffirmed elite control, marginalised essential services, and entrenched inequalities in health access.

Conclusion: Governing through Patronage

Compared to Semarang and Makassar, Kupang City offers a sobering view of how clientelism embedded in health governance can mute the gains of fiscal expansion and national reform. In a political landscape shaped by economic precarity and elite competition—and with weaker civic activism and a less organised middle class—there are few countervailing pressures to reorient the system toward equity or performance.

Across this chapter, the same logic recurs from staffing and procurement to insurance enrolment and facility development: health resources function as political instruments. Senior posts are allocated based on personal connections and for loyalty, not merit; temporary and contract positions become vehicles for patronage—especially at RSUD SK Lerik and *Dinas Kesehatan*—that operates through pre-arranged allocations and package fragmentation. The rollout of JKN widened coverage on paper but, in Kupang, dual tracks and discretionary enrolment blunted its impact. The pandemic then magnified these dynamics: emergency reallocations loosened guardrails and expanded the scope for politically directed spending, while arrears to frontline workers underscored governance weaknesses rather than policy resolve.

Healthcare outcomes reflect these arrangements. Input indicators, such as K1, K4 and skilled birth attendance improved, but maternal mortality worsened. Immunisation coverage rose overall, yet timely HB-0 delivery for infants lagged, pointing to gaps in facility-based care and uneven support to public health (e.g., health cadres/volunteers and *posyandu* as the frontline of preventive healthcare and health promotion) and cold-chain logistics. In the referral system, the growing role of private providers did not induce public-sector quality improvements; instead, delayed middle-class uptake, dual practice, and elite-linked providers reinforced fragmentation. By contrast, as we will see in greater detail in coming chapters, Semarang's stronger civil intermediation and party-mediated coordination, and Makassar's larger middle class and more competitive market, generated at least some pressures for improvement that are largely absent in Kupang.

Taken together, Kupang illustrates how clientelist incentives shape which parts of the health system are activated, neglected, or repurposed, and for whom. Expanded budgets and national health insurance schemes are necessary but insufficient when allocation, implementation, and accountability remain politically transacted. The comparative lesson is clear: without countervailing social and institutional pressures—through civic organisation, professional merit systems, and transparent procurement—health financing will struggle to translate into reliable services and improved outcomes. The policy challenges in Kupang, therefore, are fundamentally political: insulating core functions (staffing, procurement of medical devices, primary care outreach, and referral healthcare management) from patronage logics and rebuilding accountability so that health resources serve citizen needs rather than electoral calculation.

Chapter 5
The Anomalous Case of Makassar: Hybrid Governance, Partial Clientelism

Makassar offers a compelling counterpoint to the case of Kupang, highlighting how the effects of clientelism are not uniform across Indonesia's urban regions. Although clientelistic practices are pervasive in Makassar, the city performs relatively well in healthcare delivery—meeting and, at times, exceeding national minimum service standards on healthcare. Such outcomes challenge the assumption that clientelism necessarily undermines public service quality. Instead, Makassar's experience illustrates how political leaders can selectively apply clientelistic strategies, and how broad contextual factors such as economic diversification, electoral competition, and middle-class agency and market pressure can shape and constrain the nature of clientelistic politics in a particular location.

As a city selected for scrutiny, it will be recalled from the introduction, precisely because it combines high clientelism with strong healthcare outcomes, Makassar stands as an anomaly within the comparative framework of this study. My analysis in this chapter explains this anomaly by emphasising that, while patronage networks in Makassar remain central to local governance, their influence varies significantly across sectors. In the health sector, clientelistic politics persist, particularly in staffing and procurement, but they are more calibrated and less predatory than in Kupang. These differences appear to reflect not institutional robustness per se, but *strategic political choices* made by local elites navigating a complex and competitive political environment.

This chapter thus addresses a core research question: Why does clientelism in Makassar not produce the same governance failures observed in Kupang, particularly in the health sector? It does so by answering three sub-questions: (1) How do Makassar's political-economic conditions shape the form and function of clientelism? (2) How do clientelist practices operate within the health sector and influence its governance? (3) How do these dynamics impact healthcare outcomes? These questions in turn, map onto the core guiding questions of the thesis presented in the Introduction.

In answering the *first* of these questions, I show that Makassar's form of clientelism is deeply embedded in a competitive and fragmented elite landscape, where no single actor or coalition dominates the patronage system. Instead, power is negotiated among rival blocs that rely on overlapping networks of brokers, party machines, and civic intermediaries. The strength of the city's middle class, business sector, and digital infrastructure—coupled with a history of political contestation—has fostered a clientelist configuration that is *competitive, decentralised,* and *periodically recalibrated.* Unlike in Kupang, clientelism in Makassar is thus not unchecked, nor is it uniformly applied. Instead, it is shaped by contextual pressures that create both constraints and incentives for forms of governance—relatively clientelistic versus relatively programmatic—to be selectively applied in different sectors.

Turning to the *second* question, I demonstrate that clientelism operates in Makassar's health sector through a logic of *calibrated patronage*. While political elites influence appointments within the *Dinas Kesehatan* and city hospitals (RSUDs), these interventions are often bounded by performance considerations and bureaucratic norms. Procurement processes remain vulnerable to rent-seeking—evidenced by cases such as the RSUD Batua construction project and the RSUD Daya medical equipment procurement scandals which I discuss in the chapter—but they coexist with programmatic initiatives that aim to meet public expectations and achieve prescribed health indicators. Political actors, aware of the reputational and electoral stakes tied to healthcare delivery, often choose to shield parts of the health system from excessive interference to retain legitimacy and secure capitation flows from the national insurance scheme (JKN).

In response to the *third* question, I argue that the impact of clientelism on healthcare outcomes in Makassar is mediated by four key contextual factors: *middle-class demand, civil society activism, competitive health markets,* and *availability of alternative rent sources* outside the health sector. These forces limit the extent to which the health system can be captured purely for political gain. As a result, the city has maintained relatively strong performance in maternal and child health, immunisation coverage, and primary care provision. In this sense, Makassar represents a case of *hybrid*

governance: one in which performance-oriented service delivery and informal political incentives coexist within a fluid but functional patronage system.

The chapter is organised into four analytical sections, mirroring the structure of the Kupang and Semarang chapters. Section 1 outlines Makassar's political economy, examining its elite dynamics, patterns of competition, and institutional landscape. Section 2 analyses how clientelism operates in the health sector, focusing on bureaucratic appointments, budgeting, and procurement practices. Section 3 evaluates the consequences for healthcare outcomes, drawing on both performance data and qualitative accounts, and considers how contextual factors constrain or amplify the effects of clientelist governance. Section 4 concludes by summarising the main findings and situating Makassar's experience within the broader comparative framework of the study.

Figure 5.1

Makassar within South Sulawesi Province Map

Source: Open Research Repository Library, Australian National University (https://hdl.handle.net/1885/733715483).

Gateway of Growth, Arena of Brokerage: The Political Economy of Makassar

Makassar—the capital of South Sulawesi province—is strategically located on the southwestern tip of Sulawesi Island and serves as the primary metropolis of Eastern Indonesia. With a population of over 1.5 million, the city is a complex mosaic of ethnic and regional identities (Badan Pusat Statistik Kota Makassar, 2025). Dominant groups such as the Bugis and Makassarese live alongside the Torajans, Mandarese and Gorontalese communities, Chinese Indonesians, and migrants from other regions including Java, Maluku and Papua. The city's population is predominantly Muslim, reflecting the broader religious demography of South Sulawesi.

This ethnic and cultural diversity is mirrored by Makassar's long-standing role as a maritime, commercial, and administrative hub. Historically, its position as a port city made it a critical node in inter-island trade routes, connecting resource-rich regions of Eastern Indonesia with the political and economic centres of Java and Sumatra. In the post-Suharto era, Makassar's centrality has been reinforced by regional autonomy and decentralisation reforms, transforming the city into a gateway for state and private investment, and as a hub of political influence across eastern Indonesia (Buehler, 2014, pp. 162–166; Sari, 2024, pp. 198–199).

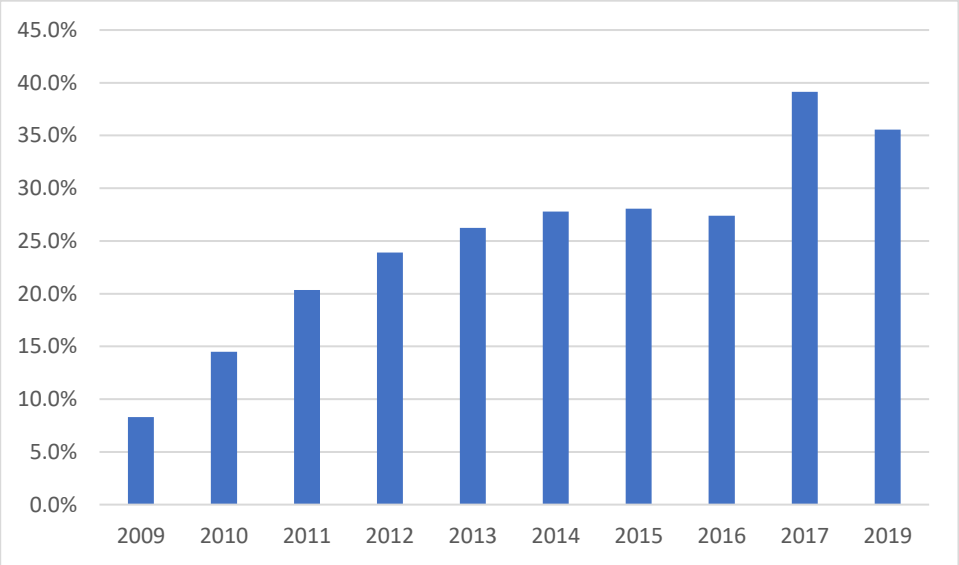
Over the past two decades, Makassar has experienced sustained economic expansion. The city has attracted significant investment in infrastructure, logistics, real estate, and industrial development. Mega-projects such as the expansion of Sultan Hasanuddin International Airport, the Makassar–Parepare railway, the Centre Point of Indonesia (CPI) coastal reclamation, and high-end commercial zones like Tanjung Bunga and Karebosi have been driven by national and local oligarchic capital, including groups such as Ciputra, Lippo, and Kalla (Alexander, 2015; Alimuddin, 2022; Buehler, 2009; Buehler & Tan, 2007; Fajar, 2022; Muin, 2019a, 2019b; Nadir, 2001; Rahmat, 2016; Sari, 2024, pp. 200–202). These developments have spurred job creation, modernised urban infrastructure, and contributed to rising human development indicators, and to the growth of the middle class in Makassar.

Makassar's fiscal architecture further reinforces this dynamic. Unlike the government of Kupang and many regions in Indonesia, the city government is notably less dependent on central transfers. Makassar has developed a strong own-source revenue base. Since 2010, Makassar's own-source revenue (*Pendapatan Asli Daerah,* PAD) has steadily increased, nearly matching the General Allocation Fund (*Dana Alokasi Umum*, DAU) it receives from the central government (see **Figure 5.2**). This fiscal independence is rooted in the city's ability to extract revenues from local taxes, charges, and business licenses. It allows greater local government discretion over how to disburse funds. Makassar's economic growth has been primarily driven by four key sectors: wholesale and retail trade, manufacturing, construction, and transportation and warehousing (Badan Pusat Statistik Kota Makassar, 2010, 2014, 2016, 2018, 2019, 2020,

2021). These sectors serve as major sources of local revenue and engines of economic growth.

Figure 5.2

Makassar's Own-Source Revenue (PAD) as Percentage of Total Revenue APBD, 2009–2019



Source: Indonesia Database for Policy and Economic Research (World Bank, 2022).

Nonetheless, central transfers—especially DAU—continue to make up more than half of Makassar's total income (World Bank, 2022). This hybrid fiscal model creates both opportunities and constraints. On one hand, the DAU provides the city with its largest and most reliable source of funding, shaping predictable patterns of public expenditure. Yet, as in Kupang, these transfers also function as political instruments. Their consistency and predictability make them well suited for clientelistic distribution, especially through staffing expansion, routine small-scale infrastructure projects and recurrent expenditures, useful for campaign-oriented programs. On the other hand, locally generated revenue (PAD) offers greater discretionary control not only of expenditure, but also over how this revenue stream is applied. Through selective application of local taxes, permits, fees and levies that constitute PAD, executives can strike political bargains with business actors, turning these revenue streams into flexible sources of patronage as well as opportunities for rent-seeking and corruption.

Makassar's economic growth has not disrupted the city's deeply embedded systems of political patronage. Instead, it has adapted to and reinforced them. Makassar exemplifies how clientelism can be strategically embedded within processes of urban development. The expansion of the city's economy has created new opportunities for elites to channel resources, distribute rents, and consolidate control. Land licensing, spatial planning, procurement, and infrastructure budgets have become key sites for the exercise of political discretion and elite negotiation (Aspinall & Berenschot, 2019, p. 14; Berenschot, 2018b, pp. 34–36). As also observed in the Kupang case and elsewhere in Indonesia, state–business collusion has enabled contractors and political operatives to profit from fragmented budgeting and project-based patronage, while poor communities are targets of vote mobilisation and micro-targeted programs.

The political economy is characterised by what this chapter terms *calibrated* or *partial clientelism*—a governance model in which local elites strategically adapt clientelistic networks to the imperatives of growth and electoral competition. In this system, local political leaders selectively insulate public service delivery—particularly in high-visibility sectors such as health and education—from overt political interference to preserve performance legitimacy and maintain citizen trust. By contrast, less visible or more pliable domains—including infrastructure, licensing, land management, and temporary employment—remain pervaded by practices of patronage, rent-seeking, and elite negotiation (Bachriadi & Aspinall, 2023, p. 331; Permana, 2024, p. 197). In effect, governance in Makassar reflects a hybrid model. Politicians pursue better service delivery to strengthen performance-based legitimacy, while simultaneously sustaining clientelistic and patronage practices to secure patronage networks essential for electoral survival and political dominance. This dual strategy helps explain why Makassar exhibits relatively strong healthcare outcomes despite the persistence of high levels of clientelism, illustrating how programmatic delivery and patronage can coexist within the same governance system.

Makassar's hybrid political order is thus not a deviation from democratic reform but a product of its uneven institutionalisation. The city's development trajectory reflects the convergence of historical brokerage traditions, oligarchic and state-led investment, and the strategic use of inequality—where disparities in wealth and service

provision are sustained to reinforce dependence on political clientelism. In the sections that follow, this chapter explores how this system has been operationalised across mayoral administrations, how it has adapted to changing political and technological contexts, and how it coexists with—and occasionally enables—strong public service outcomes.

From Aristocracy to Algorithms: Historical Legacies and Elite Transformation in Makassar

Understanding the evolution of clientelism—and specifically how patron-client relations were formed in Makassar—requires situating those practices in local historical and sociopolitical traditions. In Bugis-Makassarese society political authority was organised through customary structures dominated by the *Karaeng* and *Gallarang:* hereditary aristocrats whose power rested on martial legitimacy, kinship ties, and reciprocal obligations (Pelras, 1996, pp. 391–395). These leaders functioned not only as rulers but also as brokers of protection and access, commanding loyalty through charisma (*siri'*), performance, and social standing. As Chalbot observes in Pelras (1996, p. 399), influence in Bugis-Makassarese society combined a triad of rank (ascribed status), office (institutional role), and personality (leadership traits and delivery capacity). This configuration—where legitimacy and followership were closely tied to a leader's capacity to perform and provide tangible benefits—helps explain certain forms of personalised, reciprocal political exchange that later scholars label as a "classical form of clientelism" (Fourchard, 2023, p. 10).

This logic contrasts with patterns observed in Kupang and Semarang. In Kupang, political and customary authority has historically been anchored in inherited status and institutional proximity to the state and church, limiting the scope for continuous brokerage or performance-based claims on leadership (Tidey, 2012, pp. 96–101). While patronage relations were present, access to resources typically depended on selective and discretionary appeals rather than routinised mediation, and leaders were not expected to act as constant brokers and secure resources for followers (C. Lay & Van Klinken, 2014, pp. 150–151). In Semarang, elite authority was similarly shaped by historical traditions—most notably the Javanese *priyayi* ethos, in which legitimacy derived from bureaucratic office, cultural refinement, and inherited position rather than

demonstrated delivery. Under contemporary conditions, however, these foundations have been partially reworked through electoral competition, bureaucratic rationalisation, and performance-oriented governance, reshaping clientelistic practices into more programmatic and disciplined forms.

Despite the erosion of formal aristocratic institutions under colonial and post-independence administrative centralisation, the underlying logic of personalised authority and reciprocal loyalty has thus proven remarkably resilient. This persistence is evident beyond Makassar itself, for example, in contemporary fishing and coastal communities in South Sulawesi, where traditional forms of clientelism through relationships such as those between *ponggawa* (boat owners and traders) and the *sawi-sawi* (crew and dependants) continue to organise social hierarchy and political mobilisation. In exchange for economic protection and access to assistance, *sawi-sawi* provide labour, loyalty, and—more recently—votes (Haryanto, 2017, p. 511).

These personalised systems of clientelism were thus not eliminated under the authoritarian regime of the New Order (1967–1998) but were absorbed and modified by bureaucratic and military elites. Golkar-affiliated actors—such as Jusuf Kalla (Kalla family), Aksa Mahmud (Bosowa Group), Syahrul Yasin Limpo (Limpo family), and Nurdin Halid—preserved their influence by embedding themselves in organisations affiliated to Golkar (e.g., AMPI[21] and *Pemuda Pancasila*), business associations (KADIN, HIPMI),[22] and by using bureaucratic leverage (Buehler, 2014, p. 168; Tomsa, 2008, p. 8; and Yakub et al., 2022, pp. 303–304). Under the New Order, in Makassar as in other parts of Indonesia, civil service recruitment, licensing, and public procurement became mechanisms for maintaining loyalty and distributing patronage.

The onset of Reformasi in the late 1990s and the introduction of direct local elections in 2005 once again transformed this political landscape. Electoral reform and decentralisation opened new arenas for technocrats, civil society activists, and political

[21] AMPI: *Angkatan Muda Pembaharuan Indonesia* (Indonesian youth organisation affiliated with Golkar Party).
[22] KADIN: *Kamar Dagang dan Industri* (Chambers of Commerce and Industry), an umbrella organisation of Indonesian business chambers and associations; HIPMI: *Himpunan Pengusaha Muda Indonesia* (the Indonesian Young Entrepreneurs Association).

entrepreneurs to contest power beyond entrenched New Order structures. Yet these changes did not dismantle clientelism; instead, they rendered patron–client relations more fluid and competitive, as both incumbents and challengers were required to continually mobilise, reward, and renew political support. In Makassar, this fluidity was reinforced by an enduring logic of reciprocal obligation rooted in Bugis-Makassarese social traditions, derived from traditional social structures, which normalised the expectation that political leaders must deliver tangible benefits in exchange for loyalty. Local politics thus became characterised by a constant struggle to assemble, maintain, and reconfigure patronage networks under conditions of electoral uncertainty.

It is within this dynamic and contested environment—where long-standing traditions of personalised authority intersect with new democratic institutions—that Makassar's contemporary trajectory of clientelism has unfolded, as examined in the following sections. My effort to conceptualise the pattern of political clientelism in Makassar is guided by Tomsa's (2008, p. 8) treatment of South Sulawesi as a "mini case" of post-New Order clientelistic politics, in which personalism, factionalism, patron-client relations, and strong regional identities underpin Golkar's continued dominance. These dynamics provide a useful framework for analysing how political clientelism in Makassar has adapted rather than disappeared under democratic decentralisation.

Two Mayors, Two Patronage Architectures: Ilham and Danny Compared

Whereas the political landscape in Kupang was shaped by long-standing politico-bureaucrats and family-based networks, Makassar's politics rested on a much denser and more plural associational life, sustained by fluid and shifting patron–client ties. A wide array of organisations, formal and informal, including student organisations (HMI, KAHMI, PMII),[23] professional alumni networks, Islamic mass-based organisations such as Muhammadiyah and Nahdlatul Ulama, ethnic-based associations, and neighbourhood communities, created multiple points for entry into politics by ambitious individuals at all levels. This associational density produced a fertile intermediary market in which

[23] HMI: *Himpunan Mahasiswa Islam* (the Islamic Students Association); KAHMI: *Keluarga Alumni Himpunan Mahasiswa Islam* (the Family of Alumnae of the Islamic Students Association); PMII: *Pergerakan Mahasiswa Islam Indonesia* (the Indonesian Islamic Student Movement). These are the prominent Indonesian student organisations with a strong emphasis on both Islamic principles and nationalism).

diverse groups could act as informal political subcontractors or brokers—known locally as *peluncur*—mobilising protests, votes, and campaigns in exchange for contracts, jobs, or privileged access to municipal resources (Interview with local expert, Makassar, July 4, 2022; author's translation).

Within this environment, two figures came to define Makassar's political trajectory: Ilham Arief Sirajuddin, mayor from 2004 to 2014, and Moh. Ramdhan "Danny" Pomanto, who governed from 2014 to 2018 and again from 2020 to 2024. Both relied on brokerage politics, yet their patronage structures and clientelistic strategies diverged significantly. As one informant, a local expert, put it:

> It [the *peluncur* model] was started by Ilham Arief Sirajuddin and was refined by Danny Pomanto. HMI, KAHMI, PMII—they get regular payments and access to city assets to perform political tasks. (Interview, July 4, 2022; author's translation)

Mayor Ilham Arief Sirajuddin (2004–2014)

Ilham was first elected in 2004 through city council (DPRD) selection (the system used prior to the introduction of direct regional government head elections). His second-term victory in 2009 came under the newly introduced direct election system, where he outperformed his rivals. He states his winning playbook was based around charisma, organisational strength, coalition-building, and media leverage: "There are four keys to my success in winning the election that made me Mayor of Makassar for the second time: the power of figure, the power of team, the power of synergy, and the power of media" (Antara, 2011). He explicitly acknowledged the decisive role of publicity in amplifying his development strategies and cultivating popular legitimacy (Marewa, 2023; Sirajuddin, 2010, 2021).

Ilham's political style was deeply shaped by his family background and connections to the New Order regime. As the son of Arief Sirajuddin, a regional military officer-cum-politician who helped established the Golkar Party in South Sulawesi, Ilham inherited both political legitimacy and access to local elites in Makassar, including Golkar's extensive organisational and bureaucratic networks (Marewa, 2023). These ties

provided him with a ready-made infrastructure of top elite connections and political supporters. Once in power, Ilham expanded and adapted this inherited patronage machine to the post-*Reformasi* context, subcontracting mobilisation to student groups, alumni associations, and religious organisations, that he rewarded with contracts, jobs, and privileged access to city resources (Interview with local expert, Makassar, July 4, 2022; author's translation). Ilham's patronage architecture was vertically structured, relying on a loyal cohort of bureaucrats, contractors, and political operatives.

Once in office, he employed strategies that relied on highly visible urban transformation. Flagship projects such as the revitalisation and redevelopment of public facilities, e.g., Losari front beach and Karebosi Soccer Field, and also the reclamation of Metro Tanjung Bunga swamp land, were presented as his signature urban development projects (Gandhi, 2014; Sirajuddin, 2010). These projects helped to open more spaces for businesses (hotels, real estate, malls, stores, restaurants, etc.). He courted investors, launched high-profile infrastructure projects, and promoted Makassar as a "world class city rooted in local wisdom" (Sirajuddin, 2010, p. 1). These efforts were bolstered by partnerships with national corporations and institutions like Telkom Indonesia, which installed free public Wi-Fi along Losari Beach in 2008 as part of his "Cyber City" vision (Daniel, 2012).

These projects were widely considered to have boosted Makassar's economic growth, which surpassed 9% annually between 2008 and 20012, a rate that was above the national average (Badan Pusat Statistik Kota Makassar, 2014, p. 176; Sirajuddin, 2021). Yet they also became central channels of clientelism: local informants explain that contracts for construction, permits for businesses, and land-use concessions were tightly controlled by Ilham and his inner circle and selectively distributed to loyal allies and supporters. These are sectors where the rents are high but less accessible to public scrutiny. A local journalist explained:

> Business permits for entertainment venues were granted in violation of zoning regulations—liquour stores and night clubs were built right next to mosques or schools. The one-stop service centre was just a formality. Decisions were still made through back channels. (Interview, July 7, 2022; author's translation)

By contrast, Ilham approached the health sector with more strategic insulation. While not entirely free from patronage-based appointments or rent-seeking from procurement—particularly in high-value construction projects and medical device procurement—he selected competent officials and applied merit-based and performance-based selection/promotion in the health sector, expanded health insurance coverage to the poor, and improved compliance with minimum health service standards in public hospitals (RSUD) and *puskesmas*. He maintained a degree of technocratic authority in sectors such as health. As Ilham stated:

> The first priority as mayor is to ensure the delivery of essential services. The second is fostering economic growth. [It's a matter of] ensuring that the upper and middle class thrive while grassroots and the poor remain well-fed and cared for. (Interview, May 17, 2021; author's translation)

This reflected his calculation that visible improvements in healthcare delivery, such as ensuring adequately staffed *puskesmas* with sufficient medical supplies and medicines, strengthening RSUD capacity, and expanding access to healthcare, could translate into electoral support. In short, Ilham pursued a calibrated and hybrid form of clientelism: application of clientelism in land use, licensing, and infrastructure for resource extraction, while shielding healthcare service delivery as a domain of performance legitimacy.

Mayor Mohammad Ramdhan "Danny" Pomanto (2014–2019; 2020–2024)

Danny entered politics from outside the entrenched elite formation. Trained as an architect and contractor, he first rose to the mayoralty in 2014 with Ilham's backing (Sari, 2024, p. 203–204). Over time, however, he broke away from Ilham and set about constructing his own patronage base. Branding himself as *Anak Lorong* ("child of the alleyway") in reference to his modest family background, Danny shifted the focus of mobilisation away from established elites and middle-class constituencies toward lower-income *lorong* (alleyway) communities and neighbourhood leadership structures (RT/RW), embedding patronage at the grassroots level (Era, 2020a, 2020b; Pedoman Rakyat, 2020). Unlike Ilham, who had leaned primarily on elite networks based in

student, alumni and religious organisations, Danny fused grassroots populism with algorithmic oversight, deploying digital platforms to monitor brokers, especially community-level officials, bureaucrats, and voter behaviour. He recognised that these fragmented neighbourhood constituencies represented a crucial electoral reservoir—particularly in a context where his rivals were more deeply entrenched in elite networks, powerful family networks, and organisational infrastructure.

Danny consolidated his control through sweeping bureaucratic reshuffles and the politicisation of community leadership. A senior bureaucrat in Makassar captured the essence of Danny's clientelistic strategy after the latter won the mayoral election in 2014: "He said, I want everything 'dirty' on this table to be cleaned and sprayed, so that when people come to see it, they'll think it is clean—even if it is still dirty underneath" (Interview, August 24, 2022; author's translation). This metaphor reflected Danny's intention to purge Ilham's remaining loyalists and replace inherited patronage networks with his own (Armunanto, 2021; Rizal, 2022; Sirajuddin, 2021). He moved swiftly to consolidate executive control over both the grassroots and the bureaucracy, often bypassing formal accountability mechanisms.

This purge strategy became most evident approaching the 2018 mayoral race. Danny sought re-election against Munafri Arifuddin ("Appi")—a member of Jusuf Kalla and Aksa Mahmud's oligarchic family who also was backed by Ilham. However, Danny was disqualified by the local electoral commission (*Komisi Pemilihan Umum Daerah*, KPUD) for breaching campaign rules, specifically for distributing smartphones to neighbourhood chiefs. With only a single candidate on the ballot, the 2018 election failed to meet the minimum threshold of valid votes and had to be rerun in 2020 (Era, 2020b). The disqualification left Appi as the sole candidate, however, this did not result in his election, as more voters selected the blank slot (*kotak kosong*) on the ballot paper than voted for Appi. As a result, the election failed to produce an elected mayor, creating an unprecedented electoral impasse in which a single-candidate contest did not meet the minimum threshold of valid votes required for victory. The election was thus annulled and had to be rerun in 2020. Danny played a decisive role in this outcome, allegedly mobilising voters to abstain in 2018 as a form of protest (Aziz, 2020). When the election was repeated in 2020, he successfully converted this momentum into victory,

capitalising on widespread resentment of dynastic politics and drawing on his grassroots *lorong* networks alongside segments of the middle class to secure re-election. (Yakub et al., 2022, pp. 303–304).

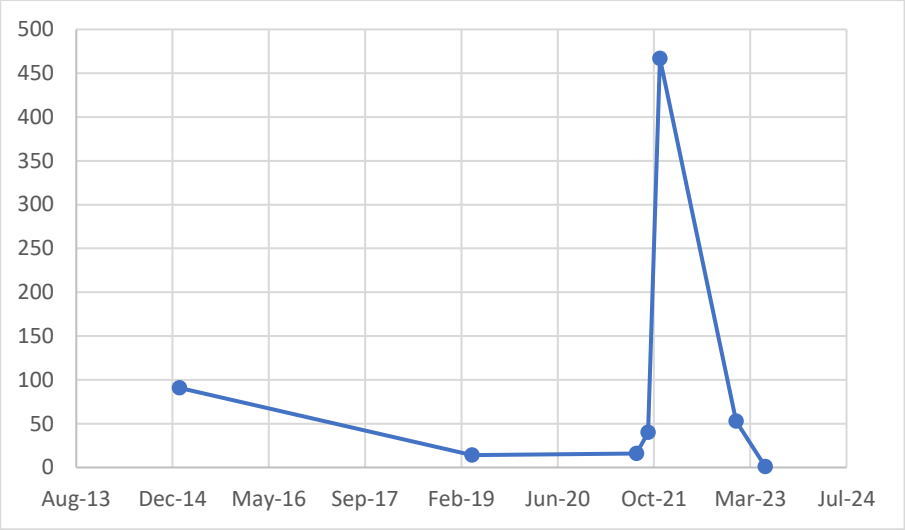
Following his return to office, Danny moved aggressively to reconfigure local power structures. In 2022 alone, more than 5,900 RT/RW leaders were dismissed and replaced, often on the basis of political loyalty to the mayor (Munsir, 2022; Azis, 2019). These interventions were reinforced by significant increases in RT/RW honoraria—they went up from as little as IDR 100,000 (approximately equal to AUD 10) per month under Ilham to up to IDR 1–2 million (approximately equal to AUD 100–200) per month under Danny (N. Dg Empo, personal communication, July 4, 2022). At the same time, digital platforms such as *Bassi Barania*[24] and the "War Room," which Danny officially promoted as innovations in smart governance, functioned in practice as surveillance tools. These platforms were used to monitor the performance of RT/RW heads in mobilising voters and political support in neighbourhoods, as well as to track the performance of his electoral campaign teams (*tim sukses/ timses*), thereby exerting pressure to secure and enforce political loyalty (Latif, 2020; Nawawi, 2022).

A similar pattern of control and monitoring also emerged within the city government administration. As shown in **Figure 5.3**, staff movements (*mutasi*) within the Makassar civil service from 2015 to 2023 display a pronounced spike in 2021–2023 following Danny Pomanto's re-election, indicating the heightened political salience of bureaucratic reshuffles. Middle- to senior-level civil service positions were used to reward political supporters within the bureaucracy and to sideline officials perceived as having failed to mobilise electoral support.

[24] *Bassi Barania* is a mobile application used to monitor the contributions of campaign teams and brokers at the grassroots level in securing voters for Danny, which often times involved the bureaucrats *(lurah* and *camat).* These teams are tasked with the goal of collecting 250 "PIN" or ID cards for each RT/RW head from their neighbours and relatives, which serve as a token of support for Danny's candidacy. Upon achieving this target, they are rewarded with contracted government jobs at the *Kelurahan* offices for their family members (Anonymous, personal communication, July 3, 2022).

Figure 5.3

Staff Movements (Mutasi) in the Makassar City Government, 2015–2023



Source: Author's analysis from various online newspapers, 2015 to 2023.

In the health sector, Danny employed strategies that blended programmatic policy initiatives with political clientelism, and which were closely tied to his grassroots mobilisation agenda. His flagship program was *Dottoro'ta Home Care* (launched in 2016), which expanded mobile healthcare through the *puskesmas* network and initially won national acclaim (Hasanuddin, 2023). Yet field informants noted that its quality declined over time as resources were redirected toward initiatives with greater political returns (Interview with DPRD member, Makassar, July 3, 2022; author's translation). Similarly, *Lorong Wisata* or "alleyway tourism" was promoted as a pro-poor initiative to beautify alleyways and so stimulate small-scale entrepreneurship and local tourism in 2021–2024. In practice, however, its implementation was unsustainable and often coercive. Several former *lurah* (ward heads) and *camat* (subdistrict heads) reported being pressured to finance the projects from their own resources and threatened with demotion if they failed to meet targets (Interview, July 4, 2022; author's translation).

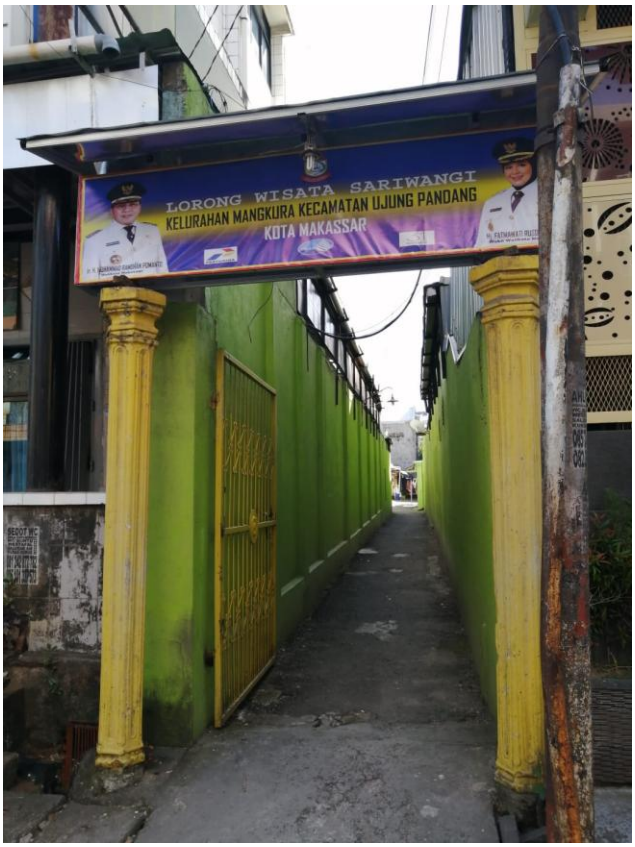
Though both Ilham and Danny relied on the basic strategies of political clientelism, they differed markedly in how they structured and deployed their patronage machines. Ilham leaned primarily on elite and organisational networks, while selectively insulating key sectors such as health to project technocratic competence and

programmatic delivery. Danny, by contrast, reoriented patronage toward grassroots neighbourhood structures and increasingly politicised health programs themselves as instruments of electoral mobilisation and control.

Taken together, the shift from Ilham's calibrated insulation—where health was preserved as a showcase of performance while rents were extracted from land, licensing, and infrastructure—to Danny's politicisation of health illustrates how Makassar's clientelism evolved into a more dispersed and extractive model. This trajectory positions Makassar between Kupang's entrenched, all-encompassing patronage and Semarang's more disciplined, programmatic governance. The critical question that follows is how this distinct patronage architecture shaped not only the politics of resource allocation but also the quality, accessibility, and equity of healthcare service delivery and outcomes across the city.

Figure 5.4

Photograph of a Lorong in Makassar



Source: Author's photograph, taken on July 2, 2022. Location is at Sawerigading Street, Makassar.

This trajectory in Makassar contrasts sharply with the patterns observed in Kupang and Semarang. In Kupang, clientelism has long been pervasive and unrestrained, with the health sector treated as a routine site for patronage and rent-seeking. Political elites in Kupang distribute positions across all levels of the health bureaucracy, just as in other sectors, with little regard for performance or visibility. The lack of institutional capacity and oversight has meant that no meaningful insulation of the health sector has ever been sustained. In contrast, Semarang, as we shall see in the next chapter, exemplifies less clientelistic governance and more programmatic politics, with PDI-P maintaining relatively centralised control over appointments and patronage distribution but preserving programmatic delivery in core sectors like health. Makassar, occupying a middle position, demonstrates how clientelist systems can shift over time: from a hybrid model that initially insulated high-visibility sectors like health, to one in which even

these sectors are increasingly politicised and monetised. The erosion of this insulation in Danny Pomanto's second term highlights the growing pressures on political elites to extract and redistribute resources from all available sectors, especially as electoral competition intensifies and discretionary tools expand.

Clientelism in Practice: Governing Health Services in Makassar

If Kupang's health sector governance has been characterised by entrenched kinship-based patronage and bureaucratic capture, Makassar presents a contrasting case of partial clientelism and hybrid governance. Here, patronage is selectively embedded within formal administrative systems, often masked by a discourse of innovation and technocratic performance. This pattern was particularly evident under the administrations of Ilham Arief Sirajuddin and Danny Pomanto, whose strategies reveal both continuities and significant shifts in how clientelism intersects with healthcare. Unlike Kupang, where clientelism permeates nearly all aspects of governance, or Semarang, where party discipline imposes programmatic constraints, Makassar represents a middle ground—where programmatic policies coexist with embedded but selectively activated clientelist strategies.

This analysis follows the same structure applied to Kupang. It begins with an overview of the health system—its institutional structure, funding patterns, and political salience. It then examines three key domains through which clientelism manifests: staffing, budgeting/spending, and procurement. The discussion traces how Ilham and Danny each leveraged these subsystems differently. Ilham by insulating parts of the health sector to project technocratic performance while extracting rents elsewhere, and Danny by politicising health programs in his later years of his administration to facilitate grassroots mobilisation. Finally, the section evaluates the broader consequences for service quality, equity, and responsiveness, situating Makassar comparatively between Kupang's entrenched patronage and Semarang's more disciplined governance.

Overview of the Health Sector in Makassar: Strategic Importance and Political Visibility

The health sector in Makassar occupies a strategically important position within local governance, both as a core public service and as a politically visible domain of electoral appeal. In line with national mandates, the city government allocated between 10% and 12% of its budget to health between 2015 and 2019, just meeting the minimum statutory requirement (Kementerian Keuangan, 2012b, 2013b, 2014b, 2015b, 2016b, 2017b, 2018b, 2019b, 2020b). In absolute terms, health allocations rose sharply: per capita spending increased nearly tenfold, from IDR 48,088 (around AUD 4.50) to IDR 467,907 (equal to AUD 45) in 2019 (Dinas Kesehatan Kota Makassar, 2021; Dinas Kesehatan Kota Makassar, 2015; Dinas Kesehatan Kota Makassar, 2016; World Bank, 2022). Yet residents' out-of-pocket health spending remained comparatively high, averaging over IDR 500,000 annually (equal to AUD 50) (World Bank, 2022).

Local budget funding patterns reveal heavy dependence on central transfers, although not as high as Kupang. In 2015, 64% of health financing derived from the general allocation fund (DAU) and special allocation grants (DAK) (World Bank, 2022). While these transfers enabled programmatic expansion—including *puskesmas* renovation/expansion, health insurance premium subsidies, and flagship programs like *Dottoro'ta Home Care*—they also created opportunities for elite brokerage, politically motivated distribution and patronage-based contracting.

Institutionally, healthcare service is organised through the *Dinas Kesehatan*, the city-run hospital (RSUD Daya), and a network of 46 *puskesmas* and *pustu* distributed across all *kecamatan* (subdistricts) and *kelurahan* (urban wards). Compared to Kupang's more limited network, Makassar's system is expansive, active and therefore politically salient. *Puskesmas* are visible touchpoints for citizens and thus attractive targets for politicians seeking electoral returns.

Staffing: Patronage, Loyalty, and Selective Insulation

Staffing patterns in Makassar reveal both continuity and divergence across mayoral regimes. Under Ilham Arief Sirajuddin, political loyalty shaped senior appointments, but he also selectively insulated the *Dinas Kesehatan* and RSUD Daya by

appointing competent officials capable of performing national minimum health service standards and expanding the access to healthcare services, using the national health insurance system and a local insurance scheme (Dinas Kesehatan Kota Makassar, 2013; Dinas Kesehatan Kota Makassar, 2012). He appointed the head of the *Dinas Kesehatan* from among individuals close to his family circle, yet the selected official was able to implement technocratic and programmatic policies without significant political interference (Interview with Andi Armunanto, Makassar, June 10, 2021; author's translation).

During Ilham's administration, there were no reports of irregular staffing reshuffles within the Health Office, and if patronage-based appointments did occur, they were minimal and largely confined to contract or non-permanent positions. Informants also noted that such allocations were often mediated by members of the DPRD, while executive appointments within city offices typically remained at the mayor's discretion. Similarly, Danny Pomanto's administration appointed key government officials from among his loyalists, using promotions as rewards for supporters while removing those he perceived as disloyal. He frequently reshuffled positions to consolidate control, making bureaucratic turnover a central feature of his governance.

Although lower- and mid-level civil service appointments in the health sector were less directly affected, Danny systematically expanded the use of contract-based staff as a patronage instrument, distributing temporary positions, such as *honorer* staff across various government offices, including the Health Office. As discussed earlier, he also intervened in the selection of RT/RW leaders, effectively placing them under mayoral control by replacing thousands of RT/RW leaders with his supporters and significantly increasing their honoraria by drawing on city government funds. In the health sector, these practices manifested in politically driven recruitment of contract staff for labour-intensive programs presented as health innovations—most notably the COVID-19 Detector task force, which blurred the line between service delivery and electoral mobilisation.

Budgeting and Spending: Health as Showcase and Political Arena

Whereas in Kupang the health budget was treated primarily as a discretionary resource for patronage that was routinely captured by mayors and their networks with little insulation for programmatic goals, in Makassar it played a more complex and hybrid role. Here, the health sector functioned simultaneously as a public showcase of performance and as an arena where there was selective application of patronage politics.

Under Ilham Arief Sirajuddin, fiscal strategy reflected this hybrid model. On the one hand, he invested in highly visible social and health programs, such as free ambulance services, subsidised health insurance premiums, improvements of healthcare facilities, and one-stop licensing centres, to project technocratic legitimacy. On the other, he maintained tight elite control over high-rent domains like land use, licensing, and construction (Interview with local expert, Makassar, July 7, 2022; author's translation). During his administration, health budgets were channelled largely toward programmatic goals, including the renovation of RSUD Daya and the integration of the local health insurance scheme (*Jaminan Kesehatan Daerah, Jamkesda*) with the national health insurance scheme (JKN). By allowing a degree of bureaucratic autonomy and selecting competent health officials, Ilham selectively insulated it from overt patronage to safeguard his reformist image and electoral legitimacy.

Danny Pomanto, however, turned health spending far more explicitly into a political instrument. His flagship *Dottoro'ta Home Care* program, once celebrated for extending mobile services through the *puskesmas* network, was poorly maintained, with resources increasingly redirected elsewhere over time. My field visits found that some mini ambulance vehicles were broken or poorly maintained only six years after the program's launch, and that hotline services were often difficult to reach. Instead, Danny launched a series of new initiatives under the banner of *Makassar Recover* during the COVID-19 pandemic, which became a vehicle for distributing short-term, labour-intensive contracts to political supporters and campaign workers (Interview with local expert, June 16, 2022; author's translation). As noted earlier, thousands of "COVID-19 detectors" were recruited to conduct door-to-door visits in *lorong* communities, while

residents were mandated to download the *Recover* app—officially presented as a health registry but widely perceived as functioning simultaneously as a citizen surveillance mechanism (Mappiwali, 2021; Taufiqqurrahman, 2021). I argue that, in practice, these instruments were also used as mechanisms for distributing patronage through short-term employment ad service contracts. The so-called "detectors" were predominantly recruited from members of Danny's mayoral campaign teams. Several informants openly acknowledged that these positions were distributed as rewards to his campaign teams, as confirmed by Danny's former campaign team, Daeng Empo and his wife, Wani (Interview with D. Empo and Wani, Makassar, July 22, 2022; author's translation).

Figure 5.5

Photograph of a Makassar Recover Centre in a Shipping Container

Source: Author's photograph, taken on July 11, 2022 in Makassar.

Figure 5.6

The Launch Event of Satgas Detektor in Makassar

Source: Antara Foto (Abhe, 2021).

Some members of the local parliament were against the mayor's spending on Makassar Recover and assesssed it as a failed program and waste of money. As one DPRD member, Hamzah Hamid, explained:

> We know the Makassar Recover recruited many people from his [Danny's] campaign teams. I and our faction in PAN [National Mandate Party] consider it as a failed program. It consumed a large budget, but if it's claimed to have handled COVID, other regions also managed to be free of COVID without spending as much as Makassar did. (Interview, July 22, 2022; author's translation)

Although many residents refused home visits under the *COVID-19 Detektor* program, the mayor responded by enforcing compliance through the introduction of a digital surveillance component, reinforcing the appearance of popular uptake of the initiative. Residents were obliged to download the app in order to obtain a QR code which granted them access to essential services. Individuals who failed to comply were reportedly denied entry to public buildings, hospitals, and even shopping centres (Mappiwali, 2021).

Taken together, both mayors used health spending as a showcase for political legitimacy, but in different ways. Ilham deployed the health sector to demonstrate technocratic performance, whereas Danny more overtly transformed health programming into a vehicle for political mobilisation. Despite these contrasts, both approaches reinforced the sector's strategic importance as a highly visible arena for legitimacy-building. Yet beyond its symbolic and programmatic functions, health also served as a lucrative site for patronage. High-value contracts for infrastructure, equipment, and pharmaceuticals opened discretionary spaces where rents could be extracted and distributed to loyalists—transactions that were less visible to the public than headline-grabbing allocations for ambulances or home-care initiatives. Unlike Kupang, where the entire health budget was the primary target of capture, in Makassar the more focused source of rent-seeking lay in procurement and the medical supply chain.

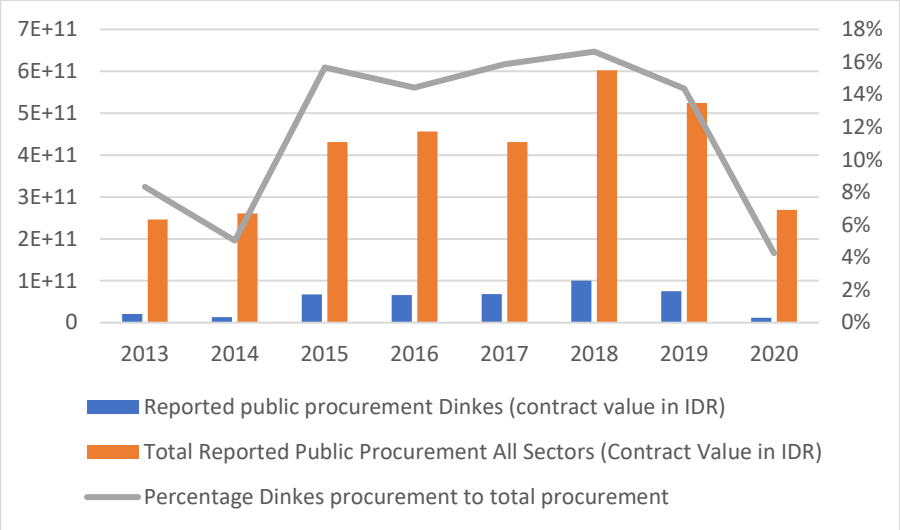
Procurement and the Medical Supply Chain: Hidden Arenas of Rent-Seeking/Corruption

Health procurement under Danny Pomanto illustrates how programmatic innovations could coexist with entrenched rent-seeking/corruption. Data from Indonesia Corruption Watch's *Opentender* platform shows that between 2015 and 2019, the share of health-related procurement rose from 5% to 14% of total city procurement, even as public procurement managed directly by the RSUD declined from 10% in 2014 to 1% in 2016.[25] Spending became increasingly concentrated within the *Dinas Kesehatan*, where between 2013 and 2019 *puskesmas* renovation and expansion consistently absorbed the largest share of procurement—ranging from 42% to 91% of the annual budget—followed by medical equipment purchases, as shown in **Figure 5.7** (Indonesia Corruption Watch, 2022). RSUD Daya alone devoted between 44% and 72% of its procurement funds to medical equipment between 2013 and 2016.

[25] No data found for 2017–2020.

Figure 5.7

Reported Public Procurement in Dinas Kesehatan (Dinkes), 2013–2020



Source: Author's own analysis from Opentender.net (Indonesia Corruption Watch, 2022).

This growing concentration of health construction spending created a fertile ground for corruption, with the 2020 RSUD Batua construction scandal standing out as an emblematic case. The project involved inflated pricing and manipulated tendering, and the head of *Dinas Kesehatan*—initially regarded as a loyalist under Ilham Arief Sirajuddin and later retained under Danny Pomanto—was arrested along with twelve others, including the contractor, bureaucrats, and consultants (Fatir, 2023; Mappiwali, 2022). Several informants suggested that the head of *Dinas Kesehatan* was less a mastermind than a political scapegoat, caught in a broader elite struggle over lucrative contracts. The central contractor, Andi Erwin Hatta Sulolipu, was not only a businessman but also served as campaign security chief for Danny Pomanto. As a local journalist said, "He was more than just a contractor; he was a political imperative" (Interview, July 19, 2022; author's translation). The project not only inflicted state losses amounting to IDR 22 billion (approximately AUD 2 million) but also left RSUD Batua half-constructed and effectively abandoned, symbolising both fiscal waste and governance failure (see **Figure 5.8**). The Batua case thus reveals how health infrastructure projects were repurposed as patronage and rent-seeking enclaves.

Figure 5.8

Photograph of the Abandoned Construction Site at RSUD Batua

Source: Picture taken from Sindonews (F. Mustafa, 2021).

Alongside the Batua scandal, procurement dynamics were further shaped by the rise of a dominant, monopolistic actor in the regional medical supply chain: Imelda Obey, widely known as *Ratu Alkes* (the "Queen of Medical Equipment"). A Chinese-Indonesian businesswoman, she is the daughter of Anton Obey, a prominent medical equipment distributor in Eastern Indonesia and South Sulawesi. Imelda was also known for her close ties to regional elites, as reported by Ali (2021) and Transsulawesi (2019). An investigative journalist in Makassar described how her networks consolidated influence over medical procurement in the region, including by securing contracts through proxy companies, manipulating bid qualifications, and offering upfront kickbacks of up to 10 % (Interview, July 7, 2022; author's translation). Her privileged access to public procurement was reportedly facilitated by senior bureaucrats, politicians, and law enforcement officials, and she was known to approach mayoral candidates ahead of elections to guarantee protection of her business activities regardless of the electoral outcome. Despite being named in corruption probes and in cases investigated by the Corruption Eradication Commission in 2021, as reported by Fajar (2021) and illustrated in **Figure 5.9**, Imelda Obey has consistently evaded prosecution.

Figure 5.9

A Newspaper Article Titled: "KPK Investigates Bribery by Medical Equipment Tycoon"

KPK Dalami Suap dari Juragan Alkes

Lanjutan Halaman 1

Beberapa nama yang diang-gap dekat dengan Gubernur Sulsel nonaktif Nurdin Abdullah pun diperiksa. Salah satunya, Imelda Obey.

Pemilik PT Naura Permata Nusantara dan PT Inaho Jaya Lestari dikenal sebagai penguasa tender alat kesehatan (alkes) di Sulsel. Dua perusahaan miliknya sering memenangkan pelbagai tender alkes.

Penelusuran di website Layanan Pengadaan Secara Elektronik (LPSE) sejak 2018, PT Naura Permata Nusantara memenangkan tiga proyek pengadaan alkes. Ketiganya yakni proyek alkes di RSUD Haji Pemprov Sulsel.

Pengadaan alkes dari dana APBD Pemprov Sulsel tahun anggaran 2018 dengan nilai pagu Rp18,65 miliar dan HPS Rp18,65 miliar. Nilai penawaran Rp18,63 miliar.

Kemudian pengadaan sistem integrasi ruang operasi RSUD H Andi Sulthan Daeng Radja Kabupaten Bulukumba. Dana berasal dari APBD Bulukumba Tahun 2019 dengan nilai pagu Rp12,9 miliar. Nilai HPS Rp12,89 miliar. Sedangkan nilai penawaran Rp12,3 miliar

Paket ketiga adalah pengadaan gedung ruang ICU RSUD KH Hayyung. Dananya berasal dari APBD Kabupaten Selayar dengan Pagu Rp7,3 miliar dan HPS Rp7,08 miliar. Penawarannya Rp6,9 miliar.

Perusahaan kedua Imelda yakni PT Inaho Jaya Lestari tersebut memenangkan dua kali proyek alkes. Pertama, pengadaan alat kedokteran, kesehatan dan KB di Rumah Sakit Ibu dan Anak Pertiwi Sulsel tahun anggaran 2010.

Nilai pagu Rp1,96 miliar dan nilai HPS Rp1,96 miliar. Sedangkan nilai penawaran Rp1,954 miliar.

Proyek kedua yakni pengadaan alat kedokteran, kesehatan dan KB di Rumah Sakit Nene Mallomo Kabupaten Sidrap pada APBD 2012. Nilai Pagu Rp14,437 miliar, nilai HPS Rp14,435 miliar dan nilai penawaran Rp14,414 miliar.

Juru Bicara KPK Ali Fikri mengatakan, ada lima orang saksi yang dijadwalkan diperiksa, Selasa, 8 Juni. Mereka dana korupsi kasus suap perizinan dan pembangunan infrastruktur di lingkungan Pemprov Sulsel Tahun Anggaran 2020-2021.

"Mereka adalah Kwan Sakti Rudy Moha, Herman Sentosa, Imelda Obey, La Ode Darwin, dan Arief Satriawan. Kelimanya diperiksa di Kantor Dit Reskrimsus Polda Sulsel," kata Ali Fikri dalam keterangan persnya, Selasa 8 Juni.

FAJAR menghubungi Imelda Obey untuk konfirmasi pemanggilannya oleh KPK. Namun, panggilan melalui nomor telepon seluler-nya tak direspons. Pesan melalui aplikasi WhatsApp juga tak dibalas. **(edo/rif-ham)**

Ketua DPD Gabungan Perusahaan Ekspor Indonesia (GPEI) Sulselbar, Arief R Pabettingi juga mengeluhkan, naiknya sewa kontainer. Khususnya ke negara Amerika Serikat, Australia, dan Eropa.

Dia mencontohkan, bia-

5 Jerman

TUMBUH -45,91%
- 2020: 1.658
- 2021: 897

TUMBUH -45,18%
- Nilai (USD)
- 2020: 4,13 juta
- 2021: 5,99 juta

6 Rusia

TUMBUH -65,30%
- Volume (Ton)
- 2020: 367,42
- 2021: 609,54

TUMBUH -51,51%
- Nilai (USD)
- 2020: 3,36 juta
- 2021: 5,09 juta

Sumber
Dinas Perdagangan Sulsel

Jalur KA M

Source: This article reported allegations of corruption implicating Imelda Obey, sourced from *Fajar* (2021).

The Batua scandal and the rise of the *Ratu Alkes* illustrate how procurement in Makassar, despite being publicly framed in the language of innovation and reform, could operate as a concealed arena of clientelism. While visible health programs such as *Dottoro'ta Home Care* or *Makassar Recover* projected legitimacy to citizens, procurement flows created discretionary rents that bound contractors, bureaucrats, and political elites. These processes, largely invisible to the public, were nonetheless central to financing electoral mobilisation and sustaining patronage coalitions, underscoring the hybrid character of health governance in the city.

Unlike Kupang, where procurement capture is pervasive across sectors and levels, or Semarang, where tighter oversight and party discipline impose stronger constraints, Makassar illustrates a hybrid configuration: pockets of procurement—such as health infrastructure and large-value medical equipment—remain highly vulnerable to patronage and rent-seeking, even as programmatic expansion continues in parallel. Within this configuration, Mayor Ilham largely relied on selective insulation at the sectoral level. Danny Pomanto, by contrast, shifted the approach to politicise some pockets within the health sector, like health infrastructure procurement and COVID-19

programming as areas for patronage. This contrast underscores how Makassar's health governance evolved from Ilham's calibrated insulation to Danny's more dispersed and extractive model, highlighting both continuity and intensification in clientelism in the health sector.

From Coverage to Control: Navigating Clientelism in Primary and Referral Healthcare Services

In contrast to Kupang's neglect and Semarang's relative programmatic discipline, Makassar displays a hybrid pattern. Primary care, referral services, and health insurance access expanded significantly under Ilham Arief Sirajuddin and Danny Pomanto, yet this expansion was closely intertwined with clientelism in selected arenas. Health programs functioned simultaneously as showcases of performance legitimacy and vehicles for political mobilisation, with service delivery shaped by a mix of technocratic insulation, grassroots patronage, and selective rent-seeking in health construction/infrastructure projects—particularly under Danny Pomanto.

Primary Care and Public Health Services

Under Ilham's administration (2004–2014), primary care—particularly *puskesmas* and public health programs—was relatively insulated from overt patronage. He invested in the renovation of RSUD Daya and the expansion of the *puskesmas* network, while also integrating the city's local health insurance scheme into JKN. Competent officials were promoted within *Dinas Kesehatan* and RSUD Daya, and services such as free ambulance provision helped project an image of technocratic governance (Interview with local expert, Makassar, July 7, 2022; with former senior staff of RSUD Daya, July 8, 2022; and with another local expert, Makassar, December 29, 2022; author's translation). This insulation meant that, compared to Kupang, Makassar's primary care network was better resourced and more consistent in meeting minimum health service standards.

Danny Pomanto (2014, 2018, 2020–2025), by contrast, politicised community-based healthcare by embedding it in his grassroots patronage strategy. Programs such as *Dottoro'ta Home Care*, which initially won national acclaim for extending mobile services

through *puskesmas* (Hasanuddin, 2023), were gradually undermined as resources were redirected to more electorally rewarding initiatives (Interview with DPRD member, July 3, 2022). Similarly, the *Lorong Wisata* program, marketed as pro-poor alleyway revitalisation, placed pressure on *lurah* and *camat* to self-finance activities, under threat of demotion if targets were not met (Interview with former *lurah,* Makassar, July 4, 2022; author's translation), placing pressure on their ability to direct resources and energy toward healthcare programs.

Crucially, Danny reconfigured neighbourhood structures into a vertically integrated patronage machine. He replaced nearly 6,000 RT/RW leaders with loyalists in 2022, and their honoraria were raised tenfold—from IDR 100,000–150,000 under Ilham to up to IDR 2 million per month (Interview with N. Dg Empo & Wani, Makassar, July 4, 2022; author's translation). Community health volunteers/cadres (*kader kesehatan*), often the wives of RT/RW leaders, were drawn into these networks, transforming community health outreach into a channel for both service delivery and political consolidation.

In contrast to Kupang—where cadres were neglected and *posyandu* networks withered—Makassar's cadres were actively politicised and linked to the mayor's campaign infrastructure. This mobilisation was underpinned by a comparatively dense network of health facilities. By 2023, the city operated 47 *puskesmas* across all *kecamatan*, alongside *pustu* and *poskeskel* (Badan Pusat Statistik Kota Makassar, 2023). This represented a higher level of coverage than Kupang, with roughly one *puskesmas* per 18,000 residents, surpassing the national benchmark of one per 30,000 by a considerable margin.

The deployment of *posyandu* volunteers illustrate how clientelism can repurpose service delivery at the community level in Makassar. Unlike in Kupang—where neglect left less than half of *posyandu* active—Makassar's *posyandu* remained both relatively numerous and active, but their functioning became closely tied to politics. As mentioned above, many community health volunteers (*kader posyandu*) are the wives of RT/RW leaders, themselves handpicked by the mayor's office. This created vertically integrated patronage chains, in which *kader* not only delivered maternal and child health programs

but also acted as brokers for electoral mobilisation. As one civil society activist noted: "In Makassar, *kader posyandu* are no longer just volunteers; they are part of the RT/RW [political] machine. Their loyalty is to the mayor, not the community" (Interview, July 3, 2022; author's translation). **Table 5.1** shows the distribution of *puskesmas* per 20,000 residents and distribution of *posyandu* per subdistrict in Makassar in 2019.[26] This data highlights Makassar's relative advantage in coverage, but interviews and site visits suggest persistent disparity between central urban and remote (islands) areas within Makassar, particularly in terms of staff quality and service readiness.

Table 5.1

Puskesmas and Posyandu Distribution Across Subdistricts in Makassar (2019)

Subdistrict	**Population**	***Puskesmas***	**Ratio of *Puskemas*/ 20,000 population**	***Posyandu***
Mariso	60,499	3	1	52
Mamajang	61,452	2	0.65	60
Tamalate	205,541	4	0.2	90
Rappocini	170,121	4	0.47	121
Makassar	85,515	3	0.7	92
Ujung Pandang	29,054	1	0.7	32
Wajo	31,453	2	1.3	35
Bontoala	57,197	2	0.7	55
Ujung Tanah	35,534	2	1.12	37
Kepulauan Sangkarrang	14,531	2	2.75	13
Tallo	140,330	3	0.4	85
Panakkukang	149,664	4	0.53	81
Manggala	149,487	5	0.67	83
Biring Kanaya	220,456	5	0.45	108
Tamalanrea	115,843	5	0.86	66
Total	**1,526,677**	**47**		**1,010**

Source: Author's analysis based on data from Dinas Kesehatan Kota Makassar (2021 and 2021).

[26] The number of *puskesmas* remains the same in 2023.

Referral Healthcare Services, Private Sector Engagement, and Healthcare Insurance (JKN) Access

Makassar's referral care landscape is more plural than Kupang's, with service delivery shaped by a mix of public and private hospitals. The city government manages RSUD Daya, while provincial and national institutions oversee larger facilities including type B and A hospitals. Alongside these, a dynamic private sector has expanded, including Siloam Makassar and a range of mid-tier hospitals, some of which are linked to political and business elites. As shown in **Table 5.2** Makassar hosts 28 referral hospitals: one city-run, four province-run, two under the Ministry of Health, one university-affiliated, one police-run, and the remainder privately operated. Among the private hospitals, several are controlled by prominent companies owned by national oligarchic families, including RS Islam Faisal (Kalla Group), RS Primaya (Saratoga Investama/Sandiaga Uno), and RS Siloam (Lippo Group/Riady family) (Adventy, 2022; Andrian, 2022; Fajar, 2022; Hema, 2022; Jurnal Asia, 2017; Kumparan, 2022b; Siloam International Hospitals Tbk., 2021).

Table 5.2

List of Hospitals in Makassar (2025)

No	Hospital Name	Owner/Management	Type
1	RSUD Daya	city government	Public Hospital (B)
2	RSUD Haji Makassar	provincial government	Public Hospital (B)
3	RSUD Labuang Baji	provincial government	Public Hospital (B)
4	RSUD Sayang Rakyat	provincial government	Public Hospital (B)
5	RSUP Dr. Wahidin Sudirohusodo	Ministry of Health	Public Hospital (A)
6	RS Mata Kemenkes RI	Ministry of Health	Eye Hospital
7	RS Universitas Hasanuddin	Hasanuddin University	Education Hospital (B)
8	RS Ibnu Sibna Makassar	Private	Public Hospital
9	RS Hikmah	Private	Public Hospital
10	RS Umum Luramay	Private	Public Hospital
11	RS Grestelina	Private	Public Hospital
12	RS Restu Makassar	Private	Public Hospital
13	RS Stella Maris	Private	Public Hospital
14	RS Primaya	Primaya Group	Public Hospital
15	RS Sitti Khadijah	Private (Muhammadiyah)	Public Hospital
16	RS Bhayangkara Polda Sulsel	Indonesian National Police	Special Hospital (police)
17	RSIA Catherine	Private	
18	RSIA Ananda	Private	

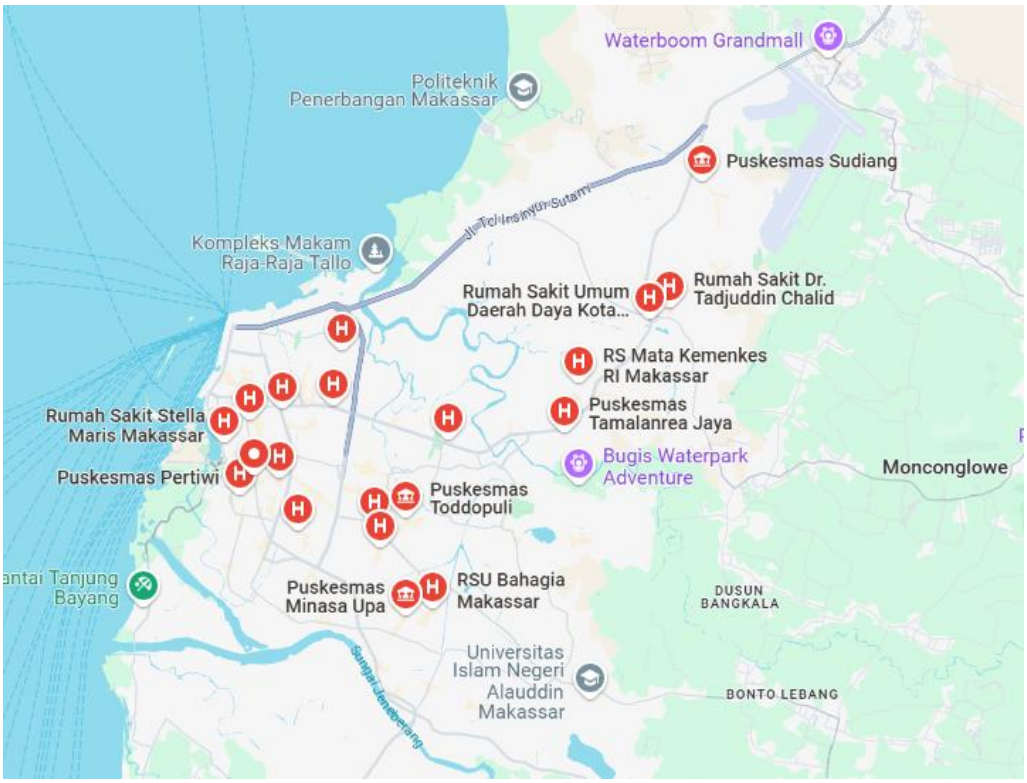
19	RS Booth	Private	
20	RS Bersalin Permata Hati	Private	
21	Pelamonia	Private	
22	RS Sandi Karsa	Private	
23	RS Fajar Medika Nusantara	Private	
24	RS Hermina Makassar	Private	
25	RS Mitra Husada	Private	
26	RS Islam Faisal	Kalla Group	
27	RS Siloam	Lippo Group	
28	RS Khusus Daerah (RSKD Dadi)	provincial government	mental health

Source: Author's analysis based on field observations, cross-referenced with Google Maps, Health Sector Profiles, and verified through individual hospital websites, accessed on 1 July 2025.

Figure 5.10 maps the spatial distribution of healthcare facilities in Makassar. While *puskesmas* are evenly distributed across the urban centre and remote islands, private clinics and hospitals cluster in urban centres, where middle- and upper-class neighbourhoods are concentrated, reflecting market segmentation. This pattern mirrors Kupang, where private hospitals are concentrated in urban centres and primarily serve elite populations, but contrasts with Semarang, where integration between private and public providers is more institutionalised and service provision is less segmented.

Figure 5.10

Healthcare Facilities Mapping in Makassar (in Red Circles)



Source: Taken from Google Maps, accessed August 24, 2024.

Makassar's growing middle class, buoyed by local economic expansion, has further increased demand for higher-quality healthcare and accelerated the shift toward private providers. On paper, the city's referral network appears relatively robust, supported by a diverse mix of public, private, and specialist institutions. Yet this strength masks persistent spatial disparities. Residents of geographically isolated areas in Kepulauan Sangkarrang (Sangkarrang Islands) continue to face severe barriers to hospital access, underscoring persistent spatial inequalities in referral care (Interview with local expert, July 5, 2022; author's translation). With no referral hospitals located on the islands and unreliable sea transport, hospital access remains highly uneven—illustrating how Makassar's plural system, though more resource-rich than Kupang's, still reproduces inequalities rooted in geography and class.

Healthcare Insurance Access and Market Competition in Makassar

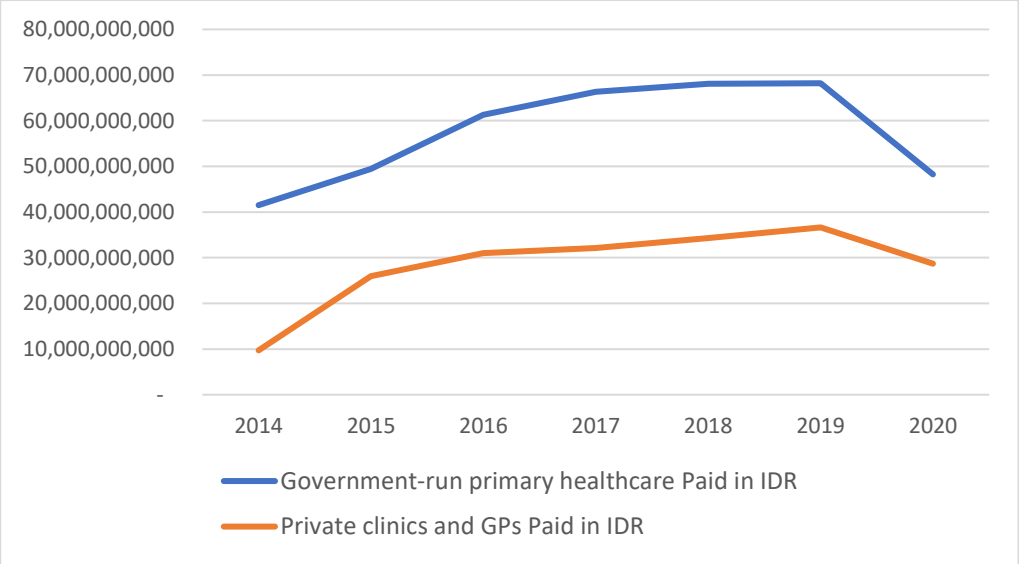
The plural referral landscape in Makassar intersects directly with the rollout of the national healthcare insurance scheme (JKN). Makassar's healthcare access and insurance coverage rank among the highest in Eastern Indonesia. By 2021, enrolment in the JKN had reached 96%, up from 70.95% in 2015 (Dinas Kesehatan Kota Makassar, 2021; Dinas Kesehatan Kota Makassar, 2016). This expansion reflects not only the effective implementation of national policy but also strong local political commitment, with successive mayors subsidising premiums for low-income residents outside the national scheme. Unlike Kupang, where the local health insurance scheme (*Jamkesda*) persisted as discretionary resource for elites, Makassar phased out its city *Jamkesda* program to fully integrate with JKN—closing off opportunities for politically mediated enrolment.

Yet high aggregate enrolment figures conceal persistent inequalities. As noted earlier, residents of remote islands in Kepulauan Sangkarrang, including Pulau Kodingareng and Pulau Barrang Lompo, remain underserved. On paper, these populations are covered by JKN, and the ratios of primary care facilities—*puskesmas* and *pustu* networks—as well as health workers, particularly general practitioners, nurses, and midwives, appear adequate according to the city's health sector profile (Dinas Kesehatan Kota Makassar, 2021). In practice, however, they continue to face structural and spatial exclusions as observed during my fieldwork.

The integration of private providers into the JKN system has reshaped the city's healthcare market. Capitation payments to private general practitioners and primary care providers rose steadily between 2014 and 2020, eventually surpassing those received by public providers (see **Figure 5.11**). Although these payments are modest, they offer predictable revenue streams, encouraging more private participation in primary care. At the same time, government-run *puskesmas* continue to serve the majority of JKN patients, signalling public trust in state-run facilities and their ability to adapt to market pressures through service innovations such as the *Dottoro'ta Home Care* program.

Figure 5.11

Claims Paid (IDR) for Primary Care (Public and Private) Facilities in Makassar, 2014–2020

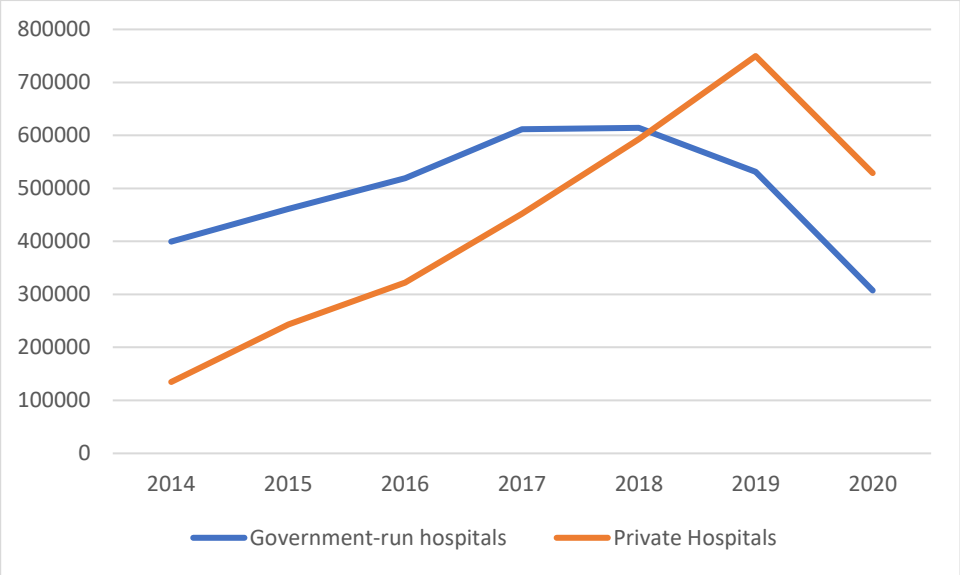


Source: Author's analysis from Self Service Business Intelligence (SSBI), December 9, 2020.

In referral care, the balance has tilted toward the private sector. By 2018, patient visits to private hospitals had already surpassed those to public facilities (**Figure 5.12**) (Note: the decline in 2019–2020 visible in that and the next figure was largely due to the COVID-19 pandemic, which discouraged people from visiting hospitals for non-urgent or non-emergency medical treatment). This shift is reinforced by JKN hospital claims data, which show that by 2019 treatment costs in private hospitals had exceeded those in government facilities (**Figure 5.13**) (Badan Penyelenggara Jaminan Sosial Kesehatan, 2020). While RSUD Daya and provincial government-run hospitals remain important, private institutions—including RS Siloam, RS Primaya, and RS Islam Faisal—now play a dominant role, particularly for middle-class patients.

Figure 5.12

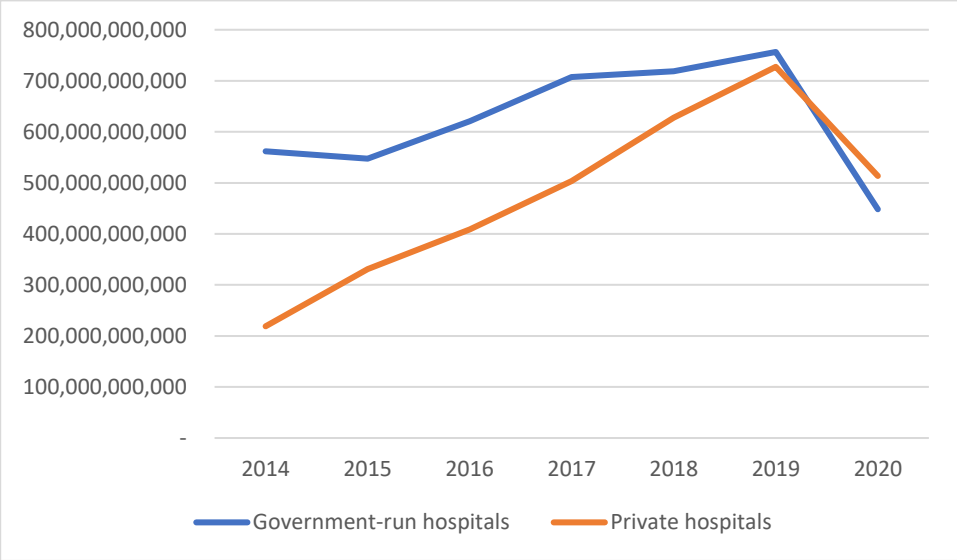
Number of Cases Treated in Referral Care (Public and Private), Makassar, 2014–2020



Source: Author's analysis from Self Service Business Intelligence (SSBI), December 9, 2020.

Figure 5.13

Claims Paid (IDR) for Referral Care (Public and Private), 2014–2020



Source: Author's analysis from Self Service Business Intelligence (SSBI), December 9, 2020.

Makassar's deeper pool of medical professionals, supplied by medical schools (e.g., Hasanuddin University and other tertiary institutions), cushions the strain of dual practice. Moonlighting remains common, but unlike in Kupang—where shortages severely undermine public provision—Makassar's larger workforce allows both sectors to operate in parallel, even if inequalities in service quality and access persist, especially in remote areas (personal observation in Makassar, July 1–14, 2022 and interviews with some residents and a nurse in Makassar).

In comparative terms, JKN has amplified subnational differences. In Kupang, it reinforced fragmentation and elite brokerage; in Semarang, as we shall see in the next chapter, it strengthened programmatic delivery and institutional coordination; while in Makassar, it expanded service options and improved overall access but also entrenched clientelism—most visibly through the capture of high-value health infrastructure projects and the politicisation of community health resources.

Figure 5.14

Photograph of RSUD Daya, Makassar

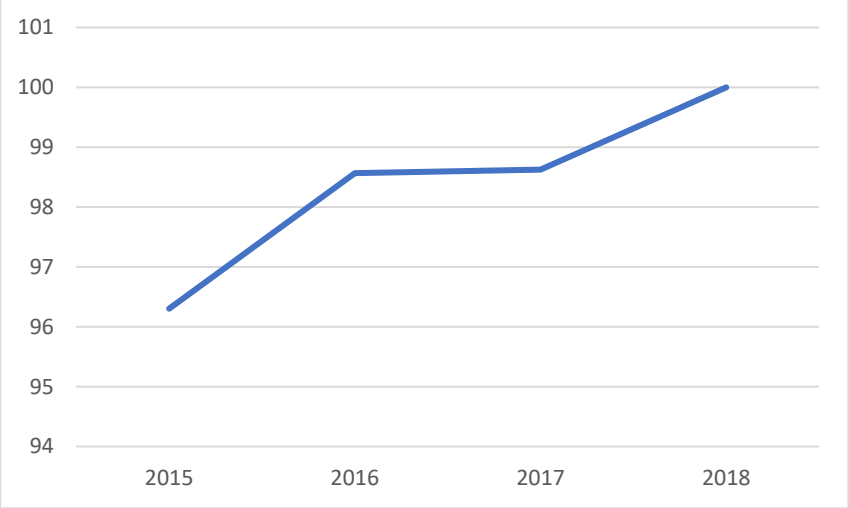
Source: Author's photograph, July 7, 2022.

From Coverage to Consequence: Healthcare Outcomes under Hybrid/Partial Clientelism

Makassar's healthcare performance is often presented as a success story. On paper, the city is a frontrunner: between 2015 and 2018, its average score for minimum health service standards (SPM) rose from 96.3 to a perfect 100. Indicators such as skilled birth attendance, obstetric emergency care, universal child immunisation, and tuberculosis treatment approached or reached full coverage (**Figure 5.15**).

Figure 5.15

Minimum Healthcare Service Standard (SPM), 2015–2018



Source: Author's analysis of Ministry of National Development Planning/Bappenas data, accessed July 7, 2019.

By 2021, JKN enrolment surpassed 96%—one of the highest in Eastern Indonesia—and the city's *puskesmas* density exceeded national benchmarks, with roughly one facility for every 18,000 residents (Dinas Kesehatan Kota Makassar, 2021). The upward trajectory continued: in 2023, Makassar once again achieved a perfect SPM score, outperforming the national average according to the Ministry of National Development Planning/Bappenas ("Makassar Raih Kuadran 1, Evaluasi SPM dan RPJPN di Atas Rata-rata," 2025). By 2024, JKN coverage reached 99%, earning the city a national Universal Health Coverage (UHC) Award (Makassarkota, 2024).

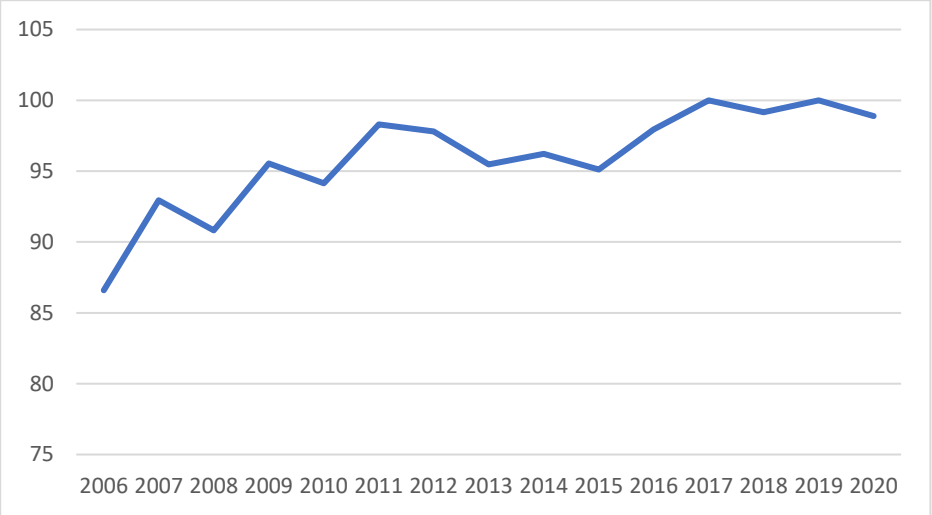
At first glance, these achievements suggest a robust and well-functioning system. Yet closer inspection reveals stagnation in several key outcomes—some of which worsened during the COVID-19 years. The pandemic response, framed through the *Makassar Recover* program, absorbed resources and reoriented community health volunteers into surveillance and mobilisation roles that did not directly strengthen maternal, child, or preventive health services.

Maternal and Child Health

Maternal health trends underscore this tension. While antenatal care visits (K1 and K2) rose steadily, maternal mortality showed no consistent decline. After dropping to 83.6 per 100,000 live births in 2015, the ratio spiked to 101.6 during the COVID-19 pandemic before falling again to 80.9 in 2022 (Dinas Kesehatan Kota Makassar, 2021; Dinas Kesehatan Provinsi Sulawesi Selatan, 2022). As **Figure 5.16** shows, skilled birth attendance has steadily increased and is now nearly universal.

Figure 5.16

Percentage of Births Attended by Skilled Health Workers in Makassar, 2006–2020



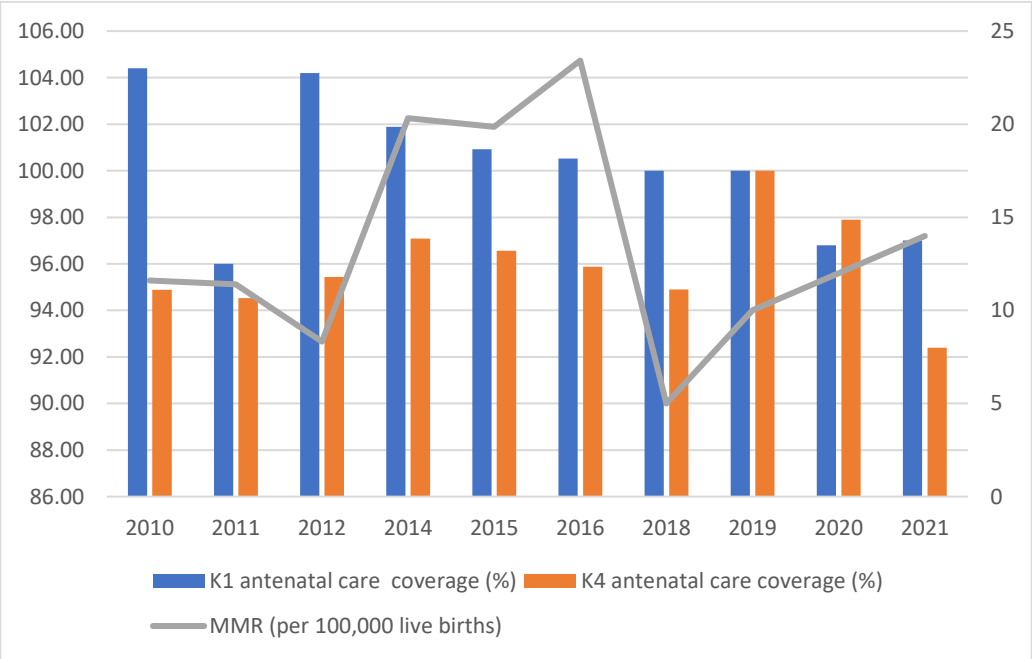
Source: Author's analysis from Indonesia Database for Policy and Economic Research (Indo DAPOER), last update November 8, 2022.

Yet volatility in the maternal mortality rate suggests that the presence of skilled birth attendants (midwives or doctors) alone is insufficient to ensure positive maternal health outcomes. This paradox reflects deeper weaknesses in Makassar's maternal

healthcare system, where governance—rather than inputs alone—shapes results. Persistent gaps in emergency obstetric care and ineffective referral pathways from *puskesmas* to hospitals for high-risk pregnancies undermine the benefits of near-universal attendance. Equally, continuity of antenatal services across all trimesters (K1–K4) and post-delivery health checks—which is critical for detecting risks early and preventing complications—remains inconsistent. As **Figure 5.17** illustrates, the fluctuation and gap between K1 and K4 visits highlight how many pregnant women initiate care but do not sustain it through the recommended four visits, reinforcing the fragility of maternal health continuity.

Figure 5.17

Maternal Health Indicators (K1, K4, MMR)



Source: Author's analysis from Dinas Kesehatan Kota Makassar, 2013, 2015, 2016, and 2021.

These shortcomings are not purely technical. They are compounded by the politicisation of community health resources, particularly the rotation and replacement of community leaders (RT/RW heads) in ways that are related to mayoral elections, which disrupt public health program stability and weaken community support systems for maternal health. In this sense, the volatility of long-term outcomes in maternal health

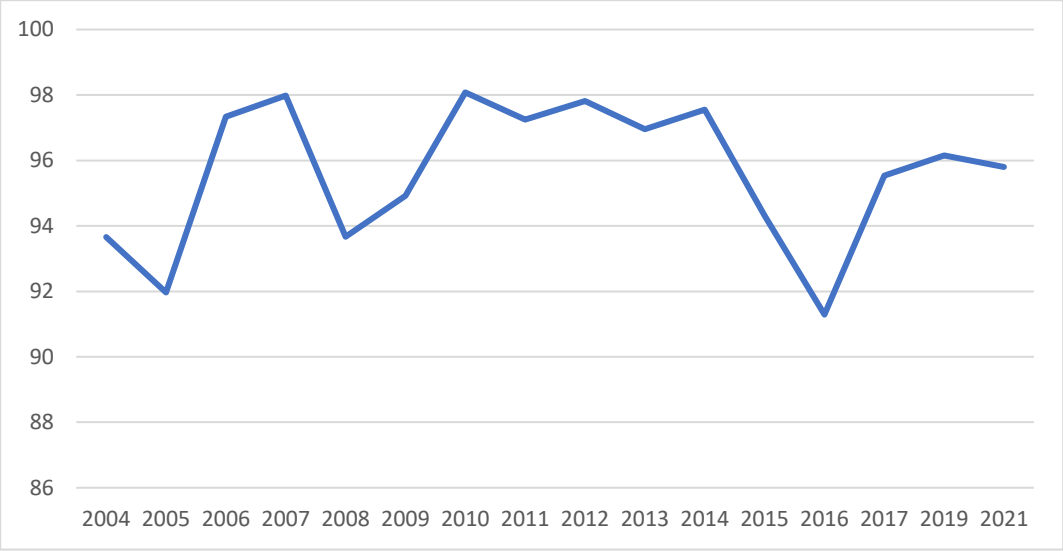
underscores a broader pattern of calibrated and hybrid clientelism: politically visible and short-term indicators, such as skilled birth attendance, receive investment, while less visible but crucial aspects of care—continuity, referral quality, and systemic support—remain vulnerable to clientelist logics and administrative disruption.

Immunisation and Preventive Care

Immunisation coverage in Makassar tells a more encouraging story than in Kupang or in many parts of Eastern Indonesia, though it is not without setbacks. Official SPM scores overall report near-universal coverage, yet administrative data show fluctuations—albeit still above 90% for full immunisation among children under five (see **Figure 5.18**) (Dinas Kesehatan Kota Makassar, 2021; Dinas Kesehatan Provinsi Sulawesi Selatan, 2022; Dinas Kesehatan Kota Makassar, 2020; Dinas Kesehatan Kota Makassar, 2015; Dinas Kesehatan Kota Makassar, 2016; Dinas Kesehatan Provinsi Sulawesi Selatan, 2022; World Bank, 2022).

Figure 5.18

Child Immunisation Coverage for Under-Fives in Makassar, 2014–2021



Source: Author's analysis from many sources as noted above.

The trajectory of Universal Child Immunisation (UCI) at the *kelurahan* level highlights this volatility. UCI coverage stood at 99% in 2009, reached 100% between 2010 and 2016, but then dropped to 61.4% in 2020 before recovering to 89.5% in 2021

and even surpassing targets 107% in 2023 (Huzair, 2024; Dinas Kesehatan Kota Makassar, 2020; Dinas Kesehatan Provinsi Sulawesi Selatan, 2022). The COVID-19 pandemic significantly disrupted routine immunisation, as volunteer replacement, mobility restrictions, and logistical bottlenecks compounded the decline. Recovery has been strong, but the swings reflect how preventive programs remain vulnerable to both political and systemic pressures.

Placed in comparative perspective, Makassar occupies a middle position. Unlike Kupang, where immunisation was consistently constrained by weak cold-chain systems, poor cadre incentives, and limited government oversight, Makassar benefitted from stronger health bureaucratic capacity and health infrastructure (such as cold-chain systems and *puskesmas* capacities) that allowed catch-up campaigns to quickly restore coverage. Yet, unlike Semarang, where programmatic discipline and tighter bureaucratic coordination sustained relatively stable coverage even through the pandemic, Makassar's outcomes show more volatility. This reflects how politicised community health volunteers' turnover and uneven attention to community health continue to shape program continuity, despite broader structural advantages.

Family Planning, Nutrition, and Community Health Structures

At first glance, Makassar's family planning and nutrition programs appear relatively well-supported. Official data show contraceptive prevalence rates (CPR) holding steady at 67–69% over the last decade, and post-natal family planning uptake improving slightly to 27.4% in 2021 (Dinas Kesehatan Kota Makassar, 2021). These indicators suggest continuity in the family planning system.

Malnutrition indicators in Makassar demonstrate an increased prevalence rate for stunting between 2015 and 2021, from 2.1% to 5.2% and severe undernutrition prevalence rose from 2.06% to 4.3%. These setbacks point to weaknesses in program continuity and outreach, despite apparently stable coverage figures in community health.

Informants directly linked these reversals to politically driven removal and reshuffling of *kader posyandu*. Under Danny Pomanto, nearly 6,000 RT/RW leaders were

removed and replaced by loyalists in 2022, with their wives typically appointed as *kader posyandu*, *kader PKK*, and *kader keluarga berencana* (*KB*) or family planning cadres, effectively displacing existing cadres. As a result, *Posyandu,* PKK and family planning volunteers—once the backbone of preventive and promotive health—were repurposed as political machinery, subordinating their technical roles to campaign mobilisation. As one DPRD member explained:

> The government no longer operates normally. Even subdistrict and ward heads [*camat* and *lurah*] can't take action without approval from the *Bassi Barania* team [Danny Pomanto's team who handled vote mobilisation and control brokers at RT/RW levels through an app]. For example, all the PKK cadres at the subdistrict and ward level were replaced at their request. So were the family planning cadres—many of their replacements weren't necessarily more competent. In fact, only the PKK chair should have been replaced, not the whole structure. The same thing happened to the *posyandu* cadres. This is what wounded the public after the last election. (Interview with H. Hamid, DPRD member, July 22, 2022; author's translation)

The consequences were particularly visible in nutrition programs, where stunting and malnutrition interventions depend on stable community outreach. Frequent cadre reshuffles undermined trust, disrupted household follow-up, and left marginalised areas dependent on inexperienced or politically appointed volunteers.

In comparative perspective, this pattern highlights both parallels and contrasts. Unlike Kupang, where cadres were largely neglected and underfunded, Makassar's were actively politicised and drawn into campaign networks that eroded professional continuity. In Semarang, by contrast, party discipline and stronger bureaucratic oversight preserved cadre structures, sustaining more consistent outcomes in family planning and nutrition.

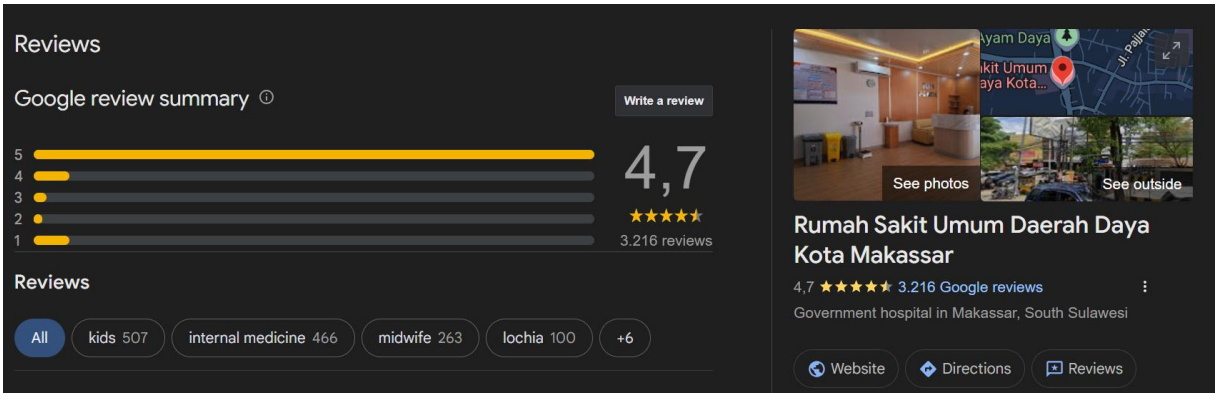
That said, my thesis does not examine family planning and nutrition in detail. These examples are used illustratively, to show how politically driven cadre turnover shaped preventive and promotive health programs. The broader argument is that, in

Makassar, calibrated clientelism delivers strong inputs in politically viable domains while undermining the quieter, everyday work of preventive and promotive care.

This tension is also visible in how citizens perceive service delivery. While politically salient inputs—such as hospital construction and JKN coverage—boost legitimacy, everyday experiences of care remain uneven. Unlike Kupang, where dissatisfaction with public facilities is widespread, Makassar's main referral hospital, RSUD Daya, receives comparatively favourable ratings. As of 28 September 2025, more than 3,200 Google reviews gave the hospital an average of 4.7 out of 5 stars (see **Figure 5.19**). Many users praised improvements in facilities, staff friendliness, and the availability of specialised services. Yet, even within these high ratings, there were scattered complaints about long waiting times and uneven responsiveness.

Figure 5.19

Google Reviews of RSUD Daya Makassar



Source: Google Map review accessed on September 28, 2025.

In comparative perspective, these findings place Makassar between Kupang and Semarang, with selective improvements shaped by its hybrid governance model.

Constraining Clientelism: Middle-Class Demands, Civic Oversight, Market Competition, and Alternative Patronage Arenas

Makassar's expanding middle class plays a pivotal—if ambivalent—role in shaping the contours of clientelism. Between 2010 and 2020, the city consistently reported Human Development Index (HDI) scores above the national average, rising

from 77.5 in 2010 to 80.3 by 2020, alongside a steady increase in Regional GDP per capita to over IDR 85 million (approximately AUD 8,500) (Badan Pusat Statistik Kota Makassar, 2020; Dinas Kesehatan Kota Makassar, 2021; Dinas Kesehatan Kota Makassar , 2015; Dinas Kesehatan Kota Makassar, 2016). This urban consumer class, while still facing out-of-pocket costs averaging more than IDR 500,000 (around AUD 50) per capita annually (World Bank, 2022), is increasingly invested in the quality of services and exerts political pressure for responsive governance. Healthcare, as a visible sector, is a natural arena for such demands.

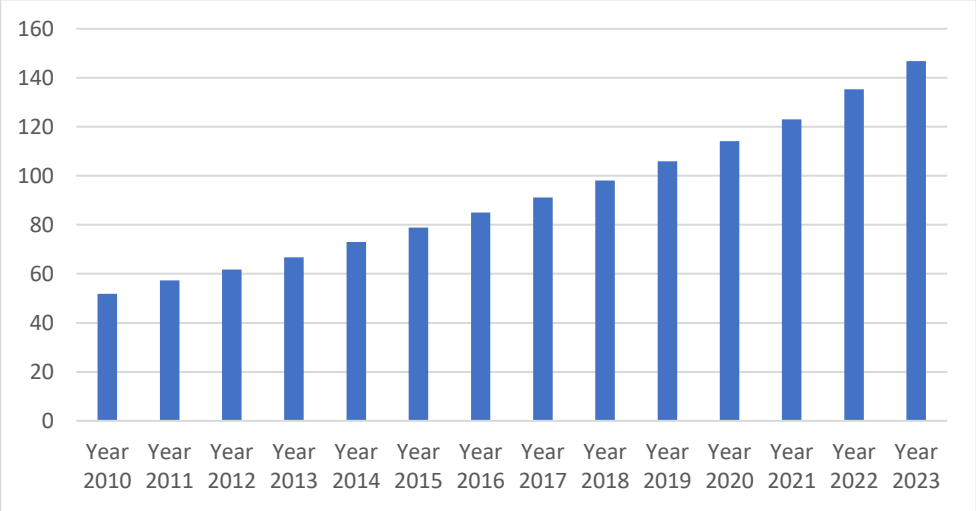
Field observations and interviews highlight the role of civil society actors and professional groups in amplifying this pressure. NGOs such as the Anti-Corruption Committee (ACC), Makassar Legal Aid Institute (*Lembaga Bantuan Hukum, LBH Makassar*) and a state body of the Ombudsman of the Republic of Indonesia in South Sulawesi provincial office, together with professional associations such as the Indonesian National Nurses Association (*Persatuan Perawat Nasional Indonesia*, PPNI), and student organisations such as the Islamic Student Associations (e.g., HMI and PMII) contribute to a political culture in which activists frequently oscillate between cooperation and confrontation. As one informant noted: “Activists here don’t stay loyal if their needs aren’t met. They know how to oppose when the opportunity comes” (Interview with KAHMI activist, July 5, 2022; author’s translation).

Universities and their student organisations have been particularly influential. HMI and its alumni networks under the coordination of KAHMI, supported by structured cadre systems, remain important recruitment grounds for both civil society advocates and political brokers (Interview with local expert, A. Yakub, July 1, 2022; author’s translation). This disruptive potential was evident in the 2018 local election, when the “empty ballot” (*kotak kosong*) defeated the sole dynastic candidate backed by four political families—demonstrating how middle-class and civic actors could challenge entrenched patronage (Era, 2020b). A local operative who is also a KAHMI member captured the sensitivity of this political environment: “Even a slight misstep in health service can provoke backlash, NGOs and student networks are highly critical and vocal” (Interview, April 20, 2022; author’s translation).

Middle-class influence is also visible in everyday service delivery. Programs such as Dottoro'ta Home Care and Makassar Recover, though presented as pro-poor initiatives, were designed with middle-class voters in mind. Rising digital literacy has amplified this scrutiny. As one bureacrat observed, "If the *puskesmas* doesn't respond fast enough, residents will post complaints online or report directly to the mayor's team" (Interview, July 4, 2022; author's translation). This digital and civic monitoring has constrained clientelistic neglect, particularly in the urban centre. **Figure 5.20** shows the increasing trend of Regional GDP per capita, an indicator of a rising middle-class.

Figure 5.20

Makassar's Regional GDP per Capita, 2010–2023



Source: Indonesia Database for Policy and Economic Research (World Bank, 2022).

At the same time, the availability of alternative patronage arenas has moderated the exploitation of the health sector by politicians. Coastal reclamation projects—such as Centre Point of Indonesia (CPI), Metro Tanjung Bunga, and Losari Beach revitalisation—have been key sites of political financing and rent-seeking, often involving collusion between officials, conglomerates, and local business elites (Sari, 2024, pp. 206–212). Procurement data reinforce this point: only 5–17% of tenders in Makassar originated from the *Dinas Kesehatan*, and just 1–11% from public hospitals, compared to over 70% in infrastructure, public works, and land development (Indonesia Corruption Watch, 2022).

Field observations in July 2022 highlighted how Makassar's urban landscape was dominated by large-scale infrastructure works—roads, sewage, and sanitation projects—far more visible than in Kupang or Semarang. These projects frequently produced severe traffic congestion, while at the same time basic public amenities remained poorly managed. For example, poor drainage systems often cause flooding, while cars and street vendors crowded the sidewalks, leaving virtually no space for pedestrians or green areas. This juxtaposition illustrates a recurring feature of Makassar's development: heavy investment in politically visible, high-value projects, often tied to patronage networks, alongside neglect of everyday public facilities and urban services that directly shape quality of life.

Collectively, these four modifying factors—rising middle-class expectations, assertive civic activism, a competitive healthcare market, and the availability of alternative sites of patronage—shaped how clientelism operated in Makassar's health sector. The first three constrained its excesses, pushing politicians to safeguard healthcare performance, while the fourth offered politicians alternative sources of rents, particularly in infrastructure and land development, where oversight was weaker. Rather than eliminating clientelism, these forces recalibrated it: since Reformasi, Makassar's elites have been compelled to show visible results in health, while relying on more lucrative, less scrutinised sectors to sustain their patronage networks. This stands in contrast to Kupang, where the absence of strong civic oversight, middle-class demand, and viable alternative rent arenas left the health sector itself heavily exposed to capture and extraction.

Conclusion: Makassar's Mixed Path—Selective Clientelism and Hybrid Governance

Makassar occupies an anomalous position in Indonesia's clientelistic landscape. Unlike Kupang's fragmented and predatory patronage networks or Semarang's governance model based on a more institutionalised and disciplined party machine, Makassar demonstrates a hybrid form of calibrated clientelism, in which patronage politics are neither fully unchecked nor firmly restrained. As a provincial capital with dense civic networks, vibrant student movements, and an assertive middle class, the city

has compelled its elites to balance patronage with performance, and to mix control with contestation.

This chapter has shown how healthcare governance in Makassar is structured by this hybrid configuration. Elite rivalry and coalition-building channel patronage into procurement—particularly large-value projects in infrastructure and medical equipment—while middle-class pressure, market competition, and civic activism impose limits on its most predatory forms. These are not institutionalised safeguards but contingent forces that render clientelism more selective and strategic, especially in politically visible and electorally sensitive sectors such as health.

Healthcare service delivery in Makassar reveals both the promise and the limits of this calibrated and hybrid governance. In formal indicators, the city performs well: near-universal health insurance coverage, dense *puskesmas* coverage, and consistently high minimum healthcare standards (SPM) signal substantial institutional capacity and administrative reach. Yet these gains in formal access have not translated consistently into equitable or stable health outcomes.

Makassar's experience challenges simple binaries of good versus bad governance. Instead, it illustrates how clientelism can coexist with service expansion, and how political incentives can both enable and constrain public sector performance. Fluctuations in maternal mortality and immunisation coverage show this tension, reflecting vulnerabilities linked to community health volunteer politicisation, disrupted preventive and promotive programs, and the diversion of resources toward electoral mobilisation. The city's trajectory thus suggests that governance reforms must engage not only with formal institutional design, but also with the informal political logics that influence shape access, influence, and accountability in practice.

Chapter 6
A Well-Ordered Machine: Institutionalised Patronage and Disciplined Clientelism in Semarang

Building on the examination of how Kupang's fragmented patronage and Makassar's hybrid coalitions affect healthcare delivery, this chapter turns to a markedly different case: Semarang, a city widely regarded for its administrative discipline and programmatic governance. In contrast to the overt, personalised and predatory clientelism that characterises Kupang, or the selectively insulated, partial clientelism observed in Makassar, Semarang represents a form of institutionalised patronage and disciplined clientelism—a configuration in which political loyalty is mediated through party hierarchies, embedded in bureaucratic routines, and reinforced with a strong emphasis on performance and compliance. It is important to note that, though I agree with the assessment of the Clientelism Perception Index that clientelism in Semarang is weaker than in the other two cases, this does not mean that clientelism is entirely absent. It is true that city mixes programmatic and clientelistic governance, with a stronger element of programmatic delivery than in the other two cities. However, I argue that Semarang's relative success lies not only in its lower intensity of clientelism but also in its *institutionalised, performance-oriented, and technocratically embedded form*. It is this distinctive configuration that sustains a well-ordered city-wide "machine"—one that blends political loyalty with public accountability in ways rarely seen elsewhere in Indonesia's patronage democracy.

Situated in **Quadrant A** of Figure 1.4 in Chapter 1—indicating low levels of perceived clientelism (Clientelism Perception Index, CPI) and high achievement on Minimum Health Service Standards (*Standar Pelayanan Minimal, SPM Kesehatan*)— Semarang broadly supports the hypothesis that lower levels of clientelism foster more accountable, professionalised service delivery. In such contexts, officials face fewer pressures to divert resources through informal networks; in addition, merit-based appointments are more likely to take hold, ultimately contributing to more equitable healthcare outcomes. In contrast, as seen in Kupang and parts of Makassar, entrenched clientelism often

undermines bureaucratic integrity, encouraging loyalty over competence and fostering rent-seeking behaviour.

This chapter elaborates the hypothesis further by addressing three interrelated questions: (1) How do the dynamics of political competition and elite coalitions in Semarang shape the character of clientelism? (2) How does this pattern of clientelism influence the governance of the health sector, particularly in terms of staffing, budgeting, and service delivery? and (3) How do these governance dynamics translate into health outcomes, and what contextual factors influence these relationships?

In answering the *first* and *second* questions, I argue that Semarang's political configuration—dominated by the Indonesian Democratic Party of Struggle (*Partai Demokrasi Indonesia-Perjuangan, PDI-P*)—has fostered a party-centred, moderated system of clientelistic exchange. Unlike fragmented or highly personalised forms of clientelism, resource distribution in Semarang is more disciplined and structured, anchored mostly in institutional structure controlled by the dominant party: the PDI-P. While ruling party elites retain control over patronage, the disbursement of patronage is typically exercised through rule-bound channels that incentivise performance rather than merely focusing on factional reward. This configuration is sustained by a system of mutual dependency among political actors, bureaucrats, and interest groups, which fosters loyalty while constraining the excesses of patronage. On the demand side, active public oversight plays a crucial balancing role. Civic actors—including student groups, NGOs, community organisations, and formal watchdogs like the Ombudsman of the Republic of Indonesia (ORI)—closely monitor public service delivery. Their efforts are reinforced by city-run digital platforms and complaint mechanisms that enforce transparency and accountability. While informal political practices persist, they are tempered by a relatively stable political settlement that prioritises institutional order and programmatic delivery over opportunism and rent-seeking.

Semarang's status as a PDI-P electoral stronghold (a *kandang banteng,* literally translated as the bull pen, or a 'red city'),[27] with the party deeply rooted in community networks, has drawn sustained attention from the party's national leaders. They see Semarang as a model of disciplined governance and closely monitor governance in the city. This national attention reinforces ideological control and national directives in the city and also draws attention to performance standards among local cadres. For local politicians, these expectations and oversight mechanisms create strong incentives to deliver results—not only to secure local legitimacy but also to strengthen their standing within the party's national hierarchy. They know that strong performance can open pathways to higher office, for example as a provincial governor, national DPR member, or minister. Health has been a key programmatic focus, resulting in *greater insulation of the sector from political interference compared to Kupang or Makassar*. While political considerations still shape some appointments in the Health Office (*Dinas Kesehatan*) and city government-run hospital (RSUD), overall technical competence and performance are central, particularly in strategic roles. Health allocations from the local budget (APBD) are determined programmatically, with limited evidence of patronage and rent-seeking. Service delivery at the primary healthcare (*puskesmas*) and secondary referral care (*RSUD KRMT Wongsonegoro*) levels also broadly aligns with national priorities under stable technocratic leadership.

Addressing the *third* question, I argue that Semarang's strong health outcomes—particularly across maternal-child indicators, immunisation, and service coverage—are not merely the result of reduced clientelism, but of its institutionalised and moderated form. Four contextual factors reinforce this configuration: middle-class pressure, civic activism, market competition, and availability of alternative patronage sectors—all present at higher levels than in the other two cities which are the focus of this study. These factors help curb political interference and reward bureaucratic responsiveness. Civic organisations, the Central Java Ombudsman representative office, and professional associations effectively act as watchdogs, while growing public demand for quality services creates electoral incentives for programmatic delivery. Together, they

[27] This refers to PDI-P's symbol: a bull *(banteng)*. This party is also strongly associated with the color red *(merah),* and Semarang is particularly known for this *red* identity—symbolising the city's status as a PDI-P stronghold.

transform clientelism from a purely transactional practice into a mechanism conditioned by performance and accountability.

The chapter is organised into four sections, following the same structure as the Kupang and Makassar chapters. The first section outlines Semarang's political economy and the structural factors that contribute to its more institutionalised and disciplined form of clientelism. The second section examines how clientelism operates in the health sector in Semarang, focusing on bureaucratic appointments, budgeting practices, public procurement, and service delivery, and briefly discusses how the COVID-19 pandemic was utilised by local elites in this city. The third section analyses the effects of clientelism on health outcomes, with particular attention to primary care, referral services through the RSUD, and selected preventive and promotive health programs that become key local innovations. In doing so, it highlights the role of institutional and societal factors in shaping outcomes. The final section summarises the key insights of the chapter and positions Semarang's case within the broader comparative analysis of the study.

The Tamed Bull: Discipline, Patronage, and Performance in Semarang's Political Arena

Semarang, the capital of Central Java province, is a coastal gateway city strategically located on Java's northern coast (**Figure 6.1**). Encompassing 16 subdistricts (*kecamatans*)[28] and 177 urban villages (*kelurahan*), the city is home to approximately 1.65 million people. The city's high population density—around 4,515 people per square kilometre—reflects its economic dynamism but also brings infrastructural stress (Badan Pusat Statistik Kota Semarang, 2023a). While Semarang's population is predominantly Javanese, it is also home to long-established Chinese Indonesians, Arab Indonesians, and the *Khoja/*Koja-Indonesians who originated from South India (Setiawan, 2024; Wiyono, 2022). These groups, many of whom arrived via colonial or precolonial maritime trade routes, remain concentrated in the lowland districts of Semarang Tengah, Utara, and Timur—areas that still reflect their multicultural heritage through *kampungs,*

[28] The 16 subdistricts are: Mijen, Gunungpati, Banyumanik, Gajahmungkur, Semarang Selatan, Candisari, Tembalang, Pedurungan, Genuk, Gayamsari, Semarang Timur, Semarang Utara, Semarang Tengah, Semarang Barat, Tugu, and Ngaliyan.

Chinatown, Arab quarters, and colonial architecture (Ahmad, 2014; Rukayah, Vania, & Abdullah, 2022; Rush, 2007, p. 68; Yuliati, Susilowati, & Suliyati, 2020).

Figure 6.1

Semarang City within Central Java Map

Source: Open Research Repository Library, Australian National University (ANU). Accessed on July 9, 2025.

This urban diversity contributed to a pluralist political economy in the late 19th and early 20th centuries. Influential figures such as Chinese-descendant tycoon Oei Tiong Ham and Javanese landlord-merchant Tasripin led commercial empires that blended ethnicity, capital, and political influence (Coppel, 1989, p. 89; Hardiman & Rukayah, 2019, p. 337; Rush, 2007, pp. 184–185). These legacies continue to inform elite structures and economic networks in contemporary Semarang.

Today, the city's cultural heritage is not only preserved but actively leveraged as a source of civic identity and political legitimacy. Restoration projects in *Kota Lama*

serve as both aesthetic and political capital, supported by national government and donor funding (Prihadi, 2021; Senjaya, 2019). These symbolic investments in cultural sites reinforce the image of a modern yet historically conscious city.

Semarang's political economy continues to be shaped by powerful Chinese-descendant business actors, notably the Hartono brothers—Robert Budi Hartono and Michael Bambang Hartono—owners of the Djarum Group and Bank Central Asia (BCA). Their business empire, one of Indonesia's largest, spans tobacco, banking, real estate, retail, media, electronics factory, plantations, and hospitality sectors (Forbes, 2024; Ayu, 2023; Saumi, 2023). While their corporate reach is national, their roots and investments in Semarang are deep, reinforcing a pattern of elite dominance in land development, campaign finance, and urban planning—issues examined later in this chapter.

Semarang remains a major hub for trade and manufacturing, with a Gross Regional Domestic Product (GRDP) of IDR 248.9 trillion in 2023 and a growth rate of 5.7%, driven by manufacturing, construction, trade, and service sectors like telecommunications and hospitality (Badan Pusat Statistik Kota Semarang, 2023a, 2024c). In contrast to Makassar's quite volatile growth trajectory, Semarang has demonstrated strong economic resilience, rebounding swiftly after the 2020 COVID-19 contraction. This recovery is supported by strategic assets such as its international port, toll roads, the northern Java railway network, Ahmad Yani Airport, and heritage-based tourism infrastructure.

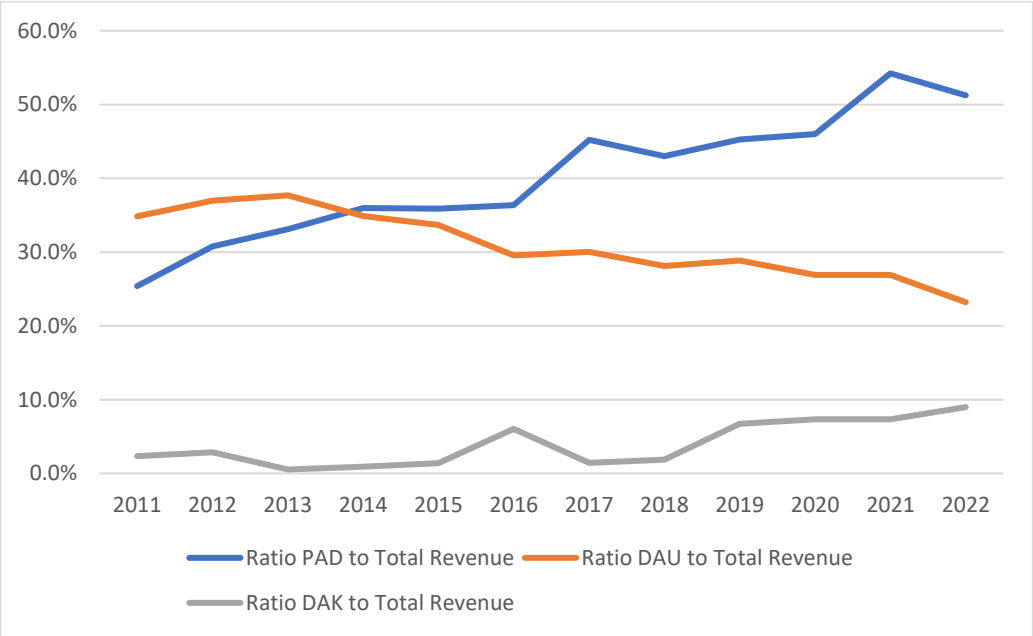
Semarang enjoys one of the highest levels of fiscal autonomy among Indonesian cities. In 2022, own-source revenue (*Pendapatan Asli Daerah*, PAD) made up 51% of its total income—well above the national average (Badan Pusat Statistik Kota Semarang, 2023a). Key revenue sources include property tax, hotel and restaurant levies, and local retail-based taxes. **Figure 6.2** illustrates the trend in Semarang's revenue composition from 2011 to 2022, showing a growing share of locally generated revenue (PAD) alongside a declining reliance on central government transfers (DAU and DAK).

Compared to Kupang and Makassar, Semarang consistently derives a larger share of its budget from PAD, reflecting stronger local revenue generation. This fiscal base is

supported by more technocratic planning and budgeting processes that guide programmatic decision-making. In contrast, as we have seen, Kupang remains heavily dependent on central government transfers and displays predatory extraction across sectors. Although Makassar's PAD has increased over time, the city still relies significantly on central transfers, with key revenue-generating sectors dominated by elite discretionary control. Semarang, by contrast, applies comparatively stronger institutional oversight and accountability mechanisms to its PAD management.

Figure 6.2

Semarang's PAD to total APBD Ratio, 2011–2022



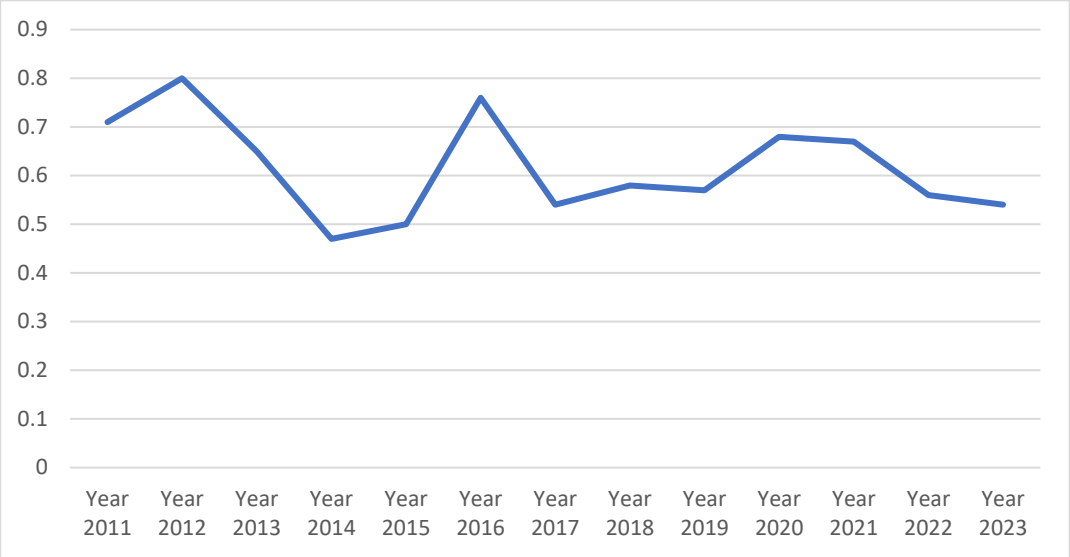
Source: Author's analysis from Indonesia Database for Policy and Economic Research (World Bank, 2022). Last updated November 8, 2022.

This fiscal robustness forms a key pillar of Semarang's programmatic governance model. Whereas Kupang remains dependent on central transfers and is marked by predatory extraction, and Makassar's growing PAD is often captured by elite interests, Semarang stands out for its relative institutional integrity and fiscal transparency.

Despite sustained economic growth, volatility in Semarang's poverty gap index (see **Figure 6.3**) points to fragile and uneven poverty reduction, with the poorest households remaining highly vulnerable to both economic and environmental shocks.

Figure 6.3

Poverty Gap Index in Semarang, 2011–2023



Source: Author's analysis from the Indonesia Database for Policy and Economic Research (World Bank, 2022) and BPS Kota Semarang data (Badan Pusat Statistik Kota Semarang, 2025a). The poverty gap index captures the depth of poverty—that is, how far poor households fall below the poverty line—rather than overall income inequality, which is measured by the Gini index.

This situation is most visibly expressed in a pronounced upland-lowland spatial divide, which underpins many of Semarang's broader social and environmental inequalities. The northern coastal lowlands (*Kota Bawah*)—particularly districts such as Semarang Utara and Genuk—were among the city's earliest settlements, yet today they are highly exposed to chronic tidal flooding and severe land subsidence, with rates reaching up to 9.85 cm per year. These environmental stresses disproportionately affect densely populated kampongs (*kampungs*), home to much of the urban poor and long marginalised in urban planning processes (Ley, 2017, pp. 85–88; Megarani, 2022; Seruntiningrum, 2022). By contrast, newer residential areas in the southern (*Kota Atas*) and western uplands—such as Tembalang, Banyumanik, Gajahmungkur, Candisari, Semarang Selatan, Mijen, and Ngaliyan—have emerged as preferred locations for the expanding middle class. These neighbourhoods are characterised by newer infrastructure, high-end real estate, and relative protection from environmental risks.

These spatial differences shape the form and deployment of clientelistic strategies across Semarang. In the flood-prone northern and central lowlands, opportunities for land-based rent extraction are limited, reducing the scope for rent-seeking. Political elites therefore rely on the delivery of popular infrastructure projects, channelling programmatic policies into highly visible flood-management projects, such as drainage systems, sewage upgrades, road improvements, and flood pumps, as gathered from various informants who live in the northern and central lowlands during my fieldwork in July 2022. Electoral support in these areas is secured through the targeted distribution of small-scale but high-demand works that address residents' immediate vulnerabilities. By contrast, in southern and western uplands, where land remains commercially exploitable, elites instead rely on discretionary governance through land-use conversion and permissive licensing. Local elites gain political support and economic benefits from property developers and similar actors in exchange for selective regulatory favours that enable private accumulation.

Nonetheless, across both zones, delivery of core services like health and education remains largely programmatic and insulated from political interference, with the goals of sustaining public legitimacy for the PDI-P in the city and maintaining equitable delivery. This spatial divergence illustrates a calibrated strategy: health remains programmatic citywide, while patronage clusters in growth-oriented sectors like land use and property development (in the uplands) and infrastructure and the old city heritage restoration (in the lowlands). These dynamics are further examined in the next section.

From Crisis to Control: Smart Governance and the Institutionalisation of Reform

Semarang's trajectory toward institutionalised and transparent governance was shaped by a deep crisis of legitimacy in its recent past. In 2012, then-mayor Soemarmo Hadi Saputro was convicted for bribing DPRD members and selling government posts. His predecessor, Sukawi Sutarip (2000–2010), had already faced intense public criticism for corruption, opaque governance, and political favouritism (Arika, 2008; Artika, 2012; Safitri, 2012). By the early 2010s, Semarang was widely seen as one of Indonesia's most poorly governed provincial capitals. In 2012 it was labelled the most corrupt city in

Central Java by anti-corruption non-government organisation, KP2KKN (*Komite Penyelidikan Pemberantasan Korupsi Kolusi dan Nepotisme*) (Detik, 2012; Indonesia Corruption Watch, 2007; Wijaya & Permatasari, 2018, pp. 2, 11).

This governance crisis set the stage for political recalibration. When Hendrar Prihadi ("Mas Hendi")[29] assumed office in 2013, public trust was at a low point. Under mounting pressure to signal reform, Hendi made *Smart City* and e-government initiatives the centrepiece of his administration. Launched that same year, these initiatives aimed to restore credibility by enhancing transparency, service delivery, and citizen engagement (Wahyuni, Purwaningsih, & Herlina, 2021, pp. 134–143). Within just three years, Semarang began shedding its tainted reputation and emerged as a national reference point for accountable, technology-driven governance (Wibisono, 2022, p. 2; Wijaya & Permatasari, 2018, p. 5).

Unlike digitalisation efforts which remained symbolic in some other cities, Semarang's reforms introduced tangible instruments of control. Real-time monitoring, grievance mechanisms, and online budgeting systems curtailed bureaucratic discretion and introduced administrative discipline. Citizen complaint platforms—including the mayor's active social media presence, the city's complaint portal, and the formal Ombudsman channel—created visible avenues for public accountability. In contrast to cities like Makassar—where *Smart City* branding has coexisted with informal brokerage and elite capture (Tempo, 2024b)—Semarang's *Smart City* innovation was paired with digital-based "smart governance" tools that expanded community participation—both in-person and online—in decision-making processes, while promoting transparency in government operations (Wahyuni et al., 2021, p. 138). These reforms helped narrow the space for opaque deal-making and budgetary manipulation, especially at the service-oriented end of budgetary processes.

Over the past decade, the city has consistently directed resources toward inclusive urban development—prioritising infrastructure, spatial planning, creative industries, green spaces, public transport, and service modernisation. These investments

[29] Mas, which means big brother in Javanese, is a casual but polite form of address.

have been accompanied by measurable improvements in health, education, living conditions, and bureaucratic service delivery, including business licensing and public health access (Badan Pusat Statistik Kota Semarang, 2014, 2017, 2018, 2019a, 2019b, 2020a, 2020b, 2021a, 2022, 2023b, 2023c, 2024d, 2025b; Prihadi, 2021; Wijaya & Permatasari, 2018, pp. 6–9). Field observations and interviews confirm that these reforms are visible in everyday life: the city is noticeably cleaner with better-integrated transportation, broader access to education and health services, and increased professionalism, efficiency, and citizen responsiveness in administrative services. These trends mirror broader patterns of governance reform observed in other progressive cities such as Surabaya, where sustained procurement and transparency reforms under Mayor Bambang DH and subsequently under Mayor Tri Rismaharini fostered cleaner bureaucratic practices, enhanced budget efficiency, and improved service outcomes as studied by Mustafa (2017, pp. 144–147, 163–165). Like Surabaya, the city has progressively narrowed the space for opaque deal-making and promoted a more transparent, performance-oriented model of urban governance.

These improvements reflect more than technocratic innovation—they signal a broader shift toward institutionalised, performance-based governance. Rather than abandoning clientelism, Semarang's leaders have reconfigured it as service delivery now serves both developmental and political objectives. Budget decisions have become tools for projecting effectiveness and maintaining control and discipline. In this hybrid configuration, performance legitimacy tempers transactionalism, and visible service delivery becomes a key resource for electoral consolidation.

Importantly, this transformation has not been driven by elite initiative alone. It also reflects the role of a politically literate middle class and an assertive civil society that demanded reform and held leaders accountable (Wijaya & Permatasari, 2018, p. 3). Nonetheless, the roots of Semarang's institutionalised governance extend beyond recent reforms. The city's technocratic and programmatic trajectory is historically grounded in PDI-P's long-standing dominance, which in turn is anchored in decades of ideological mobilisation, and the party's deep integration into civil and bureaucratic life all the way down to the grassroots. In this context, Smart Governance did not entirely displace clientelism; it helped the city's political elites to restructure and discipline clientelistic

practices, embedding political control within a system of visible, rule-bound, and ostensibly inclusive delivery.

From Red Roots to Disciplined Rule: The Historical Foundations and Contemporary Logic of Clientelism in Semarang

The relatively seamless consolidation of party-based control and civic coordination in Semarang reflects not only recent political engineering, but also deeper historical legacies. The city's political trajectory has long been shaped by traditions of ideological mobilisation, mass organisation, and disciplined networks—features that continue to inform the structure of contemporary governance. Semarang's transformation from a modest coastal settlement into a major colonial port and industrial hub laid the foundation for this political identity.

Formerly known as Pulo Tirang under the Demak Sultanate, the city came under Dutch control in 1678 as part of a debt settlement with the Mataram Sultanate (Yuliati et al., 2020, pp. 2–8). Its 19th-century industrial expansion—driven by rail, port, and sugar infrastructure—attracted tens of thousands of Javanese labourers, generating sharp class divides and fuelling early labour activism (pp. 28–34). These conditions gave rise to *Sarekat Islam* (*SI*), which emerged in Semarang in 1913 and by 1915 had over 21,000 members. Under the leadership of Semaoen—a socialist railway worker and protégé of Dutch Marxist H.J.F.M. Sneevliet—SI Semarang became the centre of leftist activism in the Dutch Indies (Ahmad, 2014, pp. 225–226; Winarni & Widuatie, 2015, p. 224). Closely linked with the *Indische Sociaal-Democratische Vereeniging* (ISDV), it played a pivotal role in founding the Indonesian Communist Party (*Partai Komunis Indonesia, PKI*) in 1920 (McVey, 1965, pp. 109–113; Shiraishi, 1990, pp. 47–52).

That same year, Semaoen led a strike of 72,000 workers involving members of 20 unions—one of the largest labour uprisings in colonial history (Ahmad, 2014, p. 230). This movement sparked an ideological split between the socialist-leaning *Red Sarekat Islam* centred in Semarang (led by Semaoen) and the more moderate *Green Sarekat Islam* centred in Yogyakarta. The Semarang branch's socialist influence extended into Islamic communities (Ahmad, 2014, pp. 230–231), embedding a legacy of class-based mobilisation, ideological partisanship, and strategic coordination that would persist well

into the postcolonial era, when the PKI and Sukarnoist PNI (Partai Nasional Indonesia) dominated local politics for the first two decades of Indonesian independence.

Today, these historical patterns are mirrored in the enduring dominance of the Indonesian Democratic Party of Struggle (PDI-P) (see **Table 6.1**), which continues to evoke Semarang's *tradisi merah* (red tradition) and commands deep loyalty. A study by Mietzner (2012) confirms this and it highlights that PDI-P, despite criticisms of its personality-centric leadership, maintains "much stronger ideological and social roots than some of the presidentialist parties in South Korea or the Philippines" (p. 527). He argues that PDI-P and its predecessors have historically provided "a politico-ideological home for several generations of nationalist, secularly oriented voters" (p. 527), and that the party's reach into "82% of all Indonesian villages" reflects its enduring grassroots presence (p. 527). As a former chairman of the Semarang Election Commission (KPUD) explained: "Even the cats born here are red" (Interview, March 1, 2022; author's translation). Thus, PDI-P's strength is not merely electoral but deeply sociocultural, grounded in historical traditions and intergenerational partisanship.

PDI-P's grip extends well beyond the electoral arena. It dominates strategic positions across the bureaucracy, legislature, and civic institutions. A local journalist based in the city hall (*balai kota*),[30] Mr. M, explained:

> Every strategic and structural position is controlled by PDI-P loyalists, from DPRD leadership posts to *lurah* [urban ward heads], UPTDs [service delivery units], and civic groups like PKK and *posyandu*. Organisations like *Pemuda Pancasila* and *Lindu Aji*[31]—that are led by Pilus [a nickname for Kadarlusman,

[30] *Wartawan Balai Kota* (city hall journalists), reporters covering local government, usually hang out at City Hall to interact with officials and wait for news to break.

[31] *Lindu Aji* originated as a local martial arts group (*tarung bebas* or free fight) and has since evolved into a mass-based organisation engaged in social and community activities. Despite its civic façade, it is frequently associated with informal security activities, racketeering, and electoral mobilisation. Similarly, *Pemuda Pancasila* (Pancasila Youth), established during the Old Order era as the youth wing of a party *(Ikatan Pendukung Kemerdekaan, IPKI)* in 1959 has long maintained close ties with political elites and local power brokers. It is viewed widely as a para-political organisation that mobilises voters and derives income from semi-legal control over local security sectors such as parking, markets, and entertainment venues (Fardianto, 2022; Fauzi, 2022; Ryter & Anderson, 2018, pp. 125–147; Safira & Pujiastuti, 2023, p. 31).

> DPRD Chair and also PDI-P Branch Secretary]—dominate the road and parking sectors. (Interview, April 21, 2022; author's translation)

This dense network thus fuses party and cross-party alliances, state institutions, and civic infrastructure. Mass organisations such as *Lindu Aji* and *Pemuda Pancasila* manage lucrative sectors including parking and urban infrastructure. Religious and civic bodies—among them National Zakat Agency (*Badan Amil Zakat Nasional*, BAZNAS),[32] Muhammadiyah, Nahdlatul Ulama (NU), the Indonesian Ulama Council (*Majelis Ulama Indonesia*, MUI), Family Empowerment and Welfare (PKK), City Health Forum (*Forum Kota Sehat*), NGO Forum (*Forum Lembaga Swadaya Masyaraka*, Forum LSM), village/ward youth groups (*Karang Taruna*), and Catholic Student Group Republic of Indonesia (*Perhimpunan Mahasiswa Katolik Republik Indonesia*, PMKRI)—are similarly integrated into, or at least connected with, the party's extended apparatus. Some of these organisations, notably Muhammadiyah and Nahdlatul Ulama, are long-established organisations respectively aligned with the National Mandate Party (*Partai Amanat Nasional*, PAN) and Nation Awakening Party (*Partai Kebangkitan Bangsa*, PKB), and thus not naturally embedded within the PDI-P network. Nevertheless, they often engage in cross-party civic alliances led by the party and its allies in the city, maintaining ties that cut across formal party boundaries.

This dominance over both the local administration and civil society landscape prove decisive during election campaigns. For example, during the 2020 local election, the incumbent mayor issued vote targets and offered promotional incentives to urban village heads (*lurah*) if they achieved them (Interview with Mr. M, April 21, 2022; author's translation) (a practice that violates what is supposed to be their political neutrality as civil servants). More broadly, the use of incumbency to mobilise bureaucrats and community networks has been a common feature of electoral politics in Semarang.

[32] BAZNAS stands for *Badan Amil Zakat Nasional,* or National Zakat Collection Agency in Indonesia. It is a state-authorised body tasked with overseeing the collection, allocation, and use of *zakat, infaq*, and *sadaqah* (Islamic charitable contributions) at the national and regional levels. It is often integrated with local government social welfare programs, working alongside government offices to distribute charity to the communities.

During the period of this study, incumbent mayors also mobilised RT/RW heads and PKK cadres to rally support. One PKK member posted a thinly veiled message on WhatsApp: "Do not forget to vote for the one with the picture," referring to the image of Mas Hendi-Mbak Ita presented on campaign flyers as the sole candidate pair. A Forum Kota Sehat activist involved in the a campaign team called *Semut* (*Semarang Utara Koncone Mas Hendi*)[33] network described her participation as voluntary in supporting the incumbent as being motivated by Mayor Hendi's performance record (Interview with community activitst, I. Dyah, April 24, 2021; author's translation). Several kampung residents similarly noted that their neighbours voted for Hendi based on perceived service improvements rather than vote-buying.

These accounts point to a form of electoral mobilisation that operates not through ad hoc transactions, but through bureaucratic discipline, civic engagement, and performance-based legitimacy. Clientelism in Semarang is institutionalised, it is anchored in party dominance, centralised coordination, and programmatic delivery. This is a model that transforms clientelism into a stabilising system, where loyalty is maintained through formalised networks and justified by visible public service improvements, particularly in key sectors like health and infrastructure. In this configuration, clientelism shifts from a transactional logic to embedded mobilisation. Party loyalty is maintained through structured civic and bureaucratic channels, while legitimacy is earned through programmatic performance.

[33] In English it means 'North Semarang is Mas Hendi's friends', but the abbreviation of Semut means 'ants.'

Table 6.1

List of Mayors and Deputy Mayors in Semarang City, 2000–2025

Name of Mayor and Deputy Mayor	Period after *Reformasi*	Party Background/ Support	Note
Sukawi Sutarip - Muchafif Adi Subrata	2000–2005	Supported by PDI-P	
Sukawi Sutarip – Machfudz Ali	2005–2010	Supported by PAN, PPP, and PKB	
Soemarmo Hadi Saputro – Hendrar Prihadi	2010–2013	PDI-P	Soemarmo was removed due to corruption
Hendrar Prihadi (Mas Hendi)	2013–2015	PDI-P	Hendi took over from Soemarmo, as Acting Mayor
Hendrar Prihadi – Hevearita Gunaryanti Rahayu	2016–2021	PDI-P, Nasdem, Partai Demokrat	Local election
Hendrar Prihadi – Hevearita Gunaryanti Rahayu	2021–2022	PDI-P	Mas Hendi resigned; President Joko Widodo appointed him as Head of the National Public Procurement Agency (*Lembaga Kebijakan Pengadaan Barang dan Jasa, LKPP*)—a position equivalent to ministerial rank.
Hevearita Gunaryanti Rahayu	2021–2023	PDI-P	Hevearita assumed the mayorship following Hendi's appointment to the national procurement agency (LKPP).[34] However, she was later named in connection with a corruption case. The position of deputy mayor was left vacant.
Agustina Wilujeng Pramestuti – Iswar Aminuddin	2025-to date	PDI-P	Agustina is a PDI-P cadre, and former DPR member. Iswar is a former *Sekda* (city secretary).

Source: Compiled from various sources (Arika, 2008; Artika, 2012; Buwono, 2012; "Daftar Nama Wali Kota Semarang Lengkap dengan Masa Jabatan," 2023; Nababan, 2025; Sekretariat Kabinet Republik Indonesia, 2022).

[34] The Deputy Mayor posts during these years were left vacant.

Calibrated Control and Inclusive Discipline: Governance under Mayor Hendi

Following a decade of weak and fragmented leadership (2000–2012), Semarang underwent a significant political shift with the rise of Hendrar Prihadi in 2013. His tenure marked the emergence of a hybrid governance model—structured, technocratic, and embedded within PDI-P's institutional dominance. Between 2013 and 2022, Semarang operated its distinctive form of clientelism: not fragmented or volatile but disciplined and integrated into formal bureaucratic procedures and party-aligned civic organisations. Under Hendi, patronage was channelled through regulated mechanisms. Mass organisations, party-linked bureaucrats, and community forums became key conduits for maintaining political loyalty. This system—bolstered by rising middle-class expectations and legitimised through consistent service delivery—stood in contrast to the unstable patronage of Kupang and the competitive brokerage of Makassar.

A dense web of interlinked bureaucratic hierarchies and civic organisations—whose leadership often overlaps with PDI-P elites—enabled the party to maintain control over appointments, procurement, service delivery, and non-government organisations while preserving the appearance of participatory governance. Strategic posts in core sectors such as the regional secretary (*Sekretaris Daerah, Sekda*), health, education, treasury, and public works were largely reserved for loyalists. Meanwhile, non-PDI-P DPRD members were granted informal quotas for contract staff and small-scale infrastructure tied to constituency development funds (*dana aspirasi*), reducing resistance to the city government's agenda from within that body. Crucially, major initiatives remained tightly centralised, serving as tools of performance legitimacy.

This carefully managed inclusiveness was a defining feature of Hendi's leadership. By extending selective access to state resources within a centralised and tightly coordinated framework, he reinforced both PDI-P dominance and cross-party alliances. As one local expert familiar with DPRD dynamics explained:

> The mayor well accommodated and facilitated the non-PDI-P factions within the Semarang DPRD, thus they become hesitant to oppose. This facilitative approach is truly remarkable. One of Mas Hendi's strengths was that he is adept at *ngopeni* [a Javanese concept referring to the ability to "take care of people"], managing

relationships, and smoothing over potential conflicts. (Interview with local expert, Mr. G, April 23, 2022; author's translation)

This logic of soft co-optation extended even to Islamic parties such as the Prosperous Justice Party (*Partai Keadilan Sejahtera,* PKS), which typically acts as a national-level opposition force to PDI-P (Muzakki, 2024; Pryatama, 2024). In Semarang, however, PKS elites publicly reaffirmed their alignment with the ruling party—as shown in **Figure 6.4**—highlighting how Hendi's calibrated engagement strategy ensured political stability by accommodating diverse actors within a unified system of control.

Figure 6.4

Photograph of News Article Titled: "PKS Affirms It Still Has a Close Relationship with PDI-P in Semarang"

PKS Tegaskan Masih Mesra dengan PDIP di Kota Semarang

SEMARANG, TRIBUN - Meski peta koalisi PDIP dan PKS menjelang Pemilu 2024 di tingkat pusat sedikit memanas karena disebut berseberangan secara ideologi, di Kota Semarang PKS justru terang-terangan mengaku hingga saat ini masih mesra dengan PDIP. Hal itu terungkap saat pengurus DPD PKS Kota Semarang bersilaturahmi ke kantor DPC PDIP Kota Semarang, Senin (7/6).

Ketua PKS Kota Semarang, Suharsono menegaskan, sangat menghargai sikap pengurus partai di tingkat pusat. Meski demikian, dia bersama jajaran pengurus PKS di Kota Semarang memiliki tanggung jawab moral untuk menjaga hubungan dengan PDIP. Suharsono juga menekankan akan selalu mendukung kepemimpinan Ketua DPC PDIP Kota Semarang, Hendrar Prihadi, sebagai Wali Kota Semarang.

"PKS ini bagian dari koalisi pemerintah Mas Hendi sehingga kami memiliki tanggung jawab secara moral dan secara struktural untuk senatiasa men-support beliau. Kami menghargai sikap dari pengurus pusat, tapi kewajiban kami untuk bersilaturahmi dengan PDIP di tingkat kota ini memang senantiasa kita jaga, saya kira itu," terang Suharsono.

"Kami mengapresiasi kerja-kerja Pak Wali yang selama ini sudah luar biasa, untuk juga kemudian PKS ini mampu berkontribusi membangun Kota Semarang bersama Pak Wali," imbuhnya.

Sementara itu, Sekretaris DPC PDIP Kota Semarang, Kadarhusman menekankan, menerima silaturahmi PKS karena partai yang kini berganti warna logo menjadi oranye tersebut, turut mengantarkan Hendrar Prihadi sebagai kader PDIP menjadi Wali Kota Semarang. Pihus, sapaan akrabnya, pun menegaskan, kehadiran PKS ke PDIP merupakan kegiatan silaturahmi biasa.

"Tidak ada agenda khusus, apalagi terkait sinyal peta koalisi di tingkat pusat. Kami ini sebagai tuan rumah, didatangi oleh siapa pun tidak bisa menolak. Kami juga tidak melihat yang di sana seperti apa tapi kami melihatnya di Kota Semarang. Jadi sepanjang niatan baik, ya kami terima dengan baik," katanya. (eyf)

ISTIMEWA

SILATURAHMI - Pengurus DPD PKS Kota Semarang bersilaturahmi ke kantor DPC PDIP Kota Semarang, Senin (7/6).

Source: Tribun Jateng, June 7, 2021.

Hendi's political authority derived not from coercion but from party discipline and ideological loyalty. Widely regarded as one of Megawati Soekarnoputri's[35] favourite cadres (*kader kesayangan*), he earned a reputation for unwavering adherence to party directives. As one senior party official, Mr. U, in Semarang remarked, "One of the qualities that Ibu Mega values most is *patuh* [unwavering obedience] in adhering to

[35] The daughter of Sukarno, Indonesia's inaugural president. Megawati is the chairperson of PDI-P. The party draws ideological inspiration from Sukarno's nationalist and egalitarian politics.

party directives—and Mas Hendi exemplifies that trait" (Interview, May 6, 2025; author's translation). This attitude translated into a disciplined focus on the part of the mayor on maintaining the reputation of the city government and for building informal consensus among important local actors in the city. As one local journalist, Mr. Y, observed, "Even minor criticism by citizens regarding bureaucratic performance can prompt officials to think twice" (Interview, May 4, 2021; author's translation), reflecting a culture of discipline and responsiveness cultivated under Hendi's leadership. Across the bureaucracy and DPRD, Hendi's leadership fostered a culture of voluntary compliance rather than overt pressure—anchored in loyalty, not fear.

Despite PDI-P's dominance, the system was not widely perceived as exclusionary. Access to minor projects, contract-based positions, and routine procurement was contingent on cooperation rather than formal party affiliation. As one DPRD member from outside the PDI-P, Mr. D, remarked, "We can still access the benefits, as long as we don't interfere with the mayor's policies. If we cooperate, we get included" (Interview, March 12, 2021; author's translation). This pragmatic logic of "cooperation" also extended into the business sector. As the chairperson of KADIN Central Java, Mr. K, explained, local business actors view "cooperation" with regional leaders as essential for business survival. His goal is to secure a steady flow of government contracts or "work packages" from local governments, arrangements perceived as mutually beneficial to political elites and to the entrepreneurs who are his KADIN members (Interview, June 3, 2021; author's translation). In return, business actors mobilise votes from their workers and their families in support of particular politicians, linking electoral backing to continued access to government contracts.

Within the bureaucracy, loyalty is internalised. While merit-based procedures formally remain, insiders describe how key political figures—such as the mayor, deputy mayor, and DPRD speaker—each maintain discretion to appoint their loyalists in senior government positions (they called it a "quota"). For example, under Mayor Hendi's leadership in 2016–2022, the deputy mayor had a "quota" to select the head of the

health office, while the mayor had the discretion to select the director of the RSUD.[36] "They all know the grey areas," said one academic. "They know what to avoid, what's been normalised, and what still occurs quietly but systematically" (Interview with Mr. G, Semarang, April 23, 2022; author's translation). Vendors affiliated with political patrons were commonly described as *bolo dhewe kabeh* [everyone is our own people, Javanese], reinforcing Mr. K's account on the pattern of patronage distribution for government contracts.

In addition to consolidating control over party, bureaucratic, and business networks, Hendi strategically engaged civil society actors to reinforce his legitimacy and broaden political support. His approach to community engagement was notably inclusive, extending beyond formal participatory forums to embrace various religious, ethnic, and cultural groups. As one journalist explained:

> Hendi was widely seen as "embracing everyone." Despite lacking a pronounced religious profile, he maintained regular engagement with *pesantren* [Islamic boarding schools] leaders, HMI and KAHMI networks, Muhammadiyah, Christian, and Hindu communities, and Chinese-descendant communities in and beyond *Pecinan* [Chinatown]. He knew key figures—priests, Hindu leaders, even Catholic advisors to the bishop. These interfaith figures likely became important informal influencers as well. (Interview with local journalist, Mr. Y, May 4, 2021; author's translation)

This outreach functioned as a form of soft co-optation, embedding patronage and legitimacy within trusted civic networks. By engaging religious and minority leaders as informal brokers, Hendi reinforced programmatic authority through culturally resonant channels, effectively complementing formal mechanisms of state control with socially embedded alliances.

The expansion of e-government platforms under Hendi also introduced partial buffers against informal practices—especially among younger civil servants committed

[36] There is no clear information on how these arrangements were established—for example why Mbak Ita was allocated a quota to select certain department heads. It is possible that in other sectors with larger resource allocations, Hendi exercised greater influence over the appointment of department heads.

to performance and transparency. These reforms fostered a degree of procedural insulation, blending bureaucratic modernisation with entrenched patronage. In this way, Semarang's governance under Hendi exemplified a co-produced and stabilised form of disciplined clientelism. Rather than operating through coercion or fragmented exchange, it relied on calibrated incentives, selective inclusion, and negotiated loyalty—anchored in the strategic alignment of party, bureaucracy, and civil society. Clientelism was not dismantled but institutionalised, embedded in a durable ecosystem sustained by both performance legitimacy and structured political accommodation. Community leaders could still use their influence to negotiate tangible outcomes—such as public works or health programs in their locale—in exchange for providing the mayor or his party with political support. "We'll vote for those who deliver," said some members of a community group (P5L)[37] interviewed in Panggung Lor, Semarang Utara. "Not for those who break their promises" (Interview with P5L members, Semarang, July 22, 2022; author's translation).

Figure 6.5

A Picture of Mayor Hendi and Deputy Mayor Mbak Ita

Source: Didik and Pangestika (2020).

[37] P5L stands for *Paguyuban Pemberdayaan Pompanisasi dan Pengelolaan Lingkungan Panggung Lor* or Panggung Lor Association for Empowerment through Pump Irrigation and Environmental Management. The group is based in Panggung Lor, a ward in the Tanah Mas residential area—the first planned real estate development in Semarang—which has been among the areas most severely affected by recurrent tidal flooding and land subsidence.

From Mas Hendi to Mbak Ita: Continuity and Divergence in Local Power

The leadership transition from Mayor Hendrar Prihadi (2010–2022) to Hevearita Gunaryanti Rahayu (commonly known as "Mbak Ita")[38] marked both continuity and divergence in Semarang's political governance. When Hendi was appointed head of the National Public Procurement Agency (LKPP) in 2022, his long-serving deputy, Mbak Ita, assumed the mayoralty. Like her predecessor, she was a PDI-P cadre and part of the party's internal network. Her political ties were further reinforced through her husband, Alwin Basri, a Central Java DPRD member known for his close connections to the PDI-P national leadership (Interview with NGO activist, Mr. W, personal communication, June 16, 2021; author's translation).

On the surface, the Hendi-Ita partnership appeared harmonious, characterised by administrative continuity and party loyalty. However, field interviews revealed a more complex and less collaborative dynamic. During Hendi's tenure, Mbak Ita was perceived as being relatively reserved and rather disengaged from government affairs. One local expert informant said that she rarely engaged in broader program discussions except for two initiatives she was closely associated with: the revitalisation of Semarang's *Kota Lama* (Old Town) and urban farming (Interview with Mr. ABM, Semarang, April 23, 2022; author's translation). Multiple informants described the Old Town restoration project as "her domain," suggesting she had made an early attempt to define a separate policy identity within a shared executive. As one informant put it, "They [Hendi and Ita] respected each other's turf. Hendi had his innovations, Ita had hers—but they weren't as united as it seemed" (Interview with local journalist, Mr. M, Semarang, September 15, 2021; author's translation).

According to the informant, such a division of "arenas"—where a deputy mayor is granted control over a specific sector and selection of senior bureaucrats—was unusual compared to other cities, where relations between mayors and their deputies are often marked by open or latent conflict. I attempted to interview Mbak Ita and exchanged several personal messages via WhatsApp. After these initial exchanges, she requested to

[38] She previously served as Vice Mayor paired with Mayor Hendi. *Mbak* in Javanese means older sister, a casual way to address a woman politely.

review interview questions in advance. Upon learning that my research focused on local politics and governance, she declined to proceed; through her adjutant she conveyed concerns that participating in my interviews might be perceived as overstepping Mayor Hendi's authority. One informant, Mr. ABM, who was well acquainted with the inner circle of city government, remarked, "Mbak Ita could be furious if Hendi interfered with her projects" (Interview, April 23, 2022; author's translation).

Her caution and respect for informal boundaries mirrored Hendi's own careful approach toward Mbak Ita's political background. The durability of this power-sharing arrangement was widely attributed to the seniority of Mbak Ita's husband within PDI-P, as well as the couple's close connections to the party's national leader, Megawati Soekarnoputri. Within this context, Mas Hendi strategically assigned Ita a *mainan* (literally, "toy")—a defined sectoral domain or project to oversee—serving both as a symbolic concession and as a mechanism for maintaining the internal power balance within the party.

Once in office as mayor, Mbak Ita acted swiftly to assert control and consolidate her influence over the local bureaucracy. One of her earliest and most conspicuous actions was a series of mass rotations and replacements of civil servants—reportedly targeting hundreds of officials perceived to be loyal to her predecessor, Hendi. According to local media reports, she carried out three major bureaucratic reshuffles during her short tenure: in August 2023, 349 staff were reassigned; in December 2023, another 184; and in June 2025, several people holding leadership positions at RSUD KRMT Wongsonegoro (RSWN) were allegedly removed following the failure of a procurement tender linked to one of her political allies (Senjaya, 2025b; Solopos, 2023; Yusuf & Krisiandi, 2025). A local expert with access to Semarang's political elite circles noted that the Head of the Health Office (2019–present) was considered a close ally of Mayor Ita, which likely explains his retention amid the broader reshuffle (Interview with Mr. W, Semarang, September 15, 2021; author's translation).

These sweeping personnel changes were widely interpreted as a strategic effort to dismantle Hendi's residual influence and embed her own loyalist network within the city administration. According to some media reports, Mayor Ita was also alleged to have

pressured several department heads to pay money as personal tribute (a practice known as *setor*) in exchange for retaining their positions—underlining how bureaucratic appointments remain vulnerable to the transactional logics of political loyalty and resource extraction (Kumparan, 2025; Senjaya, 2025a; Yusuf & Ihsanuddin, 2025). The resemblance to mayoral transitions in Makassar and Kupang, where incoming mayors routinely carried out mass reshuffles, is noteworthy, and indicates that despite the degree of party dominance in Semarang, an element of personalism did persist in city government affairs.

In contrast to Hendi's technocratic and performance-oriented leadership, Mbak Ita adopted a more personalised style of governance, marked by populist optics and symbolic gestures. Her public-facing programs focused heavily on symbolic and image-driven activities, most notably the "Lomba Nasi Goreng *à la* Mbak Ita" (Cooking Fried Rice *à la* Mbak Ita Competition), which was promoted as a platform to foster community solidarity (Kompas, 2023; Ucu, 2025). However, these events also served as tools of political branding (Muntoha, 2023; Rizqi, 2023). Observations during one such event revealed that participants were required to wear red costumes—identical to PDI-P's colour—and also to chant slogans (or *yel-yel*) about Mbak Ita (@gerakdikit, 2023; Purniawan, 2023). Even more telling, several residents were reportedly instructed to shout out their praises of Mbak Ita at the start of community meetings and city events—ranging from neighbourhood association (RT/RW) meetings and local competitions to subdistrict-level public forums. This performative display reflected a deliberate strategy to demonstrate grassroots loyalty.

Behind the scenes, Mbak Ita's leadership style elicited mixed reactions. Several senior bureaucrats interviewed characterised her as *galak* (abrasive) or *kasar* (coarse), noting a tendency toward emotional outbursts and unilateral decision-making, which was markedly different from Hendi's more measured, participatory, and managerial style (Interview with senior bureaucrat, Dr. U, Semarang, March 24, 2025; author's translation). While some civil servants adapted to the shifting political climate, others expressed concern that meritocratic procedures were being displaced by loyalty-based appointments and personalised control.

Yet despite her efforts to build a new political base, Mbak Ita's tenure was short-lived. After one year in office, she was implicated in a high-profile corruption scandal involving project-based bribery, extortion, and the sale of bureaucratic positions—allegedly with the involvement of her husband, Alwin Basri (Dikarma, Kamran; Nababan, 2025; Yusuf & Krisiandi, 2025). The scandal marked how local government had sharply departed from the relatively restrained, performance-based clientelism of the Hendi era. At the same time, the exposure of the case at an early stage also highlighted a degree of bureaucratic resilience and civic agency in Semarang—actors both within the local administration and in national oversight bodies were still capable of identifying and reporting corrupt practices despite political pressure.[39]

The 2024 direct election brought another PDI-P cadre to office: Agustina Wilujeng, a Chinese Indonesian and Catholic minority figure. Her leadership is widely expected to carry forward Hendi's legacy of technocratic governance and disciplined clientelism in Semarang (Toatubun, 2024). Agustina defeated Yoyok Sukawi, the son of former mayor Sukawi Sutarip, who was backed by the *Koalisi Indonesia Maju Plus* (*KIM Plus*) coalition of incoming President Prabowo Subianto (Yusuf & Krisiandi, 2024). Agustina's victory reaffirmed PDI-P's local dominance and highlighted the electorate's preference for performance over pedigree. It underscores the chapter's core argument: that clientelism in Semarang is more structured, party-based, and anchored in bureaucratic discipline and programmatic governance than in the other case-study sites addressed in this thesis.

With this political context in place, the following section turns to examine how these dynamics manifest in practice within the health sector—where clientelist logic persists, but is shaped and constrained by technocratic planning, institutional oversight, and programmatic distribution mechanisms.

[39] This pressure may also be interpreted as originating from the Jokowi administration's influence over PDI-P. However, the scope of this research limits for this claim to be empirically substantiated. In addition, while several informants alleged that Mbak Ita and her husband had long engaged in irregular practices by leveraging their respective positions within the executive government and the DPRD, these claims could not be independently verified and should therefore be treated with caution.

Programmatic Politics and Disciplined Clientelism in the Health Sector

The governance of Semarang's health sector generally reflects the broader ethos of public service delivery in the city: it is generally performance-driven, institutionally consistent, and civically responsive, yet not entirely free of clientelism. Rather than operating through blatant favouritism or opaque rent-seeking, clientelistic practices in Semarang are embedded within formalised, rule-bound routines, amounting to what might be termed "disciplined clientelism." Programmatic goals and political loyalty coexist, mediated by a bureaucratic culture that prizes competence and results.

Health sector staffing reveals this careful calibration. While senior positions—such as heads of the Health Office (*Kepala Dinas Kesehatan*) or Directors of RSUD Wongsonegoro—are often informally negotiated among political elites, technical qualifications remain a baseline requirement. As a senior PDI-P official put it, "We still have to consider politics, but the mayor was very clear—don't put someone who doesn't understand the job in a leadership role" (Interview with Mr. U, Semarang, May 6, 2025; author's translation). A former health bureaucrat similarly described Hendi's approach as "very open to ideas and reasonable" (Interview with Dr. W, Semarang, March 24, 2025; author's translation), highlighting a style of leadership that values result over mere allegiance.

Institutional oversight mechanisms further entrench this performance ethos. Tools like TEPRA (*Tindak Lanjut Evaluasi Pelaksanaan Rencana Anggaran,* or Follow-up on the Evaluation of Budget Execution) ensure monthly reporting on budget absorption and program implementation, while Semarang's Smart City initiative—active since 2013—integrated digital platforms to enhance transparency and public engagement across sectors (Komisi Pemilihan Umum Kota Semarang, 2024; Laeis, 2025). These instruments advanced two objectives: reinforcing measurable governance and maintaining political control.

The result is a relatively stable, professionalised health bureaucracy, even amid leadership changes. Although Mayor Ita's administration carried out overtly political reshuffles, technocratic health staff were initially shielded by institutional norms

operating within the sector. Nonetheless, the dismissal of top RSUD officials in 2025 over procurement tensions illustrated that bureaucratic autonomy still has its limits (Yusuf & Krisiandi, 2025).

Semarang's strength also lies in its human capital. Supported by *Universitas Diponegoro* (one of Indonesia's leading public universities located in Semarang) and over 50 other higher education institutions, the city benefits from a steady pipeline of health and public service professionals (Kementerian Pendidikan dan Kebudayaan, 2018), even more so than in Makassar. Patronage considerations in staffing practices—particularly for contract-based non-civil servant positions—remains present, often facilitated through DPRD networks, but is tempered by reputational concerns and procedural constraints. Meritocratic recruitment dominates at the lower ranks of the bureaucracy.

Under Mayor Hendi, daily governance was also shaped by informal, yet impactful, practices. Mayor Hendi's weekly *Jalan Sehat* (morning walks) to inspect facilities, and his consistent responsiveness via digital channels—Instagram, Telegram (@hendrarprihadi), WhatsApp, and the #laporhendi hashtag—fostered direct citizen feedback loops. These routines blurred the line between civic engagement and patronage, transforming personalistic politics into routinised accountability: citizens could report problems in service delivery, ostensibly directly to the mayor, and get a personalised response which also served to enhance performance of the system overall. Digital innovations like Universal Health Coverage (UHC) tracking, LAPOR Hendi (www.laporhendi.go.id), and Ambulance HEBAT further entrenched this model—bolstering transparency while reinforcing executive control (Yunita, 2021).

As one local academic observed, "That's the strength of the bureaucracy, especially in Semarang—it's adaptive. Patronage hasn't disappeared, but professionalism has definitely pushed it into a more disciplined form" (Interview with Mr. G, Semarang, April 23, 2022; author's translation).

Technocracy Meets Patronage: Fiscal Governance and Bureaucratic Shielding

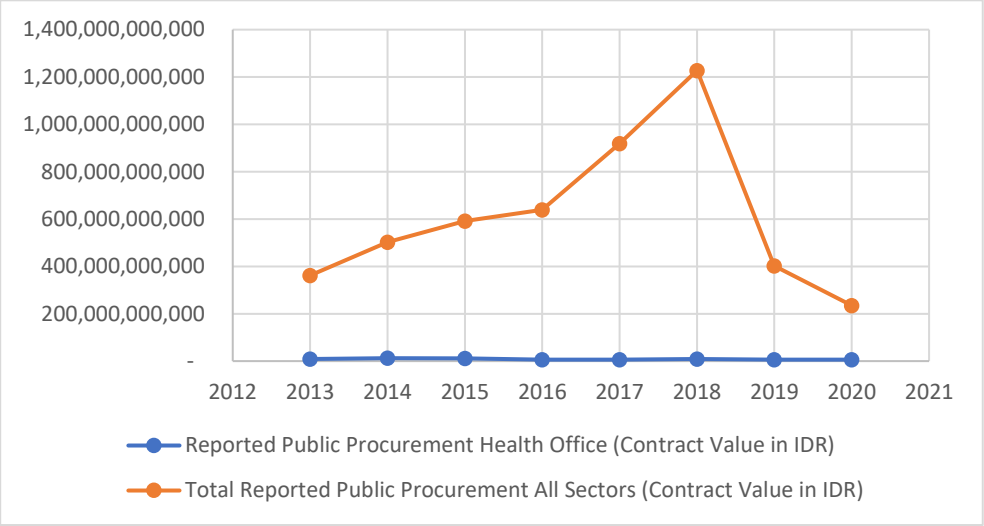
Health financing under Mayor Hendi reflected this same hybrid model. There were fiscal discipline and performance-based evaluations, yet funding in the sector was not wholly immune to informal practices. Health budget allocations consistently rose between 2015 (7%) and 2020 (15%), aided by strengthened PAD mobilisation and national transfers like DAK and operational support assistance funding for *Puskesmas* (*Bantuan Operasional Kesehatan*, BOK). By 2020, total health spending had surpassed IDR 800 billion, around 800% increase from 2015 (less than IDR 100 billion) (Kementerian Keuangan, 2012a, 2013a, 2014a, 2015a, 2016a, 2017a, 2018a, 2019a, 2020a; World Bank, 2022), significantly outpacing patterns in Kupang and Makassar.

This expansion translated into improved infrastructure and service access. By 2023, Semarang operated 37 *puskesmas* (14 with inpatient facilities), over 50 satellite *pustu* clinics, and more than 1,000 active *posyandu.* In addition to these city-run health services, Semarang has 25 hospitals (13 public, 12 private) (Badan Pusat Statistik Kota Semarang, 2024d, pp. 11–12). DAK funds were used to develop referral services, upgrade *puskesmas* facilities*,* improve maternal and chronic disease care, and for health operational costs (*Bantuan Operasional Kesehatan,* BOK) (Dinas Kesehatan Kota Semarang, 2021, p. 21).

Procurement mirrored this programmatic orientation. As **Figure 6.6** shows, total reported public procurement in the health sector—covering the *Dinas Kesehatan* and RSUD—exhibited steady performance between 2013 and 2020 compared with overall procurement in the city. Contracts across both institutions were largely aligned with frontline needs: up to 95% for infrastructure and 65% for medical equipment (Indonesia Corruption Watch, 2022)**.**

Figure 6.6

Health Sector Procurement in Comparison to Total Procurement in 2013–2020

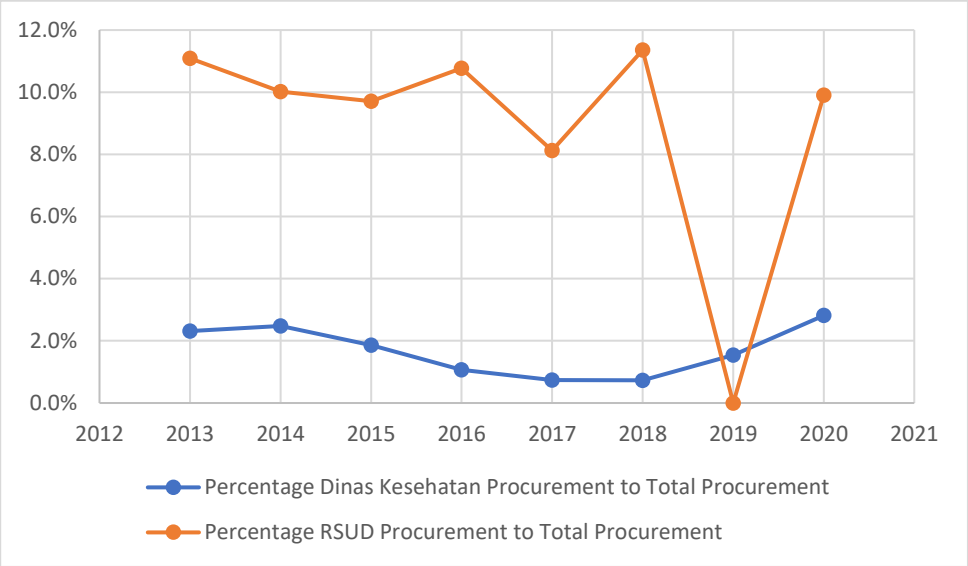


Source: Author's analysis from the Opentender.net database (Indonesia Corruption Watch, 2022). The blue line remains flat, indicating consistently low reported values of procurement activity that were reported in the database.

When disaggregated between the Dinas Kesehatan and the RSUD (**Figure 6.7**), procurement patterns diverged in predictable ways. RSUD Wongsonegoro procurement peaked in 2018, corresponding with the major renovation of RSUD Wongsonegoro, while the *Dinas Kesehatan* maintained steady investment in infrastructure and equipment throughout 2013–2020. Spending priorities were closely aligned with service delivery needs: between 47 and 95% of *Dinas Kesehatan* contracts were directed toward infrastructure projects, while between 38 and 65% targeted essential medical equipment. This allocation corresponded with observable outputs in public health facilities, including the adequacy of medical supplies and equipment, and contributed to the relatively good quality of services and infrastructure in *puskesmas*, as indicated by field observations and interviews. Meanwhile, RSUD Wongsonegoro, the city's flagship public hospital, was upgraded to provide advanced specialist services in cardiology, oncology, and maternal health (Rachmawati, 2025).

Figure 6.7

Health Sector Procurement (RSUD and Dinas Kesehatan) as a Share of Total Procurement in Semarang, 2013–2020



Source: Author's analysis from procurement data, taken from Opentender.net database (Indonesia Corruption Watch, 2022).

Although *Dinas Kesehatan* accounted for a relatively small share of total municipal procurement, its budget was strategically targeted toward frontline infrastructure, equipment, and service delivery (Badan Pusat Statistik Kota Semarang, 2019a, 2020a, 2020b, 2021b, 2023c, 2024d; Dinas Kesehatan Kota Semarang, 2015, 2018). The rising RSUD budget spending, meanwhile, was accompanied by disciplined, performance-based procurement practices, as noted by several informants.

Yet the formal process did not fully eliminate informal arrangements. While no health-sector corruption scandals were reported in the local media or by watchdog organisations, several informants pointed to a persistent reliance on "preferred vendors," who consistently won government tenders. These vendors were valued not only for their familiarity with bureaucratic procedures but also for their capacity to accommodate extra-contractual and off-budget expectations attached to government contracts. Such "expectations" often involved the provision of material assistance to appease the mayor's political supporters and enable quick responses to ad hoc demands aimed at maintaining public approval. As one informant, a local university lecturer,

explained, these practices partly reflect the rigidity of formal procurement procedures, which cannot always accommodate the immediacy of bureaucratic and political demands. As a result, officials may first rely on informal arrangements with trusted vendors and subsequently adjust documentation to ensure administrative compliance (Interview with local expert, Mr. G, Semarang, April 23, 2022; author's translation).

This thesis cannot conclusively determine whether procurement processes were consistently conducted in a fully transparent and depoliticised manner. While official records indicate an emphasis on performance-based planning and execution, interview evidence points to the persistence of informal, patronage-based procurement practices operating beneath the surface. Substantiating these dynamics, however, remains challenging in the absence of corroborating evidence from media reports or other independent reports. Even persons making such allegations, however, generally stated that procurement, on the whole, occurred in a generally fair and professional manner.

Overall, it is fair to conclude that Semarang's health sector is governed predominantly through programmatic politics, albeit with calibrated pockets of patronage and rent-seeking. Procurement practices are not fully politicised, nor are they entirely technocratic. They remain disciplined yet are not entirely depoliticised.

Community Health as Programmatic Delivery and Electoral Mobilisation

Since Hendi's administration, Semarang has distinguished itself from Kupang and Makassar through the systematic mobilisation of community health volunteers and their strong integration with national and local programs. More than 1,500 community health volunteers—including mosquito larvae inspectors (*Juru Pemantau Jentik, Jumantik*), *PKK* and *posyandu* cadres, and representatives of the *Forum Kesehatan Kelurahan*—have been formally trained, resourced, and institutionally embedded within the city's public health system. These volunteer networks are closely integrated into the Health Office's system, working in coordination with *puskesmas* officers and the *Dinas Kesehatan* officials.

A clear illustration of this approach can be seen in disease prevention initiatives addressing one of Semarang's most pressing health challenges—dengue fever—such as

the *Satu Rumah Satu Jumantik*[40] program, which designates one household member as a larva-monitoring volunteer. This initiative links neighbourhood (RT/RW) units with *puskesmas* to support household-level dengue prevention and vector control (Dinas Kesehatan Kota Semarang, 2018, pp. 70–74). Together, these arrangements exemplify a decentralised yet well-coordinated model of grassroots health surveillance.

Under Mayor Hendi, this participatory infrastructure extended well beyond vector surveillance. Family planning services were similarly decentralised and relied heavily on community actors. Family planning counsellors (*Penyuluh Keluarga Berencana*) were assigned to most *Rukun Warga* (RW) units, delivering outreach to reproductive-age couples while expanding services for adolescents and the elderly. Initiatives like *Posyandu Remaja* (for teenagers) and *Posyandu Lansia* (for the elderly) were widely implemented by communities in Semarang especially under Mayor Hendi's administration[41] to address emerging demographic risks—from teenage pregnancy to geriatric neglect—particularly during the COVID-19 pandemic when health vulnerabilities intensified.

Political commitment sustained this ecosystem. In 2021, Mayor Hendi provided the City Health Office with an additional IDR 12 billion (or approximately AUD 1.1 million) for programs such as contracted surveillance officers (*Tenaga Surveillans Kesehatan, Gasurkes*), each tasked with monitoring 20 households daily. As one local community activist noted, "Mas Hendi ensured that frontline health workers and volunteers received adequate incentives" (Interview with I. Dyah, Semarang, April 30, 2021; author's translation). Mayor Hendi's wife, Krisseptiana (popularly known as Mbak Tia), played a key role in facilitating preventive outreach through *Forum Kota Sehat* and PKK. As she explained:

> *Forum Kota Sehat* and PKK aren't part of the government [institution], even though we use public funds. We [*Forum Kota Sehat* and PKK] don't set policy—

[40] It means one house, *Aides aygepti* mosquito larva inspector. This initiative was introduced by the Ministry of Health in 2016 as a national strategy to prevent dengue fever.
[41] The *Posyandu Lansia* was introduced by the Ministry of Health in 1996, while the *Posyandu Remaja* was established later through the Ministry of Health Regulation (*Permenkes*) No. 25 of 2014, which formalised adolescent health services within the community-based health system.

> we're a bridge between the community and local agencies. When people face problems, we bring them to the relevant *Dinas* [departments]. Our role is mostly preventive—sharing information and promoting government programs like the 3-in-1 vaccination initiative for the elderly and their caregivers. (Interview with Krisseptiana, Semarang, April 30, 2021; author's translation)

While these community structures undoubtedly strengthened participatory health governance, city leaders also strategically leveraged them for electoral purposes. Interviews with community activists in Semarang Utara and Semarang Selatan revealed frequent attempts by legislative candidates (*caleg*) to offer—and at times insist on giving—donations to community health volunteers while soliciting their political support, with the expectation that the health volunteers would mobilise votes during campaign periods. As one informant—a *Forum Kesehatan Kelurahan* and *PKK* cadre—recounted:

> Many legislative candidates pressured us to accept donations and pledge our votes. Others offered various programs during campaign outreach—often coordinated jointly between city- and provincial-level candidates to maximise efficiency. In the end, people tended to support those candidates whose programs had a tangible impact on their daily lives (Interview with I. Dyah, Semarang, April 24, 2021; author's information).

During mayoral elections, activists and neighbourhood groups reported that they were sometimes explicitly instructed by government officials, such as *lurah* (urban village heads), to support the incumbent mayor's re-election efforts (Interview with local journalist, Mr. M, Semarang, April 21, 2022; author's translation).

These dynamics illustrate a hybrid model of civic engagement. While Semarang's community health networks are often cited by actors on the ground as examples of programmatic service delivery, they are also served as embedded electoral infrastructure. Cadres/volunteers function not only as public health facilitators but as trusted intermediaries in political mobilisation—blurring the boundary between programmatic delivery, empowerment and patronage. Within Semarang's

institutionalised clientelism, participatory governance thus becomes both a tool for accountable service delivery and a strategic asset for consolidating political support.

Constraining Clientelism in Semarang: The Roles of Civil Society and Civic Pressure, Market Competition, and Patronage Diversification

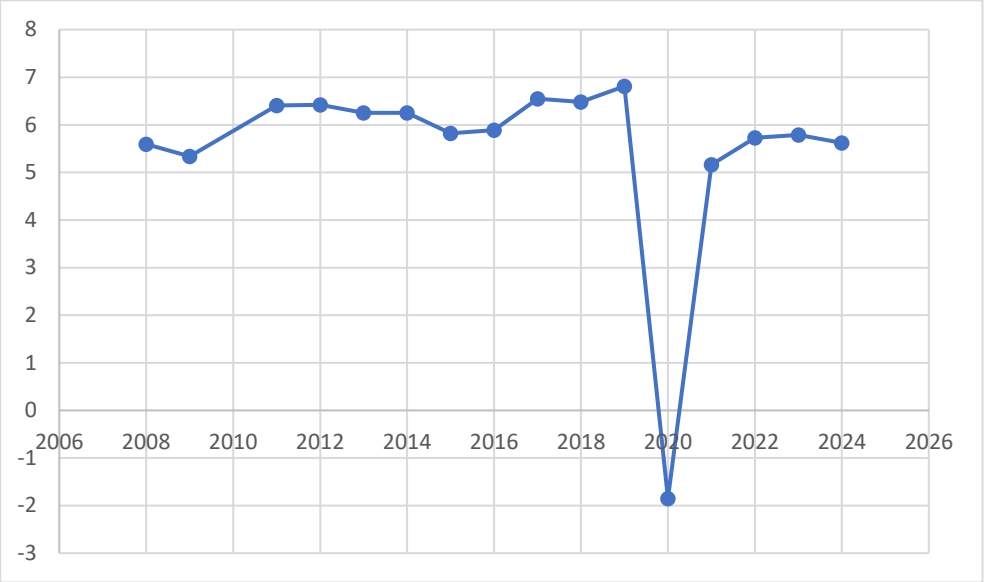
Semarang's relatively disciplined and programmatic health governance cannot be explained solely by mayoral leadership or bureaucratic capacity. It also reflects deeper structural factors—namely a strong middle class, embedded civic networks, competitive service markets, and the availability of alternative arenas for patronage. These conditions have moderated clientelism's reach, especially in service delivery sectors like health, even as party-based patronage under PDI-P remains intact elsewhere.

Middle-Class Demands and Electoral Incentives

As one of Java's leading centres of economic growth and industrial activity, Semarang has fostered a sizable and confident middle class. This is an influential constituency that both drives and disciplines local politics. This group plays a vital role in shaping policy priorities, especially in health, education, and infrastructure. As illustrated in **Figures 6.8** and **6.9**, the city's economic base has expanded steadily over the past decade, driven by sustained growth and rising household consumption in the city (Badan Pusat Statistik Kota, 2013, 2014, 2018, 2022, 2023a, 2024a, 2025a). During the COVID-19 pandemic, economic growth fell below zero, but it rebounded between 2021 and 2023.

Figure 6.8

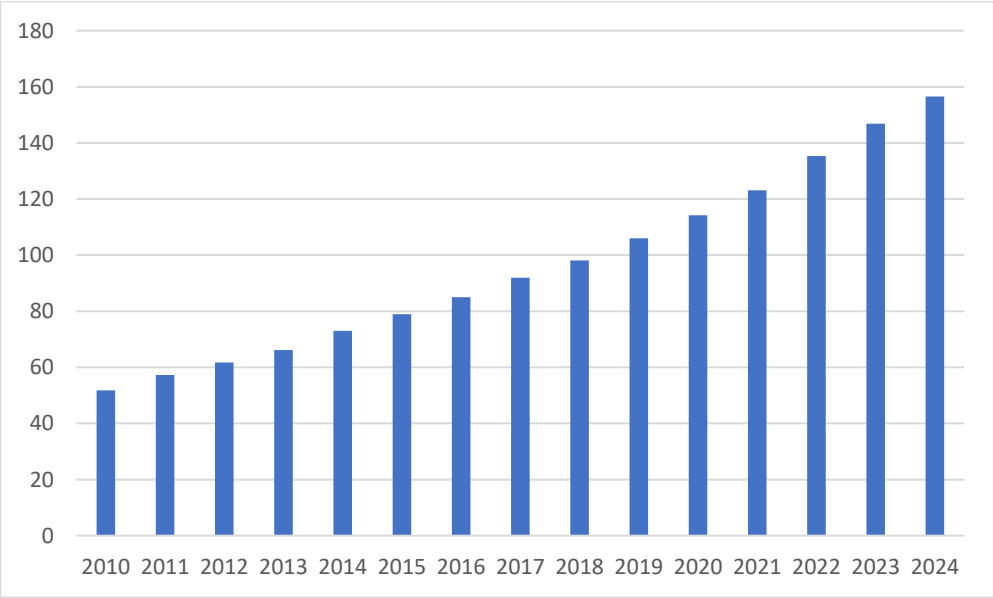
Economic Growth in Semarang, 2008–2024



Source: Data taken from statistical reports published by BPS Kota Semarang (2013, 2014, 2017, 2018, 2019a, 2022, 2023a, 2025a).

Figure 6.9

Semarang's GDP per Capita (in Millions of Rupiah), 2010–2024



Source: Author's analysis from BPS Kota Semarang (Badan Pusat Statistik Kota Semarang, 2024c).

Figure 6.9 further shows that between 2010 and 2014, Semarang's GDP per capita tripled from IDR 51.81 million to IDR 156.57 million (Badan Pusat Statistik Kota Semarang, 2024c). By 2021, more than 60% of residents had entered the middle- or upper-income brackets (Badan Pusat Statistik Kota Semarang, 2021b), marking the consolidation of a powerful middle-class constituency within the city.

These expectations have translated into heightened pressure for local government performance. As one community activist explained, "Middle-class citizens are demanding—especially when it comes to healthcare. If they have to wait too long at the *puskesmas,* they immediately complain on social media or through the other channels" (Interview with I. Dyah, Semarang, April 24, 2021; author's translation). Such pressures also meant that such voters would respond well to positive service experiences, and reinforced Mayor Hendi's strategy of localising national programs through strong city branding and a focus on service delivery—most notably the national health insurance scheme, *Jaminan Kesehatan Nasional* (JKN), which he supplemented with local budget allocations and repackaged under slogans such as "Semarang Universal Health Coverage" or "from birth to death, it's free in Semarang." Implemented citywide on 1 November 2017, this branding approach was later extended to other public health initiatives, including the city's COVID-19 vaccination campaigns in 2021–2022 (Sari, 2021a, 2021b).

During the pandemic, Mayor Hendi and his wife were highly visible in the distribution of assistance, allowing the use of the official mayoral residence as a temporary quarantine facility, and in promoting vaccination events, often alongside PDI-P leaders (Interview with NGO activist, Mr. W, Semarang, September 15, 2021; author's translation). Informants and media accounts analysed in Sari (2021a, 2021b) suggest that these activities helped build political legitimacy and blurred the boundaries between national entitlements and local delivery. As one local specialist observed: "Technically, the health coverage comes from the national program [JKN], but it was branded as if it came directly from the mayor. That boosted Hendi's image as a provider of welfare" (Interview with Mr. M, Semarang, April 21, 2022; author's translation).

In conclusion, in contrast to Kupang—where middle-class pressure is weaker—and Makassar—where responsiveness is more fragmented—Semarang's electorate rewarded performance, fostering a form of disciplined clientelism operating alongside programmatic governance. Local leaders had incentives to deliver measurable outcomes, and this reduced the political space for arbitrary clientelism in core service sectors.

Civic Oversight and Partial Co-optation

As discussed in the previous section, Semarang's participatory infrastructure—built on PKK, *Posyandu, Jumantik*, *Forum Kota Sehat,* and other community networks—provides another buffer against unchecked patronage. These groups, often led by trusted community figures, offer channels for feedback, public health outreach, and grassroots mobilisation. Supported by the city, which provides them with both funding and coordination, these groups play an active role in program planning and evaluation.

Yet civic independence in Semarang operates within clear limits. NGOs such as Pattiro, once critical of local budgeting when it received overseas funding in the early 2000s, since around 2017 become increasingly dependent on APBD-funded partnerships (Interview with Ombudsman head of representative Central Java, Semarang, April 1, 2022; author's translation). Some civil society organisations have also been drawn into coordinated networks led by political figures, such as the *Forum NGO* Kota Semarang, blurring the boundaries between civic engagement and political mobilisation. Nevertheless, a number of organisations (e.g., the Independent Journalist Alliance or *Aliansi Jurnalis Independen/AJI*, university student groups, and other community groups) remain relatively impartial and continue to provide a measure of balanced advocacy—an equilibrium more visible in Semarang than in Kupang or even Makassar.

Over time, media outlets also came under increasing financial pressures, becoming increasingly dependent on government-related income—such as public service advertisements and paid news coverage—to sustain their operations. *Suara Merdeka*, Central Java's leading newspaper, maintains close ties with the political elites in Semarang—its CEO is a long-time ally of Mayor Hendi. Meanwhile, the journalist network of City Hall (*Forum Wartawan Balai Kota, Forwakot*), enjoys privileged access to City Hall, which some say curtails critical reporting (Interview with Mr. M, Semarang,

April 21, 2022; author's translation). These dynamics reveal the partial co-optation of civil society and media, even as participatory mechanisms continue to function.

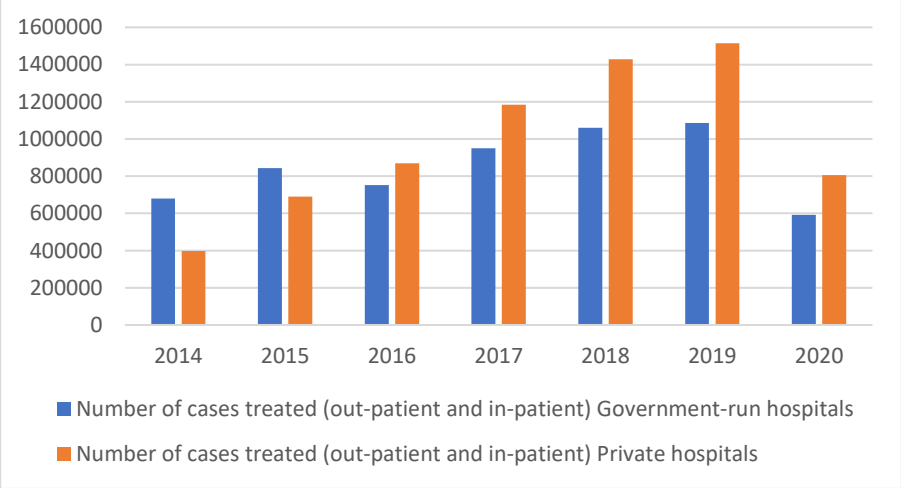
Compared to Kupang and Makassar, however, Semarang's civic ecosystem remains notably robust. Formal complaint systems, Ombudsman oversight, and digital feedback platforms (like *Lapor.go.id* and *Lapor Hendi*) offer legitimate routes for citizens to voice grievances. Alongside these mechanisms, the mayor's personal social media accounts offer more direct and personalised avenues of communication. Community health cadres and forum leaders, backed by political support and public trust, also act as intermediaries between residents and officials—helping to routinise civic scrutiny and enhance accountability, even if such engagement remains short of full independence.

Primary and Referral Care and Private Sector Integration

Health service provision in Semarang reflects a calibrated balance between public capacity and private-sector integration. By 2023, universal health coverage had reached 97.53%, aided by a 50% budget increase in local health financing compared to 2022 (Auliya, 2024, pp. 75–84).

Figure 6.10

Number of BPJS Cases Treated in Public vs Private Hospitals, 2014–2020

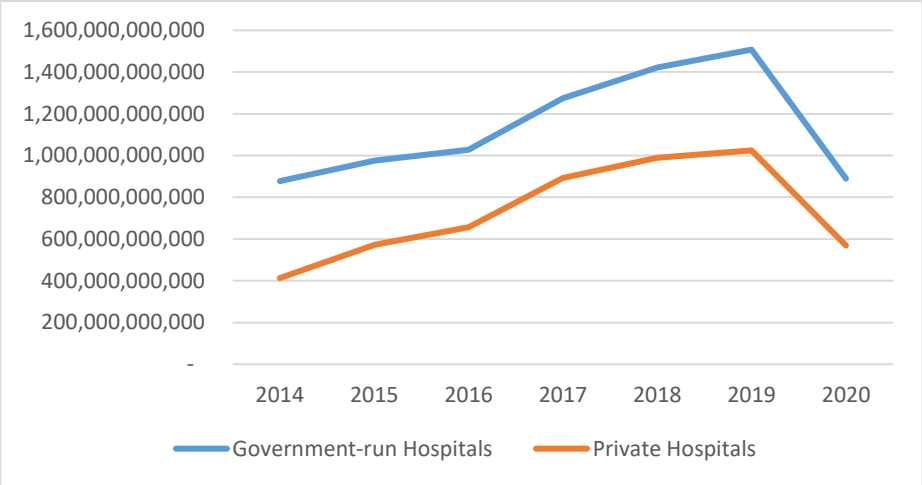


Source: Author's analysis from BPJS raw data, SSBI December 9, 2020.

As shown in **Figure 6.10**, since 2016 private clinics and hospitals have handled the majority of BPJS cases (number of cases treated), while public hospitals such as RSUD Wongsonegoro continue to manage high-cost specialist care, as reflected in their higher total claim values (**Figure 6.11**). This pattern indicates sustained public trust in city-run hospitals and their continued use for inpatient and referral services. The sharp decline in service utilisation and healthcare expenditure claims in 2020—also observed across other cities—was largely attributed to the COVID-19 pandemic, during which many patients postponed or avoided seeking medical treatment at hospitals due to fears of infection (Manafe, 2020).

Figure 6.11

Inpatients and Outpatients Claims Payment in Public and Private Hospitals, 2014–2020



Source: Author's analysis of BPJS raw data, SSBI December 9, 2020.

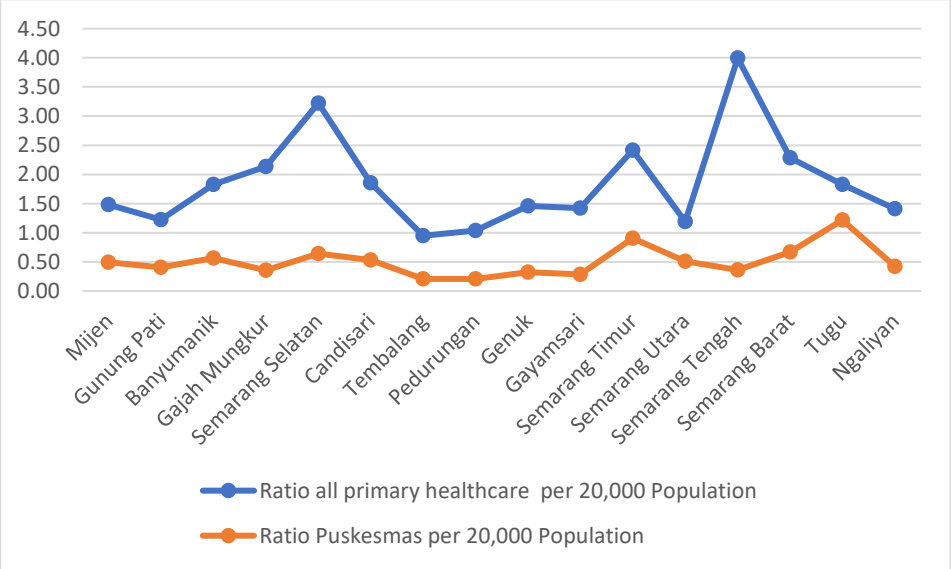
The strength of Semarang's primary and referral care is underpinned by a health workforce that has remained strong, well-trained, and relatively evenly distributed. By 2022, the city employed around 700 doctors, 1,200 nurses, and 900 midwives across public and private facilities (Badan Pusat Statistik Kota Semarang, 2023c, p. 38). Most *puskesmas* had full clinical teams, while the RSUD housed hundreds of specialists (Badan Pusat Statistik Kota Semarang, 2019b, 2020a, 2020b, 2021a, 2023c, 2024b, 2024d). This workforce capacity has been sustained by a steady stream of graduates from Universitas Diponegoro and other tertiary institutions, like health polytechnics and academies, enabling Semarang to meet rising service demands under universal health coverage.

Another factor contributing to the strength of Semarang's health system is the integration of private sector providers, which helps fill service gaps in areas where public facilities are limited. As shown in **Figure 6.12**, in 2020 only one subdistrict—Kecamatan Tugu—had more than one *puskesmas* per 20,000 residents as a public primary care provider; in other subdistricts, coverage ranged from 0.2 to 0.9 per 20,000 residents. However, once private general practitioners and primary healthcare clinics are included, all subdistricts meet the 1:20,000 ratio, with Gajah Mungkur, Semarang Selatan, Semarang Timur, Semarang Tengah, and Semarang Barat exceeding 2:20,000. Many of these private providers in Semarang are contracted under the JKN scheme, enabling residents to access care with minimal out-of-pocket costs.

By comparison, as we have seen in earlier chapters, Makassar shows broad *puskesmas* coverage on paper, yet interviews and site visits indicate persistent disparities between central and island areas in staff quality and service readiness, while Kupang continues to experience more limited provision and uneven access across its health system.

Figure 6.12

Ratio of Primary Healthcare Providers (Private vs Puskesmas) per 20,000 Residents by Subdistrict, 2020



Source: Author's analysis from Badan Pusat Statistik Kota Semarang (2020a).

The partnerships with private general practitioners and private clinics, particularly after Mayor Regulation No 43/2017, which integrated the city's local health insurance scheme into JKN, enabled Semarang to enrol an additional 50,000 low-income residents into the JKN and raise universal health coverage from 93.7% in 2018 to over 99% by 2023 (Dinas Kesehatan Kota Semarang, 2024). Complementary measures, including platforms such as Call Centre 112, free ambulance services (Ambulance HEBAT), and relaxed residency requirements, further improved access and reinforced the city's service-oriented governance image (Wijaya & Permatasari, 2018, pp. 7–9).

What sets Semarang apart is how this system-wide performance logic translated into bureaucratic enforcement. Senior officials were held accountable for coverage gaps, and the mayor routinely conducted field visits to monitor compliance. As one official recalled, "Hendi would go to the field, ask directly, and if things were off, he gave a warning—even to friends" (Interview with former Head of Dinas Kesehatan, Semarang, July 27, 2021; author's translation). In flood-prone or low-income areas alike, routine sanitation and maternal health monitoring were upheld, and were sustained by annual budget allocations and strong community engagement.

Figure 6.13

Photograph of RSUD KRMT Wongsonegoro, Semarang

Source: Author's photograph. Taken in July 2022.

Semarang's approach to health access, marked as it is by technocratic planning, structured community mobilisation, and integrated service systems, contrasts sharply with the fragmented and politically contingent patterns seen in Kupang and Makassar. Through targeted infrastructure spending, embedded civic participation, and a disciplined performance regime, Semarang has built a resilient, inclusive model of health governance. This foundation set the stage for strong health outcomes and population-level impacts, which we turn to now.

Alternative Patronage Sites: Land, Infrastructure, and Elite Alignment

While the health sector has been increasingly insulated from clientelism through the application of programmatic approaches and accountability mechanisms, sectors like land, infrastructure, and heritage renovation remain key arenas of elite patronage. Government officials have promoted Public–Private Partnerships (PPPs), which use channels like government and business entities' partnerships mechanism (*Kerjasama Pemerintah dengan Badan Usaha, KPBU*)[42] and Corporate Social Responsibility (CSR), as financing tools to reduce pressure on the city budget. In practice, such mechanisms often serve as means for distributing contracts to politically connected firms or funnelling campaign funds to politicians from business actors. As one local journalist put it:

> Semarang City is famous for its treatment towards corporates. It rolls out the red carpet for investors. Most of these KPBU projects go to firms tied to the mayor's circle or Mbak Ita. They're allowed to develop parks, PDAM infrastructure, big infrastructure projects, or real estate with little transparency, often disguised as revenue sharing models. (Interview with Mr. M, Semarang, April 21, 2022; author's translation)

Zoning manipulation and elite capture in Semarang are documented in several studies. Permana (2024, p. 210) highlights how land and property development in Semarang is governed through informal brokerage, rather than being guided by the

[42] KBPU is a public–private partnership scheme for financing infrastructure projects, funded either partially or fully by private investors through arrangements such as Build–Operate–Transfer (BOT), Design–Build–Finance–Operate (DBFO), or concession models, each defining different roles and responsibilities.

public interest, with zoning revisions negotiated between political elites and developers close to the mayoral circle. Case studies of upland development projects—such as *Bukit Semarang Baru*[43] (Mijen), Ngaliyan, Gunungpati, and Bukit Mangunharjo (Tembalang)—show that rezoning often bypasses environmental safeguards, displacing peri-urban farmers and degrading catchment areas (Harminto, 2012, pp. 16–18; Sukarsa & Rudiarto, 2014, pp. 90–93); Supratiwi (2013, pp. 4–5).

As a senior member of a local watchdog institution explained, these projects are underpinned by powerful business-political alliances:

> If you look at the housing cases in Semarang, you'll see links to land and contractors—Hendi was strongly supported by the property sector. The dominant players? Groups with strong Djarum Group ties—like PT Ciputra and PT Karyadeka Alam Lestari. Take *Bukit Semarang Baru* [an expensive residential area built on formerly green, hilly land previously used for rubber plantations] as an example. The interaction pattern has shifted—from old links between Chinese-Indonesian tycoons, politicians, and the military, to newer ties with the police. Mas Hendi was strongly backed by both Chinese-Indonesian business groups and security forces, more so than Ganjar [former Governor of Central Java Province] ever was. (Interview, Semarang, April 1, 2022; author's translation)

Permana (2024, pp. 212–215) also notes that spatial planning remains opaque, with zoning decisions rarely disclosed or debated publicly. Despite the city's reputation for transparency in other areas, spatial governance continues to rely on informal discretion and closed-door negotiations—especially in KPBU projects that often bypass environmental impact assessment (*Analisis Mengenai Dampak Lingkungan,* AMDAL). These practices have contributed directly to environmental degradation and chronic flooding. Nashr (2023) and Permana (2024, pp. 215–216) both trace chronic inundation

[43] *Bukit Semarang Baru* (BSB) City is a planned satellite township covering approximately 1,000 hectares in the hilly areas of Ngaliyan and Mijen subdistricts. Developed by the Ciputra Group, the project combines residential estates with commercial zones. The project was built on areas previously designated as green zones and former rubber forest, raising concerns about environmental degradation and politically mediated rezoning.

in Semarang's northern and upland areas to politically driven rezoning and commercial land conversion that reduces drainage capacity and green spaces.

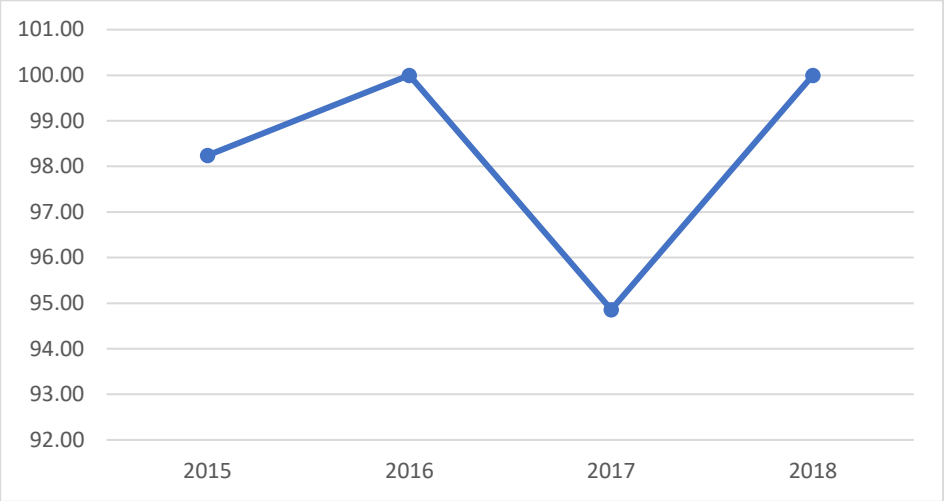
This dualism underscores Semarang's hybrid governance model. While technocratic reforms and civic participation have curbed clientelism in health and basic services, high-discretion sectors like land and infrastructure remain embedded in elite patronage networks. Unlike Makassar, where infrastructure scandals and overt rent-seeking are commonplace, Semarang's patterns are subtle: actors rely on informal discretion and network proximity and use formal procedures to mask patronage practices. Compared to Kupang's pervasive clientelism, Semarang demonstrates how urban clientelism can be selectively insulated, recalibrated, and strategically preserved across sectors, whereas Makassar's system remains highly competitive and personalised and so still features much more visible rent-seeking, corruption and elite bargaining.

From Coverage to Outcomes: Evidence of Programmatic Impact in Semarang

Between 2015 and 2018, Semarang consistently exceeded national averages in key health outcome indicators under the minimum health service standards (SPM), achieving over 95% across most categories (see **Figure 6.14**). These outcomes also greatly exceeded those found in Kupang, though they were slightly lower than in Makassar. A temporary decline in 2017, driven by limited dengue case detection (67.76%) during a national outbreak, was swiftly addressed through targeted interventions (Badan Pusat Statistik Kota Makassar, 2019). Core indicators—such as universal child immunisation, treatment of malnourished toddlers (100%), safe delivery of babies, and obstetric emergency care—showed sustained improvement. Semarang also reached near-universal coverage in referral services for the poor, infant check-ups, and tuberculosis treatment, demonstrating alignment between health infrastructure, universal health coverage expansion, and programmatic investments in service quality (Badan Pusat Statistik Kota Semarang, 2019b, 2020a, 2020b, 2021a, 2023c, 2024b; Dinas Kesehatan Kota Semarang, 2015, 2018).

Figure 6.13

Minimum Healthcare Service Standard (SPM), 2015–2018



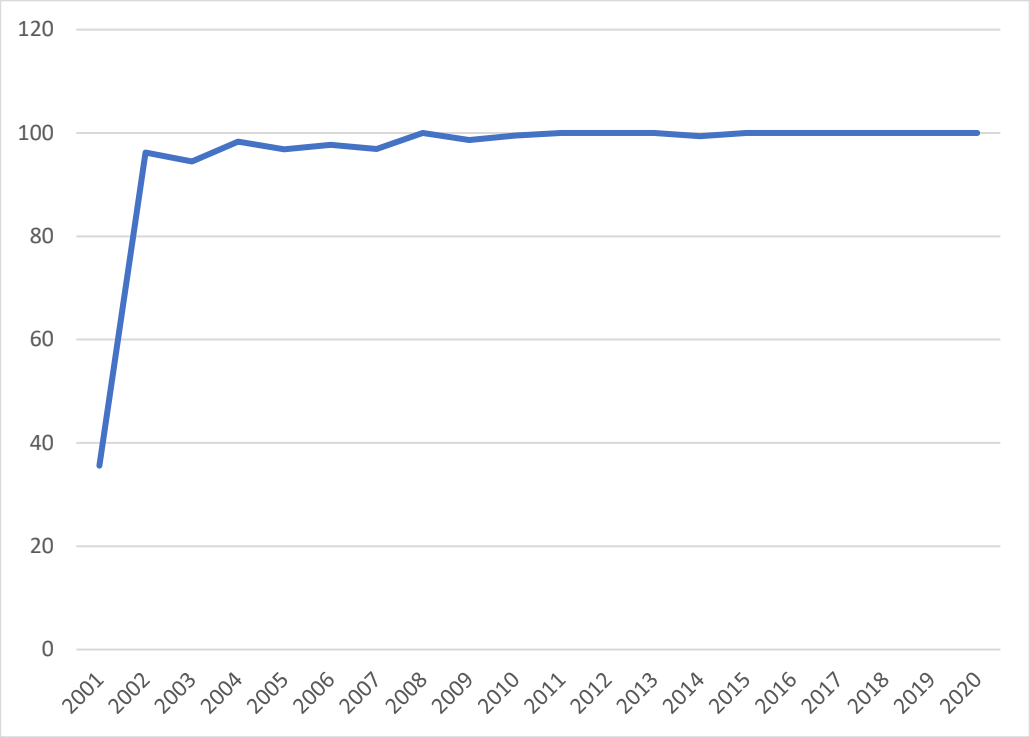
Source: Author's analysis of Ministry of National Development Planning/Bappenas data, accessed on July 7, 2019.

An informant who works closely with the Ministry of Home Affairs provided updated healthcare performance data for the three cities in 2024, indicating that Semarang achieved a 99.98 % score on SPM Health, followed by Makassar at 97.35 per cent, while Kupang recorded a low performance at 78.61 (Interview with S. Jasape, Kupang, December 6, 2025; author's translation). Taken together, these figures suggest that Semarang's healthcare performance exceeds that of Makassar, whereas Kupang remains at the lower end of the performance spectrum.

As part of the Minimum Health Service Standards (*SPM Kesehatan*), maternal and child healthcare indicators remained strong throughout 2016–2023. Coverage of the first antenatal care visit (K1) for pregnant mothers consistently exceeded 97%, while completion of all four recommended antenatal visits (K4) averaged around 90% (Badan Pusat Statistik Kota Semarang, 2021a, 2023c; Dinas Kesehatan Kota Semarang, 2017, 2018). The proportion of deliveries attended by skilled health personnel rose dramatically—from below 40% in 2001 to nearly universal coverage in subsequent years—and has remained at 100% since 2011, as shown in **Figure 6.15.**

Figure 6.14

Percentage of Births Attended by Skilled Health Workers in Semarang, 2001–2020

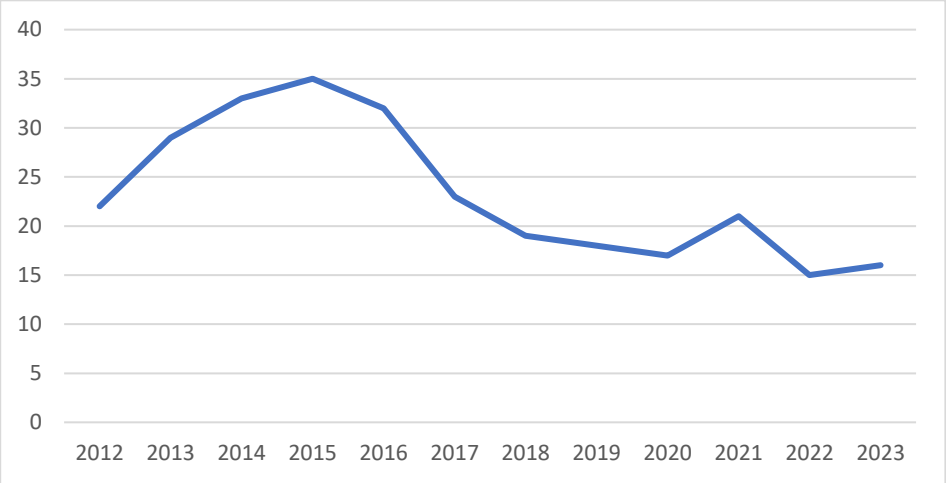


Source: Author's analysis from Indonesia Database for Policy and Economic Research (Indo DAPOER), last update November 8, 2022.

This contributed to steady declines in maternal mortality, albeit with a brief uptick in 2021 due to the COVID-19 pandemic (**Figure 6.16**). Progress in antenatal care, delivery safety, and community outreach through *posyandu*, PKK, FKK, and FKS networks played a central role in this improvement. The scale of these outreach efforts far exceeded those in Kupang, reflecting Semarang's stronger institutional capacity and civic mobilisation. As Dr. W, a retired senior bureaucrat in *Dinas Kesehatan*, recalled, "We integrate *posyandu* revitalisation with stunting reduction. And it's not just *posyandu*—PKK members are also central, and even Mayor Hendi's wife herself supports these activities directly" (Interview, March 24, 2025; author's translation).

Figure 6.15

Maternal Mortality Rate (per 100,000 Live Births) in Semarang, 2012–2023



Source: Author's analysis of data from Dinas Kesehatan Kota Semarang (2024e, p. 33; 2015, p. 35).

Family planning outcomes were equally robust. Over 76% of reproductive-age couples used modern contraceptives between 2018–2023, with long-term methods (IUDs, implants) reaching 20% in 2022 (Badan Pusat Statistik Provinsi Jawa Tengah, 2025). Unmet need fell below 5%, and adolescent reproductive health was supported through health cadres, schools and teenager *posyandu* (*posyandu remaja*) (Interview with I. Dyah, Semarang, April 24, 2021; author's translation). Preventive health programs were institutionalised across schools, workplaces, and neighbourhoods to prevent vector-born and communicable diseases. As former head of health office, Dr. Widoyono recalled, "Mas Hendi instructed us to 'blow up' [publicly expose] the dengue data [in the media]. Surveillance was decentralised and coordinated with RT/RW and *Babinsa*[44]" (Interview, March 24, 2025; author's translation).

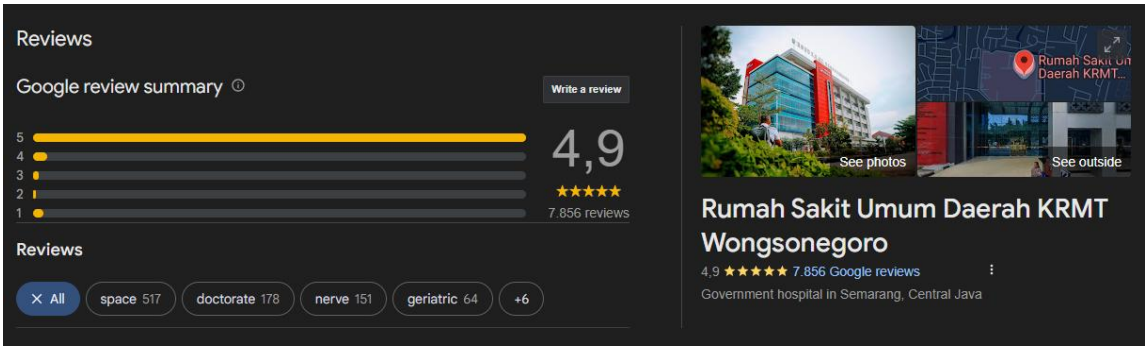
User satisfaction mirrored these achievements. RSUD Wongsonegoro averaged 4.9 stars from 7,856 Google reviews, and most *puskesmas* scored above 4.5—demonstrating strong public trust in accessible, responsive healthcare (@rswnsemarang, 2024; Badan Pusat Statistik Kota Semarang, 2024d) (**Figure 6.17** and

[44] *Babinsa (Bintara Pembina Desa),* or Village Supervisory Non-Commissioned Officer. *Babinsa* is a member of Indonesian Army assigned to village and *kelurahan* to support community engagement duties and security.

6.18). These figures reflect broad approval of Semarang's accessible and performance-based health system.

Figure 6.16

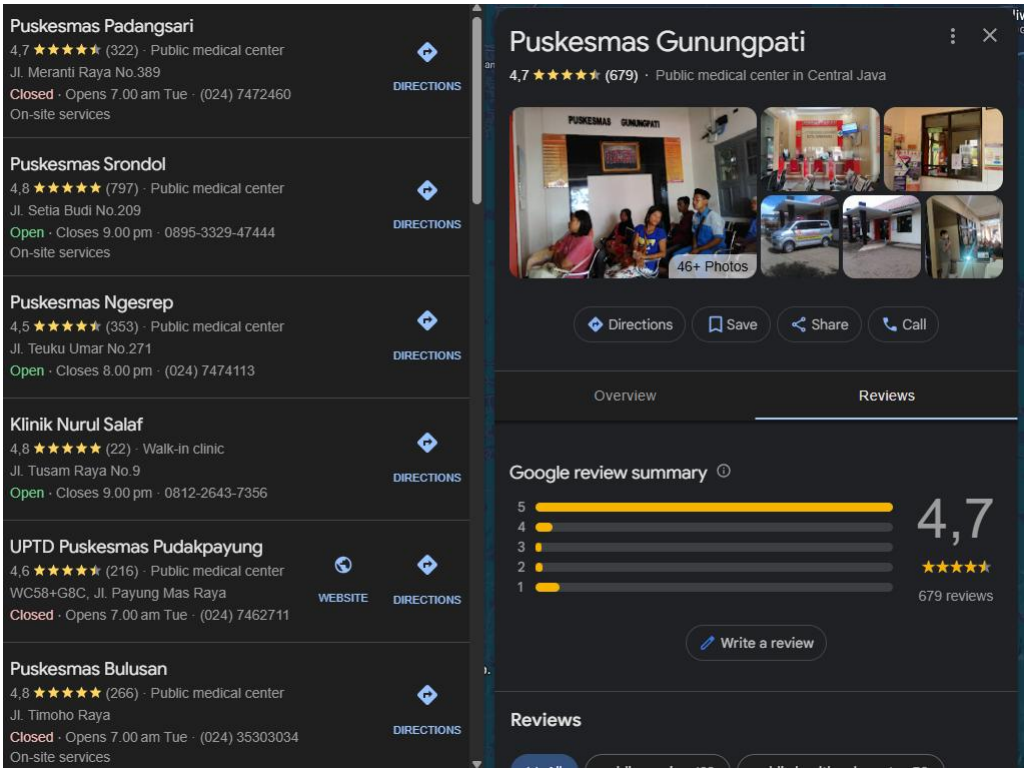
Google Map Review of RSUD KRMT Wongsonegoro, Semarang



Source: Taken from Google Maps on July 21, 2025.

Figure 6.17

Google Map Review of Some Puskesmas in Semarang



Source: Screen capture from Google Maps, taken on July 21, 2025.

In contrast to Kupang—where maternal and children healthcare remains fragmented and under-resourced—and Makassar—where selective investments coexist with politicised delivery—Semarang exemplifies how institutionalised clientelism, paired with technocratic discipline, can produce inclusive, high levels of patient satisfaction, strong public trust, and improved health outcomes.

Conclusion: Calibrated Clientelism and Programmatic Delivery in Semarang

Semarang offers a compelling case of *hybrid clientelism*—a political configuration in which health service delivery is largely shielded from day-to-day political interference, even as clientelistic practices continue to shape other arenas such as spatial planning, land use, and infrastructure. Unlike Makassar, clientelism in Semarang is more limited in scope and operates in a refined and discreet manner, reflecting the city's capacity to sustain performance-based governance anchored in technocratic planning, bureaucratic discipline, and sustained political commitment aligned with the programmatic agenda of the ruling party, PDI-P. As a result, patronage is channelled primarily through less visible mechanisms in non-core service sectors, rather than through overt rent-seeking, marking sharp departure from patterns observed in Makassar.

While pockets of patronage endure in Semarang—particularly in senior health appointments and procurement—these practices are constrained by a mix of informal norms and rule-based mechanisms that limit discretionary interference. Unlike Kupang and Makassar, where political interference more readily disrupts bureaucratic routines, Semarang's dominant party machinery has consolidated political control without undermining bureaucratic professionalism. Rather than dismantling programmatic governance, local elites have restructured clientelism by embedding loyalty within widely popular service delivery programs and channelling selective benefits through institutionalised and predictable pathways.

This configuration, however, is not without its risks. Strategic sectors such as land rezoning and infrastructure development—where public oversight is weaker and corporate influence more pronounced—remain weaker key sites of patronage. These

arenas function as alternative patronage channels, allowing elites to sustain political networks while shielding more tightly regulated sectors like health, education, and frontline public services. In this sense, Semarang's clientelism is best understood as calibrated rather than absent, redirected toward sectors offering greater discretion and fewer constraints.

Yet in the health sector, Semarang has struck a balance rarely seen in Indonesia's patronage democracy, with a well-ordered political machine that fuses political loyalty with performance, and mobilisation with accountability. Community health networks such as PKK, *Forum Kesehatan Kelurahan*, *posyandu*, RT/RW units, and other grassroots groups have been mobilised not only for service delivery but also for electoral strategy, demonstrating how participatory institutions can simultaneously serve governance objectives and political consolidation.

Semarang shows that clientelism and service delivery are not necessarily in tension. When institutional norms, civic engagement, and technocratic ethos align, even a clientelist regime can generate inclusive, accountable, and high-performing outcomes. The city thus offers an important lesson that under specific political and institutional conditions, clientelistic systems can evolve toward more programmatic forms of governance, and political machines can be restructured to serve, rather than sabotage, public welfare.

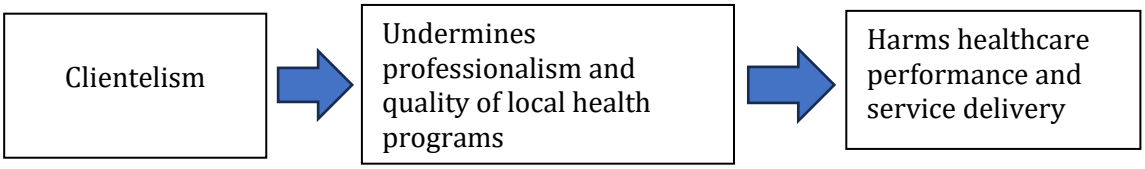
Chapter 7
Conclusion: Findings, Reflections, and Policy Implications

My study can be traced back nearly three decades, to when I witnessed informal dealings and corrupt practices within Indonesia's health sector. These early encounters led me to ask how such practices shape healthcare outcomes across different cities and districts. As I continued to pursue this question, it became clear that Indonesia's persistent regional disparities in healthcare could not be explained by structural constraints, such as economic development or technical limitations, alone. A closer examination of Indonesia's public sector—particularly decentralised health governance and the political and economic factors surrounding key health policies—reveal how shifting patron-client dynamics have rendered certain parts of the sector—particularly health worker appointments, staffing distribution, and the procurement of medicines and medical equipment—vulnerable to informal political influence. Recognising this, I turned to political science—particularly the study of clientelism and patronage—to understand how these dynamics intersect with the public health arena. Disparities in healthcare delivery, my study demonstrates, are symptomatic of deeper political dynamics, notably those involving the informal practices that shape how policies are implemented and how public resources are allocated. Social and political actors operating within formal institutions play a decisive role in either enabling or obstructing equitable service delivery. By foregrounding clientelism and patronage as analytical lenses, this study examines how these informal political dynamics intersect with public health governance, and how they help explain uneven healthcare performance across Indonesian cities.

At the heart of the inquiry, I pursued in this thesis is the first and central research question: How does variation in the nature of clientelistic politics at the subnational level affect the delivery of healthcare services to citizens? I hypothesised that regions characterised by more intense clientelistic politics would tend to exhibit poorer healthcare outcomes. **Figure 7.1**, which presents the pathways linking clientelism to health outcomes first introduced in Chapter 1—is reiterated here to anchor the discussion of this study's central relationship.

Figure 7.1

Pathway Linking Clientelism to Health System Outcomes



To test the hypothesis, I selected three cities based on a correlation analysis of three factors: Clientelism Perception Index (CPI) scores of Indonesia's provincial towns developed by Berenschot (2018b, p. 1580), performance of healthcare services delivered by the city governments (Minimum Health Service Standards, or *SPM Kesehatan*), and levels of government health spending. The correlation analysis broadly supports the study's hypothesis. For the 2015–2018 period, CPI and *SPM Kesehatan* show a moderately strong negative association (r = -0.361), indicating that higher clientelism is generally linked to poorer health service performance. By contrast, the correlation between CPI and per capita health spending (0.226) and between SPM Kesehatan and spending (-0.0077) are weak or negligible. Per capita health spending was therefore treated as a control variable, and cities with comparable expenditure levels were selected.

Using the scatter plot presented in Chapter 1 (see **Figure 1.4**), I selected three cities representing distinct combinations of clientelism and healthcare performance: Kupang (high clientelism, poor outcomes), Makassar (high clientelism, strong outcomes), and Semarang (low clientelism, strong outcomes). Kupang and Semarang align with the initial hypothesis that more intense clientelism corresponds to weaker healthcare performance and conversely, less intense clientelism corresponds to better healthcare outcomes. Makassar, however, is an anomalous case: despite high levels of clientelism, it delivers comparatively strong health services. This anomaly underscores the need to move beyond the *intensity* of clientelism and consider its *nature*. The second hypothesis therefore proposes that different types of clientelistic politics matter, drawing on the framework developed by Berenschot and Aspinall (2020, p. 11) (see **Table 1.2** in Chapter 1).

Building on these elements, I developed a conceptual framework to analyse how clientelism operates within two core components of the health sector (personnel and programs). The framework, summarised again in **Table 7.1**, identifies two routes through which political clientelism shape healthcare services: a patronage route, where jobs and resources are allocated to political supporters, and a resource-extraction or rent-seeking route, where actors extract rents—through such mechanisms as through kickbacks, bribery, and budget manipulation—to finance political networks. Needless to say, this often involves corrupt activities that contravene the law. These dynamics are contrasted with more programmatic and professional modes of governance across the sector.

Table 7.1

Conceptual Framework of How Clientelism, Patronage, and Rent-Seeking Affects Healthcare Performance

Components of health system	**Key activities**	**Clientelistic and patronage flows**		**Programmatic/ professional alternative**
		Patronage route	**Resource extraction route**	
Health workforce/ personnel	Promotion and selection of local health officials and public health provider executives, and temporary staff.	Patronage appointments for political supporters and people with political connections.	Bribery and illegal fees in exchange for promotion and selection of public officials.	Merit-based selection and promotion.
Healthcare programs and facilities (health services)	Primary and public healthcare programming, provision of key healthcare initiatives/programs, such as construction of primary healthcare centres and local hospitals, and provision of medicines and medical devices.	Healthcare programming is designed to allocate projects and government contracts to political supporters and persons with political connections.	Budget manipulation, mark-ups, illegal fees, and bribery extracted from procurement contracts. Sub-standard and/or counterfeit drugs and medical supplies.	Transparent, inclusive, universalistic health policies and programming; transparent health sector procurement.

Makassar's unexpected performance pushed me to look more closely at what really drives these differences. This anomaly led to the second research question, which asks what conditions shape the relationship between clientelism and health service delivery, and then to a third question about how clientelistic politics actually influence healthcare quality on the ground. These questions form a natural progression—from identifying the pattern, through asking why it happens, to examining the impacts. The next section summarises the findings that emerge from the five core arguments developed in this study. The findings draw on both the quantitative analysis and the qualitative evidence generated from the three case studies: Kupang, Makassar, and Semarang.

Findings and Reflections

The first argument addresses how variations in clientelistic politics shape the quality of healthcare delivery across cities and districts. Overall, the relationships follow the expected pattern: districts and cities with higher levels of clientelism tend to deliver poorer-quality healthcare, while those with lower clientelism perform better. These findings build on and deepen Berenschot's (2018b, 2019a) insights into how levels of clientelism vary across Indonesia's local governments. His work shows that higher clientelism is closely linked to weaker performance in key areas of public spending, and my results reinforce and extend that pattern within the health sector. As shown in **Figure 1.4** (Chapter 1, page 12), Semarang (Quadrant A) represents a low-clientelism, high-performance model, whereas Kupang (Quadrant D) reflects the opposite—high clientelism and poor outcomes. Most Indonesian cities and districts fall within these two quadrants (A and D), underscoring how clientelism distorts the health system by prioritising political and personal gain over public needs. It weakens merit-based recruitment for healthcare workers and bureaucrats, skews health resource allocation, and enables rent-seeking/corruption, particularly in support of political financing.

The anomalous case of Makassar, as noted above, challenges the notion that intensity of clientelism determines outcomes and thus gives rise to the second finding, that the form or pattern of clientelism also plays a decisive role in shaping health service

delivery. Employing the analytical framework developed by Berenschot and Aspinall (2020, p. 11) as shown in **Table 1.2** (page 13), my study found that:

- Kupang emerges at the most fragmented end of the spectrum of organisation and coordination of clientelistic politics, where weak party structures leave political control in the hands of individual elites. Resource allocation follows short-term political interests, and the health sector becomes a key site for patronage and rent extraction, with little incentive for reform.

- Makassar sits in the middle of the continuum. Its politics are neither strongly party-driven nor fully personalised. Instead, the city displays a hybrid pattern marked by cartel-like alliances, competing patronage networks, weak party institutionalisation, and relatively active civil society, including a strong culture of student activism. In this setting, clientelism persists, but civic pressure and reputational concerns can nudge elites toward more programmatic choices.

- Semarang sits at the other end of the spectrum, as long-standing PDI-P dominance has nurtured party institutionalisation and control over resources. Its structured patronage networks, deep community ties, and coordinated leadership have created more stable political relationships and enabled greater policy discipline; this, in turn, promote more consistent and responsive public service delivery, including in the health sector.

The third finding is that certain political conditions shape or affect the degree to which clientelism undermines healthcare delivery. A first important condition I have highlighted concerns the degree to which local elites are able to concentrate clientelist practices into specific parts of the local bureaucracy and economy, while protecting others. This selective use of influence allows hybrid governance to emerge: sectors that offer high potential returns or rent-seeking opportunities become clientelistic, while others—often those more visible to the public—are governed more programmatically. This insight extends Bussel's (2010, p. 1230; 2019, p. 8) argument that politicians weigh the loss of bureaucratic rents against the political gains of better service delivery. My contribution is to apply this logic to a sector-specific, comparative analysis of healthcare

governance, showing how factors such as civic pressure, middle-class expectations, market competition, and alternative patronage opportunities shape where elites choose to intervene, and where they hold back.

In Semarang, a diverse and vibrant economy, anchored in trade, property development, and urban infrastructure, has generally been associated with lower levels of clientelism. Nevertheless, this economic structure continues to provide multiple channels through which political actors can sustain patronage, particularly through land use and permits to urban development projects. The entrenched dominance of PDI-P further institutionalises these flows through party-linked organisations and associations such as KADIN, HIPMI, and BAZNAS. This dense network of economic and political intermediaries allows a degree of insulation for the health sector, as elites prioritise more profitable or flexible arenas of exchange.

Makassar similarly benefits from alternative rent-seeking opportunities as the commercial hub of Eastern Indonesia. Political elites often derive patronage resources from infrastructure and property ventures, which serve as key instruments for coalition-building in highly competitive electoral environments. While clientelist logic still shapes appointments of some key health bureaucrats and procurement of construction in high-value health facilities, the sector faces less interference because other rent-rich domains absorb elite attention and resources.

By contrast, Kupang presents the opposite condition. Its smaller and less diversified economy offers few alternative patronage sites beyond the public sector. With limited private sector investment or infrastructure spending, state-funded services—*especially* health and education—become primary vehicles for contributing jobs, contracts, and political rewards. In this setting, everyday governance and service delivery are deeply entangled with political loyalty, leaving little space for reform or professional autonomy.

Across these three cases, there is a clear pattern whereby when elites have access to alternative patronage resources, clientelism becomes more selective and governance

more hybrid. Where such alternatives are absent, clientelism penetrates deeper into essential services, constraining both accountability and performance.

A second set of conditions shaping how clientelism affects health services relates to the strength of the middle class, the vibrancy of civil society, and the degree of market competition. In cities like Makassar and Semarang, a growing middle class has created new pressures for better service delivery. These voters are less responsive to small-scale inducements and have greater access to private or provincial hospitals, reducing their dependence on city-run facilities. As the literature suggests, wealthier and better-informed citizens are harder to monitor and less tolerant of clientelistic practices. This shift raises the political costs of interfering in visible sectors like healthcare.

Yet a large middle class is not enough. As Weitz-Shapiro (2014, p. 5) argues, political competition also matters. My findings refine this insight by showing that, across both competitive settings such as Makassar and Kupang and less competitive contexts like Semarang, the intensity of political competition does not exert a consistent effect on the prevalence of clientelism. Instead, political clientelism adapts to different competitive environments, reshaping their forms and mechanisms rather than causing them to disappear altogether. The case studies of Makassar and Semarang show that, rather than risking political backlash in electorally salient sectors, elites strategically insulate healthcare while redirecting their attention to resource extraction opportunities in the less visible, rent-rich domains, such as land, construction, and spatial planning. This selective adaptation also helps explain the emergence of hybrid governance, where programmatic delivery in health sector coexists with entrenched clientelism in other sectors.

Civil society plays a similar moderating role. In Semarang, community organisations, neighbourhood groups, and health forums are deeply embedded in local governance and regularly engage with *puskesmas*, *kelurahan* offices, and city health officials. These networks provide routine oversight and raise reputational costs for poor performance. Makassar's civil society is more fragmented but still influential—especially at times of elections and political contestation—though grassroots groups are often co-opted for electoral mobilisation. In Kupang, civil society is far weaker. Organisations are

few, under-resourced, and poorly connected to public health institutions, exerting little pressure on political elites and allowing clientelism to permeate everyday service delivery.

Market competition further shapes these dynamics. The expansion of private healthcare under the JKN scheme has eroded the political value of public facilities as patronage resources. As private providers enter the system and offer JKN-covered services, citizens—especially the middle class—gain alternatives. Public facilities now face reputational and financial pressure to maintain quality, since poor performance risks losing patients and JKN revenue. For politicians, this reduces the effectiveness of clientelistic exchanges anchored in public services.

These moderating forces shape how far clientelism can reach into the health sector, but not how it operates within it. Across all three cities, two mechanisms consistently shape the politics of healthcare: patronage in bureaucratic appointments and rent-seeking in health budgets and procurement, though their expression varies by context. Patronage is most visible in appointments to city health offices (*Dinas Kesehatan*), city-run hospitals (RSUD), and frontline service delivery units such as *puskesmas*. In Semarang, key posts often go to trusted PDI-P loyalists, while lower-level positions and minor contracts are informally shared across parties to maintain political balance. Yet these political appointments are tempered by performance expectations: technically weak appointees are replaced, and routine civil-service hiring follows more transparent, merit-based rules.

In Makassar and Kupang, patronage and rent-seeking/corruption overlap more directly. In Makassar, appointments are tied to personal networks and campaign mobilisation, with strategic placements used to reward supporters. These roles often carry expectations that appointees facilitate access to public resources, especially in high-value projects such as hospital construction or purchase of expensive medical equipment. In Kupang, where oversight is weaker and alternative patronage sources are limited, rent-seeking becomes far more pervasive. Even routine maintenance, small health projects, and everyday service delivery can serve political purposes, making resource extraction a generalised feature of governance, including in the health sector.

Theoretical Contributions

My thesis makes several contributions to the study of political clientelism, public health, and subnational comparative politics in Indonesia and beyond. At the broadest level, it demonstrates that political clientelism is far more varied, strategic, and sector-specific than commonly assumed. Rather than operating as a uniform logic of exchange, political clientelism takes different forms—ranging from entrenched and pervasive, to selective and insulated, to disciplined and party-structured—both across and even within a single country, depending on local political economies and the incentives facing elites.

The **first** contribution is thus to the growing literature on the *varieties of clientelism*. While previous research highlights cross-national differences, such as by Berenschot and Aspinall (2020, pp. 6–10), Aspinall et al. (2022), and Hutchcroft (2014, pp. 177–178), my thesis demonstrates that meaningful variation also occurs within countries, across both subnational level (cities) and policy sectors, building on previous studies in Aspinall and Berenschot (2019, pp. 250–261), Aspinall et al. (2022, pp. 204–234), and Berenschot (2018b, pp. 1575–1583). By comparing Kupang, Makassar, and Semarang, this study directly responds to Berenschot's (2018b, p. 1565) calls for systematic subnational analysis and shows that such comparison is not only feasible but analytically revealing.

These cases also complicate the conventional binary that portrays clientelism as either personalised (individual-centred) or institutionalised (party-centred). Following a study conducted by Yıldırım and Kitschelt (2020, pp. 21–25), this study adopts the view that clientelism is adaptive rather than binary. Clientelistic practices can shift from highly visible forms such as vote-buying toward less visible, institutionally embedded patronage distribution mechanisms, including patronage appointments, manipulation of government contracts, and regulatory discretion. Drawing on expert survey data covering 506 political parties across 88 countries, they distinguish five types of clientelistic inducements and group them analytically into "spot-market exchanges" (vote-buying and goods) and "relational exchanges" (jobs, contracts, regulation discretion, and durable benefits (Yıldırım & Kitschelt, 2020, p. 24).

This framework helps illuminate the variation observed across my cases. Kupang exhibits personalised clientelism that permeates most sectors and relies heavily on spot-market exchanges. Makassar shows a mix of personalised and institutionalised clientelism that is more selective and less pervasive, with resource extraction concentrated in high-value areas alongside pockets of programmatic reform. Makassar also displays a high degree of a selective pattern in which relational clientelism is more pronounced at elite and bureaucratic levels, while spot-market exchanges persist in urban poor neighbourhoods. Semarang, by contrast, illustrates a more disciplined, party-routinised form of patronage, with clearer boundaries between political loyalty and bureaucratic performance. In line with Yıldırım and Kitschelt's findings, the Semarang case exhibits a party that not only makes stronger programmatic appeals but also relies less on vote-buying and more on relational, institutionally embedded clientelistic exchanges.

Their arguments also reinforce my findings for Makassar and Semarang, where the health sector is relatively insulated from overt clientelistic intervention, while clientelistic practices are redirected toward land use arrangements, construction, and spatial planning. Clientelism thus does not recede under conditions of political competition or programmatic governance; instead, it relocates across sectors, contributing to hybrid governance arrangements. Taken together, these sectoral and organisational variations suggest that clientelism operates through distinct and patterned modes of political mobilisation, rather than as an undifferentiated practice. The ways in which elites combine spot-market and relational exchanges, and selectively deploy them across sectors, point to broader configurations of political mobilisation that structure how patronage democracies function.

These patterns align with Aspinall et al. (2022, p. 73)'s argument that patronage democracies operate through distinct "mobilisation regimes". My findings show how these regime types can be mapped not only across Southeast Asian countries, as these authors suggest, but in a rougher way also across settings within Indonesia. **Table 7.2** summarises how each of my cases corresponds to these mobilisation regimes (but noting that, not surprisingly, each of my cases also roughly corresponds with the Indonesian pattern described in that volume).

Table 7.2

Mapping Mobilisation Regimes and Corresponding Case Studies

Country-level Mobilisation Regime*	Defining Features	Closet Case Study
Ad-hoc teams (Indonesia)	Personalised, weak party-systems, privately funded campaigns, micro- and meso-level patronage/particularism, election-time patronage.	Kupang
Local machines (The Philippines)	Durable local networks, dynastic control, mixed patronage tools.	Makassar
Party-machines (Malaysia)	Centralised, strong state–party fusion, party-centred patronage, macro-level patronage across the electoral cycle.	Semarang

Source: *Adopted from Aspinall et al. (2022, pp. 73–74; 87–88).

The Kupang and Makassar cases each exhibit characteristics that mirror broader patterns of clientelism observed in Indonesia, as set out in Aspinall et al. 2022. Kupang resembles the Philippines in its reliance on clan-based networks. At the same time, it reflects core features of Indonesian clientelism in its highly personalised electoral competition, where candidates personally finance campaigns and mobilise "ad hoc team" in the absence of strong party machines. Patronage in Kupang is dominated by micro-particularistic exchanges, such as short-term handouts or small-scale projects, rather than programmatic distributions. With limited bureaucratic discretion and weak institutional capacity, durable local political machines struggle to consolidate, mirroring the structural constraints on machine-building identified by Aspinall et al. for Indonesia (pp. 86–88).

Makassar, while also generally adhering to the Indonesian pattern, shares similarities with the Philippines in the presence of enduring dynastic networks, the use by politicians of a mixture of patronage tools and the central role of strong local brokers (Aspinall et al., 2022, pp. 73–74; 91–105). Its pattern of competitive political clientelism, shaped by locally powerful families (e.g., the Kallas, Bosowas, Limpos, Sirajuddins), entrenched elite networks, and broker-mediated mobilisation, resembles Philippine local politics, where clientelistic relations persist across electoral cycles and patronage networks are dominated by a small number of political dynasties. As in the Philippine

case, patronage in Makassar is selective and strategic, anchored primarily in personal and factional organisations rather than formal party structures. At the same time, Makassar also reflects a broader Indonesian pattern of weak party institutionalisation, with electoral competition largely financed through candidates' personal resources rather than party machinery.

Malaysia's "party machine" regime characterised by institutionalised, centralised party structures capable of distributing macro-level patronage throughout the electoral cycle (pp. 73–74) is echoed in Semarang. PDI-P's long-standing dominance in Semarang mirrors the ordered, hierarchical, and routinised patronage distribution described in the Malaysian case. Here, the party, rather than individual politicians, coordinates appointments, contracts, and political messaging. This has the effect of insulating key public services—especially health—from disruptive political meddling, much like occurs with the strong party-state-fusion in Malaysia.

The **second** contribution made by my study is its development of *a sector-specific framework* explaining the mechanisms through which clientelism interacts with healthcare. Existing studies of Indonesian clientelism and corruption have largely concentrated on visible, rent-rich domains such as infrastructure, licensing, and social assistance (Aspinall, 2015; Aspinall et al., 2022; Bachriadi & Aspinall, 2023; Lambsdorff, 2002; Mulyadi, 2013; Van Klinken & Aspinall, 2011). By contrast, relatively few studies examine how clientelistic practices operate within the health sector. A few Indonesian studies have addressed this gap, including Berenschot et al. (2018), Blunt et al. (2012), Rosser (2012), Rosser et al. (2011), and more recently Sari et al. (2023). Comparable efforts have been made in international contexts, notably in Brazil (Nichter, 2011), Lebanon (Chen & Cammett, 2012), and India (Berenschot, 2010, 2019b; Berenschot & Bagchi, 2020). Nonetheless, much of the broader literature continues to treat health governance as analytically separate from political studies, implicitly assuming that health governance is too technical or insulated to be politically attractive for rent-seeking or patronage-wielding politicians. My findings challenge this assumption. Across the three cities, I found that the health sector is deeply shaped by political incentives—but not in uniform ways. The framework identifies *two core mechanisms through which clientelism interacts with healthcare: patronage and rent-seeking*. Patronage is most

visible in bureaucratic appointments and the distribution of frontline programs, where political actors place loyalists in positions that help maintain support networks. Rent-seeking/corruption, by contrast, tends to cluster in procurement and construction—areas with higher financial returns and lower public visibility. Although developed in the context of healthcare, this framework has the potential to be applied and replicated across other public service sectors.

Yet these mechanisms do not operate everywhere to an equal degree. Instead, political elites make deliberate choices about *where* to intervene and *where* to refrain, depending on sectoral visibility, reputational risk, and the availability of alternative patronage opportunities. Kupang sits at one end of this continuum: with few alternative channels for raising rents, almost every subsector of health—frontline services, appointments of health bureaucrats, programs, and contracts—becomes a site of patronage and resource extraction. In Makassar, patronage is present in key health appointments, but the more lucrative forms of rent-seeking/corruption gravitate toward big-ticket procurement—especially hospital construction projects and medical equipment—rather than everyday service delivery. Semarang occupies the opposite end of the spectrum. Although political discretion still shapes some senior appointments, the health sector is largely shielded from rent-seeking/corruption. Procurement and program implementation follow more transparent and rules-based procedures, and political clientelism, to a much lesser extent operates primarily through the distribution of patronage rather than the extraction of rents. Though the mechanisms are similar, they can produce different governance trajectories when filtered through distinct political economies and incentive structures—a point we turn to next.

The **third** contribution is advancing the conceptual debates on hybrid governance. Across three case studies, I show that governance rarely fits into neat categories of 'clientelistic' or 'programmatic.' Instead, political actors blend strategies. They selectively insulate politically salient sectors—such as health, where middle-class scrutiny and public visibility are high—while extracting rents from less visible and more lucrative areas, including infrastructure/public works, and land use. This pattern supports Bussell's (2019, p. 4) argument that politicians weigh the political benefits of better service delivery against the opportunity costs of foregoing bureaucratic rents. My

findings extend this insight further by showing that this trade-off is not made in the abstract but through sector-specific calculations shaped by visibility, reputational risk, and the availability of alternative patronage sites/sectors. This foregrounding of the adaptive character of clientelism also echoes the study conducted by Yıldırım and Kitschelt (2020, pp. 21–25) as mentioned above. The patterns observed in my case studies align closely with a general pattern: as electoral competition intensifies and public scrutiny increases, clientelism tends to migrate from overt, personalised exchanges toward more durable, relational, and bureaucratically mediated forms integrated within local government institutions.

In this respect, the analysis also resonates with the findings of Gans-Morse, Mazzuca, and Nichter (2014, pp. 416–419), who emphasise the economic logic underlying the strategic adaptation of clientelism. They suggest that rather than disappearing under conditions of political competition or social pressure, clientelism adjusts as political actors weigh the relative costs, constrains, and expected returns of different clientelist strategies. Their study shows that while political competition and middle-class pressures rarely eliminate clientelism, they can reshape its location and form, pushing clientelistic practices away from highly visible and closely scrutinised sectors and towards less visible domains with higher rent potential.

Viewed from this perspective, political clientelism should not be understood as a default mode of governance but as a strategic political choice. Elites intervene intensely where political returns are high and constraints are weak, and they step back where performance, legitimacy, or coalition stability matter more. This explains why the same city can produce different governance styles in different sectors and why the health sector may appear more insulated in one city and more vulnerable in another.

Fourth, my thesis strengthens comparative subnational research in Indonesia by using systematic comparison analysis across a limited number of selected cities. Scholars have long noted varying government performance at the subnational level in the era of decentralisation, e.g., Aspinall and Berenschot (2019); Berenschot (2018b); Berenschot and Mulder (2019); Fossati (2018b); Kis-Katos and Sjahrir (2017); B. Lewis (2017); McCollum et al. (2018); M. Mustafa (2017, 2024); Rosser (2012); Rosser et al.

(2011); Sjahrir, Kis-Katos, and Schulze (2014); Skoufias, Narayan, Dasgupta, and Kaiser (2014). At the same time, much of the Indonesian literature on political clientelism—whether based on national-level analysis (e.g., Fionna & Tomsa, 2020; Haryanto, 2017), national-level surveys (i.e., Allen, 2015; Fossati, Aspinall, Muhtadi, & Warburton, 2020; Hicken et al., 2022; and Muhtadi and Aspinall, 2018), or comparative studies across districts and cities (e.g., Aspinall et al., 2017; Aspinall & Sukmajati, 2016; Fossati, 20116b; and Simandjuntak, 2012)—has primarily focused on its relationship with elections and the quality of democracy. By comparing Kupang, Makassar, and Semarang, this study demonstrates that clientelism is highly relevant to governance and policy outcomes writ large, and that subnational variation in clientelism is a patterned outcome shaped by four contextual factors: middle-class size, civil society mobilisation, market competition in healthcare, and alternative rent-generating sectors. These findings strengthen Berenschot's (2018b) argument that societal constraints shape the intensity of clientelism but extend it by showing how these constraints influence sectoral targeting, not just overall intensity.

Fifth, this study foregrounds the strategic agency of political elites albeit within specific structural contexts. Across cities, politicians engage in deliberate calculations to insulate the health sector when it is politically useful or exploit it when alternative rent channels are limited. Cities with similar fiscal capacities, like Makassar and Semarang, produce different patterns of clientelism in health governance. It also suggests that the political logic of clientelism is multidimensional. Elites simultaneously pursue such core goals as legitimacy, the maintenance of coalition stability, and the financing of political machines.

Directions for Future Research

By mapping these variations, the thesis adds conceptual clarity to the study of patronage democracies and invites further comparative work on how different policy sectors—education, sanitation, social welfare, infrastructure—are differentially exposed to or insulated from political interference. While this thesis advances our understanding of how clientelism operates in the health sector and of how clientelism shapes healthcare governance at the subnational level, it also provides opportunities for further

investigations. There are at least five particularly promising directions for future research that arise from my study:

1. Cross-sectoral comparison of clientelism. This study has shown that clientelism is not uniformly applied across sectors. Future research can extend this study's framework to other policy areas, such as education, public works, the environment and natural resources, to assess which sectors are most vulnerable to political clientelism and why. Sectoral-specific clientelism beyond Indonesia provides useful reference points, including research on the social protection sector in the Philippines (Swamy, 2016), construction projects in Ghana (Williams, 2017), social policy in Eastern Europe (Cook, 2014), the information technology sector in India (Bussell, 2010), financial health assistance in Lebanon (Chen & Cammett, 2012), privatisation and licensing in post-communist Central and Eastern European countries (Kitschelt & Wilkinson, 2007a), the education sector in Indonesia (Pierskalla & Sacks, 2019), and in reducing carbon dioxide emissions across 150 nations (Sommer, 2020). There is obviously significant scope for further such studies, but also for more concerted effort to compare across sectors, in order to help identify whether the health sector is distinctive, or, rather, part of a broader pattern of sectoral targeting in patronage democracies.

2. Longitudinal studies on political change and clientelistic adaptation. Clientelistic practices and strategies can evolve alongside changes in such arenas as political competition, welfare expansion, and urbanisation. Longitudinal research can examine how those practices and strategies adapt to changing institutional incentives, such as increasing digitalisation of public services, expanding public healthcare and welfare schemes, democratisation, decentralisation and anti-corruption reforms. Tracking this evolution over 10 to 20 years could clarify, for example, whether hybrid governance is a transitional phase or a stable equilibrium. I have in mind Indonesia here, but there is a need for more studies of long-term change in clientelistic politics around the world, and comparative insights from international research—such as studies by Bardhan, Mitra, Mookherjee, and Sarkar (2015); Bardhan and Mookherjee (2006); Bešić and Baća (2025); Chiru (2024); Staffan I Lindberg et al. (2022); Lindberg, Lo Bue, and Sen (2022); Lo Bue et al. (2021)—provide useful conceptual and methodological reference points for such analysis.

3. Comparative studies beyond Indonesia. The mobilisation regime framework used in my thesis can be tested in other decentralised democracies or countries where clientelism remains prevalent, e.g., the Philippines, Brazil, or India. Cross-country comparisons can deepen understanding of how institutional arrangements, social coalitions, and party systems shape sectoral patterns of clientelism as well as governance reforms.

4. The role of middle-class politics and civic mobilisation. My findings suggest that middle-class growth and civic pressure can constrain clientelistic behaviour, but the effects are uneven. Future research can investigate if, how and under what conditions different forms of civic engagement and pressure (e.g., digital activism, issue-based movements, professional associations, and student activism) can translate into sustained accountability.

5. Market competition and private sector involvement. Further research could examine how the expansion of the private sector and processes of corporatisation reshape patronage networks and local incentive structures. Comparative and longitudinal study by Kuo (2018, pp. 133–140) in the United States and Britain, for example, shows how capitalist development can foster political development by encouraging parties to shift away from clientelistic reliance toward more programmatic policies.

In summary, these future directions point toward a broader research agenda to understand how, where, and under what political conditions the grip of clientelism may potentially be loosened. This thesis offers a foundation for more ambitious comparative studies that connect political incentives, service delivery, and citizen demand in Indonesia and beyond.

Policy Implications

The theoretical contributions lead to some practical considerations for reform. They suggest that improving healthcare performance in decentralised democracies such as Indonesia requires more than technical or institutional fixes. Instead, reform efforts must address the political incentives that sustain clientelistic behaviour, recognising that

health governance is not just a bureaucratic domain but is a political arena in which political actors make strategic decisions about when, where, and how to deploy clientelistic strategies (Berenschot & Aspinall, 2020, pp. 14–16). Reform strategy that neglects this political dimension will risk reproducing the very patterns of governance failure they seek to correct.

Reforms in the health sector must recognise that clientelism follows political incentives, not sectoral boundaries. This means that in regions where health systems are electorally salient, and local communities are relatively empowered, like in Semarang, political elites have incentives to protect them from excessive political interference. By contrast, in regions like Kupang, where alternative patronage sources are limited, the health sector becomes a primary arena of patronage and resource extraction. Reform efforts must therefore be calibrated to the underlying realities of local politics and the local political economy. In highly predatory environments (such as Kupang), strengthening procurement oversight, appointment processes, and external scrutiny becomes essential. In more institutionalised settings, reforms can focus on refining accountability mechanisms.

As previously explained, my analysis underscores the logic of institutional insulation. Highly visible sectors such as healthcare, which are subject to performance scrutiny and reputational risks, are less attractive as sites of patronage. By contrast, less visible sectors with higher rent-generating potential are more attractive targets for patronage and rent-seeking. Policies that increase transparency, such as public complaint portals, performance dashboards, and mandatory procurement disclosure, therefore logically raise the political costs of interference. However, these mechanisms should not be viewed as self-sustaining. Their effectiveness depends on a supportive political context. In Semarang, a combination of relatively high levels of bureaucratic discipline and strong party machinery allow institutional insulation to be maintained without eliminating the informal expectations of loyalty that continue to underpin the system.

Merit-based appointments represent a crucial but politically sensitive frontier. Patronage thrives where bureaucratic discretion is weak and the discretion of politicians

is unchecked. Introducing open and competitive recruitment for health bureaucrats and the health workforce, standardising leadership selection criteria, and strengthening the career progression system can reduce opportunities for politicisation of appointments and promotions. To be effective, however, these reforms must be accompanied by mechanisms that limit political interference by local elites. This includes establishment or strengthening of independent oversight bodies to safeguard civil service neutrality, monitor recruitment and promotion processes, and scrutinise non-permanent staffing requests and ad hoc appointments that are often used as entry points for patronage. These civil service reforms not only improve service quality but also diminish the value of bureaucratic positions as political currency. Where appointments remain discretionary, they become conduits for political mobilisation and resource extraction, as shown in Kupang.

Nevertheless, these reforms require sustained political commitment from both the executive and the legislature at the national level. Civil service reforms introduced in 2014 through Law No. 5/2014—which established merit-based recruitment and promotion, reinforced civil service neutrality, and created the State Civil Service Commission (*Komisi Aparatur Sipil Negara,* KASN)—have been substantially moderated following the 2023 revision of the law (Law No. 20/2023) and its implementing regulation (Presidential Regulation No. 91/2024). These changes abolished KASN and transferred its functions to the Ministry of State Apparatus and Bureaucratic Reform (*Kementerian Pendayagunaan Aparatur Negara dan Reformasi Birokrasi,* KemenPAN&RB) and National Civil Service Agency (*Badan Kepegawaian Negara*, BKN), effectively shifting oversight of the merit system from an independent body to executive institutions. This trajectory illustrates the political difficulty of sustaining merit-based reforms in contexts where political actors—at both national and subnational levels—retain strong incentives to undermine civil service neutrality through discretionary appointments and political influence, as also acknowledged by Berenschot (2018a, p. 135).

My analysis also suggests that civic oversight, private sector competition, and middle-class engagement/activism can alter the political calculus for patronage-oriented politicians. The rise of middle-class constituencies making higher demands for service

quality is a pivotal constraint on clientelism. Supporting civil society organisations, advocacy groups, health professional associations, and independent journalism can enhance scrutiny of political interference in health services. As Semarang illustrates, when assertive civil society actors—supported by robust oversight mechanisms—are embedded within planning and monitoring mechanisms and routinised forums, they can reinforce programmatic policies. The increased market competition in healthcare as a result of the rising economic growth and middle-class constituencies can boost performance of public health providers.

Taken together, these contributions show that public service delivery—particularly in health—cannot be understood without examining the political incentives behind how resources, appointments, and authority are allocated. Clientelism emerges not as a uniform practice but as an adaptive, context-specific strategy that varies by place, sector, and political configuration.

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