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The Flying Doctors: A Collaborative Governance Model in Delivering Public Health Service to the Border Areas

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ABSTRACT

Although health service is the right of citizens and is the obligation of the government to provide it, empirical findings show that the service is not available evenly and has not been fully accessible to people in need. This study shows that the era of decentralization which gives broad of authority in the field of health services to local governments is able to bring an innovative spirit to provide the best service in the midst of limitations that are owned by regions that have border areas. The Flying Doctors program initiated by the North Kalimantan provincial government is a collaborative model that demonstrates the spirit of innovation to bring services to the people in the border areas that are difficult to reach by land transportation modes. Although initiated by the provincial government, other stakeholders also contributed significantly, be it the regency governments as the location of program implementation, the communitiesas the beneficiary groups, or the private sectors, especially the pioneer airlines that allow this program to run. As the conclusion, there are at least fourfactors encouraging the actors to collaborate. *First*, geographical aspect such as areas that are difficult to reach will encourage actors to collaborate. *Second*, limitation in allocated budget, structure and infrastructure, will push the actors to joint their resources into a collaborative actions. *Three*, relations between the central and local governments that are decentralized will encourage local governments to make innovative decisions in providing the best services to the community.*Four*, sharing action will be possible if there is a sharing vision between stakeholders.

KEYWORDS: Collaborative governance, health services, flying doctors, decentralization

INTRODUCTION

Health services are the rights of every citizen that must be provided by the government as guaranteed by various laws and regulations in Indonesia. However, in practice there are still many citizens who have not received adequate health services from the government as mandated by the various regulations above. One of the groups of people who have not access to adequate health services are those who live in border areas with other countries. Public health status and health service coverage in remote border areas are still low. In addition, the public generally does not have the knowledge and behavior of healthy living and unfavorable environmental conditions (Suharmiati et al., 2012:24). Geographical conditions that are far from the center of government, inadequate means of transportation, limited health facilities and infrastructure available, and the very limited number of health workers are crucial factors that cause health services in the border area to not optimally delivered (Lestari, 2013:9).

One of the border areas that still have a serious problem in health services is North Kalimantan. The youngest province in Indonesia is located in the northern part of Kalimantan Island. The province, which was recently ratified as the 34th province in 2012, is directly adjacent to Malaysia, especially the State of Sabah and Sarawak. North Kalimantan itself consists of four regencies and one city with relatively different regional characteristics, which two of them, namely Nunukan and Malinau regencies bordering Malaysia. The selection of North Kalimantan as the location of this study is also quite reasonable. *First*, North Kalimantan is the youngest province in Indonesia, which was inaugurated in 2012, so it has many limitations compared to other provinces, for example from aspects of government institutions, human resources of regional government apparatus, as well as limited infrastructure facilities owned by the regions. *Secondly*, North Kalimantan geographically is also unique because there are several locations that can only be reached by air, thus bringing its own challenges in providing services to the community. *Third*, North Kalimantan represents a border region that has two characteristics at once, namely the sea and land borders, each of which has different management consequences (Sulaksono, 2017).

Some serious problems in the health sector found in North Kalimantan are the unavailability of adequate health facilities in these border areas. As a result, many Indonesians living in the border region occasionally chose to go to Malaysia, especially in Tawau. They reasoned, health facilities in Tawau were more adequate, and access to the hospital was also closer therefore not time consuming. This is a consideration for people who are seriously ill for treatment at Tawau. According to Jacob, a former Indonesian navy who lives in Sebatik Island, legality is also not a problem for Indonesian citizens who will seek treatment in Tawau because they can be taken care of later. Indonesian citizens are also treated well by hospital staff, without discriminating between Malaysian citizens. (Jacob, interview, September 5th, 2017).

In conditions that are full of limitations, there is an interesting breakthrough initiated by the North Kalimantan Provincial Government. Through the provincial Health Service Office, since 2014 the provincial government has initiated a "Flying Doctors" program to bring services closer to people in need, especially those living in border areas who have many limitations in terms of facilities and infrastructure as well as competent human resources. Although there were some obstacles during its implementation over the past four years, this program was very interesting to study because it showed a pattern of collaboration in terms of providing services to citizens, especially in the health sector. In this pattern, it is seen the role of each stakeholder in the program. Not only the state as the leading sector, the private sector and the public also plays its role so that the program could continue and still provide benefits for residents in the border area.

In the end, we conclude that *first*, the success of the program is inseparable from the pattern of decentralized central and regional relations imposed in post-New Order Indonesia. With decentralization, the local government has the authority to formulate policies and run programs related to the affairs within its responsibility. Furthermore, decentralization has also forced regions to innovate in providing services to their communities in the midst of limitations and difficult situations in the border region. However, the role of the central government also cannot be underestimated, because as the main regulator in a unitary state, the central government still has the highest authority in making national-scale policies, including in allocating resources owned by a State to overcome problems

that faced by its citizens such as providing optimal health services to the remote areas. *Secondly*, beside of the decentralization pattern, we also suggest that geographical aspect such as areas that are difficult to reach will encourage actors to collaborate. *Third*, Limitation in allocated budget, structure and infrastructure in a certain public issue, will push the actors to joint their resources into a collaborative actions. Health issue in border area is proven to be a trigger for the actors to collaborate. *Fourth*, sharing action will be possible if there is a sharing vision between stakeholders. Actors involved in the collaboration aware that the improvement of health condition in border areas is a common concern.

NORTH KALIMANTAN AS A BORDER AREA

Concept of Border Area

In Kolossov and Scott's view (2013: 1), borders can be viewed as a philosophical category as well as a social phenomenon. The study of borders has grown tremendously since the 19th century which at that time still saw the border as a geographical attachment. Today the study of borders reflects continuity and change in scientific thoughts and is also the result of countless contributions to the conceptualization of social space. Through investigations on the border, there is awareness that there is no hegemonic dominance of a particular social theory in understanding space and its social significance. Regardless of whether the space is abstract or absolute, people begin to realize that it is the border that ensures space and makes it concrete.

Border studies have shifted from an attention to the outermost side of the state and ethno-cultural areas to studies of borders on socio-spatial and geographical scales, ranging from very local to global, regional and supra-state levels. Border studies have also become a research field that is wide range of disciplines: ranging from political science, sociology, anthropology, history, international law, more recently, the humanities - notably art, media studies, and philosophy to ethics. Arguably, this disciplinary wealth of borders studies has rendered exclusive fixations with geographical, physical and tangible borders obsolete; equally important are cultural, social, economic and religious borders that though often invisible have major impacts on the way in which the human society is ordered organized and compartmentalized.

The novelty of the border study that we are celebrating today is partly due to the emergence of counter narratives against discourses in the late 80s to the early 90s. For a rather short but influential period, prophesies of "borderless worlds" abounded in which global technologies, cyberspace, capital flows, East-West political convergence and interstate integration would make political borders obsolete. However, perhaps ironically, globalization has instead been ubiquitous - not always visible, but always with clear social impacts. The present state of debate shows that the fields of the study have opened up possibilities for the questioning of the rationale behind everyday border making by understanding borders as institutions, processes and symbols. Borders are thus not given, they emerge through the socio-political processes of border-making or bordering that take place within society (Kolossov& Scott, 2013: 2).

The problem of borders is important because it relates to state sovereignty, utilization of natural resources, safeguarding security and territorial integrity. The development of border areas is basically an integral part of national development. The border region has strategic value in supporting the success of national development. There are various

reasons related to the emergence of border issues, including regulating the migration of people both legal and illegal, withdrawing customs taxes, preventing arms smuggling, narcotics, illegal trade, terrorism and others. In addition, as stated by Paasi (2012, p. 2307), understanding borders is tantamount to understanding how the State functions and how borders are exploited to mobilize and ensure territory, security, identity, emotions and memory, as well as various forms of national socialization.

Michael Eilenberg, in The Edge of States: Dynamics of State Formation in the Indonesian borderlands, stated that the border is an attractive location to conceptualize the dynamics of the state-society relation and the type of government that Indonesia has experienced since the colonial era, independence to the era of decentralization. However, similar to Paasi, Eilenberg notes that in any case this region is a place where state authority seems to be questioned or even manipulated so that border people have multiple loyalties and are very contradictory to the conceptions of sovereignty, territory and citizenship. The border area for Eilenberg is a "unique laboratory" to understand how border people connect with their nation-states and how this group is involved in loyalty contestation and multiple identities that are inherent in everyday life. In addition, the border area will also challenge our view of the state as a monolithic "unit" and we can see the complexity of networking between local residents and the state. Frontier residents for Eilenberg are not passive victims of state power but active actors play their political strategies. These people are disguised among the shadow of legality, and use border life as an opportunity (Eilenberg, 2012).

In the national regulatory system of Indonesia, the Border Area is defined as part of the State Territory located on the inside side along the boundaries of Indonesia with other countries, in terms of the State Territory on land, Border Regions are in the sub-district (Law No. 43 of 2008 concerning Territory of the State). Whereas in Law Number 26 of 2007 concerning Spatial Planning, which is further elaborated in Government Regulation Number 26 of 2008 concerning the National Spatial Plan (RTRWN), it is stated that the scope of the state border area is the Regency/City area which is geographically and demographically directly adjacent to neighboring countries and / or the high seas. The country's border area includes land and sea including the outermost small islands.

From what is contained in these regulations, it is clear that formal legal regulations in Indonesia define the border area only spatially. In it does not contain the issue of complex relationship dynamics as conveyed by Paasi or by Eilenberg above. In fact, the reality is that the dynamics that characterize the daily practice of people's lives on the border. Therefore, in addition to a formal legal approach, this study also uses an empirical approach in interpreting border areas that define borders not only geographically, but what Eilenberg calls a unique laboratory to understand how people on the border relate to the nation-state.

In Indonesia, the border is always tackled with areas that are left behind and lack of government attention. The impression of lack of attention from the Government towards the border area is always associated with development approaches used in the past, which emphasize securitycompared to prosperity. When Jokowi was elected President, the hopes of border residents to get better government attention grew. Border development is contained in the third point of Nawacita which is known as a priority agenda for Indonesia. There, Jokowi-JK thickened the phrase 'building Indonesia from the periphery'.

Development is no longer centralized in urban areas, but must be spread across all areas of decentralization.

North Kalimantan as a Border Area

North Kalimantan Province is one of 13 provinces in Indonesia that have border regions between countries. The vast area of North Kalimantan Province causes all regional characteristics to be found in this area, starting from the border region of North Kalimantan inland, remote, mountainous, coastal and island. North Kalimantan has an area of about 75,467.70 km^2 consisting of four regencies, namely Malinau, Nunukan, Bulungan, TanaTidung and one city, namely Tarakan. From the table 1 below shows that in North Kalimantan there are 444 villages, 38 sub-districts and 50 kelurahans. Among the 50 sub-districts, 20 of them are bordered by Malaysia, namely 5 sub-districts in Malinau regency and 15 sub-districts in Nunukan regency. The border area of North Kalimantan Province in the north borders Malaysia (Sabah), in the east borders the Sulawesi Sea, in the south borders the West Kutai Regency, East Kutai, KutaiKartanegara and Berau regency, East Kalimantan Province, and the west borders the State of Sarawak, Malaysia (Central Bureau of Statistics, East Kalimantan Province, 2018).

Table 1. Number of sub-Districts, *Desa* (Villages) and *Kelurahan* in North Kalimantan Province

Kabupaten/Kota *Regency/Municipality*	**Kecamatan** *Subdistrict*	**Desa** *Village*	**Kelurahan** *Village*
(1)	(2)	(3)	(4)
Kabupaten/*Regency*			
1. Malinau	15	109	-
2. Bulungan	10	71	10
3. Tana Tidung	5	32	-
4. Nunukan	16	232	8
Kota/*Municipality*			
1. Tarakan	4	-	20
Kalimantan Utara	**50**	**444**	**38**

Source: Central Bureau of Statistics, East Kalimantan Province, 2018.

Subsequently, from table 2 below, it can be seen that Malinau is the regency that has the largest area compared to other districts / cities. The Malinau area reaches 42,620.7 km2 or covers 56% of the total area of North Kalimantan Province, while the City of Tarakan is the smallest area with an area of only 250.8 km2, equivalent approximately to 0, 33% of the total area of North Kalimantan Province.

Table 2. The Large of North Kalimantan Province

Kabupaten/Kota *Regency/Municipality*	Luas (km²) *Total Area (square.km)*	Persentase *Percentage*
(1)	(2)	(3)
Kabupaten/*Regency*		
1. Malinau	42 620,70	56,48
2. Bulungan	13 925,72	18,45
3. Tana Tidung	4 828,58	6,40
4. Nunukan	13 841,90	18,34
Kota/*Municipality*		
1. Tarakan	250,80	0,33
Kalimantan Utara	**75 467,70**	**100,00**

Source: Central Bureau of Statistics, East Kalimantan Province, 2018.

Table 3 below shows the current population of North Kalimantan Province. The total population reaches 691,058 people, with a male population of 366,677 people and a female population of 324,381 people. From the table, it can also be seen that the population distribution between regions is relatively uneven. Tarakan city is the most populous region with a total of 253,026 people or reaching around 37% of the total population of North Kalimantan, while the population of North Kalimantan living in Tana Tidung regency only covers 25,084 people or covers 3.7% of the entire population of North Kalimantan.

Table 3. The Number of North Kalimantan Population in 2016

Kabupaten/Kota *Regency/Municipality*	Jenis Kelamin *Sex*			Rasio Jenis *Kelamin Sex Ratio*
	Laki-Laki *Male*	Perempuan *Female*	Jumlah *Total*	
(1)	(2)	(3)	(4)	(5)
Kabupaten/*Regency*				
1. Malinau	45 178	38 610	83 788	117,01
2. Bulungan	72 396	63 374	135 770	114,24
3. Tana Tidung	13 800	11 284	25 084	122,30
4. Nunukan	102 886	90 504	193 390	113,68
Kota/*Municipality*				
1. Tarakan	132 417	120 609	253 026	109,79
Kalimantan Utara	366 677	324 381	691 058	113,04

Source: Central Bureau of Statistics, East Kalimantan Province, 2018

From the aspect of population density, Tarakan City is the area with the highest density level, which covers 1,008 people per km2, while Malinau Regency is the lowest density because it only covers 1.97 people per km2, as shown in table 4 below.

Table 4. The Population Density of North Kalimantan Province

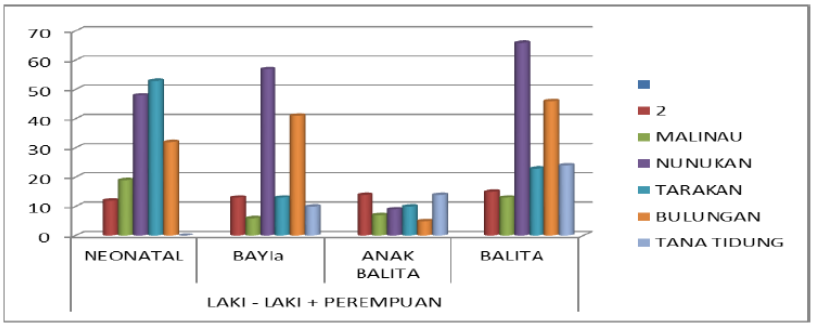
Kabupaten/Kota *Regency/Municipality*	Persentase Penduduk *Percentage of Total Population*	Kepadatan Penduduk per km² *Population Density per sq.km*
(1)	(2)	(3)
Kabupaten/*Regency*		
1. Malinau	12,12	1,97
2. Bulungan	19,65	9,75
3. Tana Tidung	3,63	5,19
4. Nunukan	27,98	13,97
Kota/*Municipality*		
1. Tarakan	36,61	1 008,88
Kalimantan Utara	**100,00**	**9,16**

Source: Central Bureau of Statistics, East Kalimantan Province, 2018

The pattern of population distribution of North Kalimantan Province according to its area can be said to be very unequal, causing differences in the level of population density striking between regions, especially between districts and cities. The district area with a total area of 99.65% of the Province of North Kalimantan is inhabited by around 63.25% of the total population of the province. While the rest, which is 36.75% of the population settled in the city whose area is only 0.35% of the area of North Kalimantan Province.

Geographical factors that influence the phenomenon or one of the problems in the pattern of population distribution can be seen because most of the province is dominated by protected areas, which is characterized by a fairly high slope / slope (76.27% is on the slope> 40%) and located at an altitude of 500-1000m above sea level (38.77%) making North Kalimantan Province have limitations in the development of the region. In developing the area, a non-protected area must be chosen so that the chance of disaster occurrence can be minimized. This geographical condition has resulted in the high availability of physical infrastructure in the form of road networks or other infrastructure (Bureau of Developmental Planning of North Kalimantan Province, 2016).

Table 5. The Number of Baby Death in North Kalimantan Province in 2016



Source: North Kalimantan Provincial Health Office, 2016

Maternal Mortality Rate (MMR) is one indicator to evaluate women's health status. The reduction in MMR is also one of the MDG targets, namely the 5th goal of improving maternal health by reducing the risk of maternal mortality. The intended maternal death is a mother's death caused by a pregnancy disorder or treatment (not including accident

or incidental cases) during pregnancy, childbirth and during the *puerperium* (42 days after giving birth) without taking into account the length of pregnancy. During 2015 based on reports from regencies / cities in North Kalimantan Province there were 21 cases of maternal deaths. Maternal mortality occurred in 4 (four) regencies / cities and in 2015 the most occurred in Nunukan and Bulungan Regencies with 7 cases respectively. (North Kalimantan Provincial Health Office, 2016).

Morbidity in the population comes from community based data obtained through observation, especially those obtained from health care facilities through routine and incidental recording and reporting. North Kalimantan Province is also faced with the problem of double load. On the one hand cases of infectious diseases are still high, but on the other hand degenerative diseases also increase. In addition, the behavior of unhealthy people is still a major factor in addition to the environment and health services. Some diseases that are still the focus of health services because of the high number of sufferers are Tuberculosis, Child Pneumonia, HIV and Sexually Transmitted Diseases, Diarrhea, and Leprosy.

In 2016, the total number of TB patients (all types) reached 2,514, and as many as 520 of them were new cases of BTA +, so in 2016 there was an increase in case finding. The death rate during treatment caused by pulmonary tuberculosis in 2016 was quite high at 4 per 100,000 population. The Cure Rate in 2016 was 55.65%. This figure is below the minimum number that must be achieved, namely 85% (North Kalimantan Provincial Health Office, 2016).

The third indicator to see the degree of public health is nutritional status. The nutritional status of the community is usually depicted by nutritional problems experienced by the population who are prone to nutrition, especially children under five. The nutritional status of a toddler can also be an indicator to determine the welfare of the community, besides also showing the physical quality of the population. Nutritional status as a result of the interaction of food intake and body needs. If this balance is disrupted, then there is a disturbance in body growth. This disorder is reflected easily from changes in body weight (BB) or height (TB). The prevalence of malnutrition in North Kalimantan Province in 2016 also increased. The most undernourished toddlers are in Bulungan Regency. Based on the WHO classification on nutrition issues as a public health problem, most areas in North Kalimantan in 2016 are in poor and poor condition. Nutritional insecurity shown by 3 parameters (underweight, stunting and wasting) illustrates that nutritional problems in North Kalimantan are chronic and acute.

Health Services for the North Kalimantan Border Community

This unsatisfactory public health condition is inseparable from the number of inadequate health facilities, especially for residents living in border areas, due to various limitations encountered in rural areas which result in their difficulties in accessing adequate health facilities and services. The information obtained in this study states that many patients prefer to access health facilities in Malaysia, which are considered closer and more complete in their facilities, rather than having to go to a hospital in North Kalimantan alone for various reasons and considerations. Some Puskesmas (sub-district community health center) have not been able to deal with serious illnesses so they have to be referred to big cities, for example to Tarakan. Unfortunately, the only access to go to a big city is by plane that not every citizen could access.

From table 6 below shows that in North Kalimantan there are nine hospitals and two maternity homes. Unfortunately, facilities in the form of hospitals are only concentrated in cities but in some areas are still lacking, especially in border areas. The number of hospitals in the district is still limited and is still type C, so specialist doctors are still very limited. In Nunukan regency, there is only one RSUD (local government public hospital), whereas the area is very wide. In Malinau regency with a very large area, there are only 2 hospitals of type C, whereas in Bulungan District, the capital of the province is also just one hospital with type C, and is currently in the process of building a government hospital there. (Bureau of Developmental Planning of North Kalimantan Province, 2016).

Table 6. The Number of Health Facilities in North Kalimantan Province 2016

Kabupaten/Kota *Regency/Municipality*	**Rumah Sakit** *Hospital*	**Rumah Bersalin** *Maternity Hospital*	**Puskesmas** *Public Health Center*	**Posyandu** *Maternal & Child Health Center*	**Klinik/Balai Kesehatan** *Clinic/Health Center*	**Polindes** *Village Maternity*
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Kabupaten/*Regency*						
1. Malinau	2	-	16	53	-	-
2. Bulungan	1	2	12	184	10	32
3. Tana Tidung	1	-	5	30	-	-
4. Nunukan	1	-	16	225	-	-
Kota/*Municipality*						
1. Tarakan	4	-	9	-	-	-
Kalimantan Utara	**9**	**2**	**58**	**444**	**10**	**32**

Source: Central Bureau of Statistics, East Kalimantan Province, 2018

Malinau and Nunukan regencies are border areas which should have quality health facilities for its acute health problem. But in reality health facilities are still very minimal, so the existence of quality health services will be very helpful in the areas. To cover the area, supporting puskesmas and poskesdes (village community health center) are very helpful in the coverage of health services in the area. Unfortunately, in Malinau District there are still 15 villages that do not have supporting health facilities at the Puskesmas.

The number of health workers in the province of North Kalimantan is still very minimal and far from ideal as illustrated by the table 7 below. From the ratio of doctors and the ratio of other health workers, it still shows that it is not in accordance with the standards, especially in border districts. In Malinau regency, more than 30 villages did not have permanent doctors and 12 villages did not have midwives and other health workers who were residing. In Nunukan regency, namely in the sub-district of Lumbis Ogong, Sebatik Barat and Sebatik Utara do not have doctors. In this district, a total of 127 villages did not have village midwives. Equitable health workers need to be improved so that services are evenly distributed. The flying doctor program is a reflection of the absence of specialist doctors in certain areas in the Province of North Kalimantan (Bappeda of North Kalimantan Province, 2016).

Table 7. The Number of Health Personnel 2016

Kabupaten/Kota *Regency/Municipality*	Tenaga Kesehatan/*Health Personnel*				
	Tenaga Medis *Medical Personnel*	Tenaga Keperawatan *Nursing Personnel*	Tenaga Kebidanan *Midwifery Personnel*	Tenaga Kefarmasian *Pharmacy Personnel*	Tenaga Kesehatan Lainnya *Other Health Personnel*
(1)	(2)	(3)	(4)	(5)	(6)
Kabupaten/*Regency*					
1. Malinau	35	249	288	26	17
2. Bulungan	76	516	259	60	159
3. Tana Tidung	9	91	52	5	19
4. Nunukan	72	217	94	27	60
Kota/*Municipality*					
1. Tarakan	108	499	88	65	149
Kalimantan Utara	**300**	**1 572**	**781**	**183**	**404**

Central Bureau of Statistics, East Kalimantan Province, 2018

Despite all the limitations, the health sector seems to be promising as an object of collaboration. The author's interview with the head of Nunukan puskesmas, dr.Ika, shows that it is common for civilian and military health personnel who work in the border area to lend medicines to treat their patients, because patient safety is seen as a shared concern (Dr. IkaBihandayani, interview, September 6th, 2017). A military member, captain Firdaus, also admitted that the personnel of Indonesian army frequently support the health service in border Puskesmas since the lack of civilian health workers in the remote areas (Capt. Firdaus, interview, September 6th, 2017). Even medicines belonging to the Nunukan District Health Office which previously had difficulty distributing to inland areas can be channeled to the five border Puskesmas in Krayan, South Krayan, West Krayan, East Krayan, and Central Krayan, because it was transported by the Air Force Cassa 212 aircraft. (http://kaltara.prokal.co/2018). The Cassa 212 aircraft was taken from the Air Squadron 4 Squadron Abdurrahman Saleh, Malang, with the Nunukan-Krayan route with the frequency between 2-3 times a weeks. (http://kalimantan.bisnis.com, 2017).

DECENTRALIZATION IN A UNITARY STATE

The Concept of Decentralization

The conceptual notion of decentralization departs from the thoughts of Brian C. Smith in his book entitled Decentralization: of the Territorial Dimension of The State. Etymologically decentralization means reducing administrative concentration in a particular center and granting power to local (local) governments. Based on this understanding, Smith (1985) asserts that the idea of decentralization as a political phenomenon involving administration and government. Decentralization involves delegating power to a lower level in a territorial hierarchy, both in terms of the level of government in a country and the level of position in a large-scale organization. According to Smith (1985), decentralization can be viewed from a political perspective. In this perspective decentralization refers to the distribution of power based on territory (territorial). Decentralization deals with the extent to which power and authority are handed over through a geographical hierarchy within the country. The consequence is that decentralization requires the division of state territory into smaller regions and the establishment of administrative and political institutions in the region.

Departing from B.C Smith's thinking, Muluk (2009) states that decentralization can be reviewed by social science theories including liberal democracy and public choice (public choice). In the perspective of liberal democracy, decentralization is seen as capable of supporting democracy at two levels (national and local government). First, decentralization contributes to the development of national democracy. Where local government can be a means of popular political education, provide training for political leadership, and support the creation of political stability. Second, local government can benefit from political equality, responsiveness, accountability, accessibility, and the spread of power.

Whereas in the perspective of public choice theory, decentralization is an important medium in improving individual welfare through public choice. According to Stoker as quoted by Muluk (2009), individuals are assumed to choose their place of residence by comparing various service packages and taxes offered by different cities. In addition, the perspective of public choice theory also provides benefits for local government. First, there is public responsiveness to individual preferences. In addition, local government also provides a way for population preferences to be communicated through elections and other political procedures. Second, local government has the ability to meet the demand for public goods. Decentralization is able to increase the number of government units and the degree of specialization of their functions so as to increase the government's ability to fulfill public demand. Third, decentralization is able to provide better satisfaction in providing the supply of public goods.

Health Services in the Era of Decentralization

As stated in the previous section, health services are the rights of every citizen that must be provided by the government as guaranteed by various laws and regulations in Indonesia. This is guaranteed in various laws and regulations starting from the 1945 Constitution and various regulations below. In Article 34 paragraph (3) of the 1945 Constitution, it is stated that the State is responsible for the provision of health care facilities and appropriate public service facilities.

In the post-New Order decentralization policy, there was a division of authority between the central and regional governments in health services. The central government is more positioned as a regulator and policy maker, while the provincial and regency / city governments are spearheading the health service providers. As an example, in Article 12 of Law No. 23 of 2014 concerning Regional Government stated that health is one of the functions that must be carried out by local governments in addition to education, public works and spatial planning, public housing and residential areas, peace, public order, and community protection, and social.

The right of citizens to obtain health services is also guaranteed in Law No. 36 of 2009 concerning Health. Article 5 paragraph (1) of the law also states that everyone has the same rights in obtaining access to resources in the health sector. In addition, also in paragraph (2) also states that everyone has the right to obtain health services that are safe, quality and affordable.

Regulations regarding health services also exist in North Kalimantan, which shows the extent of the provincial government's attention to public health issues. North Kalimantan Regional Regulation Number 2/2017 concerning Public Health Services states that there are several government obligations stipulated in this regulation. Among them the

regional government is obliged to prioritize health services in remote, coastal and border areas. In addition, fulfilling health services for people with special needs, namely people with disabilities, pregnant and lactating women, infants and toddlers, victims of sexual violence and victims of natural disasters. Local governments are also responsible for planning, regulating and organizing, coaching and overseeing the procurement of health workers fairly and equitably according to the needs of the community. Likewise with facilities and infrastructure, the government is also obliged to provide adequate health posts in rural and border areas to support health services. In terms of budget, the Provincial Government is also obliged to allocate funds for health at least 10 percent of the total APBD (local government annual budget).

Even though the central and regional governments already have a lot of regulations related to health services, the facts show that in certain areas there are still many citizens who have not received adequate health services, including in North Kalimantan, which has many border areas that have limitations in terms of facilities and health personnel. One of the reasons for the low health services in North Kalimantan Province is that in some regions there is still limited access to health services. This is caused by insufficient infrastructure, so that areas that are remote, inland, and borderless have difficulties in seeking treatment in their own countries.

The facts in the border area are that people prefer to seek treatment in Malaysia because the distance taken to get there is much easier and closer, and better quality so that it is more effective and efficient than seeking treatment in their own country (Ruru, 2018). Difficult access can increase the risk of death, due to delays in reaching health facilities in the event of an emergency. On the other hand, the lack of interest in health workers willing to be placed in the remote and outermost areas contributed to the low health status of the community. (Lestari, 2013). The unsatisfactory health status of the people of North Kalimantan, especially from the high infant and maternal mortality rates and the many dangerous diseases that are too late to handle because low accessibility indicates that there must be innovation to reach the public with limited access to services, especially those in border region.

FLYING DOCTORS: A COLLABORATIVE MODEL IN IMPROVING HEALTH SERVICES

The Concept of Collaborative Governance

Collaborative governance is a type of governance in which public and private actors work collectively in certain ways, using certain processes, to make rules and laws for the provision of community needs (Ansell & Gash, 2007). Interaction between the three governance domains, namely government, society and the private sector must be synergistic and refer to the same goals. The governance concept that promotes the principle of cooperation in the administration of government and service affairs is known as collaborative governance. Collaboration is a process whereby organizations that have an interest in a particular problem try to find a jointly determined solution. This collaboration involves a variety of intensive parties, including conscious efforts to enlightenment in goals, strategies, agendas, resources and activities. Some institutions that have different goals to build shared vision and then try to make it happen together.

Collaborative governance is a management practice that appreciates the diversity of values, traditions and organizational culture, works in a relatively loose structure and is

network-based, controlled by shared values and goals and has the capacity to manage conflict (Dwiyanto, 2012). This collaborative management is needed to manage partnerships between government institutions and the private sector and the community in managing border areas. Collaboration of various stakeholders in the field of border area governance is an innovation in the field of governance. If the three pillars of governance, namely state, society and the private sector collaborate for the same purpose, synergy will be created. The synergy will strengthen the government's capacity to manage border areas.

Relations between stakeholders are transformative from command, coordination, and cooperation to collaboration. Initially the relationship between the government and other stakeholders was command. At this stage it is still hierarchical, there is strong control from the government and stakeholders are not involved in decision making. The second phase is coordinative, where the government and other stakeholders have been collectively involved in decision making. Furthermore, it increases to a cooperative relationship. In this connection there has been a sharing of ideas and resources to get mutual benefits. The final stage of the relationship is collaborative because there has been a relationship to the stage of sharing creation (shared creation) which is realized in the form of permanent and autonomous institutions (Shergold, 2008).

The Flying Doctors as a Model of Collaborative Governance

Flying Doctors Program or Specialist Doctor to Remote Area, Border and Islands (DTPK) has been rolling since 2014. This program was initiated by the North Kalimantan Governor Irianto Lambrie. 'Flying Doctors' is a program to provide doctors, health workers and medicines to reach isolated areas on the border. According to Governor Irianto, the flying doctor's program needs to be intensified considering that there are still many inland and border areas in Kaltara where people have not been reached by health facilities such as health centers, especially hospitals. Without airplanes, many people in North Kalimantan cannot access health services because land access is still difficult (Ferdiani, kaltara.antaranews.com, 2018). This Flying Doctors is designed to supply health workers to locations that cannot be penetrated by land.

In 2017, there were six points reached by pediatricians and internal medicine specialists and other paramedics as shown in table 9 below. Within a year there are 3 times the flying doctors' activities carried out every quarter. In every single activity, there were two locations visited. Once the doctor's services fly, it lasts two to three days. Not only dealing with people who experience ordinary diseases, if there are emergency patients, they are also directly treated because there are at least two specialists in the group (kaltara.antaranews.com, 2018).

Table 9. The Implementation of Flying Doctors Program in North Kalimantan 2017

No.	Location	Sub-District	Regency/City	Specialist Doctors
1.	Puskesmas Atap	Sembakung	Nunukan	Internist & pediatrician
2.	Puskesmas Seimenggaris	Seimenggaris	Nunukan	Internist & pediatrician
3.	Puskesmas Long Bawan	Krayan	Nunukan	Internist & pediatrician
4.	Puskesmas Long Layu	Krayan Selatan	Nunukan	Internist & pediatrician

5.	Puskesmas Pembeliangan	Sebuku	Nunukan	Internist & pediatrician
6.	Puskesmas PembantuSei-Ular	Seimenggaris	Nunukan	Internist & pediatrician

Source: Ferdiani, kaltara.antaranews.com, 2018

The Head of the Kalimantan Utara Provincial Health Office, Usman said that he could not transport many health workers every time the service. In addition because the number of specialists is still minimal, also because of the limited budget. It was stated, the flying doctors' program budget for 2018 was only Rp. 519 million. Mainly the budget will be used to lease aircraft and provide honorarium to health workers involved (ferdiani, kaltara.antaranews.com, 2018).

Of the six times the implementation in 2017, the specialist doctors who were deployed were internists and pediatrician. During the implementation of the program the number of patients successfully treated reached 1,474 people consisting of internal diseases and pediatric diseases as shown in table 10 below.

Table 10. The Number and Types of Treated Patients, 2017

No.	Location of Program	Pasien yang ditangani		
		Internal disease	Child disease	Amount
1.	Puskesmas Atap	179	60	239
2.	Puskesmas Seimenggaris	396	101	497
3.	Puskesmas Long Bawan	268	84	352
4.	Puskesmas Long Layu	137	105	32
5.	Puskesmas Pembeliangan	196	56	252
6.	Puskesmas PembantuSeiUlar	298	115	413
	Jumlah	1.474	521	1.995

Source: Ferdiani, kaltara.antaranews.com, 2018

Collaboration between Stakeholders in the Flying Doctors Program

As the name suggests, this collaborative governance model will not be possible unless there is collaboration between stakeholders in it. Likewise, the Flying Doctors program in North Kalimantan was successfully implemented despite various constraints and limitations. The Provincial Government is the initiator as well as the main motor that drives this program, including providing and allocating the necessary resources. However, in its implementation, other stakeholders also contribute so that this program can be implemented. The role of the district government in this program cannot be underestimated. The Nunukan and Malinau Governments, the two most targeted areas of this program, supply data to the provincial government, especially the health department, related to the disease that affects most people in the border area, so that the Provincial Health Service can allocate the right resources. During implementation at border or remote area health centers, Nunukan and Malinau health workers who work in the puskesmas also work side by side with specialist doctors who are flown from the provincial capital. The provision of specialists serving in North Kalimantan alone cannot be separated from central sup-

port, especially with the Nusantara Sehat program which then places specialist doctors in North Kalimantan.

Private companies are also not left behind in contributing. There are two airlines that are involved in maintaining this program, namely MAF (Mission Aviation Fellowship) and Susi Air. MAF is an airline that since the 1970s has helped Kalimantan people in the interior to get out of isolation. The airline faithfully provides services to the public without charging because the airline is carrying a social mission. MAF also supports this government program by flying specialist doctors and other health workers to a remote village in the middle of the wilderness of North Kalimantan so that the people of North Kalimantan in the interior and border get better health services with four fleets, in the form of two Cessna planes and two Quest Kodaik aircrafts.

Communities in the border area also do not stay silent. They try according to their capacity so that this program continues. Two times the MAF airline was stopped by the central authority, namely in 2015 and 2017. The impact was that many patients were late handled, even to death. Seeing this, the community, supported by the North Kalimantan Provincial Parliament and the provincial government, then made various efforts including peaceful action and meetings with the transportation ministry, the community finally succeeded in asking the central authority to return to allow MAF to fly and serve the community. Although MAF's operational permit in accordance with the Ministry of Transportation Decree No. KP 59 of 2016 was not extended, the Ministry of Transportation did not revoke the MAF social aviation permit.

There are two main obstacles to this program, funds and availability of specialist doctors. In 2018 the available funds were only 519 million, so this program could not be expected to reach all border areas. As an illustration obtained in the implementation of the program in 2017, the highest cost is for the operational costs of aircraft leasing that reach 6o million rupiah per hour, so that the funds available for 2018 can be predicted will not be able to increase the frequency of services. The budget is also allocated to the personnel honorarium involved as explained in the following table 11.

Table 11. Amount of Payment for the *Flying Doctors Personnel*

Health Workers	Amount of Honorarium
Specialist doctor	Rp. 5.000.000,-
General practicioner/dentist	Rp. 2.500.000,-
nurse/midwifery/pharmacist	Rp. 2.000.000,-

Source: Ferdiani, kaltara.antaranews.com, 2018

The second obstacle isrelated to the existence of specialist doctors in the province that is still very limited, so that if they are sent to remote areas for long periods or frequencies that are too often, it feared to disrupt services at the referral hospital in Tarakan or TanjungSelor. Therefore the addition of specialist doctors in North Kalimantan is one thing that cannot be bargained again in order to be more optimal in providing more quality services to the people in the border region.

CONCLUSION

There are four main conclusions drawn from this study. *First*, this study shows that the implementation of the program is inseparable from the pattern of decentralized central and regional relations imposed in post-New Order Indonesia. However, the role of the central government also cannot be underestimated, since as the main regulator in a unitary state, the central government has the highest authority in making national-scale policies, including in allocating resources owned by a State to overcome problems that faced by citizens, including in providing optimal health services to the remote areas.This pattern becomes an ideal political environment for the establishment of collaborative governance for at least two things: the decentralization policy provides flexibility to the regions in terms of discretion to carry out various programs that suit the needs of local communities and regional capabilities; and the decentralization policy has been proven to be able to encourage local governments to take initiatives and carry out various innovations in order to fulfill their responsibilities to provide the best service to the community.

Second, we also suggest that geographical aspect such as areas that are difficult to reach will encourage actors to collaborate. Some border areas in Northern Kalimantan Province only reachable by airplane, such is in Krayan and LumbisOgong sub-districts. North Kalimantan Province as initiator of the program has to collaborate with the regency governments in implementing the program. The Province also has to take the airline into action since the absence of airplane resources. Third, the limitations in allocated budget, structure and infrastructure in a certain public issue, will push the actors to joint their resources into a collaborative actions. Serious health issues in border area are proven to be a trigger for the actors to collaborate. Last but not least, sharing action will be possible if there is a sharing vision between stakeholders. Actors involved in the collaboration aware that the improvement of health condition in border areas is a common concern.

This study has weaknesses in terms of the depth of information obtained due to the limited time available at the research location as the impact of limited resources. As a consequence, this study relies more on documentary data and media coverage without sufficient factual verification. Therefore, more serious field studies are expected to be able to reveal more interesting facts besides those already exposed in the media and documentary data that are the mainstay of this study.

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