I. BACK GROUND

As economy crisis strikes Indonesia since June 1997, the country is striving to preserve and improve its achievement in very difficult situation. Statistics shows that utilization rates dropped during this crisis and less resources is available. The heavy reliance on public sector poses the government with even a greater problem. There is a potential of decreasing quality of services rendered through public facilities, the primary care as well as the hospital care. Public health measures also suffer from diminishing resources for surveillance and its related activities. At the same time the number of poor population increased dramatically from 11% prior to the crisis to about 17-20% now. Anecdotal evidence also shows the increasing number of children suffering from malnutrition across the country. Then, equity becomes a central issue: how to protect and to guarantee access of health services for this vulnerable group. But over the last 3 years, the trend has been for the better. Indonesia appears to have navigated the most treacherous passage of the crisis. The parliamentary elections in 1999 were held peacefully and successfully— that made our people proud. In the economic sphere, broad macroeconomics indicators—GDP, prices, the exchange rate, and interest rates—has shown encouraging improvements and this has been accompanied by indications of return in investor confidence. Resolving these challenges will require steady and determined economic reforms, placing a premium on policy continuity as the country goes through political transition. The growing domestic consensus for changes offers Indonesia a chance to turn crisis into opportunity, an opportunity to implement fundamental reforms and propel the economy on the path of rapid, effective, sustained, equitable growth. The health reform also needed since that the health development is a subsystem of the national development. The call for total reform emerges as there are still discrepancies in health development results among the regions and communities, the public health level is still left behind compared to neighboring countries, and due to the lack of autonomy in health development. Beside that, health reform is also needed considering the 5 main phenomena that have great influences toward the success of health development. First, fundamental changing in population dynamics that affected demography and epidemiological transition. Second, substantial discoveries in medical science and technology that brought to the new perspective of the process of life, health, illness and death. Third, the global challenges as a consequence of free trade policies, and rapid revolution in information, telecommunication and transportation. Fourth, changes in the environment that influence the health level and efforts. Fifth, democratization that is requires empowerment and partnership in health development.
II. THE SITUATION ANALYSIS AND TRENDS

Before crisis the existing health development programs so far being implemented has succeeded in increasing health level of the people significantly, though there are still various problems and obstacles that will influence health development implementation. Below are described briefly, problems, opportunities, threats and strategic issues of health development Indonesia is facing these days.

A. PROGRESS

1. Health Status

Up to now the infant mortality rate (IMR) has been lowered with a lowering rate of on average 4.1% per annum. While in 1967 the IMR in Indonesia was still 145 per 1000 live births, in 1991 IMR was already 51 per 1000 live births. If projected to 2010 IMR will be 32 per 1000 live birth.

The under-five-years death rate (UFDR, 0-4 years) has also been lowered significantly. In 1986 it was still 111 per 1000 live births, in 1993 it was lowered to become 81 per 1000 live births. None the less, the differences of IMR and UFDR between provinces still vary wide. Mean while the Maternal Mortality Rate (MMR) has also lowered from 450 per 100.000 live births in 1986 to become 390 per 100.000 live births in 1994 , and 373 in 1995 per 100.000 live birth. In line with this development, life expectancy at birth has also been increased from average 5.7 years in 1967 to become 64.4 years in 1991, 64.8 IN 1998, 65.5 IN 1999 and by projection will be 73 years in 2010.

Several contagious diseases being observed were showing increasing trends of morbidity, such as malaria, Dengue Hemorrhagic Fever (DHF) and HIV/AIDS. Annual parasite incidence (API) of malaria decreased from 0.21 per 1000 residents in 1989 to become 0.09 per 1000 residents in 1996 in Java-Bali, then increased again to 0.30 per 1000 in 1998 and 0.52 per 1000 in 1999. Parasite rate (PR) of malaria outside Java-Bali islands, which was formerly 3.97% in 1995, increased to 4.78% in 1997.

Lung TB is still an illness requiring attention as though its prevalence has been decreased from 2.9 per 1000 residents in the period 1979-82 to become 2.4 per 1000 residents at 1989. In certain regions as West Java, Aceh, and Bali, the prevalence of lung TB was ranging between 6.5-9.6 per 1000 residents. Degenerative diseases and non-contagious diseases also show rising trend. The results of Household Health Survey of 1995 show that per 1.000 people, 83 suffering from hypertension, 3 ischaemic heart disease and 2 from stroke respectively. Other diseases also significantly increase i.e.: Emotional mental disturbances, Blindness, and Traffic accident.

2. Health Facilities

Health development that has been implemented during the last 30 years has succeeded in preparing health service facilities and infrastructures evenly
throughout Indonesia. At present time to fulfill basic health service there are 7,237 health center available where 1,676 of them have been up graded to become caring-health center that have in-patient beds, 21,267 sub health center and 6,392 mobile health center. Hence there is at least one health center in each sub-district in Indonesia, and more than 40 percent villages have been served by government’s health service facilities. The ratio of health center to population is recorded to be 1:27,600 and Sub Health Centre to population is 1:9,400.

The even distribution of basic health service facilities is also followed by the increase in referral health service facilities. At the present there are 4 units of A Class General Hospital, 54 units of B class General Hospital, 213 units of C class General Hospital, 71 units of D class General Hospital, 335 units Private General Hospital, 77 units of Government’s Special Hospital, and 139 units of Private Special Hospital. Total beds are reaching 130,000 units, so the ratio to residents is 1:1,700. The rate of utilization and the capability of services of hospitals are increasing from year to year. For the purpose of assuring the smoothness in medicines distribution in governmental sectors especially for the health center there have been built 314 units of district/ municipal pharmaceutical warehouses. While in the private sector there have been operational 5,724 units of dispensaries throughout Indonesia.

3. Human Resources for Health
The number and distribution of human resources for health have improved significantly enough so that now there are registered about 32 thousands or so of medical manpower (physician, specialist, and dentist) and 7 thousands or so of dentists, including specialists, and 6 thousands or so of pharmacists distributed throughout Indonesia. The number and distribution of nurses and midwives are also improving very fast. There are registered about 160 thousands or so of nurses with various levels of education. While the number of midwives is registered 73 thousands persons or so including 52,042 persons in the villages. Hence it means that nearly all villages in Indonesia have midwives already. In order to support the development with health paradigm there has also been manpower in the field of public health. At present there are registered about 11 thousands or so of human resources for health with various expertise including among them in the nutritional field about 1,500 persons, and in environmental health about 4,000 persons.

4. Health Inventories
Since early 1997 Indonesia has been able to produce generic drugs which are conducted by 4 BUMN and 60 private owned pharmaceutical plants. The generic drugs have been more and more accepted by the society. In the attempt to cure and improve health a portion of the society use Indonesian indigenous medicines. The needs for vaccines in order to prevent diseases, among others the BCG, hepatitis, polio, measles, DPT and tetanus toxoid have been fulfilled from domestic production. Some of the health inventories such as health instruments
have been manufactured locally, while those using high technologies are imported.

5. Health Financing
In the last 30 years the government’s commitment for health financing has increased. While the health budget in 1987/1988 was 2.32% of total government’s spending, then in 1997/1998 the health budget was 4.55% of total government’s spending. The funding from private sector primarily the society’s spending is the largest portion of the health funding. The contribution of private sector and society in funding health is about 65 percents. The majority of the society pay for their health still using the ‘fee for service’ model. Only 14 percents of the society are covered in the health insurance programs. The Public Health Maintenance Assurance Program (JPKM program) which has been developed in all districts/ municipalities is hoped to be able to rationalize funding from the public as a base for achieving equality and improving health service quality.

So far the health development has been built not only upon self-strength, but it is also supported by foreign assistance either in the form of off shore loans or grants. To some extent due to the economic crisis the foreign helps component in the health budget has shown rising tendency. During economic down turn, much greater use was made of donor assistance, but such support did not contribute to the sustainability of health financing and spending.

Responding to this situation the government of Indonesia develops the Social Safety Net program for the Social sector including health, to provide services for this target group: the poor, the infants and children under five, and the pregnant mothers. This program is jointly funded through Asian Development Bank (ADB) and International Monetary Fund (IMF). However, this question is still on short-term rescue program, which may last this year. We are still developing The EXIT STRATEGY, the way to exit from the people dependency in SSN program. The question is still on finding the money to preserve health programs in the country.

We realize that we can not rely on donor agencies to have a sustainable health program. Moreover, the government may not agree on the program design understanding that both parties might have different views and interest in conducting health programs. Thus, in the long run Indonesia has to increase resource mobilization in the country and to work closely together with the private sector and the people in optimizing resources available in the country.

6. Health Policies
The health development that had been done in nearly the last 40 years has undergone enormous changes and improvements in policies. In 1st Five Years Development (Pelita I, 1969-1973) the policies were more emphasized on consolidation. The service functions were directed more towards integration and comprehensively being focused more on the governmental sectors. In the years 1980s the service model started to shift towards the private sector. In Pelita II (1974-1978) the policies were prioritized on equity such as through INPRES
(presidential instruction) on health facilities and manpower. During Pelita III (1979-1983) and IV (1984-1988), beside equality, attention is also given to health service *quality improvement*. The matter is reflected among others on the change in health center function to become caring health center. Next, during Pelita V (1989-1993) a policy has been determined to *put midwives in the villages*. In terms of hospital services, since Pelita V and specifically in Pelita VI (1994-1998), much attention has been put to *improve service quality through standardization of services, development of accreditation instrument and compilation of indicators of hospital instruments' performance*. With the issuance of Health Law No. 23 approved in 1992, then a renewal has happened in the written laws about health development.

The development of state governance at the present time shows a very strong wave of decentralization. The implementation of The Law 22/1999 on Regional Government and The Law 25/1999 on Intergovernmental Fiscal Relations will strongly influence the execution of development including the health development.

Decentralization of health efforts offer authority to the districts and municipalities to self determine the health development’s priority of the respective regions according to local capabilities, conditions and needs. As a consequence the success in health development in the future will depend very much on the capability of the manpower resources in the regions.

**B PROBLEMS**

1. **Health Status**
   Morbidity of some contagious diseases being observed which formerly were declining, but recently have shown increasing trends, such as malaria, Tuberculosis. The trends in morbidity of contagious diseases, non-contagious diseases, degenerative diseases, injuries due to traffic accidents, and other health problems as well as other diseases are problems that will influence the health level of the public in the future, all that require optimal management steps. Yet, the health status of Indonesian still worse than other ASEAN member countries.

2. **Human Resources of Health**
   The weakness of health development from the point of view of human resources for health is regarding the uneven distribution, yet inadequate educational quality, unbalanced human resources for health composition due to over dominance of medical manpower and the low performance and productivity. One of the issues is the utilization, where their uneven distribution becomes a principle problem. Beside that, the career development of the human resources for health becomes a matter that strongly needs to be developed, it covers human resources for health of both the public sector and the private sector.
3. **Cross-Sector Cooperation**
Health problems are national problems that can not be disconnected from the various policies of other sectors, hence health solution should involve other sectors as well. The main issue is how to improve cross-sector cooperation more effectively.

4. **Health Expenditure System**
As a result of the strong roles of the central government in deciding policies, the mode of spending given by the central government is based on budget allocation that has been decided with its detailed activities. Subsidy given by the government for health sector in 1st Phase of Long Term Development, 1968-1993) is only about 2.5% of GDP which is far from the minimum standard recommended by WHO i.e. 5% from GDP. In practice the relatively small budget subsidized by the government mostly is given in the form of subsidy to the service provider as regular spending (including wages), development spending, and operational costs as well as maintenance costs. In other words, the mode of funding practiced so far is not oriented to the needs of the public and is not directly directed to subsidy the poor people. National Health Account studies showed that 35% of total health expenditures come from the government budget, while the rest 65% comes from the private sector (the out of pocket/direct household payments and third party the reimbursement).

5. **Quality of Health Facilities**
Even though the number and distribution of health facilities have been regarded adequate, but from the aspect of service quality the services are still below standard. Other health facilities such as hospitals even have not met the minimum requirement yet. In such a situation, the quality of health services being offered is still far from expectation.

A. **OPPORTUNITIES**

1. **Demography**
In 1980 the Indonesian population totals 147,49 millions, it increases to 179,38 millions in 1990, 210,439 millions in 2000. It estimates nowadays 214 millions, in 2010 is projected to be ca 235 millions. The growth of population is also signaled by the change in age structure of the population where there is a shift from young population age structure to old population age structure. The large number of Indonesian population and the productive age structure are potential market and resources for the development of nation-wide health efforts. Beside that, various changes occurring on the demographic characteristics as a result of development success such as education and social economic sectors will open the opportunities for the implementation of health services that are more effective, efficient and qualified.
2. Globalization
Globalization in economic sector with its main core being free global trading gives opportunity for Indonesia to take part in international trading. In the health sector, the opportunity is mainly the chance for health workers to work abroad. For that efforts to increase quality of the health workers to equal those from the other countries should be done among other ways through improvement in education system. The entry of foreign capital to Indonesia will expand even more the employment opportunities for health workers, beside it will help accelerate the transfer of technologies that are needed for the improvement of quality and professionalism of health services in Indonesia.

3. Economic Crisis
The economic and credibility crises hitting Indonesia until now is a good opportunity to do various changes in health sector, including to eliminate various bureaucratic obstacles in the effort to increase efficiency and partnership in development implementation. Difficulty in getting health services due to low purchasing power opens bigger chance for development and consolidation of JPKM (Managed care).

4. Cooperation and Partnership
In the global era there are many changes that have occurred in national, regional, as well as international levels which bring multidimensional impacts and which possess high intensity of interrelationship between sectors. Hence, cooperation and interconnection are the main pre-requisite to achieve a new era that is better off based on the new paradigm based on the win-win principle. The phenomenon of partnership that is equal, open and mutually beneficial is a good opportunity especially for the development of private businesses either of national, regional, or international scales for the development of basic and referral health services, prevention of diseases, and promotion of health.

A. THREATS

1. Macro Economic Situation
The macro economic situation which has not recovered from economic crisis is one of the biggest and heaviest threats to national development, especially the health development as the consequence of the even more limited existing resources. This situation becomes more severe with the still high level of dependence upon imported goods for implementation of health services. The macro economic situation recovery is very much influenced by political situation which is not yet stable enough till now. Hence, though at national level there is already a commitment to give larger allocation for health funding up to 5% of GDP, but there is still a real threat from the macro economic situation that the resource may still not yet ready to be prepare within 2-3 years time ahead.
2. Demographic Structure
The great number of population, the relatively still high growth rate, the still low level of education and income, as well as uneven distribution among regions can be a threat to development, including the health development. Beside that the age structure that tends to be young together with the increasing number of elderly groups become the double burdens of development.

3. The Economic Condition of Society
The prolonged economic crisis has also shown increase in the number of poor people together with the decline in various health indicators, especially the rise of overt Protein Energy Malnutrition incidence primarily among infants and children. This condition is a threat to the achievement of health development’s target as one of the efforts in increasing the nation’s productivity. The declining economic condition of the society also influences access of the people toward health services, especially for the poor people. Efforts done through the JPSBK (social safety net in health sector) have indeed increased the access, but in the long run this program is hard to sustain by the available resources. The various worries in economic sector that is easy to be triggered into riots and also conflicts occurring in various regions in Indonesia which have been unsettled so far become threats toward health development and at the same time become obstacles to achieve the healthy Indonesia.

4. Geography
The geographic condition of Indonesia that is an archipelago country with more than 17,000 islands and the very great area of ocean is a challenge in the implementation of health development. An archipelago state like this in fact needs transportation and communication facilities as well as a high operational cost. On the other side with the openness of various archipelagoes, Indonesia becomes susceptible to the possible entry of prohibited goods/drugs illegally. Indonesia being on the crossroad position between big countries in the world, is in the transportation line, this potentially can bring negative impacts toward public health with the possibility of entry of various negative habits toward health and various diseases from outside world.

5. Behavior, Morale and Ethics
Abuses of narcotics, psychotropic drugs and additives tend to rise, in fact it has touched the poor people and primary school children with even wider and more complicated escalation of the problem. So are the production and utilization of alcoholic beverages and other addictive including cigarettes inclined to rise steadily with broad negative impacts to the public. Beside that, various deviations in sexual behavior, lack of discipline in traffic transportation, smoking habit and unbalanced food consumption become threats to the increment of public health level. The use of prohibited chemical substances as food additives, sanitary problems as well as hygienic processing especially among household industries are also threats to the consumer community’s health.
6. Social Unrest
Since 5 years ago, there are many refugees or Displaced person in Indonesia due to social conflict, Social unrest, ethnic-clashes or religion clashes that happened in 22 out of 30 provinces. Up to now approximately 0.8 million refugees/displaced person which are burden to the local and central government. Indonesia received assistance from many countries, donor agencies, to cope the problems. Even though some of them already been transferred to the province where they need but there still ½ of them living in refugees camp. In the camp they live in improper place, bad condition and improper water sanitation. Another problems is the secessionist movements that threat our stability (Separatist in Aceh (GAM), Papua (GPK), South Maluku (RMS) This situation really threaten the development in Indonesia particularly in health, education and other social aspects.

7. Globalization
Globalization is a phenomenon occurring in the end of the 20\textsuperscript{th} century that is signaled by the occurrence of inter-penetration and inter-dependence among all sectors, either economic, political, or social and cultural. This situation causes the occurrence of transformation of the nation society toward global society so those state boundaries become inconspicuous any more. Ease in transportation, communication, and various information dispersion will also influence the dispersion of diseases, narcotics, psychotropic drugs and other addictive, free sexual behavior and other unhealthy life styles. This situation has very great influence upon the health level of society, especially the younger generation of the nation.

8. Environmental Pollution and Global Climate
Pollution to the environments, including air, water, soil and food will increase. Air pollution in the big cities in year 2000 is estimated to rise 2 folds from that of 1990 with its main source coming from the emission of motor vehicles and industrial activities. Management of domestic wastes in the urban, either solid or liquid wastes, which has not taken into consideration its impacts on public health is a threat to people living in the urban areas and their surroundings. The limitation of clean water supply is a threat to the health of society. The limitation in public affordability especially in the rural and urban slum areas is also a serious challenge for the creation of healthy environment.

III. STRATEGIC ISSUES
After studying the various strengths, weaknesses, opportunities and threats as mentioned above, then the strategic issues that should be dealt with are as follows:

1. **Cross-Sectoral Cooperation**  
   A part of the health problems are national problems that are inseparable from various policies of other sectors so that the solution should strategically involve the related sectors. The main issue is the improvement in cross-sectoral cooperation, as cross-sectoral cooperation in health development so far has been frequently less success.

2. **Human Resource for Health**  
The quality of health sector's human resource is strongly determining the success of health efforts and management. They must always follow the progress in science and technology, and strive to master the state of the art science and technology. Beside that, the quality of the human resource is also determined by the moral values being adopted and applied in the task execution. It is realized that the number of Indonesian human resource in health sector who follows the progress of science and technology and applies professional moral and ethical values is still limited. The emergence of competition in the free market era as a result of globalization should be anticipated by improving the quality and professionalism of the human resource in health.  
   In relation to decentralization, an increase in capability and professionalism of the health managers in every level of administration is a very urgent need.

3. **Quality and Accessibility of Health Services**  
The distribution of health services facilities either health center or hospitals and other health facilities including health efforts supporting facilities can be regarded as evenly distributed all over the territory of Indonesia. Nonetheless it should be confessed that the physical distribution has not been fully followed by increase in quality of services and accessibility by all layers of the society. The quality of health services is very much influenced by the quality of physical facilities, types of work force available, medicines, health instruments and other supportive facilities, services conferring process, and compensation received and the expectation of the consumer society. Hence the increase in quality and aforementioned factors are preconditions to be fulfilled.

4. **Prioritization, Funding Resource and Community Empowerment**  
So far health efforts are still lacking in prioritizing the approach of health maintenance and promotion as well as disease prevention, and they are insufficiently supported by adequate funding resource. Financial constraint from the government and the public is a big threat for the continuity of programs and threat to the achievement of optimal health level. Hence, more intense effort is required to increase funding resources from the public sector being prioritized for health maintenance and promotion activities as well as for diseases prevention. Funding resources for curative and rehabilitative activities need more exploration
from resources in the society and directed to become more rational, and more effective and efficient in order to increase the services quality. This situation urges the need for strategic steps in creating funding system with prepayment property already known as JPKM. The availability of limited resources, especially in the public sector requires efforts to increase participation of the private sector especially in the attempt which are curative and rehabilitative. The attempts will be done through empowerment of the private sector to become independent, equal partnership and mutual beneficially between the public and the private so that available resources can be used optimally. Other matters that strongly require settlement are empowerment and independence of the public in health efforts that have not been as expected.

5. Social unrest, refugees and displaced person.
The refugee’s problems can not be solved by health sector, because in influenced by political and social-economic sectors. Indonesia is facing the acute and emergency problems that should be cope immediately, beside continue keeping health development improvement. In this case the government and NGO considered to implement the forum namely Health as a Bridge for Peace in effort to solve the problems.

IV. PRINCIPLES, VISION AND MISSION OF HEALTH DEVELOPMENT

The application of the new health development paradigm i.e. HEALTHY PARADIGM is an attempt to improve the nation’s health that is proactive. The healthy paradigm is a health development model, which in the long run can push the society to become autonomous in maintaining their own health through heightened awareness on the importance of health services that are promotive and preventive.

In order to materialize the Healthy Paradigm as the new health development paradigm, a thorough review on principles, vision and mission of health development needs to be done. The principles, vision and mission of health development should not only be able to settle all 5 challenges of therefore mentioned conventional health development, but also should be able to anticipate various changes in the future. HEALTHY INDONESIA should be implemented consistently and continuously.

Principles of Health Development

The ideal principle of the national development is the Pancasila (Five Pillars), while the constitutional principle is the 1945 Constitution. Health development is an integral part of the national development. On the Act number 23 year 1992 about health it is stipulated that health is the condition of well being of the body, mind and social life that enables every person to live productively socially and economically. While on the constitution of WHO year 1948 it is agreed among other things that the achievement of the highest level of health is the fundamental right of every person regardless of his/ her race, religion, political affiliation and
social economic position. The principles are the foundation for the compilation of vision, mission and strategies as well as principal directors in the implementation of health development nation-wide:

1. **Humanity**
   Every health attempt should be based on humanity, which is being spirited, moved and controlled by faith and devotion to The Only God. The human resource for health needs to have noble character and hold tight the professional ethics.

2. **Empowerment and Sustainability**
   Every person and also the society together with the government have a role, vocation and responsibility to maintain and improve the health level of each individual, family, society and his/her environment. Every health effort should be able to produce and push the participation of the society. Health development is conducted based on trust and self-capability and strength as well as making the personality of the nation as the pivot point.

3. **Justice and Equality**
   In the health development, each person has the same right in getting the highest health level, regardless of differences in ethnicity, grouping, religion, and social economic status.

4. **Prioritization and Utilization**
   The implementation of qualified and up to dated science and technology’s health efforts should put priority on health maintenance, promotion, and disease prevention approaches. Beside that, taking into consideration local needs and situation should do health efforts professionally, effectively and efficiently. The health efforts are directed so that they would give maximal benefit for the improvement of public health level, and they should be executed with full responsibility according to the prevailing rules and regulations.

**Vision Of Health Development**

The picture of Indonesian society in the future that is hoped to be achieved through health development is the society, nation and state characterized by its people living in a healthy environment and with healthy living behaviors, having capability to reach qualified health services justly and evenly, as well as possessing highest level of health in all the territory of Indonesia. The picture of Indonesian society in the future or Vision expect to be reached through the health development is formulated as: HEALTHY INDONESIA 2010

In the Healthy Indonesia 2010, the expected environment is the conducive one for the realization of healthy condition i.e. environment that is free from pollution, which is equipped with clean water, adequate environmental sanitation, healthy housing and settlement, zone planning with health concerns, and the realization of social life that is helping each other by keeping cultural values of the nation.
The expected social behavior of Healthy Indonesia 2010 is the proactive one to maintain and promote health, prevent risks for diseases, protect one from disease threats and active participate in healthy society movement. Furthermore, the expected capability of the society in the future is able to access qualified health services without obstruction, either economic or non-economic one. The qualified health services referred before are those satisfying the users of the services and those being implemented according to standards and ethics of professional services. Hopefully with the materialization of healthy environment and living behavior beside the increase in the society’s capability as stated above, the health level of individuals, families and society can be upgraded optimally.

Mission Of Health Development
In order to materialize the vision HEALTHY INDONESIA 2010, four missions of health development have been determined as follow:
1. Activating national development with health concerns
2. Urging society’s autonomy for healthy living
3. Maintaining and improving qualified, equal and accessible health services
4. Maintaining and improving health of the individuals, families and society as well as their surroundings

Strategies of Health Development
Strategies aimed at achieving Healthy Indonesia 2010 are:

1. National Development with Health Concerns
All national development policies that are still or will be arranged should have health concerns. It means that national development programs should provide positive contribution to health, at least in 2 aspects: toward the formation of healthy environment and toward the formation of healthy behavior. It is hoped that each national development program being done in Indonesia can bring positive contribution toward the achievement of the healthy environment and behavior.

2. Professionalism
Professionalism is implemented through the application of progress in science and technology, as well as through the application of moral and ethical values. The implementation of qualified services needs support from application of various medical progresses in science and technology. To materialize health services like that, development of health human resources is deemed to be very essential. Professional health services cannot be realized when they are not supported by executing manpower, i.e. health human resources that follow the state of the art of science and technology. Moreover, for the implementation of qualified health services, it should also be supported by the application of high professional moral and ethical values.

In order to consolidate public autonomy in healthy life style, public participation needs to be supported as broad as possible, including participation in funding. JPKM which is principally a structure of subsystem within health funding in the form of public fund mobilization is a real shape of the public’s participation, when it is successfully implemented will have a great role as well in accelerating equality and accessibility of health services.

4. Decentralization

For the success of health development, arrangement of various health efforts should start from the problems and specific potentials of each region. Decentralization, whose core is delegation of greater authority to the regional governments in regulating their own governance system and local affair is in fact seemed to be more suitable for the management of various national development in the future. It is a certainty that for the success of decentralization, various preparations is necessary, including the utmost important are the organizational wares and the human resources.

VI. HEALTH DEVELOPMENT PROGRAMS

In line with the situation, problems and trends being faced and by putting attention to the direction, aims and targets as well as policies and strategies of health development already decided, which in principle is putting more emphasis on health promotion and maintenance efforts and attention is also put on the availability of health resources, then health development programs are grouped into main program. Therefore, we set the main programs of health development to achieve Healthy Indonesia 2010, are as follows:

1. Main Program of Healthy Behavior and Community Empowerment
2. Main Program Healthy Environment
3. Main Program of Health Efforts
4. Main Program of Health Resources
5. Main Program of Drugs, Foods, and Dangerous Substances
6. Main Program of Health Policy and Management Development
7. Program of Health Science and Technology Research & Development

Then those program were discussed intensively with the parliament’s member, and National Board of Development Planning, the result is that among health programs only 6 of them will be executed in the 1st Five Year Development Program (*Propenas*) in 2001-2004 by Government Regulations No. 25/2000. The programs are as follows:

1. Healthy Environment, behavior and community empowerment
2. Health Efforts
3. Nutrition improvement
4. Health Resources Development
5. Drugs, Food and Hazardous material
6. Health Policy and Management

In the decentralization era, all the programs that already decide by central level should be tailored and implemented in province and district that related to the local specific problems and condition.

As an addition, since 2000 up to now other specific programs are also being implemented:
- Malaria Eradication (Gebrak Malaria)
- Integrated National Movement Against Tb (Gerdunas Tb)
- Exit Strategy The Anticipation Program on Energy Subsidy Cut (PD-PSE)
- "Health as a Bridge for Peace approach " as an alternative way to reconcile in province that suffered of conflict or social unrest
- Hospital based Specialist Education
- Public Health Worker to be paced in village

VII. HEALTH RESOURCE REQUIREMENTS

For the implementation of health development toward Healthy Indonesia 2010, the availability of adequate health resources is necessary. As for what is meant by resources in this respect that it covers manpower resource, fund resource and health facility resource.

A. HUMAN RESOURCE FOR HEALTH

1. Manpower Requirement
At present health manpower in Indonesia is around 769,832 workers, which consist of 364,916 society’s workers and 384,916 governmental workers. The trend in manpower supply by 2010 is about 1,399,624 workers who consist of 699,812 society’s workers and 699,812 governmental workers. By observing the need of health program such as that stipulated in health developmental plan toward Healthy Indonesia 2010, and the possible projected supply and empowerment of the workers, it is planned that health manpower throughout Indonesia by 2010 is 1,988,000 workers. Totally it seems that the number needed and the supply of health manpower in 2010 is in enough balance. But when it is perceived more specifically the supply in several categories of worker is still lacking in the effort to fulfill the need of the manpower, i.e. mainly of general practitioners, specialists, nurses, and midwives, as well as public health scholars.

2. Supply of Manpower
In order to fulfill manpower requirement that has been planned, an upgrading in education and training as well as management of existing manpower is needed.
Supply of health manpower is done through manpower administration and training that is organized by the society and government. Government decides the policy of manpower preparation for civil servants, which covers education and training as well as organization of education and training for health manpower that is strategic.

3. Health Manpower Utilization
Health manpower utilization will be the most important element in the development of health manpower in the future. Hence ability to utilize manpower at all levels should be increased. The career development of health manpower either from private or government is vital to be improved continually and matched gradually. In this respect, government applies the policy of civil servant cultivation at central and regions that covers among other things regulation of facilities, standards and procedures of workmanship and career development. Professionalism of manpower will be increased continually and done through the application of state of art science and technology and through the application of moral values and ethics.

V. CONCLUDING REMARKS:
1. Indonesia can retain from the past crisis and is trying hard to solve the problems regarding the complication of the crisis i.e.: reduced incomes, job losses, high inflation, decrease the ability to pay for health services. In the other hand, Indonesia is facing the secession movements and disintegration threats.

2. The health development is a subsystem of national development, that affected by national level policies. The heath problems is dynamic, complex, changing rapidly and uncertain. Health policy always follow those dynamics and need proper analyzes, future predictions and promptly response.

3. Healthy Indonesia 2010 with primary emphasis on prevention and promotion efforts. This will lead to more resources for health promotion and prevention will be allocated incrementally over the next few years, while at the same time we will proceed with continuing our national health insurance scheme for preventive, curative and rehabilitative services.

4. To achieve Healthy Indonesia, some efforts already be done through various programs, as well as crash programs i.e.: Hospital based Specialist Education and the deployment of Public Health Worker in a village through out the country.

-bss-
Bibliography

2. Center of Health Data, *Basic Health Indicator and Health Situation*, 1999
3. Center of Health Data, *Basic Health Indicator and Health situation*, 2000

Acknowledgement

I would like to express my gratitude to the JICA and The Organizing Committee for providing me opportunity to attended this meeting. I am very thankful to officials of The Ministry of Health Indonesia, especially Dr. Dadi S. Argadiredja, MPH; DR. Dr. H.R. Hapsara, DPH; Mr. Zaenal Arifin and Mr.Ruswandhi.
Human Resources of Health
Indonesia

Prepared by
Dr. Bambang Sardjono Santoso, MPH
Bureau of General affairs and Public Relations,
Secretary General, Ministry of Health
The Republic of Indonesia

'bss

Presented on “The 1st ASEAN & Japan High Level Officials Meeting on Caring
Societies: Human Resource Development for
Social Welfare and Health Services in ASEAN Countries and Neighbor
Economies.
Tokyo, 4-8 November 2003