

# **COUNTRY HEALTH PROFILE**

**INDONESIA**



*The boundaries shown on the above map do not imply official endorsement or acceptance by the World Health Organization.*

## **SECTION 1: TRENDS IN POLICY DEVELOPMENT**

The government of Indonesia emphasizes the development of human resources as an area which is important to national development. Priority is also given to improving health and education. In its efforts to promote the development of health care, the government recognizes the role of the private sector, particularly in the provision of secondary and tertiary levels of health care, thus relieving the need for large governmental investments in costly health facilities. The increasing role of the private sector in health will pose questions related to access and equity, though private facilities are required to provide subsidized services to the poor. This situation will warrant introduction of effective regulatory mechanisms. Substantial institutional changes will also be needed in the Ministry of Health.

A policy of zero personnel growth to optimize efficiency has been adopted in the public sector. This would have negative effects on health service delivery in the public sector, by limiting its capacity to open new facilities and provide more services. The government continues to strengthen decentralized management, particularly at district and municipal levels, which will require close coordination with the centre if effective implementation of HFA strategies is to be realized.

## **SECTION 2: TRENDS IN SOCIOECONOMIC DEVELOPMENT**

### **2.1 Economic trends**

There has been a relatively constant annual growth rate in the gross national product (GNP) of almost 7.25% between 1992 and 1995. The GNP per capita increased from US\$661 to \$978 during the same period. The percentage of poor, both as a total and in rural areas, has shown marginal declines to 11.7% and 12.6% respectively. Oil and natural resources remained the predominant contributors to growth. However, several other sectors, particularly agriculture, home industries and tourism, have grown quite significantly. Poverty still remains a substantial problem. Regional inequities in health care are important considerations, particularly maternal health which is still a major problem in rural areas.

### **2.2 Demographic trends**

According to Census data the population is estimated to be 203 million (2000). The annual population growth rate (1995-1998) was 1.14 and the crude birth rate (CBR) and crude death rate (CDR) 22.5 and 7.49 respectively. The total fertility rate (TFR) was estimated at 2.597 (1998). Issues relating to health include an increasing trend in the number of older persons (over 60 years) which will demand more personalized health care services; increased urban migration (35-37% of the population now live in urban areas) with future projections estimating that by the year 2020 over 50% of the country's total population will live in cities; and the commuting labour force that moves in and out of the cities. The needs of the increasing number of older persons will add to the double burden of disease, with prevailing communicable diseases on the one hand and the rising prevalence of noncommunicable diseases on the other.

## **2.3 Social trends**

The adult male and female literacy rates in 1998 had increased to 93.4% and 85.5% respectively. The number of women in the labour force is on the increase. Literacy and numeracy are being addressed through nonformal group education, the main constraints being in reaching the poor and those in remote areas.

## **2.4 Food supply and nutritional status**

There were overall improvements in nutritional indicators between 1986 and 1997. In 1997 the incidence of low birth weight was 7.7%. The proportion of children under five years whose weight-for-age was below 80% of the median was 20.3%, the proportion of schoolchildren with iodine deficiency disorders (IDDs) was 27.2% (1992), with disparities in prevalence between provinces. The proportion of pregnant women with anaemia was 51.0% and children under five years 40.5% (1995). The reduction in the prevalence of vitamin A deficiency has been substantial. The national xerophthalmia survey (1992) revealed a national prevalence of 0.33% which is less than the accepted cut-off point. However, three provinces still have a problem of vitamin A deficiency. The main constraints are inadequate coverage by supplementation programmes (iron, vitamin A and iodine) due to geographical and sociocultural factors, supplementation being restricted to endemic areas, and inadequate funding. Other general factors include low community awareness, lack of community participation in nutrition activities, and indifferent support from other sectors in the implementation of integrated nutrition programmes.

## **2.5 Lifestyle**

Health problems related to changes in lifestyle have been associated with changing food habits, for example adolescents and fast-food, and smoking, particularly the increase in young smokers. The proportion of the population aged 15 and over who are regular smokers was estimated to be 23% in 1995. Substance abuse, sedentary lifestyles, lack of exercise, and violence also contribute to health problems. The main constraint is lack of social support and national commitment, particularly with regard to smoking.

# **SECTION 3: HEALTH AND ENVIRONMENT**

## **3.1 General protection of the environment**

The increase in industrialization, vehicular emissions, tourism, etc. are leading to degradation of the environment. The quality of air in urban and industrial areas far exceeds acceptable standards. Surface and ground water in some areas is polluted due to untreated industrial waste water. The prevailing environmental problems have resulted in health problems, including respiratory, skin and bowel diseases. The main constraints are lack of skilled personnel and technical equipment, limited financial resources, and poor enforcement of environmental legislation. The renewal of HFA strategies will emphasize increasing public awareness, setting standards and developing an environmental code of regulations, providing laboratory facilities for environmental health concerns, and strengthening intersectoral coordination and action.

## **3.2 Water supply and sanitation**

Although in 1998 it was reported that accessibility to clean water had increased to 88.2% in urban areas and 71.9% in rural areas, there is evidence that the bacteriological standards of the water are relatively low. The major cause for this situation is contamination associated with the proximity of "clean water" facilities to septic tanks. It has been reported that in urban areas this was as high as 75% and in rural areas 55.9% (BPS 1995). The proportion of the population with adequate excreta disposal facilities was 86.9% in urban and 54.2% in rural areas in 1998. The management of clean water is the responsibility of several different departments and coordination needs to be strengthened if this major health hazard relating to the proximity of septic tanks to clean water is to be resolved.

## **SECTION 4: HEALTH RESOURCES**

### **4.1 Human resources for health**

The ratio of health personnel to population had increased since 1986, but then slowed down following the 1990 government policy of zero growth for civil servants. Health professionals are now employed on a contract basis for a limited period. This limited absorptive capacity of the public sector has caused a shift of health professionals, particularly of doctors, to the private sector. In 1997/1998, physicians per 10,000 population was reported to be 1.1, midwives 3 and nurses 4. The main constraint to HRH development, particularly of paramedical staff, is the lack of instructors in the respective paramedical disciplines. The quality of the training has also been found wanting. To rectify this situation, training centres for teachers and instructors, particularly for nurses, have been developed in five provinces. A centre to study and evaluate all types of health training has been developed which will undertake the review and development of curricula implemented by the paramedical schools.

### **4.2 Financial resources for health**

With the increase in population and the growing health problems arising out of the epidemiological transition, the demand for public health services of high quality has increased, necessitating the allocation of adequate financial resources for health. However, the government's capability to provide adequate funds is very limited. Therefore, better financial management is of paramount importance in addition to soliciting community resources to provide additional funding for health services. Alternative mechanisms of funding health services include community health maintenance insurance schemes, user fees to support operational activities of hospitals, and privatization. The latter may warrant adjustments for the lower income groups and the regulation of private sector health care. The total national health expenditure as a proportion of the GNP increased from 2.5% in 1986 to 2.7% in 1998. The total government health expenditure as a proportion of the GNP declined from 0.7% to 0.67% between 1986 and 1998. The total government health expenditure per capita in 1998 was US \$3.

### **4.3 Physical infrastructure**

Significant improvement in the physical health infrastructure took place during recent decades. The number of hospital beds increased from 63,643 in 1973 to 123,168 in 1998.

The number of health centers in 1998 were 7602, sub centers 21,811 and mobile health centers 7035.

However, the poorest 20% of the population still have inadequate access to health services. To ensure development and maintenance of institutions, "self financing" units in public hospitals have been developed. The main constraints to improvement in physical infrastructure were the limitation of funds and meeting the needs of isolated communities in the Indonesian archipelago. To respond to challenges in health development, a "proactive hospital" concept which is similar to the "hospital without walls" concept is being tried out with WHO collaboration in two districts in West Java province.

#### **4.4 Essential drugs and other supplies**

Following implementation of the national essential drugs list in public health facilities throughout the country and interventions made for the rational use of drugs, there has been a considerable decline in the excessive use of antibiotics, multidrug combinations and injections. The proportion of health centers experiencing shortages of drugs has decreased, and the availability and the range of drugs have shown improvement. In 1995 a sample of remote facilities was found to have about 45% of the drugs listed. It was observed that allocations made for drugs are increasingly used for life-saving drugs, particularly for children.

To ensure the availability and timely supply of high quality essential drugs at low cost, government owned companies have been designated as the main source of supply. The production of generic drugs is now done by four government and 26 private pharmaceutical companies. Essential drugs to the public sector are subsidized by the government and the price of drugs for use at PHC level is also controlled. The main constraints are the lack of understanding and suspicion by the community about the quality of generic drugs, the irrational use of drugs that still prevails among service providers, and the limited budget.

#### **4.5 International partnerships for health**

Foreign aid plays a very important role in public health. Since the fourth plan (Pelita IV), 20-30% of public health expenditure has been borne by foreign aid, of which more than 70% has been used for the development of health services and human resources for health. A constraint to the development of international partnerships is the non-availability of skilled personnel to prepare proposals to mobilize and manage foreign aid. The role of NGOs such as Lions Club, Rotary, etc. is considerable in health programmes, and relationships will be further strengthened.

### **SECTION 5: DEVELOPMENT OF THE HEALTH SYSTEM**

#### **5.1 Health policies and strategies**

With regard to health policies and strategies, a number of innovations have been introduced in many areas, such as in manpower planning, nutrition, immunization, water supply, generic drugs, health care financing and district health management. Implementation of the "zero growth" policy for civil servants has adversely affected the recruitment of doctors to serve in government health centres. To circumvent this problem, the MOH

introduced a scheme for employing doctors on contract, which does not provide job security and is therefore not attractive. In 1992 a health law was passed which defined the role of government in health for the next decade and laid the groundwork for other health regulations. A social security law was also passed in 1992 which mandates employers with more than ten employees to provide them with some sort of health benefits.

## **5.2 Intersectoral cooperation**

The atmosphere for intersectoral cooperation is promising, as evidenced by the joint efforts of different sectors in implementing the global strategy on AIDS, the polio immunization campaign, rural water supply and sanitation, etc. Intersectoral bodies with representation from concerned ministries and other relevant persons have been set-up, for example the AIDS commission and the committee for the polio immunization programme. Coordination meetings are organized by the Ministry of Welfare. Despite these efforts, negative sectoral attitudes still remain, as well as resistance to working with NGOs and the private sector.

## **5.3 Organization of the health system**

In 1987, some public health responsibilities were transferred to provincial governments and district authorities. As a result of this decentralization, local governments were granted the authority and responsibility to provide primary health care and referral services. At the next level, health centres and hospitals provide services, and at the tertiary level are the larger hospitals and other specialized health institutions. The provincial health office has operational responsibility, while control on matters of policy and technical guidance is retained by the Ministry of Health which has representatives/offices at district and provincial levels. In 1994 a National Health Advisory Council was appointed by the President with experts from various fields to advise the Ministry of Health on national health policy. In 1996 the reorganization of provincial and district health offices was undertaken to strengthen the decentralization process and to increase the quality of technical and operational guidance to local health services and the private health sector.

## **5.4 Managerial process**

Technical policy determined by the Ministry of Health is translated into provincial policy to meet specific provincial considerations and needs. Bottom-up planning is encouraged through coordination meetings at each managerial and service level. There is better handling of the data and information needed for health management. The budgeting process has been modified to enable projects to be managed at district level. There has also been an increase in subsidies for local government. Budget preparation is not only based on projections but also on the actual needs and aspirations of the community. The main constraint is the lack of managerial expertise at the various levels and willingness to assume responsibilities conferred through the decentralization process.

## **5.5 Health information system**

Health information has been strengthened by developing a simplified health centre recording and reporting system to ensure the completeness and accuracy of data, as well as an improved, integrated surveillance system. A formal mechanism for an executive report on

health to be transmitted from provincial to national level has also been established. National, regional and district health profiles have been developed. Advanced computer technology, which offers almost unlimited opportunities for improvement of the information system, is also being introduced.

## **5.6 Community action**

There has been an increasing trend in community, NGO and private sector participation in health development. Examples of such participation include assistance in the implementation of national health programmes (e.g. immunization, AIDS control, MCH/FP, and other disease control programmes), contributions in cash or assistance in kind for construction of health facilities, and support from health volunteers. A climate conducive to better NGO participation is also being created and health personnel are receiving skills training in working with the community. The Ministry of Health has developed a guidebook on "management of community action for health" in support of a social approach to health development.

## **5.7 Emergency preparedness**

Actions taken to improve emergency preparedness are the identification of risks and hazards, improving preparedness by disaster exercises/drills, and life saving actions and procedures. The main constraints are the lack of a rapid assessment and rapid response strategy, inadequate contingency plans for the health sector, and plans for community action during disasters and emergencies. Measures to improve emergency preparedness are the development of a disaster information system and improved training to deal with emergencies.

## **5.8 Health research and technology**

By ministerial decree, the National Institute of Health Research and Development (NIHRD) is obliged to provide guidance for research and development activities within the scope of the MOH. Important research outcomes have been reported and utilized where relevant in the areas of communicable diseases, anaemia, vitamin A fortification, IDD, protein-energy malnutrition (PEM), national health policy research, etc. Actions taken to develop health research and technology include priority setting in research, improving research communication, capacity building (training, career structures, research facilities and the Hellis network), mobilizing resources, and utilization of research results. Much more, however, needs to be done to support these areas. For the future, research coordination and management will receive priority attention.

# **SECTION 6: HEALTH SERVICES**

## **6.1 Health education and promotion**

Health education and promotion is given priority consideration. Health law makes a clear reference to health education and promotion (HEP) when it states that "the focus of health development is to increase the knowledge, attitudes and practice (in health) of the people". HEP is a main programme - not just a supportive programme. In the last 2-3 years, HEP has focused on certain priority health programmes, namely MCH, nutrition,

environmental health, changing lifestyles, and health financing. HEP has been carried out in household settings, schools, workplaces and health institutions. Networking with NGOs has also been strengthened. The main constraints are lack of health education specialists at provincial and lower levels, as well as inadequate funds at all levels to improve programme effectiveness,

## **6.2 Maternal and child health/family planning**

In 1998 the proportion of pregnant women attended by trained health personnel during pregnancy (4 or more visits) was 71.85%. The proportion of deliveries attended by health personnel was 62.29% and of infants 66.56%. The proportion of women of childbearing age using contraception was 66.4%. The deployment of 54,120 community midwives to work at village level increased trained assistance at delivery from 32% in 1992 to 46.59% in 1995 and influenced the reduction in maternal mortality. Advocacy and social mobilization for safe motherhood have also been strengthened. There is an increasing awareness of the need for improving the quality of care in the provision of MCH services. Other actions include integrated programme planning and budgeting at district level, intersectoral coordination, training in life saving skills for midwives, and the introduction of "health cards" to provide a safety net for the poor. The main constraints are limited resources and the wide variation in topography, sociocultural behaviour and available health infrastructure between the provinces.

## **6.3 Immunization**

Achievements of the immunization programme have been considerable. In 1998/99 the proportions of infants fully immunized with individual vaccines coverage were 95.01% for DPT, 88.4% for OPV3, 86.76% for measles vaccine, and 93.14% for BCG. The proportion of women immunized with two doses of tetanus toxoid was 73.42%. The immunization programme is sustainable and is valued by parents and well supported by volunteer health workers. Funds are mainly from the national budget with only a small fraction of foreign assistance. The main constraints are the lack of good quality surveillance and budgetary constraints to undertake operational research studies, etc.

## **6.4 Prevention and control of locally endemic diseases**

Partial success has been achieved in the prevention and control of locally endemic diseases. With regard to the directly transmitted diseases, such as pulmonary tuberculosis, leprosy, diarrhoeal diseases, childhood pneumonia and STDs, considerable reduction in cases and deaths, as well as improvements in programme management have been achieved. Tuberculosis (TB) sputum conversion and cure rates have been more than 80%, the prevalence of leprosy has declined from 0.36 in 1992 and 0.19 in 1995 to 0.09 in 2000.

With regard to vector-borne diseases such as dengue, malaria, filariasis and schistosomiasis, no major improvement has been noted. For example, the DHF case fatality rate decreased from 2.9% in 1992 to 2.5% in 1995 – continued to be within 2 to 3% which is considered as being too high, but the incidence rate increased from 9.45 per 100,000 population in 1992 to 18.41 in 1995 and fluctuating thereafter in similar pattern. The incidence of malaria has fluctuated among the islands. Filariasis and schistosomiasis have

shown hardly any change. The main constraints have been the vast land area, the difficult terrain, sociocultural differences, and financial limitations.

## **6.5 Treatment of common diseases and injuries**

With regard to the treatment of acute respiratory infections (ARIs), the emphasis has been on early recognition and referral of children with pneumonia by village midwives as well as the community. ARI clinical training and standard case management have been intensified in medical and nursing schools as well as in health care facilities. In respect of diarrhoeal diseases, the ORS user rate increased from 77% in 1992 to 86.2% in 1995, with increased access to ORS and treatment facilities. Standard case management of diarrhoea has also been established. The prevalence and estimated incidence of cancer in Indonesia is 113 and 60 cases per 100,000 population in 1998. However, only 3.2% of new cancer cases seek treatment in hospitals. A programme conducted by the community-based integrated cancer control project in Sidoarjo resulted in a 10-20% increase in cancer cases receiving hospital treatment. A similar approach in five provinces in Java-Bali resulted in similar results. Efforts are underway to reduce the high cost of drugs and strengthen early case detection capabilities. In 1995 cardiovascular diseases ranked as the leading cause of death in Indonesia (national household survey). The Monica study in Jakarta identified high blood pressure and elevated blood lipid levels as risk factors. Actions taken will focus on early detection and improved facilities for treatment, together with increasing the level of awareness in the community. Introducing the concept of 'proactive' hospitals will be a future strategy.

## **SECTION 7: TRENDS IN HEALTH STATUS**

### **7.1 Life expectancy**

The life expectancy at birth has increased for both sexes, 61.9 years for males and 65.7 years for females (1996) which will result in an increase in the number of older persons and an increase in the incidence of degenerative diseases. This will warrant increased health expenditure. A comprehensive approach to promote health status and improve life expectancy has been initiated using the family as the focal point. The technical unit to which this function is assigned is the directorate of family health promotion within the Ministry of Health.

### **7.2 Mortality**

Between 1986 and 1997, the infant mortality rate (IMR) declined from 71 to 41.44 per 1000 live births, and the under five year mortality rate from 111 to 59 per 1000 live births. The maternal mortality ratio (MMR) declined from 450 in 1986 to 373 per 100,000 live births in 1995. Several factors, including increased immunization coverage, community participation, economic growth in rural areas, health promotion and education, greater community awareness, and improvement in health facilities/services, have contributed to these significant changes in mortality. Constraints to reduction in mortality include increasing urbanization, poverty, and the large numbers of remote/small islands, which have made communication very difficult. Future strategies will emphasize intersectoral cooperation, community participation, and delegation of authority to provincial and lower levels.

### **7.3 Morbidity**

Several significant changes in morbidity have taken place since early 1990s. The country has achieved the leprosy elimination goal at the national level and is now working towards achieving at sub-national elimination goal. Malaria control activities have had a minimal effect on the incidence of malaria, with the number of estimated cases increasing from 1,518,140 in 1995 to 3,232,762 in 1998. Case finding and treatment have been intensified but the main constraints are drug resistance of *P. falciparum*, transport difficulties, and limitation of funds. The prevalence of tuberculosis also appears to be having upward trend due to limited coverage of the intervention programme, high treatment dropout rates, and multidrug resistance. This is in spite of priority attention being given to the use of directly observed treatment, short course (DOTS), with over 80% coverage. Following the high immunization coverage, the incidence of polio is expected to decline significantly. In 1995 improved surveillance and reporting of acute flaccid paralysis was introduced, with diagnosis supported by laboratory findings. A decline in cases of neonatal tetanus was observed between 1992 and 1995 (807 to 390) due to the increase in immunization coverage, better surveillance, and improvement in clean delivery practices. A dramatic decline in measles morbidity from 91,645 cases in 1992 to 37,594 cases in 1995 and in poliomyelitis from 148 to 14 cases was observed due to high immunization coverage, intensive surveillance, and outbreak containment. There has been zero reporting of polio cases for last three years since 1998.

### **7.4 Disability**

National surveys have estimated the prevalence of blindness to be 1.47% (1996). The main cause of blindness was cataract with a prevalence of 1.02%. Future strategies will need to integrate primary eye care activities into the PHC system and also establish a comprehensive "cataract relief service" programme. For locomotor disability, the community based rehabilitation (CBR) approach was adopted and commenced implementation in Central Java with provision for expansion. The main constraints are shortages of human and financial resources. Future actions for disability would be to strengthen health policy and develop better coordination with NGOs and the private sector.

## **SECTION 8: OUTLOOK FOR THE FUTURE**

### **8.1 Overall assessment and strategic issues**

Mortality rates have shown a gradual but slow decline, particularly the maternal mortality ratio. The persistence of many of the communicable diseases, which are still of public health significance and the re-emergence of others, are of concern. The increase that is observed in noncommunicable diseases, particularly CVD and the degenerative diseases, is another important issue that needs to be addressed. Nutritional concerns of importance are PEM and micronutrient deficiencies, particularly iron deficiency anaemia, IDD and vitamin A deficiency.

Efforts have been made to reallocate some of the subsidies for public hospitals to support primary health care services, particularly for the underserved, by means of converting public hospitals into self-supporting service units (Swadana). The 'health card' programme was also introduced to improve the access of the poor to health care services. The public has

been encouraged to join the "voluntary managed care plan" (JPKM) for better health protection and access to services.

In the management of resources, the allocation of public funds to support cost effective interventions is a crucial issue. Within this context, a process of integrated planning and budgeting would allow more discretion to district level administration to provide more resources towards supporting specific cost effective district actions. As a consequence of the national policy of zero growth for civil servants, doctors, nurses and paramedical personnel are now recruited on contract for a specific period, and this has proved unattractive to serving in the public sector.

In the development of the health system, some of the crucial issues concern law enforcement and legislative actions for health protection, organization of health administration for effective management, review of health ministry functions in keeping with the policy of a decentralized district administration, development of the health management information system (HMIS), and the move towards privatization of health services with increasing demand for sophisticated medical techniques and services. In the area of health services, though availability has substantially improved, attention needs to be paid to the quality of services provided, particularly in public health facilities.

The trends in socioeconomic development have overall been positive, though negative influences related to changes in lifestyle are observed in urban areas. A political environment conducive to health development, the role of women, equity, and community participation could be perceived as great opportunities for health development in the future.

International partnerships for health were dominated for a period of time by multilateral and bilateral financial assistance, mainly for physical infrastructure development. Recently, more collaborative initiatives have been pursued involving other Southeast Asian countries.

## **8.2 Futures vision**

The broad basic objective will be to attain the goal of optimal health, which would allow the people to pursue economically productive lives (HFA goal). To achieve this, health services will have to be of adequate quality and accessible to all. The health system should provide a setting favourable to more decentralized health administration, particularly at the district level, and streamlining of the Ministry of Health's organizational structure to provide greater technical support, effective programme review, policy analysis, and better resource mobilization for health, and to create an environment, which favours healthy lifestyles.

## **8.3 Proposed strategies**

A framework for future strategies is proposed under five main areas. These are ensuring equity for health, strengthening health promotion and protection, strengthening the health sector, developing and strengthening specific health programmes, and strengthening international partnerships in health. All this calls for orientation of health system, better governance, stewardship which can lead to better health system performance.

**Country reported data for basic health indicators**

Indicator	Latest available data	Year	Source	Remarks
<b>Population and Vital Statistics</b>				
Total population (in millions)	203.0	2000	1	Census data
Population density (persons per sq km)	106	2000	1	Census data
Sex ratio (males per 100 females)	99.78	2000	1	Census data
Population under 15 years (%)	30.77	1999	2	
Population 65 years and above (%)	4.61	1999	2	
Crude birth rate (per 1000 population)	22.55	1998	3	
Crude death rate (per 1000 population)	7.49	1998	3	
Annual population growth rate (%)	1.14	1995-98	3	
Total fertility rate (per woman)	2.597	1998	3	
Urban population (%)	39.3	1999	2	
<b>Socioeconomic Situation</b>				
Gross national product per capita (US\$)	978	1995	4	
Adult literacy rate (%):				
Male	93.4	1998	3	For 10+ years olds
Female	85.5	1998	3	
Median number of years of schooling:				
Male	6.3	1997	5	
Female	5.6	1997	5	
Prevalence of low birth weight (weight <2500 grams at birth) (%)	7.7	1997	5	
Prevalence of underweight (weight-for-age) in children <5 years of age (%)	20.3	1998	3	Protein energy deficiency
<b>Environment</b>				
Population with safe drinking water available in the home or with reasonable access (%)				
Urban	88.2	1998	3	
Rural	71.9	1998	3	
Population with adequate excreta disposal facilities available (%)				
Urban	86.9	1998	3	
Rural	54.2	1998	3	
<b>Health Resources</b>				
<i>Facilities</i>				
Number of hospital beds	123,168	1998	3	Computed value
Population per hospital bed	1,658	1998	3	
Hospital beds per 10,000 population	6.03	1998	3	
Number of health centres:				
(a) Health centres	7,602	1998	3	
(b) Sub-health centres	21,811	1998	3	
(c) Mobile health centres	7,035	1998	3	

Indicator	Latest available data	Year	Source	Remarks
<b><i>Human resources</i></b>				
Physicians per 10,000 population	1.1	1998	3	
Nurses per 10,000 population	4.0	1997	3	
Midwives per 10,000 population	3.0	1997	3	
<b><i>Budgetary resources</i></b>				
Total Expenditure on Health (THE) as % of Gross Domestic Product (GDP)	2.7 %	1998	6	
Public Expenditure on Health (PHE) as % of Total Expenditure on Health (THE)	25.5 %	1998	6	
Private Expenditure on Health (PvtHE) as % of Total Expenditure on Health (THE)	74.5 %	1998	6	
Public Expenditure on Health (PHE) as % of General Government Expenditure (GGE)	3.3 %	1998	6	
Social Security Expenditure on Health (SSHE) as % of Public Expenditure on Health (PHE)	20.8 %	1998	6	
Tax funded Health Expenditure (TaxFHE) as % of Public Expenditure on Health (PHE)	60.3 %	1998	6	
External Resources for Health (Ext Res HE) as % of Public Expenditure on Health (PHE)	18.9 %	1998	6	
Private Insurance for Health Risks (Pvt ins HE) as % of Private Expenditure on Health (PvtHE)	3.9 %	1998	6	
Out-of-Pocket Spending on Health (OOPS) as % of Private Expenditure on Health (PvtHE)	96.1 %	1998	6	
Per capita Total Expenditure on Health (THE) at official Exchange rate (X-Rate per US\$)	12	1998	6	
Per capita Public Expenditure on Health (PHE) at official Exchange rate (X-Rate per US\$)	3	1998	6	
Per capita Total Expenditure on Health (THE) in international dollars (int'l \$)	54	1998	6	
Per capita Public Expenditure on Health (PHE) in international dollars (int'l \$)	14	1998	6	
<b>Health Services</b>				
Pregnant women attended by trained personnel during pregnancy (%)	71.85	1998	3	Four visits
Deliveries attended by trained personnel (%)	62.29	1998	3	
Infants attended by trained personnel (%)	66.56	1998	3	Two visits (Neonatal service coverage)
Women of childbearing age using family planning (%)	66.40	1998	3	Ratio of active FP acceptors to Fertile age couples

Indicator	Latest available data	Year	Source	Remarks
Infants reaching their first birthday that have been fully immunized against diphtheria, tetanus, and whooping cough (%)	95.01	1998/99	3	DPT1
Infants reaching their first birthday that have been fully immunized against poliomyelitis (%)	88.40	1998/99	3	Polio3
Infants reaching their first birthday that have been fully immunized against measles (%)	86.76	1998/99	3	
Infants reaching their first birthday that have been fully immunized against tuberculosis (%)	93.14	1998/99	3	
Women that have been immunized with tetanus toxoid (TT) during pregnancy (%)	73.42	1998	3	TT2
<b>Health Status</b>				
Life expectancy at birth (years): Total	63.9	1996	3	Projections
Male	61.9	1996	3	
Female	65.7	1996	3	
Total	64.25	1997	3	
Total	68.23	2002	3	
Infant mortality rate (per 1000 live births)	41.44	1997	3	
Under-five mortality rate (per 1000 live births)	59	1997	3	
Maternal mortality ratio (per 100,000 live births)	373	1995	3	NHHS 1995

- Sources:** 1. Indonesia, *Census 2000 (Draft report, 20 December 2000)*  
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