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IMPLEMENTATION OF GENERAL ASSEMBLY RESOLUTION 60/251 OF 15 MARCH 2006 ENTITLED "HUMAN RIGHTS COUNCIL"

Written statement* submitted by the International NGO Forum on Indonesian Development (INFID), a non-governmental organization in special consultative status

The Secretary-General has received the following written statement which is circulated in accordance with Economic and Social Council resolution 1996/31.

[28 February 2007]

* This written statement is issued, unedited, in the language(s) received from the submitting non-governmental organization(s).

The Right to Health in Indonesia[1]

In Indonesia, women, children, the disabled and the poor are socially disadvantaged groups who have less access to health information and services. The stark realities in Indonesia are reflected in the Millennium Development Goals (MDGs).[2] Although progress has been made over the last four decades, health indicators like the under-five mortality rate (U5MR) are still high at 46 per 1000 live births, a figure that significantly exceeds that of other members of the Association of Southeast Asian Nations (ASEAN).[3] Moreover, there are great disparities within the country. One province, West Nusa Tenggara, had the highest U5MR between 1998 and 2002, with 103 per 1,000 live births, which is five times higher than the rate in Yogyakarta.[4] The other MDGs similarly reflect the need for improvement in health in general and a need to improve the great disparities in health among different populations in Indonesia.

As a general view, Indonesia's health problems are:

1. High incidences of diseases and deaths from diseases. There are now the three burdens of infectious diseases (malaria, dengue fever, tuberculosis), degenerative or new diseases (Avian Flu), re-emerging diseases (polio)
2. The national health system which is not functioning optimally. Many community health centres have been built, but are not manned by enough doctors and nurses nor supported by adequate logistics. The health financing system is weak, using out-of-pocket payments instead of an insurance scheme that is accessible for the poor.
3. Political commitment is weak in solving health problems in a systemic way.

Specifically, the lack of right to health in Indonesia, especially for marginalized groups is reflected in the following conditions:

1. The "poverty, under-educated/illiteracy, poor nutrition" burdens which give way to major infectious diseases and public health problems such as diarrhea, tuberculosis, vitamin A deficiencies, malaria, endemic goitre, among others.
2. The new emerging infectious diseases such as tuberculosis among the HIV/AIDS people, SARS and avian flu among the poor, women and children.
3. The Poor performance of health services especially for women and children because of discrepancies in the quality of medical and health personnel.
4. The curative-sickness mindset of the people including the doctors, instead of the healthy-promotion-prevention paradigm.
5. Poor sanitation and bad environmental conditions.
6. Low accessibility, affordability, quality and distribution of health services, especially for the poor, women and children (health sector budget was 2.26%, below 5% of WHO standard).
7. Poor conditions of the poor and vulnerable people (HDI-2004-score was 65.8 and Gender-related Development Index/GDI score was 59.2; Gender Empowerment Measurement score was 54.6).
8. Disparity of health status: the poorer the patient, the lower the standard of health care.

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[1] Uplift International – Indonesia also shares the views expressed in this statement.
[2] Indonesia Progress Report on the Millennium Development Goals, http://www.undp.or.id/pubs/IMDG2004, last visited July 30, 2004.
[3] Ibid.
[4] Ibid.

9. Existing health-related laws which are not gender-sensitive and not based on a rights approach.
10. Corruption, collusion, nepotism and discrimination practices in the health sector at all levels of government, judiciary, and parliament.

Legal and policy framework

The existing Constitution, article 28 H, point 1, clearly stipulates the right to health. How the right to health is being interpreted in policy, action plans and programs in Indonesia is not yet clear. Although the Health Act No. 23/1992 has many basic rights, it has to be amended to give more attention to the gender issues, women and reproductive rights. The Medical Act (N0. 29/2004) and Social Security Act (N0. 30/2004) also have the mission to protect the people from bad doctors and guarantee the poor with rights to health. There is the declaration: "Healthy Indonesia by the year 2010", followed by the National Health System as an attempt to have a comprehensive implementation model of improving the health sector. Despite these frameworks, the weak implementation and lack of political will is a huge detriment to citizens having the right to health.

Impact of decentralisation

Decentralisation has given more powers to the provinces and districts/cities, and its weak implementation has not supported the equitable delivery of health services. For example, the public health policies in some districts/mayoralties are handled by the district/city parliaments rather than the executive/government arm, resulting in chaos. Some district hospitals run by local governments have changed their core functions, not as the public services agents, but as the local income generating arm for the local governments. Some districts do not have the immunization, surveillance and sanitation units in the local health offices.

Recommendations

We urge the UN Human Rights Council to pressure the Government of the Republic of Indonesia to:

1. Revise all health-related laws that contradict the International Covenant on Economic, Social and Cultural Rights and reform all policies to respect the right to health of every person.
2. Have a national policy that is based on a public health approach instead of the curative approach.
3. Allocate adequate allocations in the National Budget to health in accordance to the Constitution and the commitment of Millennium Development Goals and International Covenant on Economic, Social and Cultural Rights.
4. Link health to human rights in order to have an equitable distribution of health care services, looking into the underlying determinants of health, which includes adequate nutrition, clean water and sanitation, good environmental health, healthy work and living conditions, non-discriminatory access to information and education on health.
5. Eradicate corruption which eviscerates a health care system that is already severely underfinanced. Corruption can take place in procurement, recruitment, the theft of

money and supplies, absenteeism, induced demand for unnecessary goods and services and the solicitation of bribes for services.

6. Have a distinct separation between the public–private health services, providing a role model of “good and accountable public services”.
7. Strengthen the capacity of central and local government to better coordinate inter-sector cooperation in health services delivery, together with civil society such as grassroots communities and health professional associations.
