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Improving the Access of the Indonesian Community to Qualified Health Services

Santriani Hadi[1], Hasta Handayani Idrus[2]
[1] *Department of Parasitology Faculty of Medicine,, University Muslim Indonesia, Makassar, Indonesia*
[2]*Department of MicrobiologyFaculty of Medicine, University Muslim Indonesia, Makassar, Indonesia*

Abstract
Health development is faced with a variety of important issues including health status disparities; double burden of disease; quality, equity and affordability of health services; community protection in the field of medicine and food; and clean and healthy life behavior. **Methods:** The method used in this short communication is descriptive-comparative where we review Safety Culture in Indonesian Health Services in five aspects, namely Health Services for the Poor, nutritional problems that are never complete, Extraordinary Events of Communicable Diseases, Poor health in Disaster areas, and finally the number of health workers still lacking and comparing the problem of Human Resources Health problems in Indonesia according to WHO (2011) and the Indonesian Ministry of Health (2009). **Results:** The results obtained in this brief communication are that we get new information in the form of problems encountered in Safety Culture in Indonesian Health Services, examples of cases that occur, policies taken by the government in handling them and the results obtained after the implementation of the policy. All of these are reviewed in five aspects. **Conclusion:** The conclusion we can take in this brief communication is that health problems that occur in Indonesia have not been resolved even though the government has implemented policies related to these problems but has not been resolved to date

Keywords: qualified health services, safety culture, Indonesian community

I. Introduction

Health development is faced with a variety of important issues including health status disparities; double burden of disease; quality, equity and affordability of health services; community protection in the field of medicine and food; and clean and healthy life behavior. Some other important issues that need to be addressed immediately are increasing the access of the poor to health services, handling malnutrition problems, tackling infectious disease outbreaks, health services in disaster areas, and fulfilling the number and distribution of health workers [1].

Health development is an effort to fulfill one of the basic rights of the people, namely the right to obtain health services. Health development must be seen as an investment to improve the quality of human resources and support economic development, and have an important role in poverty reduction efforts [2].

Steps that have been taken are increasing access to health, especially for the poor through free health services; increased prevention and control of infectious diseases including polio and bird flu; improving the quality, affordability and equity of basic health services; increasing the quality and quantity of health workers; quality assurance, safety and efficacy of drugs and food; health management in disaster areas; and increasing health promotion and community empowerment [3].

As a follow up, health development is directed at increasing the equity and affordability of health services; improve the quality of health services; improve hygiene and healthy behavior; increase efforts to prevent and eradicate diseases; improve the state of community nutrition; and improve handling of health problems in disaster areas [4].

The main problems of health development at present include the high disparity in health status between socio-economic, interregional levels, and between urban and rural areas. In general, the health status of populations with high socioeconomic levels, in western Indonesia, and in urban areas, tends to be better [5]. Conversely, the health status of the population with low socioeconomic status, in eastern Indonesia and in rural areas is still lagging behind [6].

Other important problems faced are the double burden of the disease, namely not yet overcoming infectious diseases suffered by the community such as pulmonary tuberculosis, acute respiratory infections, malaria, and diarrhea, and the reemergence of polio and bird flu [7]. However, at the same time there was an increase in non-communicable diseases such as heart and blood vessel diseases, as well as diabetes mellitus and cancer. On the other hand, the quality, equity, and affordability of health services is also still low. Quality of service is a constraint because medical personnel are very limited and inadequate equipment [8].

In terms of numbers, the ratio of health workers to the number of people that must be served is still low. The affordability of services is closely related to the number and equity of health facilities. In 2002, for every 100,000 residents there were only 3.5 Puskesmas. Even then, some residents, especially those living in remote areas, do not use the Puskesmas because of limited transportation facilities and geographical constraints [9].

In addition, the original Indonesian medicine has not been fully developed, even though its potential is huge. Community behavior also often does not support clean and healthy living [10]. This can be seen from the widespread smoking habit, the low level of exclusive breastfeeding, the high prevalence of undernutrition and over nutrition in children under five, as well as the tendency of increasing numbers of people with HIV / AIDS, sufferers of narcotics, psychotropic, addictive substances, and accidental death [11].

II. Methods

In this descriptive-comparative study, we review Safety Culture in Indonesian Health Services in five aspects, namely Health Services for the Poor, nutritional problems that are never complete, Extraordinary Events of Communicable Diseases, Poor health in disaster areas, and finally The number of health workers is still lacking (Table 1). We compare the issue of Human Resources Health problems in Indonesia according to WHO (2011) and the Indonesian Ministry of Health (2009) (Table 2).

III. Results

The results obtained in this brief communication are that we get new information in the form of problems encountered in Safety Culture in Indonesian Health Services, examples of cases that occur, policies taken by the government in handling them and the results obtained after the implementation of the policy. We can see in at the **table 1.** and in **table 2**. we can see a comparison of Issues of problems of Health Human Resources in Indonesia according to WHO (2011) and Indonesian Ministry of Health (2009).

Table 1. Shows an overview of Safety Culture in Indonesian Health Services reviewed in five aspects

Problems encountered	Examples of Problems	Government Policy Steps	The Results Achieved
Health Services for the Poor Society	Jamkesmas is a social assistance program for health services for the poor and disadvantaged. This program is organized securely so that there will be cross-subsidies in order to create comprehensive health services for the poor [3].	1. The implementation of the 1945 Constitution article 34 paragraph 1 and 2, since 1998 has been carried out several efforts to maintain the health of the poor population. The aim of this effort is to maintain and improve the quality and access to health services for the poor, especially health services in puskesmas and hospitals [12] . 2. Free health services for the poor have been sought by the Government since the economic crisis in 1997 [4]. 3. The implementation of Law No. 40 of 2004 concerning the National Social Security System, efforts to improve access of the poor to health services are further enhanced through efforts to maintain the health of the poor with a health insurance / insurance system [6]. 4. The health service program for the poor is carried out with the principles of (a) comprehensive services in accordance with health standards; and (b) basic health services in the Puskesmas and outpatient and inpatient referrals in hospitals [5].	1. The National Social Security System improves health services for the poor through efforts to maintain the health of the poor with a health insurance / insurance system [7]. 2. The poor are included in health insurance with a premium paid by the Government [8]. 3. The implementation of the health service program for the poor is carried out with the principle, among others, comprehensive services in accordance with health standards and basic health services in Puskesmas and outpatient and inpatient referrals in class III hospitals [2]. 4. The poor can get free health services both at the puskesmas and in the hospital [7]. 5. The poor can get access to the Puskesmas and operational costs and motorbikes have been provided for officers, four-wheeled mobile Puskesmas, and Puskesmas around motorized boats [13].
nutrition problem that is never complete	The problem of malnutrition and measles in Papua is a clear example of cases of malnutrition that occurred in Indonesia. The Ministry of Health sent 39 health workers in response to the incidence of malnutrition in this area. In addition, assistance was also provided by the Indonesian national	1. Organizing a coordination meeting to reactivate the Food and Nutrition Team [14]. 2. Implementation of the Food and Nutrition Alert System (SKPG), as well as case investigations to all potential areas [15]. 3. Interventions conducted in dealing with malnutrition are directed at preventing death and disability through early discovery of cases	1. The results achieved include the enactment of an extraordinary event of malnutrition in the province of West Nusa Tenggara and the exemption of fees for sufferers of malnutrition who are hospitalized [15]. 2. One tonne of complementary breastfeeding food has been sent to sufferers through the regency / city government in West Nusa Tenggara Province and 1.5 tonnes of complementary breastfeeding food for East

	army by sending health workers [14].	of malnutrition and providing professional management at the community, health center, and hospital level [15].	Nusa Tenggara Province, as well as assigning special staff to carry out investigations [15]. 3. Additional food assistance was provided to 26,200 toddlers, 8,400 pregnant women and 38,000 school children in West Nusa Tenggara Province and 23,200 toddlers, 6,700 pregnant women, and 43,000 school children in East Nusa Tenggara Province [16].
Extraordinary Occurrence of Communicable Diseases	The extraordinary incident of polio in Indonesia was last reported in 2005-2006 for type 1 polio virus originating from the Middle East. This extraordinary incident occurred in 10 provinces and 47 regencies / cities throughout Indonesia, with a total of reported cases of 305. On the other hand, the availability of polio vaccine in Indonesia is nothing to worry about [17] .	1. increase coverage of routine immunizations for infants to the village level that is given free of charge. 2. Carry out additional immunizations through the National Immunization Week, National Immunization Sub-Week for 5 provinces and carry out the Immunization Month for School Children [18]. 3. Perform routine surveillance of Acute Flaccid Paralysis or sudden paralysis in children under 15 years routinely [19].	1. The results of the implementation of routine polio immunization activities nationally in the last three years the coverage reached more than 90 percent but the activity was still not evenly distributed in all villages. This happens because the village Universal Child Immunization in the last three years has not reached 80 percent [9]. 2. With the outbreak of Polio in the Provinces of West Java, Banten, Central Java, Lampung and DKI Jakarta, Outbreak Response Immunization has been carried out in these provinces to prevent transmission of the polio virus [10]. 3. Well implemented Outbreak Response Immunization activities that are strived to prevent transmission of wild polio virus around patients. 4. The implementation of limited mass immunization or mopping up to break the wider chain of transmission of wild polio virus [4].
Poor health in the Disaster area	The impact of disasters on public health varies, among other things depending on the type and magnitude of the disaster that occurred. Injury cases that require medical treatment, for example, are relatively more common in earthquake disasters	1. For the management of natural disasters, policy measures have been taken to address emergency health with the aim of providing immediate health services to the living population. 2. Also carried out rehabilitation of various health facilities and infrastructure so that health	1. Built and operated 7 Satellite Health Posts in several dwellings, while 23 Satellite Health Posts are still in the completion stage [22]. 2. For the management of the Satellite Health Post, 880 health workers have been recruited, consisting of 110 doctors, 165 midwives, 110 public health scholars, 55 nutritionists, 55 environmental health workers, 330

	compared to injury cases due to floods and tidal waves. Conversely, floods that occur in a relatively long time can cause damage to the sanitation system and clean water, as well as lead to the potential for extraordinary events such as diseases transmitted through water-borne diseases such as diarrhea and leptospirosis [20].	services can function as before. All this was done in a coordinated way, especially with volunteers from within and outside the country [21]. 3. A more comprehensive health and rehabilitation plan for the disaster area has been prepared, as stated in the blueprint for the Rehabilitation and Reconstruction Plan for the disaster area [21].	nurses, and 55 pharmacist assistants [23]. 3. The implementation of health services by the mobile medical team using the facilities of 4-wheeled vehicles and wheels 2. In an effort to meet the needs of specialist doctors and skilled nurses, initially carried out through special assignments [24]. 4. Specialist doctors and nurses are further developed into permanent staff placements currently being recruited [24]. 5. The recovery of the function of health services is carried out by rehabilitating health service facilities that were slightly damaged by provincial and district / city health offices in collaboration with local community social institutions [25]. 6. Conducting counseling training for health workers on a regular basis followed by early detection of community psychiatric disorders and treatment in health care facilities.
The number of health workers is still lacking	The number of general practitioners in Indonesia has exceeded the quota, but the uneven distribution makes 728 health centers in Indonesia do not have general practitioners, 728 health centers are only filled with health workers such as midwives and nurses. While supporting health workers other than doctors are also needed for promotive and preventive efforts such as environmental health workers, pharmacists, nutritionists, public health and medical laboratory experts [26].	1. In the context of increasing the quantity and quality of health human resources, the policy step taken is the recruitment of medical personnel, especially for puskesmas and hospitals in remote areas [27]. 2. The preparation of the plan for the placement of health workers shall be allocated from the regular appointment of doctors for non-permanent employees and prospective civil servants [28].	1. As a result, 1,040 doctors, 139 dentists, and 3,937 midwives were appointed to Non-Permanent Employees in 2004. There are 466 doctors, 77 dentists and 1,651 midwives who are placed in disadvantaged areas. To improve equity, of these 276 doctors, 31 dentists, and all midwives were placed in remote and very remote areas [29]. 2. Selection of Prospective Civil Servants of the Ministry of Health in 2004 was conducted on 28,929 applicants to fill the formation of 2,384 people. From the area it was reported that 409,746 applicants had been selected to be placed in disadvantaged areas as many as 6,235 people [29]. 3. In addition, the Presidential Decree No. revision

	concept has also been prepared. 37 of 1991 and Presidential Decree No. 77 of 2000 concerning Strategic Health Workers for Non-permanent Employees and the concept of the Presidential Regulation on Strategic Health Workers as Non-permanent Employees [29]. 4. There was also a discussion on the draft of the Presidential Regulation on the Appointment of Strategic Health Workers for Non-Permanent Employees and the Policy for Providing Incentives for health workers in disadvantaged areas with provincial health offices, several district health offices, several regional public hospitals, and cross-sectoral officials [29].

table 2. Comparison of Issues of problems of Health Human Resources in Indonesia according to WHO (2011) and Indonesian Ministry of Health (2009).

Issues of problems with Health Human Resources in Indonesia according to WHO (2011) Issues of problems with Health Human Resources in Indonesia according to the Indonesian Ministry of Health (2009)	**Issues of problems with Health Human Resources in Indonesia according to WHO (2011) Issues of problems with Health Human Resources in Indonesia according to the Indonesian Ministry of Health (2009)**
The development of health workers has not been able to meet the needs of health workers for health services / development. Health workers continue to improve in number, quality and distribution, but are still unable to meet the needs of health services in all regions, especially in disadvantaged, remote, border and island areas. The quality of health workers does not yet have the competitiveness in meeting the demand for health workers from abroad [30].	Development and empowerment of Human Resources for health has not been able to meet the needs of Human Resources for health development. Because the amount is not enough and the distribution of health workers that has not been resolved [31].
Regulations to support efforts to develop health workers are still limited. Much of the training needed by health workers is paid and quite expensive so that many health workers cannot upgrade their knowledge due to cost constraints [30].	Health human resource policy and program planning is still weak and has not been supported by an adequate health human resource information system [31].
Planning for health personnel needs still needs to be improved and not yet supported by an adequate health workforce information system. The overall plan for the need for health	There is still a lack of harmony between the needs and procurement of various types of health human resources. The quality of health human resource education and health

workers has not been prepared as expected, so it has not been fully used as a reference in the procurement / education of health workers, utilization of health workers, as well as guidance and quality control of health workers [32] .	training in general is still inadequate [30].
There is still a lack of harmony between the needs and the procurement / education of various types of health workers. The study of the type of health workers needed has not been carried out properly. The quality of the education and training of health workers in general is still inadequate. There are still many educational institutions which are not accredited and meet the standards. This will have an impact on the competence and quality of graduates of health workers. Problems in the education of health workers in general are systemic, among others there is a mismatch in the competence of education graduates with health services needed by the community, weak cooperation between actors in health development and health workforce education, more dominant education of health workers oriented to hospitals compared to Primary Health Care [32] .	In the utilization of Health Human Resources, the distribution of quality Health Human Resources is still lacking. Career development, reward and sanction systems have not been as appropriate. Regulations to support Human Resources for health are still limited [33].
In the utilization of health workers, even distribution and utilization of quality health workers is still lacking, especially in disadvantaged, remote, border, island and less desirable areas. This is due to the socio-economic, cultural and regional government disparities, including geographical conditions between regions, reducing the interest of health workers to be placed in the area. In addition, the development and implementation of career development patterns, rewards and sanctions systems have not been implemented as expected. Continuing professional development (Continue Professional Development / CPD), and Training Need Assessment (TNA) still needs to be developed [34].	Development and supervision of health Human Resources and health Human Resources support is still lacking. Mainly in remote areas because many doctors do not want to be placed in remote areas and they are only concentrated in urban areas [2].
The guidance and supervision of the quality of health workers cannot be carried out as expected. Registration and certification of health workers is still limited to doctors and dentists. Dissemination and application of laws and regulations in the field of health personnel development have not been carried out adequately. Resources supporting the development and empowerment of health workers are still limited. Health personnel information systems have not been able to provide accurate, reliable and timely data. Support of financial resources and other resources has not been sufficient [34].	The problem of Human Resources for Health at the Global level that has not been resolved even though many programs are in line [5].

IV. Discussion

A. Problems Encountered

Basic problems in the last ten months, there have been at least five important issues in the health sector that need immediate treatment, namely guaranteeing poor people's access to health services, handling malnutrition problems, handling infectious disease outbreaks, health services in disaster areas, and meeting the number and distribution of health workers [5].

1. Health Services for the Poor Society

Nationally the status of public health has improved. However, the disparity in health status between the able population and the poor population is still quite large. Various data shows that the health status of the poor is lower when compared to the rich population. This can be seen, among others, from the high infant mortality rate and infant mortality rate in the poor population group. According to the 2002-2003 Indonesian Demographic and Health Survey, the infant mortality rate in the poorest group was 61 compared to 17 per 1,000 live births in the richest group. Likewise, the under-five mortality rate in the poorest population (77 per 1,000 live births) is much higher than the under-five mortality rate in the richest population (22 per 1,000 live births). Infectious diseases that are the leading cause of death in infants and toddlers, diarrhea, neonatal tetanus and birth complications, are also more common in poor populations [7], [13].

2. Nutrition problem that is never complete

Health problems that have caused considerable public attention lately are problems of malnutrition and poor nutrition. Although since 1989 there has been a relatively sharp decrease in the prevalence of undernutrition, starting in 1999 the decline in the prevalence of undernutrition and malnutrition in children under five is relatively slow and tends to remain unchanged. Currently there are 10 provinces with a prevalence of malnutrition above 30, and some even above 40 percent, namely in the provinces of Gorontalo, West Nusa Tenggara, East Nusa Tenggara, and Papua.

Lack of energy and protein at a severe or more popular level called malnutrition, can cause major health problems and can even cause death in children [15], [35].

3. Extraordinary Occurrence of Communicable Diseases

Another health problem that is of concern to the community is the outbreak of various infectious diseases. Most infectious diseases suffered by the community are infectious diseases such as pulmonary tuberculosis which currently ranks third in the world, acute respiratory infections, malaria, and diarrhea. In addition, Indonesia also faces emerging diseases (newly developing diseases) such as HIV / AIDS and Severe Acute Respiratory Syndrome and re-emerging diseases (diseases that previously began to decline, but increased again) such as dengue hemorrhagic fever and Infection lung [36].

One infectious disease that has recently emerged is the emergence of polio cases in several regions such as West Java, Banten, Central Java, Lampung and DKI Jakarta. Polio is a very dangerous infectious disease caused by a virus that attacks the nervous system and can cause permanent paralysis or death. One in 200 cases of viral infection will cause paralysis, 5-10 percent of patients die from paralysis of the respiratory muscles. There is no cure for polio. This disease can only be prevented by immunization. The vaccine for immunization is safe and by the Indonesian Ulema Council declared halal [15].

4. Poor health in the Disaster area

The natural disasters of the earthquake and tsunami that occurred in Aceh, Nias, Alor and Nabire have had a major impact on the health sector. Many victims died, disappeared and were injured. Many health facilities and infrastructure were destroyed and did not function optimally, such as hospitals, puskesmas, supporting puskesmas, health offices, health laboratory centers, pharmaceutical warehouses, vaccine warehouses, health polytechnics, and port health offices . The tsunami disaster in Aceh caused damage to 9 hospitals, 43 health centers, 59 sub-health centers, 700 village polyclinics, and 55 mobile health centers, and other facilities such as hospitals, laboratories and health offices. The number of health workers who died or disappeared was 683 people [17], [37].

5. The number of health workers is still lacking

The condition of health workers in 2004 was not much different from that because the education system was still unable to produce sufficient numbers of health workers, and the recruitment system and incentive patterns for health workers were less than optimal[38]. In addition, the number and distribution of community health workers is still inadequate so that many puskesmas do not have doctors and community health workers. This limitation is exacerbated by the uneven distribution of health workers. For example, more than two-thirds of specialist doctors are in Java and Bali. Doctor ratio disparity general per 100,000 population among regions is also still high and ranges from 2.3 in Lampung to 28.0 in Yogyakarta [3], [30].

B. Examples of Problems

1. Health Services for the Poor Society

The 1945 Constitution Article 28H and Law Number 36 of 2009 concerning Health, stipulates that everyone has the right to receive health services. Therefore every individual, family and community has the right to obtain protection for their health, and the state is responsible for regulating the fulfillment of the right to a healthy life for its population, including for the poor and disadvantaged. The establishment of the National Social Security System is realized through Law Number 40 of 2004 concerning the National Social Security System which has a health insurance program, work accident insurance, old age insurance, pension insurance and death insurance. This social security is the government's effort in dealing with the monetary crisis. As is known, the crisis began in 1997 until now, due to multidimensional factors including the transfer of the subsidy program for the poor in the form of fuel subsidies for the health sector for the poor to the Health Safety Net program for the Poor [33], [39].

2. Nutrition problem that is never complete

One of the most terrible problems that occur in Indonesia is the problem of malnutrition. The problem of malnutrition in general can be divided into problems of over nutrition as well as nutritional deficiencies. There are 8.4 million children in Indonesia who are malnourished and experience what doctors call the term stunting. Stunting is a condition where a child has a very small body size compared to children their age [4].

The problem of malnutrition and measles in Papua is an extraordinary event. The Ministry of Health has deployed 39 health workers in response to an outbreak of severe malnutrition and measles. In addition, assistance was also provided by the Indonesian National Army by sending health units. The local government also formed a team that was immediately sent to the field to conduct prevention and treatment and supplementary feeding. Habits of people who do not care about health are the cause of the outbreak [6].

3. Extraordinary Occurrence of Communicable Diseases

From the beginning until now, outbreaks of disease have been attacking the people of Indonesia, and not infrequently cause extraordinary events. The Ministry of Health implements Extraordinary Events to classify an outbreak of a disease. Indonesia has struggled to face a variety of Extraordinary Events. Here are some examples of the extraordinary events of infectious diseases that have hit Indonesia is the outbreak of polio in Indonesia was last reported in 2005-2006 for type 1 polio virus originating from the Middle East. This extraordinary incident occurred in 10 provinces and 47 regencies / cities throughout Indonesia, with a total of reported cases of 305. On the other hand, the availability of polio vaccine in Indonesia is nothing to worry about [18], [19].

4. Poor health in the Disaster area

One of the impacts of the disaster on the declining quality of life of the population can be seen from various public health problems that occur. Disasters that are followed by displacement have the potential to cause health problems that are actually preceded by problems in other fields / sectors. Earthquakes, floods, landslides and volcanic eruptions, in the short term can have an impact on the death toll, victims of severe injuries that require intensive care, increased risk of infectious diseases, damage to health facilities and water supply systems. The emergence of health problems, among others, starts from a lack of clean water which

results in poor personal hygiene, poor environmental sanitation which is the beginning of the proliferation of several types of infectious diseases [24], [25].

5. The number of health workers is still lacking

World Health Organization said, Indonesia is included in the group of countries with the most serious shortages of health workers. WHO identifies Indonesia, Bangladesh, Bhutan and India as countries with less than 23 health workers including doctors, midwives and nurses, per 10,000 population. The ratio of 23 health workers per 10,000 population is considered the minimum limit to reach the 80 percent coverage of the most essential health interventions. A study on human resources carried out in February 2012 found that a country that experienced a crisis of health workers could not increase the number of health workers to a minimum. Even financial assistance is not enough to achieve the desired progress in this field [28], [29].

C. Government Policy Steps and The Results Achieved

1. Health Services for the Poor Society

Recognizing the importance of sustainable handling of the health problems of the poor as an effort to fulfill the mandate of the 1945 Constitution article 34 paragraph 1 and 2, since 1998 a number of efforts have been taken to maintain the health of the poor. The aim of this effort is to maintain and improve the quality and access to health services for the poor, especially health services in puskesmas and hospitals [4].

Free health services for the poor have been sought by the Government since the economic crisis in 1997. The results of monitoring the implementation of health services for the poor indicate that there are several obstacles, including inefficient use of funds. Therefore, in 2005, in line with Law No. 40 of 2004 concerning the National Social Security System, efforts to increase access of the poor to health services are further enhanced through efforts to maintain the health of the poor with a health insurance / insurance system[40]. With this system, poor people are included in health insurance with premiums paid by the Government [41].

2. Nutrition problem that is never complete

Learning from the experiences of nutrition management in Indonesia and experiences in various countries, overcoming the problem of malnutrition is carried out with a holistic approach involving all parties including families, communities, governments and economic actors. Interventions to overcome the problem of malnutrition consist of short-term (emergency), medium-term, and long-term stages.

The efforts that have been made are mass weighing to find cases early, holding a coordination meeting to reactivate the Food and Nutrition Team, implementing the Food and Nutrition Alert System, and investigating cases to all potential areas. Interventions conducted in dealing with malnutrition are directed at preventing death and disability through early discovery of malnutrition cases and providing professional management at the community, health center, and hospital level [2], [15].

3. Extraordinary Occurrence of Communicable Diseases

To achieve eradication of polio, various efforts have been carried out, namely (1) increasing coverage of routine immunization in infants to the village level that is given free of charge; (2) conduct additional immunizations through the National Immunization Week, Sub- National Immunization Week for 5 provinces and carry out the Immunization Month for School Children; and (3) routine surveillance of Acute Flaccid Paralysis with sudden paralysis in children under 15 years old [4], [17].

4. Poor health in the Disaster area

The earthquake and tsunami disaster in the Province of Nangroe Aceh Darussalam and Nias, North Sumatra in addition to causing casualties, missing and injured, has also destroyed thousands of houses, infrastructure, and various public service facilities including health care facilities . For the prevention of natural disasters in Nangroe Aceh Darussalam Province, policy measures have been taken to address emergency health in order to provide immediate health services to the living population [24].

In addition, rehabilitation of various health facilities and infrastructure was carried out so that health services could function as before. All this was done in a coordinated way, especially with volunteers from

within and outside the country. In addition, a more comprehensive rehabilitation and reconstruction plan for Aceh and Nias in the health sector, such as the blueprint or blueprint for the Rehabilitation and Reconstruction Plan for Aceh and Nias, North Sumatra [41].

5. The number of health workers is still lacking

In order to improve the quantity and quality of health human resources, the policy steps taken are the recruitment of medical personnel, especially for puskesmas and hospitals in remote areas. The preparation of the planned placement of health workers is allocated from the regular appointment of non-permanent employees doctors and prospective civil servants [29].

In addition, the draft revision of Presidential Decree No. has also been prepared. 37 of 1991 and Presidential Decree No. 77 of 2000 concerning Strategic Health Workers for Non-permanent Employees and the concept of the Presidential Regulation on Strategic Health Workers as non-permanent Employees. Do also a discussion on the draft of the Presidential Decree on the Appointment of non-permanent Employees Strategic Health Workers and the Policy on Providing Incentives for health workers in disadvantaged areas with provincial health offices, several district health offices, several regional public hospitals, and cross-sectoral officials [30].

D. The next step must be taken

By considering the problems encountered, the policy steps taken, and the results that have been achieved as mentioned above, the necessary follow-up plans can be described as follows.

1. Health Services for the Poor Society

In order to improve the quality of health services, efforts will be made to appoint and place health workers, such as doctors and nursing staff, especially in remote areas, increasing the proportion of puskesmas that have doctors; an increase in the proportion of district / city hospitals that are have basic specialist doctors, and improve the quality of education and training of health workers [2].

Planning for the need for health workers needs to be increased to meet the needs of health workers, especially for health services in puskesmas and their networks, as well as district / city hospitals, especially in remote and disaster areas. This step needs to be followed by improving the skills and professionalism of health workers through education and training of health workers, fostering health workers including career development of health workers; and the preparation of competency standards and regulations of the health profession [42], [43].

2. Nutrition problem that is never complete

In order to improve the nutritional status of the community, especially in pregnant women, infants, and children under five, nutrition education and community empowerment need to be carried out for the achievement of nutritionally aware families. Reduction of protein energy, iron nutrient anemia, disorders caused by iodine deficiency, lack of vitamin A, and other micronutrient deficiencies need to be improved, in line with over nutrition control, and nutritional surveillance [14].

3. Extraordinary Occurrence of Communicable Diseases

In order to improve clean and healthy living behaviors activities will be carried out (1) developing health promotion media and communication, information and education technology; (2) developing community-based health efforts, (such as integrated service posts, village maternity halls, and school health businesses) and young people; and (3) improvement of public health education [17].

Efforts to improve clean and healthy living behavior need to be supported by improving the quality of the environment carried out through the provision of clean water and basic sanitation facilities, especially for the poor; maintenance and supervision of environmental quality; controlling the impact of environmental pollution risks; and developing healthy areas [17], [18].

4. Poor health in the Disaster area

In the context of mitigating the effects of disasters occurring in various regions, efforts that will be continued include rehabilitation and reconstruction of damaged health service facilities, fulfillment of health personnel, prevention and eradication of diseases, provision of medicines and health equipment, nutrition improvement, and efforts to restore the function of health services in the affected areas. Furthermore, in the context of mitigating the effects of the earthquake and tsunami disaster in Nangroe Aceh Darussalam and Nias, North Sumatra, to improve the efficiency and effectiveness of health services, in the rehabilitation and reconstruction phase, cross-sectoral and cross-program cooperation will be further enhanced, especially with the Rehabilitation Agency and Reconstruction of Aceh and Nias, North Sumatra, including the availability of funding sources [21], [22].

5. The number of health workers is still lacking

Increasing the equitable distribution and affordability of public health services is carried out through, among others, the provision of free health services for the poor in the puskesmas and its networks, as well as in hospitals. Through this effort it is expected that the level of disparity in health status among the population rich and poor are decreasing [26].

To anticipate various technical obstacles in the field faced by the poor in getting proper services, for example administrative and procedural barriers, socialization and advocacy to implementing institutions will be further improved, in addition to strengthening monitoring and safe guarding. In addition, an increase in facilities and infrastructure at the puskesmas and its networks was also carried out; construction and repair of hospitals, especially in the affected areas and selectively lagging; procurement of medicines, procurement of equipment and health supplies; and providing operational and maintenance costs [27], [28].

V. Conclusion

The conclusion we can take in this brief communication is that health problems that occur in Indonesia have not been resolved even though the government has implemented policies related to these problems but has not been resolved to date. therefore the role required by various parties in solving this problem is primarily the role of the wider community in the application of government programs so that problems in the health sector can be immediately resolved mainly in five aspects namely health status disparities; double burden of disease; quality, equity and affordability of health services; community protection in the field of medicine and food; and clean and healthy life behavior.

Ethical considerations

Ethical issues (Including plagiarism, informed consent, misconduct, data fabrication and/or fal-sification, double publication and/or submission, redundancy, etc.) have been completely observed by the authors.

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Conflict of interest

The authors declare that there is no conflict of interests.

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