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Ageing in Indonesia – Health Status and Challenges for the Future

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Abstract Ageing and problems concerning the aged were until recently the domain of developed countries, but they are now becoming an increasing and alarming reality in developing and underdeveloped countries such as Indonesia. Families and even the nation are facing many challenges relating to support for the elderly. This is because in the past developing policies, and caring for, the elderly were not major priorities of Government as the elderly represented a small percentage of Indonesia's population. One of the challenges impacting on the provision of care for the elderly is the lack of health service programs for the elderly who are living in their own homes. Health personnel shortages including community health nurses have been identified as a significant contributor to this health service problem. This paper will initially consider Indonesia's geography as a nation comprising many islands. It will then discuss the impact of a changing population profile and present an overview and critique of the current level of health services provided to promote wellbeing for the elderly.

Keywords Ageing · Indonesia · Elderly · Health System · Programs for elderly

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Background

The Republic of Indonesia is a transcontinental country in Southeast Asia and Oceania that comprises 17,505 islands of which 6000 are inhabited. Administratively, the Indonesian region is divided into 33 provinces. Each province is subdivided into districts (the decentralized administrative unit) and municipalities. There are 399 districts and 98 municipalities. Furthermore the districts and municipalities are subdivided into sub-districts and villages. In 2010 there were 6,651 sub-districts and 77,126 villages (BPS Statistic Indonesia 2010). The distribution of the population within the 33 provinces is not even. Almost 59 % of the total population live in Java, an island which covers only 7 % of the total landmass of the nation. In contrast, the province of Papua covers around 19 % of the total land area but is only inhabited by 1 % of the total population. The population in Indonesia has grown and changed in terms of demographic profile in different areas as an outcome of differing economic conditions and standards of living, as well as nutrition, availability and effectiveness of public health and family planning programs, and differences in cultural values and practices.

Socio-Demographic Characteristics of Indonesia's Elderly

Like many other countries, especially in East and South East Asia, an ageing population is a demographic reality resulting from continued decline in fertility and improvements in longevity. From the latest world population census, Indonesia has experienced an increase in the number of older people (60 years and above) from 3.7 % in 1960 to the current level of 9.7 % in 2011. This figure is projected to increase to 11.34 % by 2020 and 25 % by 2050 (BPPN, BPS & UNFPA 2005; UNDESA 2011). By 2050 the number of older people in Indonesia will reach approximately 74 million, creating a substantial burden on resources not experienced at any other time. Currently, the total number of older people in Indonesia is ranked fourth largest in the world after China, India, and America (MENKOKESRA 2011; U.S. Census Bureau 2011).

Older Indonesians are geographically spread throughout the country although proportionately the number of older people varies in different regions. According to the National Health Survey in 2007, the provinces that have the largest older population are *Daerah Istimewa* (*DI*)(the Special Region of) Yogyakarta (14.04 %), Central Java (11.16 %), East Java (11.14 %), Bali (11.02 %) and South Sulawesi (9.05 %) (BPS 2007). The proportion of older people living in rural areas is significantly higher than in urban areas. The migration of younger people from rural to urban areas seeking education and employment opportunities contributes to the higher proportion of older people in rural areas. According to Hareven (1995 cited in (Noveria 2006)) there is a delayed migration of older people to urban areas as some relocate later to join their families or relatives in urban centres as a means of gaining financial and social support.

The family has been the most important support system for older people in Indonesia. This group of population in both rural and urban areas mostly live with their children and other family members; only a small number of them live alone. Most older people

co-reside with at least one child; the urban elderly are more likely to live with their children, while the rural elderly are less likely to live with their children.

Indonesia is experiencing a social change. There is a move away from the larger extended family toward nuclear family groups. This change in the living arrangements of Indonesian families maybe explained by the move of young people from rural to urban areas in search of improved work and living opportunities. Although currently only a small number of older persons reside in residential aged care homes or in Indonesia is known as social nursing homes/social older homes (Panti Sosial Tresna Werdha [PTSW]) the decline in family size, coupled with globalization and migration, means that the need for residential aged care homes and other support to ensure older Indonesians are able to stay at home, is increasing. The majority of the Social nursing homes or social older homes where older people receive supported living environments in particular for neglected and/or sick elderly who cannot live without support (Depsos RI 2008; United Nations 2011) are managed by the government (Ministry of Social) and private sector, including community and social organizations with the highest percentage in West Java (89) and the lowest percentage in South Sulawesi (33) (Abikusno et al. 2007). This lower figure for South Sulawesi is assumed to result from cultural influences. As with many other cultures in Indonesia, in the local cultures in South Sulawesi there is an obligation for children (usually the youngest child) to look after aged parents. Culturally it is still considered shameful for a family to admit their parents to a residential aged care facility. Rather, families care for older people through an informal caregiver process that generally involves daughters, living with elderly parents and providing assistance that includes supporting all activities of daily living. A UNPFA report on the Older Population of Indonesia has identified that this system is problematic particularly for those aged above 75 years. There are many older people who are neglected in rural and urban areas, although the proportion is higher for those residing in rural areas compared to urban areas (Abikusno et al. 2007). It is preferred that families in rural areas usually have a lower level of education and lower socio-economic status than urban families. As a result, these families do not have the financial capacity, understanding and time to provide appropriate care for their aged parents.

The Indonesian Health Service Systems

The Ministry of Health developed a new Strategic Plan for 2010–2014 that contained a vision for self-reliance and equitable access to health care for all Indonesians. The government is committed to improving both financial and physical access to quality health care. Past and current reforms aim to improve the supply, quality and use of care to produce better health outcomes, particularly in remote areas and among the poor. Strategies to be implemented in the period 2010–2014 are: 1) To improve health and nutrition in the community; 2) to reduce the morbidity rate due to communicable diseases, 3) to implement non-communicable diseases control program, and 4) to increase the public budget for health to reduce financial risk for health problems.

At the primary health care level, Indonesia is generally considered to have a relatively adequate coverage with one community health centre (*Puskesmas*) for every 30,000 people on average (WHO 2007). These averages do, however, cover

up major issues in relation to geographic access, particularly for those who live in rural and remote areas. In addition, there is a shortage of human resources in health care; distribution is not equal throughout the regions, and the health care workforce productivity is reportedly low. Under decentralization, it has become more difficult for civil servants to be reposted and move across different levels of government. Furthermore, other factors that complicate management of the public sector workforce include poor incentives, widespread dual practice as the Indonesian health care system is a mix of private and public providers, and the increasing expansion of the private sector into health services.

The Decentralization Policy which promotes regional autonomy, particularly in financial matters, has been implemented in Indonesia since 1999. There are no hierarchical links between the first three levels of regional autonomy, however, the Provincial Health Office provides administrative support, direction and monitors operations of the districts and municipalities. While the provinces have limited autonomy, under this structure they broader responsibilities as representatives of the central government. In addition, there is greater decentralization at the district and municipality levels of government. Thus, regional development is undertaken at the district/municipal level, while at the provincial level it is limited only to circumtances that have not been covered at the district/municipality level. Meanwhile, the central Ministry of Health is responsible for policy formulation and standards as well as providing guidance to the lower levels of government. Below is the diagram of health system organizational structure in Indonesia (Fig. 1).

Each sub-district in Indonesia has at least one health centre, managed by a medical doctor, and usually supported by two or three sub-centres. At the village level, the

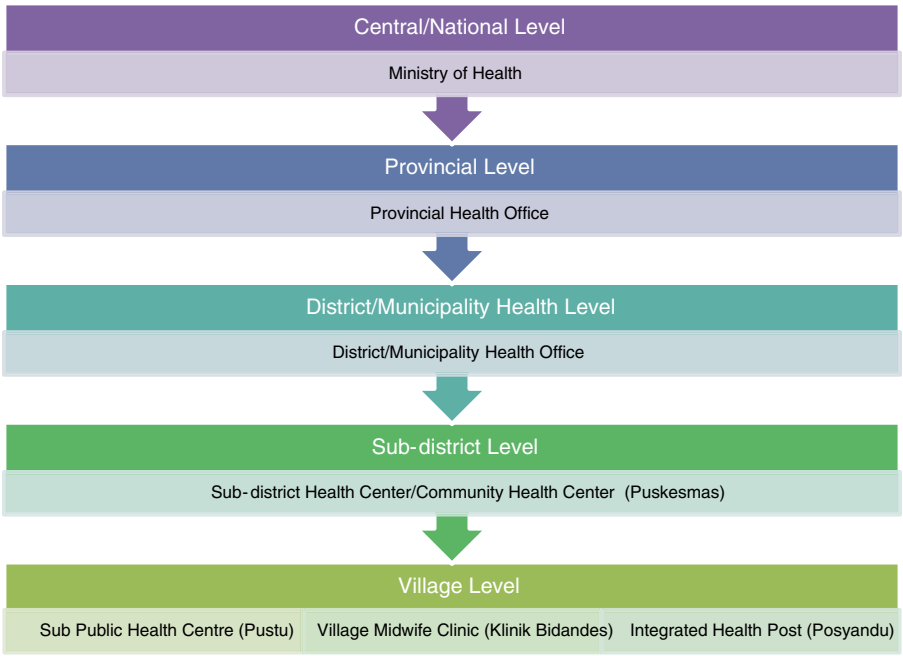

Fig. 1 Organizational structure of health system

integrated family health post (*Posyandu*) provides preventive and health promotion services. These *Posyandu* are established and managed by the community with the assistance of the community health centre (*Puskesmas*) staff. These centres formerly provided maternal and child health services, but now, in some areas of Indonesia they have extended service provision to include older people. *Posyandu* offer health examinations of people who present with some also providing simple laboratory tests for older persons. These activities are under the supervision of the local *Puskesmas*. Not every region is able to offer the range of services described due to a lack of health care personnel and disinterest in additional service provision by the community.

The Community health centres generally have motor vehicles or motorboats available enabling the provision of mobile health centres. Many centres, however, have limited or no transportation options limiting capacity to provide outreach or mobile health clinics. These limitations impact adversely on remote and rural communities that may not be serviced locally by any level of health service.

The Health Status of Older People

A study undertaken by UNFPA found that the majority of diseases experienced by older Indonesians are infectious diseases. This study postulated that the spread of such diseases is directly related to health behaviours and environmental conditions. The prevalence of infectious diseases among the older population is reported to be slightly higher among the rural aged compared with those living in urban areas (Abikusno et al. 2007).

Healthy behaviour is the adoption of healthy lifestyles preferably early in life such as good nutrition, exercise and environmental health relates to healthy environments that include reduced or no over-crowding in domestic dwellings and workplaces, buildings with good ventilation, good lighting, pest-free, and with appropriate sewage and waste disposal facilities. Other studies related to the health conditions of older Indonesians found that rural aged are predominantly female and significantly older than the urban aged (above 80 years), mostly live alone, are socio-economically disadvantaged, and they experience chronic illnesses and degenerative diseases such as rheumatoid arthritis, hypertension, eye complaints and impaired vision, and have stomach problems (Abikusno 2002, 2007; Van Eeuwijk 2006).

Older people seek medication at a variety of outlets, most notably the local health centres, private practices and paramedic practices. This is because geriatric services are largely offered by hospitals in the provincial capitals. There are some differences between urban and rural trends in this respect: Not surprisingly urban people are more likely to have access to hospitals and hence are more likely to seek medication there than their rural counterparts.

Programs for Older Indonesians

The Indonesian government has implemented an array of programs to enhance the wellbeing of older people. A five-year National Strategy to Improve the Welfare of the Elderly was initially started in 2003. This program was established by the Office

of the Coordinating Ministry of Social Welfare (*MENKOKESRA*). The aim of this strategy was to improve the welfare of older people by enhancing the coordination of activities of governmental institutions, community organizations, the private sector, civil society organizations, and organizations representing elderly Indonesians (Depsos RI 2008). To support this national strategy the then President, President Megawati Soekarnoputri, issued a Presidential Decree (*Keppres* No. 52/2004) to create a National Commission for the Elderly. This committee is mandated to assist the President to coordinate the implementation of the National Strategy to Improve the Welfare of the Elderly, and to provide professional advice to the President on the creation of the government's social policy for the elderly (Wibowo 2007). The Decree specifies a 25 member committee, with representatives from various government agencies, civil organizations working in the field of welfare for the aged, universities, and the private sector/NGOs. In addition to the National Commission for the Elderly, provincial and city/municipal governments in Indonesia are able to establish their own committees that must coordinate with the national committee. It is anticipated that these new initiatives will encourage the development of a comprehensive policy for the aged in Indonesia. The implementation of this Decree has been slow and inconsistent across Indonesia particularly in the eastern and rural areas of Indonesia. It is proffered that not all provinces and cities/municipalities in Indonesia have established committees that are consistent with the national strategy. Furthermore, the government also provides services for older population, in particular for the neglected or sick elderly were delivered through social nursing homes or social older homes (Panti Sosial Tresna Werdha/PSTW), day care and social security for the elderly (Depsos RI 2008). At present, there are around 278 nursing homes all over Indonesia and since 2006, the Government has implemented an assistance programme that supplement the basic needs of elderly living in nursing homes as well as gradually increasing the provision of social security for the neglected elderly (United Nations 2011). The reality this institution is not too popular among elderly who still have family to live with because for some cultures in Indonesia, it is an obligation to take care of older parents thus it is considering a disgraceful to send them to nursing home.

In addition, there are also programs and services managed and funded by the Ministry of Health through the Department of Health (DOH) targeting aged population. A number of information brochures for aged people and their families (Sakti and Boldy 1998), and booklets for health professionals and health volunteers, have been published. These publications cover disease prevention, health improvement and physical exercise. The booklets for health professionals and health volunteers cover information about the ageing process, general health assessments such as physical and mental health, and how to establish groups for aged people in the community. Another project established by the government and UNFPA was a 3 year project (1998–2000) that addressed ageing issues though the development of policies and programs relating to social, health and gender issues, particularly among the poor elderly (UNFPA 2002a, b).

In mid-September 1998, the "*Healthy Indonesia 2010*" inter sectoral program was introduced. The philosophy underpinning this program is reflective of the Ottawa Charter for Health Promotion that argued that health is a shared responsibility between all levels of government as well as the private sector. Non-government

organisations (NGOs) and the community must work together to achieve the goals that have been articulated. The Healthy Indonesia policy, however, did not explicitly target aged persons. The initiatives promoted by the Indonesian government represent acceptance that an ageing population will create new challenges and must be planned for, however, the fiscal and human resources required to support the implementation of relevant strategies have to date been inadequate. The relatively low quality of the workforce is partly attributed to the poor quality of care, especially for the elderly. It is argued that the shortage of health practitioners who are responsible for delivering services, including services for the elderly in community centres, is one of the challenges found in the field (Kadar 2011).

Furthermore, the National Plan of Action for Older Persons' Welfare in Indonesia on the one hand, and the Healthy Indonesia Policy on the other, request the Ministry of Health to formulate policy for the elderly in Indonesia (Depsos RI 2003). The cornerstones of the plan support improving older persons' health status by promoting healthy lifestyles, preventing illness, and improving access to therapeutic interventions such as providing special spaces for the elderly in community centres and rehabilitation centres. Implementation of the plan included community initiatives such as *Karang Werdha* which is a group activity for older in East Java province, and the establishment of integrated health posts (*Posyandu*) for the elderly in other areas of Indonesia.

The community health centres are expected to implement programs for older Indonesians. The focus of these programs is preventing illness and promoting optimal health. One of the programs that the Ministry of Health established for supporting older people is the reorientation of the *Puskesmas Santun*, the community health centres, so that they now provide health services for the elderly including health promotion, prevention, cure, and rehabilitation.. These services emphasize being proactive, ensuring access for, and being respectful of older persons. To date, not all community health centres have changed practices to accommodate the recommendations advocated by the Ministry, particularly in the eastern region. Implementation of the strategies outlined in the programs has been limited because of fiscal and human resources. A shortage of health care personnel, particularly in rural areas, has limited implementation. The majority of health care personnel, especially the nurses who are working in community health centres, have limited or no specialist skills in caring for the aged in community settings (Kadar 2011). Furthermore, not every centre offers programs for older populations because these are not included in the suite of programs supported by the community health centre (*Puskesmas*). Offering programs beyond those planned by the individual Puskesmas can is reliant surplus funding.

Challenges for the Future – Health Sector

Changes in population structure have resulted in many challenges, particularly in regards to the government's responsibility for providing services and fulfilling the needs of specific population groups. Programs that have been established relate to social welfare such as community-based home-care programs and empowering older persons. The Indonesian government supports some programs relating to the health care of older people. Unfortunately there are no clear directions from the national

Health Department to the various layers of health service providers to target and implement programs to meet the needs of older Indonesians particularly for those who are healthy and living independently in the community.

The challenges for Indonesia in dealing with an ageing population are increased disease, both infectious and degenerative, and limited resources to implement effective strategies to support this group remain healthy and independent. Addressing the identified needs of an ageing population requires the adoption of a primary health care plan which should be

- available,
- accessible (physically, socially and financially),
- appropriate (facilities and staff, appropriate knowledge, skills and attitudes),
- affordable (equitably financed)
- and integrated with other health and social and service providers (WHO 2004 cited in Kandiah-Evans (2006)).

Improving the health of an ageing Indonesian population will not be met if the current approach to health care service provision continues. Although the government has established many programs and enacted regulations that target welfare and health for the aged, the success of these programs has been hampered by poor fiscal and human resourcing. Inadequately prepared staff and a lack of direction from the government to support service delivery modification and renewal that is inclusive of new models of care that are prevention oriented is impeding the progress of health services to accommodate the growing demands an ageing population presents. These factors have reduced the effectiveness of government reforms (Loo 2001).

The decentralised health care system has resulted in fragmentation and inequitable distribution of available resources particularly to rural areas that have lower population levels compared with urbanised areas. Another challenge impacting on the capacity of the national Ministry of Health to implement recommendations aimed at addressing the needs of an ageing population is to ensure that the health care staff are appropriately educated for their roles. Educational preparation of health staff must include enhanced knowledge and clinical skills required to work effectively with and advocate on behalf of older Indonesians. Many of the health care staff providing services for older people in community health centres do not have, or have limited, knowledge relating to care of the elderly. Very few nurses, particularly those delivering care at the community level have expertise in gerontology, with many having low level qualifications that may or may not be related to nursing adults (Depkes RI 2005; Kadar 2011). Health care staff who have responsibility for implementation of government funded programs that relate to the older people have limited understanding of the programs. It is recommended that The DHO (District Health Office) must provide direction and enhance assistance to health care workers who provide services for older people in the community health centres if the needs of this groups of Indonesians are to be met.

Community participation is integral to improving health and welfare outcomes for older Indonesians. Health care volunteers in the villages assist the health care staff in implementing programs for the elderly in their communities (*Posyandu*). The health care volunteers are valuable asset in supporting health care staff in the field, as they live locally and know the community and the people. Supporting these volunteers

with access to ongoing training relating to caring for the older people will improve their skills and knowledge and ultimately health outcomes for this population group. Enhancing the role of volunteers through training can have a positive impact on the community and particularly the aged. It is important to support them through education and training and acknowledged for their contribution by health care staff and Government.

Conclusion

Indonesia's population is ageing. It is therefore timely that a review of health service provision occurs. The increasing numbers of older Indonesians requires Government consider the skill mix of the healthcare workforce, numbers of staff, the distribution of the workforce and the models of care utilised Deployment of health care staff to underserved regions, particularly rural areas is necessary to ensure equitable access to appropriate levels of health care for all Indonesians. The Indonesian Government must prioritise the ageing population and commit resources to improve health and welfare outcomes for this group if the level of morbidity and related social burden currently impacting on them is to be reduced.

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