Inequality of Access to Social Welfare Programs for Older People in Indonesia

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Abstract

In recent years, public debate on inequality in relation to gender and social class has returned in all its intensity. However, little research attention has been given to investigating inequalities in access to social rights for older women and men in rural Indonesia. This paper aims to analyse the extent of access of older people to the elements of the social welfare program, the determinants of exclusion from these programs and how existing programs can be improved. Data is drawn from the 2016 Ageing in Rural Indonesian Survey (ARIS). The Indonesian government has made efforts to fulfil the social rights of older adults through social welfare programs that can be clustered into social assistance, social insurance, health provisions, empowerment, and awareness raising. However, logistic regression analysis indicates significant variation and inequalities in access to government services among rural older adults depending on sex, living arrangements, region and social class. The extent of access is influenced by the state's approach and certain cultural assumptions in the local communities themselves. The state influence works through the way programs are organized and provided. This paper also highlights the challenges that affect the quality of services for older adults, including very limited coverage, underfunding, poor targeting, decentralization and lack of integration, and poorly prepared health care workers. Potential strategies aimed at improving service delivery for older people can be identified including increasing public spending and coverage; mobilizing networks from the United Nations, companies and other non-government organizations; broadening the usage of village budget (*Dana Desa*); integrating separated services, and improving the competencies and skills of health professionals.

Key words: Ageing population in Indonesia, social policy for older adults, social exclusion

My income is not enough to take care of my two aunties… I am suffering, crying in my heart, truly crying… I am worried, if one of my aunties dies, who should I talk to, who will pay the cost of the funeral, only fulfilling daily needs is so difficult, to find a job is difficult… there is nobody that I can ask for help…. my children never send me money, … there is nobody to talk to (Bugoharjo, 5/02/2017, F34LS).

1 Introduction

The narrative above was provided by a poor older woman of 64 who takes care of her two aunts who are 87 and 90 years old. It is an example of the limited social support faced by olderpeople in their old age in rural Indonesia. The OECD (2019) reported that poverty in Indonesia is concentrated among older and rural people. Poverty and a lack of support systems which would enable older people to live in dignity are among the most serious difficulties. When the support systems from family, community and government are not in place, older persons experience hardship, in some cases extreme hardship.

Indonesia is a nations where rapid demographic changes have occurred and population ageing is rapid (Arifin & Ananta, 2016; Hugo, 2000; Niehof, 1995; Suryadinata, Arifin, & Ananta, 2003; Van Eeuwijk, 2006; Witoelar, 2012). It has one of the world's most rapidly ageing populations (Arifin and Ananta, 2016) and was estimated to have the largest growth in the aged population (more than 400 percent) between 1990 and 2025 of 50 countries studied (Adlakha & Rudolph, 1994). Indonesia is projected by 2020 to be well ahead of other Southeast Asian countries in the absolute number of the older people, followed by Vietnam, Thailand and the Philippines (United Nations, 2010).

The number of persons aged 60 and over increased dramatically from 5.3 million (4.48 percent of Indonesia's total population) in 1971 to 11.3 million (6.29 percent) in 1990 and to 18.1 million (7.6 percent) in 2010. Presently, there are 26 million people aged 60 and over, and this number is projected to rise to 48 million by 2035 when the percentage of the population at these older ages will be almost 16 percent (Adioetomo & Mujahid, 2014; BPS, 2019). The annual rate of growth of the older population is 4.7 percent which is higher than that of the general population at 2.9 percent (Arifin & Ananta, 2016). The increasing number of the older adults combined with the lack of support systems documented in this paper imply an urgent consideration of formal and comprehensive old age security is required.

The Government of Indonesia has made efforts to promote the well-being and fulfil the social rights of older adults through social welfare programs that can be clustered into five

groups: social assistance, social insurance, health services, empowerment, and awareness raising. The first cluster, social assistance, covers both cash transfers (such as the Family Hope Program for the Older adults-*Program Keluarga Harapan Lansia*/*PKH Lansia* and Social Assistance for the Older adults-*Asistensi Sosial Lanjut Usia*/*Aslut*)[1] and in-kind assistance (such as home care, food vouchers or non-cash food assistance-*Permakanan*, nursing homes and rice for the poor-*Beras Miskin/Raskin)*. The second cluster, social insurance, includes benefits related to employment status and/or contributions paid (Gough, Bradshaw, Ditch, Eardley, & Whiteford, 1997). A contributory mechanism is implemented through the National Health Insurance Program (*Jaminan Kesehatan Nasional-JKN*) and employment-related pensions.

The third cluster is the provision of health services operated from the village level up through the various levels of government. Health services at the village level are provided through *Polindes* (village health services) and are managed by the village midwife. The midwife is also responsible for managing the *Posyandu Lansia-Poslansia* (integrated health service posts for older adults), a community-based program aimed at improving the health status of older adults at the village level. *Poslansia* offers health examinations and provides simple laboratory tests for older persons. At the sub-district level, the health services provided to older adults include the community health centre (*Puskesmas*) and, more specifically for this analysis, the "older adults friendly community health centre" (*Puskesmas Santun Lansia*). At the higher levels (district and provincial), health services are provided in hospitals and some hospitals contain geriatric clinics (*Poli Geriatri*). Another provision is *Prolanis - Program Pengelolaan Penyakit Kronis* (Management of Chronic Disease Program). This program is provided to people with chronic illnesses, particularly high blood pressure and diabetes.

The fourth cluster is empowerment aimed at increasing the incomes of poor people. Empowerment programs are provided for the productive older adults and their families. Older people are provided with vocational training and funding subsequent to the training. Another activity of the empowerment program is the provision of livestock such as goats. The fifth cluster comprises awareness-raising programs aimed at increasing both the awareness and the capacity of older persons' stakeholders, particularly their families, in fulfilling the rights and needs of older adults. Two main programs use this approach including the national day for the older adults (*Hari Lanjut Usia-Halun*), and *Bina Keluarga Lansia-BKL (empowerment program*

[1] Both programs provide a cash transfer of around IDR 200,000 (US$14) to older persons who are living in poverty in order to meet their basic consumption needs and to maintain their wellbeing at each month for selected recipients. The beneficiaries and eligibility requirements of both programs are different. The Family Hope Program for the Older adults is provided to the poor older adults (aged 70 and over) while the *Aslut* program is provided for those who are poor, neglected, or bedridden or disabled. In selecting the beneficiaries, *PKH Lansia* uses a top-down approach in which the central government determines eligibility through the criteria determined by the Unified Database (UDB), a common targeting instrument for all social assistance programmes that links beneficiaries to complementary interventions (OECD, 2019). The *Aslut* program employs a bottom-up approach that relies on social workers to identify the older persons who need assistance.

for families of the older adults)). *Hari Lanjut Usia-Halun* is conducted on 29 May every year campaigning for the fulfilment on the rights of older adults. *Bina Keluarga Lansia-BKL* seeks to advocate and strengthen the role of the family in caring for older adults.

Little attention has been given to examining the extent of access of the older generation to the components of these government programs, particularly how age, gender, region and social class relate to the experience of exclusion in later life among a diverse group of rural-dwelling older people. In recent years, the public debate on social inequality in relation to gender, age, region and social class has returned in all its intensity. Social inequalities include differences in income, resources, power and status within and between societies. Social inequality refers to the unequal distribution of life chances and opportunities among different people and groups (Binelli, Loveless, & Whitefield, 2012). In this paper, social inequality refers to social exclusion. By social exclusion, we mean the dangers and risks encountered by the older generation in claiming and using their rights of social citizenship "including equal access to the labour market, to education, to health care, to the judicial system, to rights and to decision-making and participation" (Jehoel-Gijsbers & Vrooman, 2008, p. 3).

This paper examines the extent of access of older people to social welfare programs. Inadequate access to government services ('social rights') covers a wide diversity of domains including inadequate access to health care, housing, social services, and social security. Access to quality services such as healthcare and social services in old age remains a major concern for much of the ageing population in Indonesia.

More specifically, this paper examines the level of coverage of five important services for older persons: health insurance, pensions, *Poslansia, Raskin* and *Aslut,* using an intensive study of older persons in six Indonesian villages.

2 Data Sources

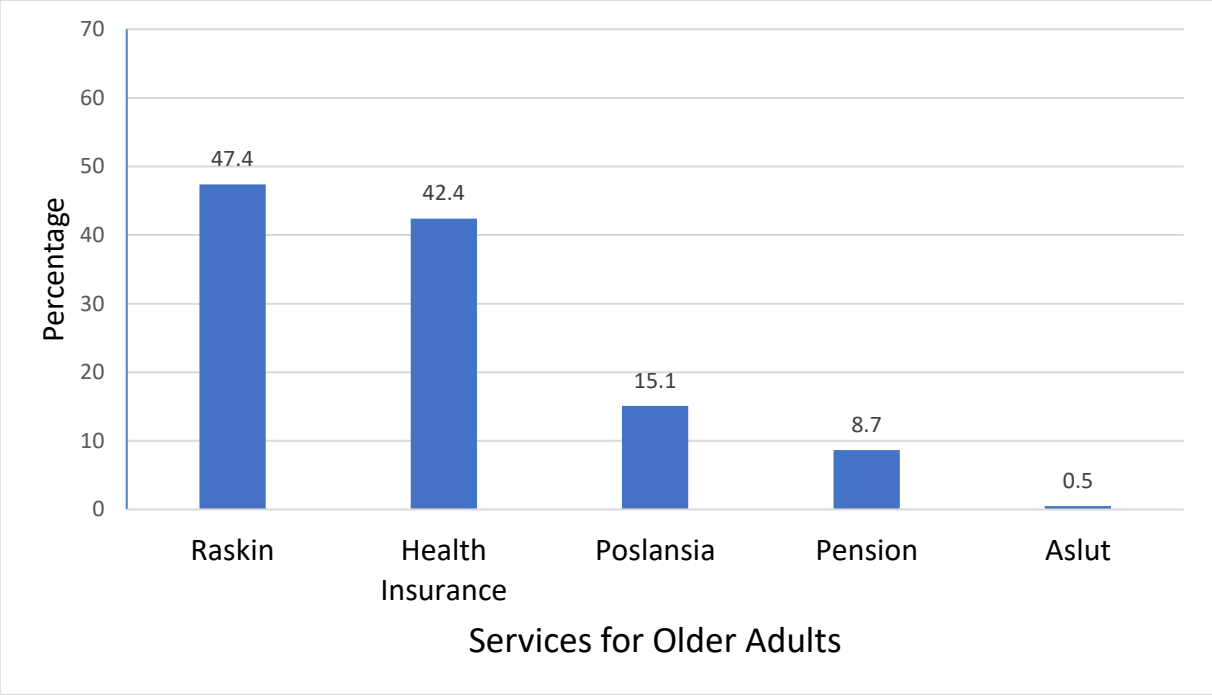
The data are drawn from the 2016 Ageing in Rural Indonesian Survey (ARIS) conducted in ten rapidly ageing communities (villages) spread across Indonesia. Using data from the 2010 Census, the ageing communities were deliberately selected on the basis of high levels of out-migration of young people that would be the children of the older people, differences in cultural and traditional practices; and environmental and ecological differences across the communities (Utomo, Mcdonald, Utomo, Cahyadi, & Sparrow, 2019). Three main methods were employed in data collection including surveys, in-depth interviews and non-participant observation. For the analysis in this paper, we have selected six of these communities where more intensive qualitative information was obtained in 2017. The selection includes one community from Sumatra, namely Muara in North Sumatra Province. Next, four sample villages were drawn from Java: Cacaban (West Java Province), Giriasih (DI Yogyakarta

Province), Bugoharjo, and Rejo Agung (East Java Province). Lastly, one village from Bali, Gunung Sari (Bali Province) was selected. The six villages represent four major ethnic groups in Indonesia: Batak, Sundanese, Javanese and Balinese. The villages also represent three main religions: Islam, Christian and Hindu. The sample size for the quantitative data collection was 1,805 respondents (811 males and 994 females).

3 Coverage Levels for the Five Services

While social welfare programs for older persons in Indonesia are very comprehensive and progress has been made in terms of national policy commitment to provide services to older people, coverage remains very limited (Figure 1).

Figure 1: The percentage of older persons who receive five government services, six selected villages



Source: Calculated from the 2016 Ageing in Rural Indonesia Survey

Raskin (47.4 percent) has the largest number of beneficiaries and *Aslut* (0.5 percent) has the smallest. The low coverage of *Aslut* reflects the small coverage at the national level as nationally the program only covers 26,500 older persons (0.2 percent) while the number of neglected older persons in all Indonesia was around 2.8 million in 2010 (Jakarta, 17/10/2015, M133JS). Less than half of older people (42.4 percent) were enrolled in the National Health Insurance program and just over 15 percent participated in the *Poslansia* program. The percentage of older persons enrolled in health insurance is low given that the target of JKN

was to achieve 95 percent coverage of the Indonesian population by 2019. Moreover, the percentage of older persons who receive a pension is very low at just under 9 percent. The Central Bureau of Statistics-BPS (2011) reported that the pension system only caters for workers in formal sectors that employed under one third (32 percent) of the workforce of 108 million in 2010. The low coverage of these programs in the ARIS villages is representative of the low coverage at the national level as the percentages of program beneficiaries are relatively similar at the national level. For instance, the coverage of the pension program nationally was 8 percent and of Aslut was 0.2 percent (Priebe & Howell, 2014) which were very similar to the project sites (pension 8.7 percent and Aslut 0.5 percent).

Older people in the future can be expected to have a low pension coverage as the Transition to Adulthood Longitudinal Survey in Greater Jakarta showed that only 17.3 percent of young adults aged between 20 and 34 years were members of pension schemes in 2010 (Transition to Adulthood Longitudinal Survey, 2010). If Greater Jakarta as the capital city and the centre of government and industry contains only a small proportion of young workers who are members of pension schemes, coverage in rural areas will be much lower as most of the working sectors there are in agriculture. This low level of coverage will become a serious issue if the support systems for the increasing aged population are not upgraded soon.

Schmitt and Chadwick (2014) maintain that Indonesia spends much less on old age pensions than Thailand and Vietnam. The latter two countries spend between 37 and 49 percent of their total social protection public expenditure on income security for older persons. The low proportion of older persons in Indonesia who are enrolled in any pension system indicates that the majority are vulnerable to old age poverty. The reliance of older persons on income support from their children was prominent in the ARIS villages but the level of support depended heavily on their number of children, the income levels of their children, and on the competing demands upon the incomes of their children such as housing costs in cities and the education costs of their own children (i.e. the grandchildren of the older person). For a minority, there were no income transfers from children. Reliance upon remittances from children is a precarious approach to income support for older people.

One of the main problems causing the minimal social security coverage for older persons is that two-thirds of the labour force is concentrated in the informal sector. “Informal” work and social exclusion are closely correlated. These two-thirds are usually not covered by any formal pension or health insurance scheme. This means that over 73-million people will potentially face poverty upon their retirement, when their ability to work diminishes, and consequently their income from work declines. Pension systems have the purpose of combating this degree of social exclusion. Pensions have to “ensure that elderly people are not placed at risk of social exclusion; that they can enjoy a decent standard of living, that they share in the economic and

social well-being of their country, and can accordingly participate in public, social and cultural life" (CEPS, 2004, p. 58) cited by Jehoel-Gijsbers and Vrooman (2008).

The low coverage of social welfare programs for older adults is due primarily to the lack of funding allocated for social protection programs. In 2017, the total investment of Indonesia's social protection system was 0.73 percent of GDP, and the social protection programs for older adults (and disability) accounted for only 0.001 percent of GDP. This is less than expected for a middle-income country like Indonesia, resulting in major gaps in coverage. Other countries, such as Nepal, have a much lower GDP than Indonesia but invest approximately two percent of GDP on social protection (TNP2K, 2018). The World Bank (2004) stated that spending very little on the poor is an indicator of failed services. The mean cost of a basic package of social protection including a universal pension covering old age, disability and a child benefit, would amount to about two to three percent of GDP (Barrientos & Hulme, 2008).

Underfunding is also reflected in the amounts allocated to the ministries responsible for providing services for the older adults. The allocation for *Aslut* in the Ministry of Social Affairs, for instance, was just 0.53 percent of the central government's budget for social assistance. Plainly, a very large number of older persons are excluded from any old age pension through either insurance or assistance (Adioetomo, Howell, McPherson, & Priebe, 2013). Another example is the budget for the Directorate of Family Resilience, Older Persons and Vulnerable Groups in the National Population and Family Planning Board (BKKBN), which was only IDR 7 billion. The allocated budget for older persons in the Directorate was used mostly for training, advocacy and developing materials such as books and tool kits to promote the wellbeing of older adults. A staff member of BKKBN stated:

> *Our obstacle is also funding …the difference between the Ministry of Social Affairs and our institution is that the Ministry of Social Affairs provides direct cash transfers to the older adults, while the funding from our institution is used for advocacy. The seven billion rupiah of our budget in a year is used for training and training of trainers. Recently we have been developing BKL[2] kits using a participative method through games to maintain the cognitive health of the older adults. The funding does not reach the villages (Jakarta, 1/112015; M135JB).*

Similar challenges are also experienced at the local government level where the funding for older persons is very limited. For instance, the Health Office of North Tapanuli district where Muara is located reported that funding for older persons is very limited. The limited funding was illustrated by the staff by the number of program for older people that is one program for older persons and four programs for expectant mothers due to limited funding. Limited funding

[2] *Bina Keluarga Lansia*: Training for the families of older people.

was also the experience of the Yogyakarta Health Office which noted a total lack of support since 2011 from the central government. All the funding for older-person activities were provided locally. The provincial government allocated 278 million rupiah, a small amount, which was distributed to the five districts in Yogyakarta (Yogyakarta, 05/10/2015; F90GKD) even though Yogyakarta Province has the highest proportion of older persons among the provinces of Indonesia.

The limited funding for health and social care for older adults in Indonesia reflects the contemporary global debate on the extent of affordability in terms of the strain on official budgets (Hall & Scragg, 2012). In the United Kingdom, for instance, since the 1980s, social welfare has been portrayed as something of a residual luxury, and oppositional to the national requirements of wealth creation and economic competitiveness (Beresford, 2005). In Indonesia, the limited funding and small coverage of social welfare programs for older persons indicates that they are a neglected segment of society and not a high priority of government. A government officer from Ministry of Social Affairs stated: “The government only focuses on the wellbeing of children without considering the ageing population that will emerge soon” (Jakarta, 15/10/2015; M133JS).

Policy makers see funding of children’s services as investment for the future. The corollary, however, is that lack of funding for older people is justified because they are not the future. The RPJMN 2020-2024 (Medium-Term National Development Plan) as a road map of policy development also shows that children, expectant mothers and young people are the major concern of the government, whereas the plan contains no specific reference to policy on older people. The government priority in designing programs and budget allocations shows that people are stratified by their age. This stratification often leads to unequal treatment. O'rand (2018) maintained that age is a relatively persistent principle of stratification in high-income countries.

Similarly, a Health Office staffer in Yogyakarta who had responsibility for managing programs for older persons maintained that developing programs for older adults is a choice and not a priority in health service centres. As they stated:

> *In the Health Office, programs for the older adults have existed for a long time. However, such programs have not become a priority yet, and it is a choice or optional program (Program Unggulan) in one of the health centres. So, it has not become a priority (Yogyakarta, 05/10/2015; F90GKD).*

Importantly, according to the Health Office staff member, one of the causes for the low level of concern about older people is because they are not mentioned specifically in the MDGs (Millennium Development Goals). Even the MDG goal of eradicating extreme poverty and

hunger, while providing examples of poverty among working age people and children, makes no mention of older people (UN, 2021) .

> *In the health sector, the MDGs address environmental sustainability but older persons are not mentioned. Older persons are not included as well in the minimum service standards (Standar Pelayanan Minimal-SPM). Older persons were only included in the life expectancy sector in 2008 (Yogyakarta, 05/10/2015).*

The health staffer mentioned during the interview that the MDGs are used as a basis in planning programs in the Ministry of Health. In 2015, when the interview was conducted, the SDGs were not yet implemented. In the MDGs, older persons are not explicitly mentioned, unlike children and expectant mothers. In the MDGs, it is explicitly stated that the goals include achieving universal primary education, reducing child mortality and improving maternal health. In the SDGs, one of the basic principles is “leave no-one behind” and by implication older persons must therefore be involved in the stated SDGs aims of poverty eradication, good health, gender equality, economic growth and decent work, reduced inequalities and sustainable cities. Nevertheless, there is almost no specific reference to the needs of older people in the SDGs. It may be no surprise then that, in the local context in Indonesia, older persons are still left behind more than any other age group.

The exclusion of older people also appears to influence the quality of the services they receive. Low quality service is often experienced by older persons who have health insurance. Some of them said that the health insurance system fails to provide access to good quality service. Amir, an 81-year-old retired civil servant living in North Sumatra, for instance, stated:

> *I am self-reliant and healthy, I take my medicine regularly, every week I go to the doctor, every Thursday we check our health, we go using public transport, if we go to the Puskesmas, we use health insurance…if I go to the Puskesmas, I usually will not get better (ga sembuh-sembuh), so we go to the (private) doctor. If we go to the doctor, I recover quickly, I have health insurance, but it fails (gagal). (Muara, 16/3/2017; M44TD)*

Similarly, Udin, a sick and poor man of 85 years stated:

> *I feel sad when I do not have money, as I cannot pay a doctor (ga ada buat suntik)…I have health insurance (KIS). Using medicine covered by KIS does not make me feel better (rasane ra ono blas), KIS is nothing (pake kartu ga ada apa-apanya), I feel much better if I pay for the medicine, the medicine is different, I feel more confident if I pay for medical treatment” (Bugoharjo, 5/02/2017; M33LS).*

The cases above illustrate the low quality of treatment under health insurance. Both Amir and Udin prefer to go to a doctor and pay for their treatment when they can rather than go to the community health centre using their health insurance due to the low quality of treatment. Amir, a former government official and now a pensioner clearly stated that the National Health Insurance had failed him. Living in poverty does not always stop an older person from

accessing paid quality health care. They force themselves to pay for quality services in order to recover from their illness. The case of a poor woman of 64 years old, Tina, who cares for her two aunts, both aged over 90 years, is relevant. She forced herself to pay for quality health services for her aunts as she did not satisfy with KIS medical treatment. She said:

> "*My aunts have health insurance, however (using medicine covered by health insurance) does not make them feel better (ga ada rasanya), I have to pay IDR 25,000 to 30,000 per visit from paramedics*" (Bugoharjo, 5/02/2017; F34LS).

Devarajan and Reinikka (2004) maintained that social services fail when the services are too often inaccessible or prohibitively expensive, but even when accessible, the services are often dysfunctional, very low in technical quality, and unresponsive to the needs of a diverse clientele. So, many poor people bypass such services as KIS and use more costly medical treatment or seek better quality medical treatment.

4. Determinants of Inequality in Access to Social Welfare Programs for Older Adults

Logistic regression analysis was used to study risk and protective factors determining the likelihood of social exclusion in accessing social welfare programs for older adults. Using the 2016 ARIS survey, access to social welfare programs is assigned by a binary dependent variable, a value of one if the person is enrolled in the program and zero if the person is not. The logistic regression method in the analysis assumes that older persons have two conditions: having access to the social welfare program or not having access.

Outcome Variables

The dichotomous outcome variables are whether or not the respondent receives or has access to each of four social welfare programs for older adults: health insurance, pensions, *Poslansia* and *Raskin*. Access to each social welfare program is operationalised by enrolment or participation in the program. All older persons are eligible for health insurance and the *Poslansia* program and so all respondents are included in the regression. Although eligibility for pension and *Raskin* applies only to specific groups, for example, only poor households in the case of *Raskin*, in practice, medium and high-income families have been found to benefit from these programs (McCarthy & Sumarto, 2018). Accordingly, for these programs, inclusion of all older persons in the regression is aimed at examining who has access to the services and investigating the adequacy of the targeting system.

Independent Variables

Three groups of factors may influence the access of older persons to services, namely socio-demographic characteristics (exposure), need or illness level, and coping capacities (Cao & Rammohan, 2016; Schröder-Butterfill & Marianti, 2006; Van Minh, Ng, Byass, & Wall, 2012). Exposure refers to older persons who are at higher risk of bad outcome (Schröder-Butterfill & Marianti, 2006). These include being unmarried, childless, female, "oldest-old" and living outside Java. Need or illness level refers to disability measured in the survey by difficulties in performing one or more Daily Living Activities (ADLs). This disability measure is often used to measure the need of care or the need of services. Coping capacities are assets and relationships, which allow individuals to protect themselves from an adverse outcome or recover from a crisis (Schröder-Butterfill & Marianti, 2006). Coping capacities include higher education, coming from a higher income family, land and livestock ownership, being employed, receiving financial support from children and access to health insurance.

Results and Discussions

Table 1 describes the odds ratios for the correlates of participation in each program. Table 1 shows significant inequalities in accessing government services associated with sex, region, economic activities, child transfer and social class.

Gendered pattern of social welfare programs

Table 1 shows that the sex of the older person is a significant predictor of enrolment in the pension system and *Poslansia* participation, but sex seems to have no association with reporting enrollment in health insurance and receiving *Raskin*. Men are three times more likely to be enrolled in the pension system than women. In their culturally expected role of breadwinner, many men had retired from the civil service or formal business sectors where pensions are the norm. This means that in the absence of an effective government pension system, older women are more vulnerable to old age poverty. The situation of older women is exacerbated by limited access to resources, inheritance and property. Women in patriarchal communities, for instance, have minimal resources and limited rights to inheritance. Women also tend to live longer than men and that in turn increases their vulnerability.

Table 1: Logistic regression model: determinants of social exclusion from social welfare programs for older adults

Variables	Health Insurance (N: 1,793)	Pension (N: 1,547)	*Poslansia* (N: 1,426)	*Raskin* (N: 1,793)
SOCIO-DEMOGRAPHIC CHARACTERISTICS				
Male (VS Female)	1.115	4.878 ***	0.345 ***	1.103
Age group (VS 60-69)				
70-79	0.783 **	1.014	0.874	0.902
80+	0.944	0.654	0.418 ***	0.825
Married VS Unmarried	0.923	1.355	1.060	1.247 *
Child Presence (VS Migrant child only)				
Both migrant and non-migrant child	1.021	0.676 *	0.968	1.034
Non-migrant child only	0.912	0.749	0.563 **	0.855
No children	0.623	0.539	0.317	0.977
Region (VS Rejoagung-East Java)				
Giriasih (Yogyakarta)	0.450 ***		1.608 *	2.412 ***
Muara (North Sumatra)	0.735	1.827 *	0.214 ***	1.277
Cacaban (West Java)	1.741 ***	1.873 ***	1.000	0.493 ***
Bugoarjo (East Java)	0.844	0.041 ***	0.326 ***	1.948 ***
Gunungsari (Bali)	0.792	1.432	0.782	0.140 ***
NEED OR ILLNESS LEVEL				
ADLs Difficulty (VS None)	0.970	0.797	0.507 ***	1.163
ENABLING/COPING CAPACITIES				
SES (VS Poor)				
Medium	0.770 **		0.763	0.611 ***
Rich	0.938		1.095	0.266 ***
Education Attainment (VS Non or less than primary)				
Primary	1.080		1.601 ***	0.789 *
Secondary +	2.434 ***		2.008 ***	0.473 ***
Land Ownership (VS None)	2.098 ***	0.890	1.436 **	2.154 ***
Child transfer (VS None)	1.030 ***	0.958 **	1.019	1.016
Working (VS None)	0.672 ***	0.246 ***	1.584 ***	1.311 **

Note: - Significance level *** p<0.01, ** p<0.05, *, p<0.1.

In contrast, women are significantly more likely to participate in *Poslansia* activities than men. Older men have significantly lower odds at around 66 percent of participation in *Poslansia*. The field observation strengthens this finding as can be seen in the Pictures 1 and 2.

Picture 1: *Poslansia* Activity in Giriasih (photo taken in 2015)

Picture 2: Poslansia Activity in Rejoagung (photo taken in 2016)

As can be seen in the pictures, only a small number of men attend *Poslansia*. Picture 1 shows the keenness of the older women doing *senam lansia* – an aerobic exercise specifically-choreographed for older people - through the uniforms they wear and their performance. Most of the women also use casual clothes in contrast to the men who use very formal clothes. The formal clothes worn by the men depict their masculinity and symbolise their public role, and the casual uniform indicates that older women attend the activity regularly. *Poslansia* also involves other social activities, for example, in Rejoagung, women often sell foods to other participants. The transactions are made after the exercise finishes.

The health cadres also indicate that *Poslansia* activities are mostly attended by women. For instance, the head of *Poslansia* Krajan (Rejoagung village) stated:

> *The active membership of Poslansia is 37, there are only five male participants but sometimes they don't attend. There are two or three men who are frequently participating. We encourage men to join, however, they are not motivated to participate (Rejoagung, 02/03/2017; F55JI).*

Moreover, the word often used by midwives and health cadres, particularly in Cacaban village, to describe participants in *Poslansia* is "*Ibu*" (*women*).

The midwife for instance stated:

> *Here, exercise activity is often conducted in the mosque…it depends on the "ibu"s (women) whether to check their blood pressure, gout, or cholesterol. If they only want to check their blood pressure, it is free (Cacaban, 18/02/2017;* F20ST*).*

The gendered patterns of *Poslansia* and pensions reflects the influence of state and cultural systems in the community. The first factor is state influence which works through the

way programs are organized and provided. State influence can be seen from the fact that the government staff responsible for older people's health, the midwives and health cadres, are all women (Picture 3). At the sub-district level, *Puskesmas* staff who are responsible for the health of older people in the research areas were also women. These *Puskesmas* staff support and supervise *Poslansia* activities in the villages. This may also reflect that the world of caring is often associated with women. Women are characterized or even stereotyped as nurturing and caring personalities (Kandal, 1988).

Poslansia is also often attached to PKK (Family Welfare Movement) activities. The PKK is a women-based organization designed in the Suharto era aimed at improving health and welfare in villages. The PKK is usually headed by the wives of village officials. Based on this situation, some older men may feel embarrassed to participate in *Poslansia* activities as they regard it as a woman's activity. A man of 86 who lives with his wife of 82 and his daughter describes some of the male attitudes towards *Poslansia* activities. His wife still participates in *Poslansia*, particularly for free medical checkups. She stated that she often goes alone to *Poslansia* as her husband is reluctant to attend. Her husband stated: "I do not want to attend, I feel ashamed (*isin kok*), even though I will be taken by motorcycle, I do not want (*emoh*) to go to *Poslansia*" (Bugoharjo, 6/02/2017; M37LS). Similarly, a young organization leader in Tapanuli Utara insisted that the men in his community were ashamed to attend *Poslansia* as they thought it was women's business (Muara, 16/03/2017; M135TT).

Picture 3: *Poslansia* cadres in Bugoharjo village

The state influence can also be seen in the requirements to access social assistance such as *home care, Aslut* , BKL and *PKH Lansia*. These programs require the availability of a care provider from the family. The carer of the older person is usually a female family member such as a wife, daughter or daughter in law. The higher participation of older women can reflect gender inequality in the division of labour in the household. In general, men are breadwinners, as such, they are responsible for earning money. Therefore, while still active, they prefer to earn money than participate in *Poslansia*. Joko, an older man who is still working, maintains that the older men in Giriasih have a more intense passion to earn money ("*makin getol kerjo"*) than young people. Therefore, they prefer to engage in money-generating activities than attending *Poslansia* (Giriasih, 5/01/2017; M5GKT). In contrast, women are responsible for domestic tasks and have more time than the men to attend *Poslansia* (Rejoagung, 3/3/2017; *F55JI*). This does not imply that women have an easy time in Giriasih. In the 2016 fieldwork, poorer women in Giriasih worked in the fields for long hours for very low wages and the shortage of clean water in the village meant that women were often carrying large quantities of water from a well (the only water source for the village) two kilometres from the village.

In addition to the division of work, certain public activities in Muslim communities – especially religious ones – often involve physical separation between women and men. In Islamic recitation (*pengajian/tahlilan/istighosah/mujahadah*) for instance, older men or women collect in different groups and conduct activities at different times. Women's groups tend to conduct group activities more often than male groups. Based on this, local leaders maintain that older women are more active than the men in public activities (Bugoharjo, 4/02/2017; M28LT).

The beneficiaries of *Aslut* are also mostly older women as stated by a Gunung Kidul Social Office staff member:

> *The number of Aslut beneficiaries was 240 people in 2016. However, I do not have data on the detailed numbers of each sex. From my observation, the majority of beneficiaries are women as they are more vulnerable than the men. Older adults men often die earlier, and female older adults can take care of themselves (Yogyakarta, 15/02/2017;* M9GKP*)*

A social worker who works with older people in Giriasih also noted the predominance of women as *Aslut* beneficiaries:

> *There are 10 beneficiaries of the Aslut program in Giriasih. Eight of them are older adults women. Most of them experience a very difficult situation. Many of them are very old, very poor and very sick. One of them has a mental problem (Yogyakarta, 12/01/2017;* M2GKS*).*

The predominance of women among *Aslut* beneficiaries observed in Giriasih reflected the composition of the *Aslut* program at the national level in which female beneficiaries outnumber

men (Adioetomo et al., 2013). The likelihood of women to receive social assistance is partly caused by their higher life expectancy and their lower health status than their male counterparts. Eligibility for cash transfers from the Family Hope Program is limited to recipients over 70 years old, and this age group is mostly dominated by women. ARIS data shows that 55.1 percent of older adults in the research area are women, much higher than men at 44.9 percent.

Unequal access to services for older adults by social class: a participation and targeting problem?

In general, social protection programs are designed to help poorer families. This paper employs household income to measure the level of socio-economic status (SES). Educational attainment and land possesion are used to measure social class. The education of older persons is also used as a proxy of human capital which is often treated as a proxy for SES overall.

Table 1 shows that socio-economic status has a significant association with access to social services. The higher the social class of an older person– notably higher educational attainment – the higher their likelihood of accessing social services including pensions, health insurance and *Poslansia*. This model implies that belonging to a lower social class has a negative influence on the prospect of accessing major social welfare programs for older adults and may lead to exclusion from available social services. In contrast, consistent with the social assistance approach, if older people are more educated or have a higher SES, they have a lower likelihood of receiving *Raskin*.

Although the wealthier social classes are less likely to receive *Raskin*, the percentage of higher class (non-poor) receiving *Raskin* is still relatively high. It was found that 30 percent of wealthy older persons and 33.7 percent of those who have completed secondary and higher education are receiving *Raskin*. This result indicates poor targeting as *Raskin* is designed to benefit low-income families. This arises because the distribution of *Raskin* in some regions is not restricted to poor households. This fact strengthens the finding of the OECD (2019) that the rice subsidy for the poor program as the largest social protection program has historically been inadequately targeted.

The poor targeting issue is also encountered in the Family Hope Program for the Older adults (*PKH Lansia*). This program uses BPS data or the Unified Database (UDB) as a basis for determining beneficiaries. The verification conducted by social workers found that the data from the central government are inadequate as many beneficiaries are in fact not poor. Protests are sometimes heard from members of low-income families who are not included. In one case, some of the older adults were appealing to the head of the village asking to be included in the *PKH Lansia* program. The village head then passed the issue to the social

worker. As a result, the house of the social worker was besieged by many older persons asking to be included in the program. The problem was that the beneficiaries were determined by the central government and adding the new beneficiaries needed time before approval was granted by Jakarta (Yogyakarta, 16/03/2018; F136YD). In Cacaban village, for example, several families had been resettled because their previous village was to be inundated by a new dam. In Cacaban, they had no access to land and few employment opportunities but their eligibility for assistance was based on the assessment that had been made at their previous village five years earlier. In the previous village, they may have owned land or had a decent income. There was no mechanism for updating central government poverty assessments although situations may have changed dramatically as in this case.

This finding supports previous research on the targeting of various programs which concluded that the targeting performance of various safety net and poverty programs was low, meaning that these programs are only slightly pro-poor (Sumarto & Suryahadi, 2001; Suryahadi, Yumna, Raya, & Marbun, 2010). McCarthy and Sumarto (2018) expressed scepticism at the top-down approaches used in the targeting of social assistance programmes. They suggested that community-based targeting, developed using existing community practices, would produce better and more acceptable results.

The top-down identification of social assistance beneficiaries by the central government is also criticized by the village leaders as it does not involve consultation with them. The local leaders based on local knowledge and community meetings have their own data on poverty and the potential beneficiaries of social assistance. They propose those potential beneficiaries to the government but the central government uses its top-down approach resulting in different and even inappropriate beneficiaries (Bugoharjo, 6/02/2017; M28LT).

Another crucial issue related to the top-down approach is the lack of community or older adults' participation in designing appropriate social services based on the local context and needs. In most social welfare programs for older adults, prospective beneficiaries have little or no involvement in the design, implementation, and monitoring of the programs, and were treated as passive subjects. Lack of participation from older persons influences the mainstream approach to service delivery which is mostly focused on charity, as stated by a former staffer of the older people's commission in Jakarta.

> *So, the approach of services for older people is charity. They are considered as the program objects or program beneficiaries (program receivers). Older persons' roles are not as subjects or actors who are implementing the programs. The charity approach regards older people as objects. If the older people's position is as a subject, they can participate actively, however, their participation is very limited (Jakarta,* 18/10/2015; M136JK).

Lack of participation from older people influences the implementation of various social protection programs which are highly dependent on the role of local activists or cadres (*kaders*). The cadres are usually young women as shown in Picture 3. Some older persons, however, are now becoming cadres of the *Poslansia* program such as in Gunung Sari and Rejoagung villages in which older people lead the cadres of the program. Lack of participation by older people in planning and designing the program could contradict local values. In Bugoharjo, for instance, the exercises for older adults through the *Poslansia* program have attracted little participation as the exercise is held out in public which is not appropriate for older adults in this strictly Islamic village. Physical exercise is seen as socially inappropriate for older adults as it is considered as an activity for the young, and older persons are seen as more appropriately involved in religious activities (Bugoharjo, 5/02/2017; M28LT).

In addition to lack of participation, the logistic regression also highlights the targeting problem particularly the "missing middle" problem in the implementation of Indonesia's National Health Insurance program, where older persons from middle-income groups are not covered by health insurance (Table 1). There is no significant difference between older persons from low-income families or from wealthy families in terms of enrolment in the National Health Insurance scheme, as the government pays the insurance for poor families while wealthy families can pay for themselves, or their institutions will cover the cost. In cases where they are retired from the civil service or from working in the formal business sector, they are also covered. Informal workers however often find themselves in the "missing middle" of social protection coverage because they are ineligible for social assistance programs but at the same time excluded from employment-based contributory schemes (OECD, 2019).

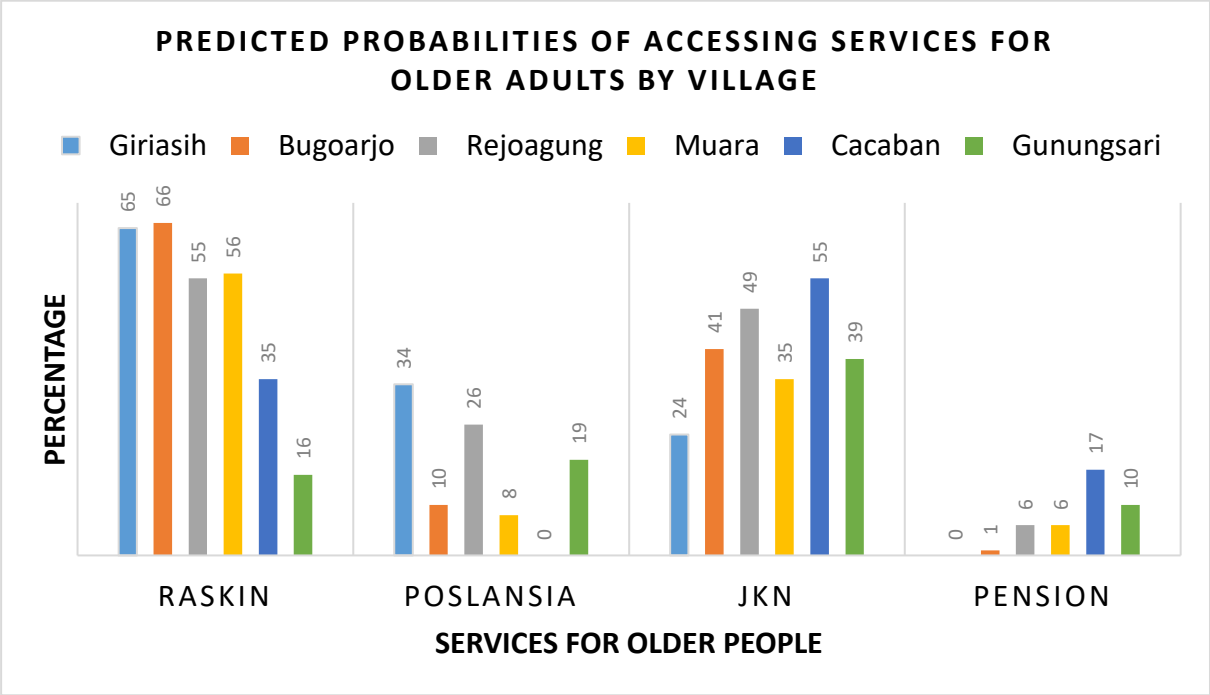
Unequal access to services for older adults: a decentralization problem?

The village is used as a proxy for the region as the six villages are in six different regions or districts (*kabupaten*) and five different provinces. Under decentralization, the national budget is distributed to the district level for the determination of expenditure priorities. Services which provide basic access to food, medication and living costs are central to the survival stategy of many older people. However, the gaps in these services are wider in some districts than in others. Table 1 shows that the village has a significant association with access to social services. Figure 2 describes the predicted probabilities of accessing social services for older adults.

The probabilities that the three Javanese villages (Giriasih, Bugoharjo and Rejoagung) can access social assistance (*Raskin*) are relatively higher than for the three non-Javanese villages (Figure 2). The qualitative data also show that the Javanese villages have a higher access to direct social services for older persons such as *PKH Lansia* and *Aslut* (Table 2)

although direct social services for older persons were available in only some of the Javanese villages perhaps due to the distribution of other programs such as the Older adults Friendly Community Health Centre (*Puskesmas Santun Lansia*) and *Poslansia*.

Figure 2: Predicted probabilities of accessing social services for older adults by village



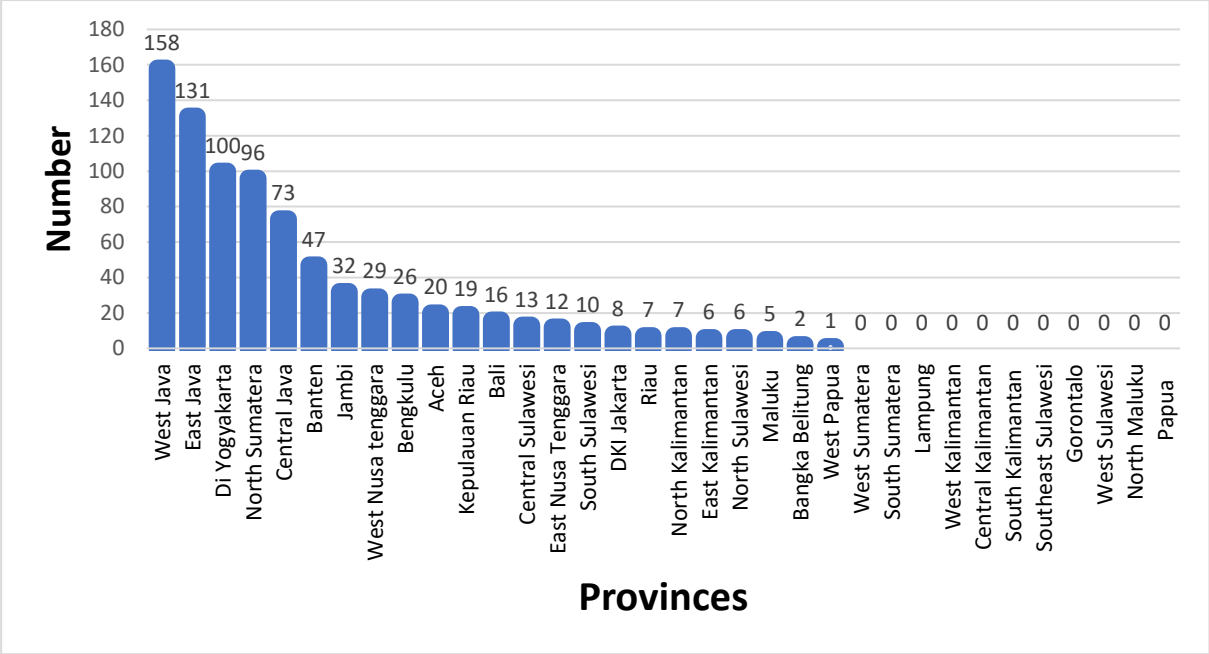
Source: Calculated from 2016 Ageing in Rural Indonesia Survey
Note: There was no access to *Poslansia* in Cacaban in 2016, but the *Poslansia* program was created in the village after the 2016 ARIS survey as a consequence of the community meeting held during the fieldwork.

Table 2: Available social assistance programs by village

Villages	Direct services to older persons
Giriasih	*PKH Lansia*
	Aslut
Bugoharjo	*PKH Lansia*
	Aslut (existed in district level but not covering Bugoharjo)
Rejoagung	*Aslut* (existed in district level but not covering Rejoagung)
Muara	None
Cacaban	*Aslut* (existed in district level but not covering Cacaban)
Gunungsari	*Aslut*

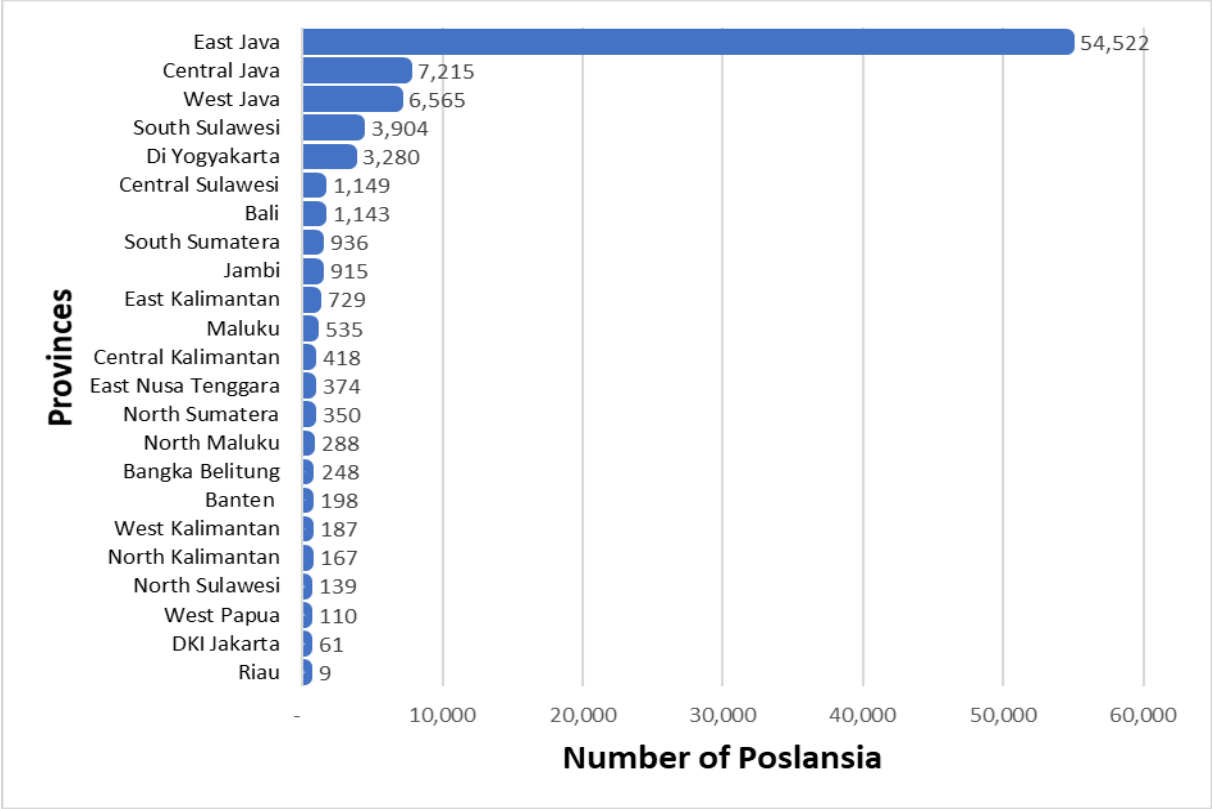
Source: Interviews with village officials and local government staff members, 2016-2017

Figure 3: The distribution of *Puskesmas Santun Lansia* by province in 2015



Source: Ministry of Health, 2015

Figure 4: The distribution of *Poslansia* program by province in 2015



Source: Ministry of Health, 2015

Figure 3 and 4 illustrate the unequal distribution of *Puskesmas Santun Lansia* and *Poslansia* by province in 2015. The *Puskesmas Santun Lansia* program is clearly concentrated

in the six provinces on the island of Java. For instance, the highest program coverage is located in West Java, followed by East Java and Yogyakarta, while the eastern Indonesian provinces such as Papua, North Maluku and Gorontalo have the lowest access. Similarly, Figure 4 shows the concentration of *Poslansia* activity in Java, especially in the province of East Java.

Moreover, inequality in accessing social programs by region is evident for other programs. Based on the 2014 Village Potential Statistics (PODES) data from the Central Bureau of Statistics, the East Java villages of Bugoharjo and Rejoagung received the National Program for Rural Community Empowerment (*Program Nasional Pemberdayaan Masyarakat Mandiri Perdesaan-PNPM Mandiri Pedesaan*). The National Program for Rural Community Empowerment is the largest community-driven development program in Indonesia. The objective of *PNPM Mandiri Pedesaan* is to alleviate poverty by having the communities design their development agenda. Improving access to education and creating jobs are components of *PNPM Mandiri Pedesaan*. This program is likely to be beneficial in economic terms for older persons in the villages where it operates.

Other poverty alleviation programs such as house reconstruction (*Program bedah rumah/plesterisasi*) and sanitation are also more readily available to villages in Java. The village of Bugoharjo, for example, has access to the sanitation and house reconstruction programs to the benefit of its senior citizens. As stated by the head of Bugoharjo village:

> *Another program is house reconstruction (plesterisasi) delivered to those households with a soil floor, including older people. Another program is sanitation through providing an appropriate toilet to 10 needy households (Bugoharjo, 4/02/2017, M28LT)*

Another indicator of unequal exposure to government programs is access to income generating activities which are mostly provided by the local governments in Java. The local government of Lamongan district (*kabupaten*) which includes the village of Bugoharjo, through its social office, provides an income generating program for older people. The greater exposure of villages in Java to development programs further indicates the unequal development opportunities across rural Indonesia. Recent development programs like the Pre-Employment Card (*Kartu Pra Kerja*), are also concentrated on Java. Kusumaningrum, Aidulsyah, and Meilianna (2020) reported that 70 percent of the beneficiaries of the Pre-Employment Card are located in Java. The Card is aimed to provide vocational training assistance to young workers who are seeking work, as well as unemployed workers and active workers who would like to improve their skill/competency. The program provides a non-cash voucher to support the training costs, ranging from 3 to 7 million rupiah per person that can be used within a year.

Policy tends to focus on Java because the population of Indonesia is concentrated in Java. For example, an informant from the Ministry of Social Affairs stated:

> *It is a problem in our ministry where the eligibility for social services is everywhere, but the largest proportion is in Java because the population in Java is the largest compared to other provinces outside Java (Jakarta, 30/10/2015;* M133JS*).*

Similarly, a staffer of BKKBN said:

> *The programs are focused in Java and Bali, while other regions such as the east Indonesian regions get less attention. The funding to those regions is also very limited (Jakarta, 30/10/2015)*.

The other reason for unequal coverage is the requirement, when implementing social assistance from the central government, that recipient districts should be fully prepared. Part of necessary preparedness for the *Aslut* program at the district level, for instance, is the recruiting and training of social workers. If the district is not ready, the district is excluded from the service. Moreover, local governments have different resources in implementing the central government programs. One of the concerns of the provincial and central governments is that they do not have the authority to deliver direct services as, after decentralization, the district government gained the authority to deliver direct services to the people. On the other hand, most programs for older persons are initiated by the central government and a very small number of programs are initiated by local government. Social programs initiated by local government are usually charity-based such as basic food assistance and are often very small in scope. The provinces are representatives of the central government in providing administrative support, direction and monitoring the operations of the districts and municipalities. However, provincial offices have limited autonomy in delivering direct services (Kadar, 2013).

Part of the role of the provincial and central governments is to increase the capacity of human resources at the district level through training the trainers. After that, it is the responsibility of local governments to fund and implement direct services, including services for older persons. The problem is that not all district governments prioritise older persons and this depends on the political will of the individual regent (Yogyakarta, 8/10/2015; F90GKD). A good example of a local government which gives priority to older persons is Jember District in which the regent (*Bupati*) instructed all village heads to allocate six million Rupiah (around $600) per village from their village fund every year to run direct services to older persons based on local needs (Jember, 24/09/2016; M101JD). The village of Regoagung is in Jember district.

The central government began to disburse village funds at an average amount of Rp 280 million for each village in 2015. The amount has continuously increased in subsequent years, reaching Rp 800 million per village in 2018. Most villages allocated the largest portion, more

than 70 percent, to infrastructure development, particularly roads. Only a small share was allocated for community empowerment (Suryahadi & Al Izzati, 2018; Syukri et al., 2018).

The breakthrough in Jember district might be replicated in other districts as the main concern from local government is lack of funding. Village heads in the research sites are concerned about how to use village funds for services for older adultsas the government limits the use of the fund to infrastructure and community empowerment (only) (Giriasih, 3/01/2017; M1GKT). The lesson learnt from Jember district is that the village can fund direct services for older adults as part of the "community empowerment" category. The lack of understanding of the empowerment concept contributes to a lack of funding for older adultsat the village level. However, this problem also applies at the national level. According to a staff member of the Ministry of Social Affairs, the challenge in implementing social services for older adults is the assumption that these services only involve spending the government's money and are not generating income. Therefore, the focus is on economic development. This different interpretation of community empowerment influences the amount of funding allocated by the central government for older people.

The Ministry of Social Affairs also insisted that the central government is focusing on developing a model for older-person services. It is the role of local government to replicate the model developed by the Ministry of Social Affairs funded from the local government budget. However, up to now, replication of the central government's plan at the district level is not being implemented. The key is political will.

The 1999 decentralization of 1999 placed a strong reliance on institutional capacity at lower levels of government. Greater responsibilities, including authority over budget and expenditure management, were acquired by regional governments, both at provincial and district levels. Patunru, McCulloch, and Von Luebke (2009) and Milne (2006) reported that decentralization greatly increased the responsibility of districts for most service delivery, providing public facilities and infrastructure, and issuing local regulations on social, political, and economic matters. Decentralized government and the resulting new aspects of the political system posed new issues for the support of older people, and to some extent created inequalities and challenges for the fulfilment of older people's rights. This is especially the case when the necessary political will is lacking to back support services for older persons. One example of the drawbacks in the implementation of decentralization is the fragmented and unequal distribution of health care resources, particularly to rural areas (Kadar, Francis, & Sellick, 2013). For example, in 2016, in the village of Sei in East Nusatenggara, one of the ten ARIS villages not covered in this paper, the district *Puskesmas* had had no doctor for a year.

Multiple stakeholders lead to lack of program integration and coordination

The existing social welfare programs for older persons in Indonesia are very comprehensive in the form of social assistance, social insurance, health provision, empowerment and awareness raising. This is a strength that constitutes to some extent good practice in social welfare programs for older adults. However, the implementation of the programs lacks integration as programs are mostly run separately by different institutions without program integration. Coordination is conducted among the government agencies but effectiveness limited partly due to absenteeism and changes in the personnel responsible for coordination. Moreover, coordination meetings are often attended by lower-level staff who lack authority for decision making (Yogyakarta, 8/10/2015; F90GKD). This finding strengthens the finding of the OECD (2019), which reported a lack of co-ordination in social protection provisions across different levels of government. As a result, national programmes might not receive the buy-in they need from provincial and local governments, and the implementation of centrally-led reforms can differ from what was intended.

Lack of integration and coordination also occurs within a ministry. For instance, the Ministry of Health runs the *Posbindu* and *Poslansia* programs, both of which have similar designs and beneficiaries. Both programs conduct health checks and exercise programs for older adults but these are implemented by different staff at the *Puskesmas* level and different cadres at the village level. Lack of suitable human resources in the *Puskesmas* and the villages hampers the implementation of both these programs (Buleleng, 28/09/2016; F137BD). Another example is the complaint by the head of Pucuk *Puskesmas* about coordination problems at the sub-district level. Coordination is conducted with the unit office of BKKBN at the sub-district level once each month, but BKKBN does not implement programs at the sub-district level and this limits the scope for coordination (Lamongan, 16/09/2016; M78LT). Lack of coordination of inter-governmental ministries and between central government, provincial and district government agencies is a serious challenge in implementing social protection programs.

Poorly prepared health care workers

The most common health services accessed by older people are health services provided by the midwife and paramedic (*Mantri*) (ARIS, 2016). The midwife usually manages *Polindes* (health services at village level) and *Poslansia* activity. Midwives are often unprepared to effectively manage the health care needs of older adults as their educational background is directed at helping children and expectant mothers. They are rarely trained to work with older people and how to manage old-age health issues such as dementia, depression and frailty. Midwives and other health-care professionals need the right

competencies and skills to care for older persons, In the ARIS villages, because the number of births had declined overtime, midwives were eager to provide basic health support to older people and they had the time to do so. They were also respected by the older people in the village. Midwives often received good support from the sub-district *Puskesmas* but, at base, they lacked the necessary training. Kadar et al. (2013) also found that most of health care staff, especially the nurses in community health centres, have limited or no specialist skills in caring for the aged in the community. They also found that health care professionals responsible for implementation of government funded programs for older people have limited understanding of the programs. This story is not all negative. While the researchers were interviewing the village midwife in Salo village, West Sumatra (one of the ten ARIS villages not included in this study), an old man arrived with an infected foot resulting from an accident. The midwife immediately provided him with proper treatment effectively saving his life. This example indicates the central importance of having a trained health worker at the village level.

Ideas for improvement of service delivery

Some potential strategies to improve the service delivery for older people can be considered. The first is increasing public spending and coverage for social welfare programs to accommodate the aging population and provide the health care, retirement income and security needs of older people. It is the role of government to ensure that no one, including older persons, is left behind, if the Sustainable Development Goals (SDGs) are to be achieved. Leaving no-one behind is the basic principle in the SDGs agenda. However, older persons are a neglected segment of society and they do not receive sufficient priority, as discussed in the previous section. Social protection may be relatively expensive and indeed needs adequate policy design and sufficient funds, and this presents a challenge for low-income countries. The mean cost of a basic package of social protection including a universal pension covering old age, disability and a child benefit, would amount to around two to three percent of GDP (Barrientos & Hulme 2008). One of the strategies to increase the funding for social welfare policies for older people is a mix of funding from different levels of government (central, district and village government) and from the community. A good example is Jember District where the *Bupati* (regent) instructed all village heads to allocate six million Rupiah (around $600) annually from their village fund to run direct services to older persons based on local needs. The village fund is one of the alternatives to finance services for older adults. The political will and the capacity of local government are key to the achievement of better services for older people.

The second approach is to develop and mobilize networks of the United Nations, the corporate social responsibilities of companies, and other non-government organizations, so that both local and international institutions take part in promoting social welfare for older adults. The collaboration between government and non-government institutions is vitally important in helping solve limited budget issues in the effort to improve the welfare of older adults in Indonesia. Corporate social responsibilities (CSR) of companies, for instance, has a large amount of funding to run development programs for communities. Indonesia is the first country to introduce mandatory legal requirements for CSR through the Law 40/2007 on Limited Liability Companies (LLCs) (Rosser & Edwin, 2010). The government could facilitate and give technical assistance to focus CSR programs on providing social welfare programs for older adults. The government also could provide tax incentives or reductions for the companies that offer services for older persons.

The third approach is encouraging local government to replicate the model of social services developed by the central government. This replication should use local government budgets. The fourth is increasing the coordination and integrating social services for older people based on the strength of each government institution. Currently, the existing social services for older people tend to be separated across institutions. The approach of services for older persons should be changed from the current *ad hoc* approach and to an approach that provides integrated services based on the relative strengths of each government institution. For instance, *Bina keluarga lansia-BKL* (Empowerment program for families of older persons) conducted by the BKKBN could be integrated into *Poslansia*, *PKH Lansia* and *Karang Werdha*. One of the strengths of the BKKBN is awareness-raising concerning the care of older persons. The tool kit developed by BKKBN can be used in *Poslansia* and *Karang Werdha* activities. Another example is the Social Office's *Permakanan* (food voucher) program which could be used to collaborate with the healthy food programs in *Poslansia* as lack of funding is often one of the obstacles in providing healthy food. The *Permakanan* program could support the healthy food programs in *Poslansia* and simultaneously attract older people to attend *Poslansia*. Handled properly, program integration could provide a strategic breakthrough which could reduce the distribution of unhealthy foods such as instant noodles for older persons. Improving coordination among key stakeholder organizations is essential for program integration and program effectiveness. In practice, integrating services for older people is challenging. Therefore, the role of a case manager is essential in integrating services for older people. Case management in developed countries is often conducted by a social worker. Social workers are educated and trained in coordination of services needed by older people. In the Indonesian context, social workers are organized under the Ministry of Social Affairs. Assigning social

workers as a case manager in integrating services for older people is important for program integration.

The final consideration is improving the competencies and skills of health professionals including midwives and health cadres at the village level and doctors and nurses at the *Puskesmas* in such disciplines as gerontology, geriatrics and management of health conditions faced by the older population such as frailty, osteoporosis, arthritis, depression and dementia. It is important to include these competencies and skills in the schools or higher education curricula for health professionals. Geriatric specialists with expertise to treat complex cases should also be placed in hospitals in the regions where the percentage of older persons is high, though this is a longer-term aspiration.

5. Conclusion

This paper argues that older people have a right to access services that will improve their welfare. However, as young people are educated and leave the villages, the agricultural labour force in Indonesia has been ageing. Thus, keeping older people healthier longer is also an important consideration in maintaining Indonesia's agricultural production.

The main aim of this paper was to analyse the extent of access of older people to the components of the main government programs and how existing programs can be improved. The Indonesian Government has made efforts to fulfil the social rights of older adults through social welfare programs that can be clustered into five groups: social assistance, social insurance, health provisions, empowerment, and awareness raising. However, these programs are very limited in scope. The low coverage and lack of funding indicate that older persons are still a neglected segment of society.

In addition to the low coverage, there are inequalities in accessing the existing programs. The first is the gendered pattern in implementation which is influenced by the state's approach and certain cultural assumptions in the local communities themselves. State influence works through the way programs are organized and provided. Almost all government staff responsible for the health of older adults at the village level, i.e., midwives and health cadres, are women. State influence can also be seen in the eligibility rules of access to social assistance programs such as *home care, Aslut*, BKL and *PKH Lansia*. Those programs require the availability of a care provider from the family and that is commonly a female family member such as a wife, a daughter or a daughter in law. The influence of the cultural system on the gendered pattern of social welfare programs can be seen in the higher participation of older women. While the higher participation of older women might reflect the gender inequality of the standard "division of labour" in the household, the provision of services for older men is important. This means that new approaches are required for the delivery of village-level

services for men, especially in Muslim communities where men and women are separated in public activities.

The second factor is unequal access to services because of social class. The higher the social class of older adults(notably higher educational attainment), the higher their likelihood to access social services including pensions, health insurance and *Poslansia*. Although the higher social class are less likely to receive the *Raskin* program, the percentage of the higher classes (non-poor) receiving *Raskin* is still relatively high. This indicates poor targeting as *Raskin* is designed for low-income families. The poor targeting issue is also encountered in the Family Hope Program/Conditional Cash Transfer for older adults (*PKH Lansia*). The Family Hope Program uses BPS data as a basis for determining beneficiaries, but the verification conducted by social workers found the data inadequate as many beneficiaries are not poor. The "missing middle" problem also arises in the implementation of Indonesia's National Health Insurance program where the older persons coming from middle-income groups remain uncovered by health insurance.

The third problem is the unequal access to older adults' services by region. Services for older people are more easily accessible in Java than elsewhere. This reflects the disproportionate focus on western Indonesia in development programs. Decentralization also contributes to the unbalanced access of older people to service delivery. Another challenge is the lack of involvement and participation from older persons and the lack of program integration among ministries.

Potential strategies aimed at improving service delivery for older people can be identified, including increasing public spending and coverage of social welfare programs; developing and mobilizing networks from the United Nations, corporate social responsibilities of companies, and other non-government organizations; broadening the usage of village budget (*Dana Desa*) to finance social welfare services for older adults; integrating social services to older people based on the strength of each government institution, and improving the competencies and skills of health professionals including midwives and health cadres.

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