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

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Abstract

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 adults 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 Ageing in Rural Indonesian Study (ARIS). The Indonesian government has made efforts to fulfil the social rights of older adults. However, logistic regression analysis indicates significant variation and inequalities in access to government services among rural older adults depending on sex, region and social class. The extent of access is influenced by the state's approach and certain cultural assumptions in the local communities. 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.

Key Words: Ageing Population, Social Policy For Older Adults, Inequality, Social Exclusion

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INTRODUCTION

Indonesia, an archipelagic nation comprising over 17,500 islands and home to more than 273 million people, is characterized by striking geographic, economic, and social diversity. The country is administratively divided into 33 provinces, which are further subdivided into districts, municipalities, sub-districts, and villages—amounting to over 77,000 villages as of 2010. Java, the most populous island, hosts nearly 59 percent of Indonesia's population while accounting for only 7 percent of its landmass, leading to a heavy concentration of economic activity and development in this region (Kadar, Francis, & Sellick, 2013). This unequal distribution has resulted in persistent regional disparities: poverty rates in eastern provinces such as Papua and East Nusa Tenggara remain significantly higher than the national average and the human development index (HDI) in eastern Indonesia is among the lowest compared to the west (BPS, 2020a; BPS, 2020b).

Indonesia is a plural society, with more than 700 ethnic groups speaking more than 1,000 languages. (Ananta, et al., 2015). The basic institutions such as the kinship

system and social structures prevailing in these groups are varied (Ihromi, 1994). The situation of the older adults varies considerably across regions, ethnicities, and socio-cultural backgrounds, affecting their access to support systems and social rights (Ananta, Arifin, & Bakhtiar, 2005; Hermalin, Ofstedal, & Mehta, 2002; Thristiawati, 2013). These disparities are exacerbated by Indonesia's rapid demographic transition-the share of the population aged 60 and over has risen from 4.5 percent (5.3 million) in 1971 to 9.6 percent (26 million) in 2019, and is projected to reach 16 percent (48 million) by 2035 (BPS, 2019; Kudrna, Le, & Piggott, 2022). This demographic shift intensifies the urgency of providing equitable social protection for older adults, particularly in rural and marginalized communities.

Despite economic growth, older Indonesians remain highly vulnerable to poverty and social exclusion, particularly in rural areas where formal support systems are limited and many elderly continue to work (Kudrna et al., 2022; Utomo, Mcdonald, Utomo, Cahyadi, & Sparrow, 2019). The Indonesian government has responded to these challenges by implementing a range of social welfare programs clustered into five categories: 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)* 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. One of the services is *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.
The fourth cluster is empowerment provided for the productive older adults and their families aimed at increasing the incomes of poor people. The fifth cluster comprises awareness-raising programs aimed at increasing both the awareness and the capacity of older adults' stakeholders, particularly their families, in fulfilling the rights and needs of older adults.

However, despite the expansion of social welfare initiatives, little attention has been given to examining the extent to which the older generation can access to the components of these government programs and how these inequalities are shaped by intersecting factors such as gender, region, and social class among a diverse group of rural older adults. While some studies have addressed aspects of ageing and social protection in Indonesia (for instance Sri Moertiningsih Adioetomo & Pardede, 2022; Muis, Andi Agustang, & Adam, 2020), few have systematically analyzed the determinants of exclusion from social welfare programs or assessed the adequacy and reach of these programs for the most vulnerable segments of the older population. In particular, the experiences of older women and men in rural and remote areas—where formal support systems are weak—have received insufficient scholarly attention.

This paper addresses this critical research gap by analyzing data from the Ageing in Rural Indonesian Study (ARIS) to assess the extent of access to five key

social welfare services—health insurance, pensions, *Posyandu Lansia, Raskin*, and *Aslut*—among older people in six Indonesian villages. The study aims to identify the determinants of exclusion from these programs, with a particular focus on the roles of age, gender, region, and social class, and to offer recommendations for strengthening social protection for Indonesia's rapidly growing and diverse older adults' population.

By foregrounding the multidimensional nature of inequality and exclusion in later life, this research contributes to ongoing debates about social citizenship, welfare rights, and the future of ageing in Indonesia (Binelli, Loveless, & Whitefield, 2012). The findings are intended to inform policy and practice, ensuring that social welfare programs are more inclusive and responsive to the needs of Indonesia's older adults.

METHOD

Data

The data are drawn from the 2016 Ageing in Rural Indonesian Survey (ARIS) conducted in ten rapidly ageing communities (villages) spread across Indonesia. Three main methods were employed in data collection including surveys, in-depth interviews and 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). We complement the analysis of the survey data with insights gathered through in-depth interviews with informants from government employees, village leaders, religious leaders, midwives and older adults themselves. A summary of the characteristics of each of the six study sites is provided in Table 1.

Table 1. The characteristics of study sites

Study Site	Province	Share of population aged 60+	Main religion	Main Ethnicity	Kinship System	Total ARIS Respondents	% Respondent Needing LTC
Muara	North Sumatra	14.6	Christian	Batak	Patrilineal	215	28.8
Cacaban	West Java	23.4	Islam	Sunda	Bilateral	368	15.8
Giriasih	Yogyakarta	22.0	Islam	Jawa	Bilateral	246	14.0
Bugoharjo	East Java	24.0	Islam	Jawa	Bilateral	307	16.7
Rejo Agung	East Java	16.4	Christian	Jawa	Bilateral	339	8.6
Gunung Sari	Bali	19.1	Hindu	Bali	Patrilineal	330	18.6

Source: 2016 Ageing in Rural Indonesia Survey and 2010 Indonesian Census

MEASUREMENTS

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 in the program. All older adults 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, middle and high-income families have been found to benefit from these programs (McCarthy & Sumarto, 2018). Accordingly, for these programs, inclusion of all older adults 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 adults to services, namely socio-demographic characteristics (exposure), need and coping capacities (Cao & Rammohan, 2016; Schröder-Butterfill & Marianti, 2006; Van Minh, Ng, Byass, & Wall, 2012). Exposure refers to older adults 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). 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 ownership, being employed, receiving financial support from children and access to health insurance.

RESULT AND DISCUSSION

Coverage Levels for the Five Services

While social welfare programs for older adults in Indonesia are very comprehensive, coverage remains very limited (Figure 1). *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 adults while the number of neglected older adults in all Indonesia was around 2.8 million in 2010 (Jakarta, 17/10/2015). 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 adults who receive a pension is very low at just under 9 percent. 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).

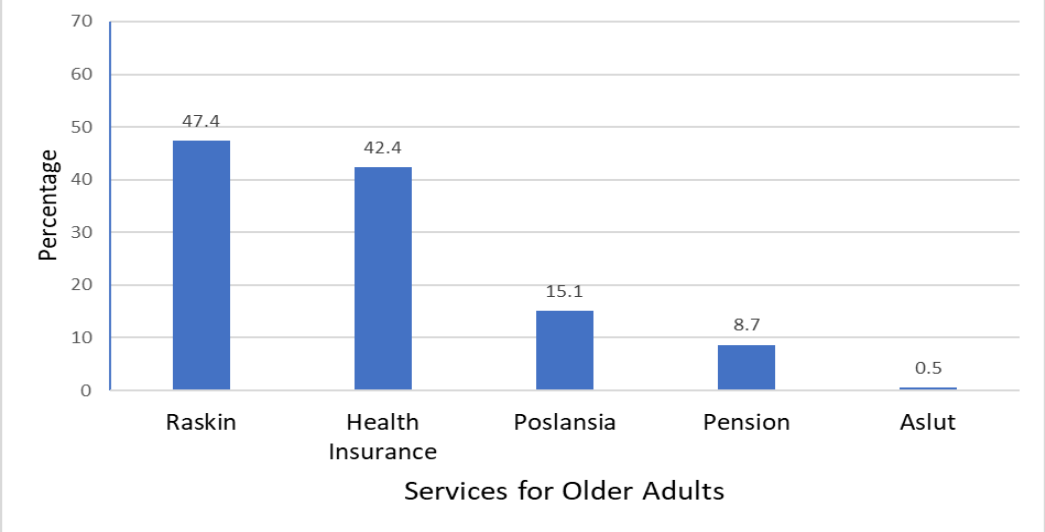

Figure 1. The percentage of older adults who receive five government services, six selected villages

Source: drawn by the author

Older adults 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). As 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 adults. The low proportion of older adults in Indonesia who are enrolled in any pension system indicates that the majority are vulnerable to old age poverty.

One of the main problems causing the minimal social security coverage for older adults 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.

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 (2003) 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 adults are excluded from any old age pension through either insurance or assistance (S.M Adioetomo, Howell, McPherson, & Priebe, 2013). Another example is the budget for the National Population and Family Planning Board (BKKBN), which was only IDR 7 billion. The allocated budget for older adult 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 seven billion rupiah of our budget in a year is used for training and training of trainers. Recently we have been developing BKL[1] 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).

Similar challenges are also experienced at the local government level where the funding for older adults is very limited. For instance, the Health Office of North Tapanuli district where Muara is located reported that funding for older adults 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 adults and four programs for expectant mothers. Limited funding 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) even though Yogyakarta Province has the highest proportion of older adults 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 adults 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).

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 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 administrator in Yogyakarta who had responsibility for managing programs for older adults 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 in one of the health centres. So, it has not become a priority (Yogyakarta, 05/10/2015).

The exclusion of older adults also appears to influence the quality of the services they receive. Low quality service is often experienced by older adults 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 take my medicine regularly, 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)

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).

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 adult from accessing paid quality health care (Udin case).

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.

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. 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 adults have two conditions: having access to the social welfare program or not having access.

Table 2. 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.
Source: calculated by the authors

Gendered pattern of social welfare programs

Table 2 shows that the sex of the older aduly 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. Women also tend to live longer than men and that in turn increases their vulnerability.

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 health cadres also indicate that *Poslansia* activities are mostly attended by women. For instance, the head of *Poslansia* 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).

The gendered patterns of *Poslansia* and pensions might 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. 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 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). 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).

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). In contrast, women are responsible for domestic tasks and have more time than the men to attend *Poslansia* (Rejoagung, 3/3/2017). 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, 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).

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. Older adults men often die earlier, and female older adults can take care of themselves (Yogyakarta, 15/02/2017)

The predominance of women among *Aslut* beneficiaries observed in Yogyakarta reflected the composition of the *Aslut* program at the national level in which female beneficiaries outnumber men (S.M 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.

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

Educational attainment, household income and land possesion are used to measure social class. Table 2 shows that social class 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, 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 adults 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 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 adults 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).

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).

Another crucial issue related to the top-down approach is the lack of 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 planning and implementation of the programs, and were treated as passive subjects. Lack of participation from older adults influences the mainstream approach to service delivery which is mostly focused on charity, as stated by a former administrator 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 adults' roles are not as subjects or actors who are implementing the programs. The charity approach regards older people as objects (Jakarta, 18/10/2015).

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. Some older adults, 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 adults are seen as more appropriately involved in religious activities (Bugoharjo, 5/02/2017).

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 adults from middle-income groups are not covered by health insurance (Table 2). There is no significant difference between older adults 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. 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 by region: a decentralization problem?

The village is used as a proxy for the region as the six villages are in six different regions. 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 2 shows that the village has a significant association with access to social services. 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. The qualitative data also show that the Javanese villages have a higher access to cash transfer such as *PKH Lansia* and *Aslut* although direct social services for older adults 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*.

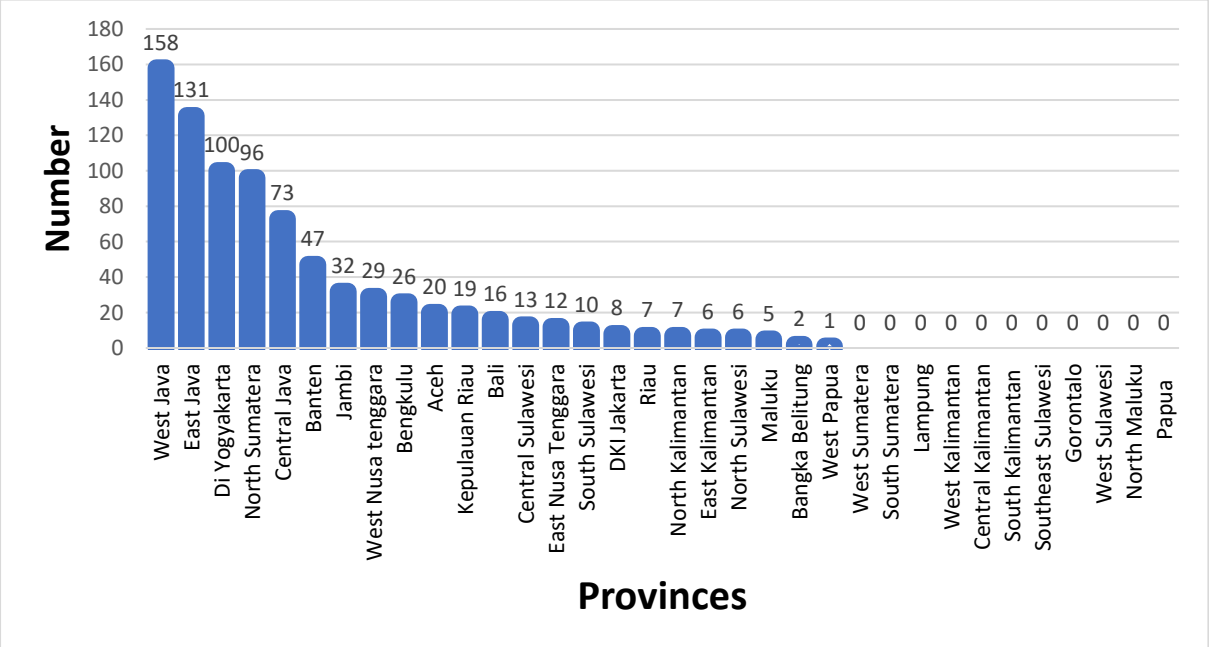

Figure 2. The distribution of *Puskesmas Santun Lansia* by province in 2015
Source: Ministry of Health, 2015

Figure 2 and 3 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.

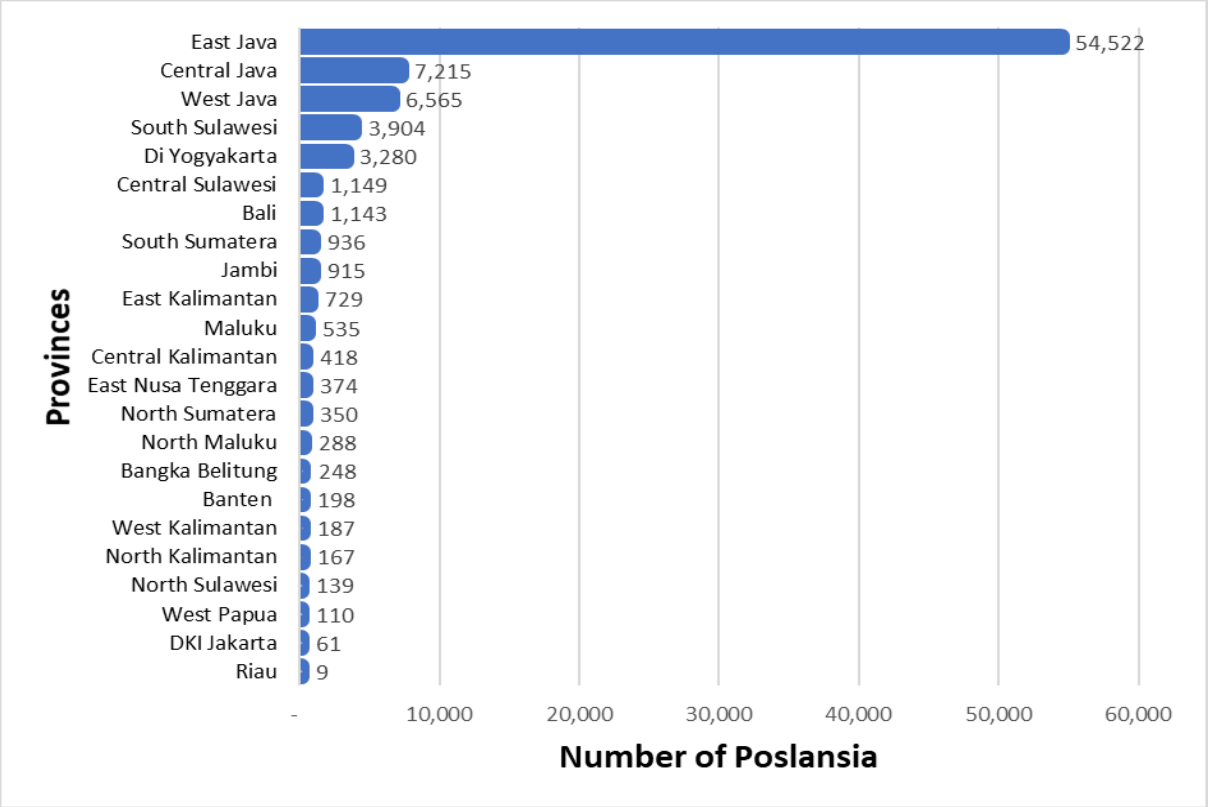

Figure 3. The distribution of Poslansia program by province in 2015
Source: Ministry of Health, 2015

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 Javanese villages received the National Program for Rural Community Empowerment (*Program Nasional Pemberdayaan Masyarakat Mandiri Perdesaan-PNPM Mandiri Pedesaan*). The program is the largest community-driven development program in Indonesia aimed 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 adults in the villages where it operates.

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).

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 adults 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 adults. The problem is that not all district governments prioritise older adults and this depends on the political will of the individual regent (Yogyakarta, 8/10/2015).

Multiple stakeholders lead to lack of program integration and coordination

The existing social welfare programs for older adults 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).

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).

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 adults.

In the ARIS villages, because the number of births had declined overtime, midwives were eager to provide basic health support to older adults and they had the time to do so. 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 administrator, 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 adults 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 adults can be considered. The first is increasing public spending and coverage for social welfare programs. 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 non-government institutions the community. The village fund (*dana desa*) is one of the alternatives to finance services for older adults. Another potential funding is corporate social responsibilities (CSR) of companies. 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 provide tax incentives or reductions for the companies that offer services for older adults.

The second is integrating separated services. In practice, integrating services for older people is challenging. Therefore, the role of a case manager is essential in integrating services for older adults s. 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. 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 adults 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.

CONCLUSION

The Indonesian Government has made efforts to fulfil the social rights of older adults through social welfare programs. However, these programs are very limited in scope. The low coverage and lack of funding indicate that older adults 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. 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. The 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 "missing middle" problem also arises in the implementation of Indonesia's National Health Insurance program where the older adults 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 adults 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 through corporate social responsibilities of companies, and broadening the usage of village budget; program integration, and improving the competencies and skills of health professionals.

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