

**Refugee Review Tribunal
AUSTRALIA**

RRT RESEARCH RESPONSE

Research Response Number: IDN33316
Country: Indonesia
Date: 23 May 2008

Keywords: Indonesia – Elderly women – Public health – Hospitals – Cost of living

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Questions

1. Are family members expected to care for elderly/sick/frail in Indonesia?
2. What does family mean? Does it extend to nieces and nephews?
3. What are the chances of an elderly/sick/frail person attending a rehab hospital or aged care facility in Indonesia? How expensive are they? Are they subsidized by the government? Is there a 'medicare' equivalent?
4. What are the subsistence wage and the average wage in Indonesia/ Tanjung Pandan?
5. Does the Indonesian government target the provision of health for the elderly, expecting that their families should take care of them, or is it just that the government does not have enough money for the care of all Indonesians?
6. Is there access to pharmaceuticals for the average person in Indonesia?
7. What rent would get an elderly/sick/frail person a two bedroom place in Tanjung Pandan?
8. How much would such a person have to spend on food a month?
9. What is the cost of the return flight from Jakarta to Tanjung Pandan?
10. If an elderly/sick/frail person is in a wheelchair, are those airports friendly to wheelchairs (ramps etc).

RESPONSE

1. Are family members expected to care for elderly/sick/frail in Indonesia?

Two recent studies on the elderly in Indonesia indicate that there is a lack of state resources dedicated to aged care and that families are expected to care for the aged within the home. According to this information, care of the aged is undertaken by the immediate family, available relatives, close neighbours and others within the local community. Close relatives, such as a child or spouse, would be the most likely to look after a person needing long term care and assistance in daily living activities, such as bathing and toileting. The role of carer usually falls to the females in the immediate family. Sources also indicate, however, that kin

support is not automatically forthcoming and is something which requires negotiation. The level of care often depends on a person's marital, economic, and social status, as well as the severity of illness, and the availability of relatives. Gender is also a factor. An article in *Ageing & Society* states that "the older people who are most vulnerable to inadequate and inappropriate care provision are unmarried women and poor widows" (Eeuwijk, P. 2006, 'Old-age vulnerability, ill-health and care support in urban areas of Indonesia', *Ageing & Society*, vol. 26, issue 1, January – Attachment 1; Kreager, P. & Schröder-Butterfill, E. 2007, 'Gaps in the Family Networks of Older People in Three Indonesian Communities', *Journal of Cross-Cultural Gerontology*, vol.22, no.1, March <http://www.soton.ac.uk/socsci/economics/research/papers/documents/gaps.pdf> – Accessed 20 May 2008 – Attachment 2).

Note: Tanjung Pandan is located on the island of Belitung in the province of Bangka Belitung. Brief information on the people of Belitung and their kinship system is included in this response as Attachment 17 ('Belitung of Indonesia' (undated), Frontiers website <http://www.frontiers.org/Websites/frontiers/Images/profiles/belitung.pdf> – Accessed 26 May 2008 – Attachment 17).

Dr Elisabeth Schröder-Butterfill is a researcher at the Oxford Institute of Ageing where she is involved in comparative research on the elderly in Indonesia. In a 2003 article she describes the various social networks upon which the elderly, especially those without children, are dependent (the information is based on case studies in East Java where the levels of elderly childlessness are high [25 per cent]). Dr Schröder-Butterfill states:

Despite the lack of formal welfare provisions, it is often assumed that the elderly in rural Indonesia are nonetheless protected by social networks. These networks extend beyond the nuclear family and household by encompassing wider kin and community members.

...Contrary to expectation, kin support was not automatically forthcoming but had to be carefully negotiated. Moreover, kin support should not be seen as a distinct type of support, operating somewhere in the space between the family and the community. Rather, kin stand in one of three social relationships to an elderly person – relations of filiation, patronage, charity – which are also found among non-relatives. The quality and acceptability of assistance from kin depends on the relationship in which the arrangement is cast; this in turn is affected by the social and economic status of those involved, and their willingness and ability to invest materially and practically in relationships (Schröder-Butterfill, E. 2003, 'Patterns of Kin and Community Support', *IIAS Newsletter*, no. 32, International Institute for Asian Studies website, November http://www.iias.nl/iiasn/32/Theme_ECI_patterns_of_kin_and_community.pdf – Accessed 22 May 2008 – Attachment 3).

A 2006 journal article in *Ageing & Society* by Peter van Eeuwijk reports a study of the care and support received by chronically ill older people in urban areas of North Sulawesi, Indonesia. Eeuwijk states that "the vulnerability of frail older people is strongly related to the resources, capability and willingness of kin and non-kin to act as care-givers for extended periods. Normative filial piety and kinship obligations are no longer undisputed". He notes that the "majority rely on close family members, most often a wife or a daughter (or both), to provide treatment, care and support". He further states:

The correlates of a frail older person's vulnerability with failing care include not only their socio-demographic characteristics, such as marital status and gender, and their physical and material circumstances, e.g. illness severity and economic position, but also attributes of their

social position like the gender of their closest relatives and social capital. Vulnerability to failure in care and support is therefore a function of a person's personal and social attributes, including their own, their family's and their community's attitudes, practices and modes of behaviour. In urban Indonesia, as elsewhere, the older people who are most vulnerable to inadequate and inappropriate care provision are unmarried women and poor widows. In the social context in which the provision of treatment, care and support for frail older people is the outcome of pragmatic and harsh negotiations (and re-negotiations) among family members and extended kin, as particularly with the Minahasa and Sangihe ethnic groups' bilateral kinship systems, older women occupy a weak bargaining position, particularly the 'adat deviant' such as unmarried women and widows. Given the 'triangle of uncertainty' surrounding old-age support systems in North Sulawesi, Minahasa and Sangihe households are not 'safe havens' for elderly women, for whom good health and access to adequate care and support decreases with increasing age (Eewijk, P. 2006, 'Old-age vulnerability, ill-health and care support in urban areas of Indonesia', *Ageing & Society*, vol. 26, issue 1, January, p. 77 – Attachment 1).

The following sections of the article may also be relevant:

The term 'old-age vulnerability' is understood to refer to the threat of negative outcomes, which include the failure to provide adequate care and support. The consequences can range from increased discomfort to hastened death. Elderly urban Indonesians are particularly vulnerable in this respect if they suffer from one or more chronic illnesses. Analyses of our research data has shown that the level of an ill older person's vulnerability to inadequate care and support in urban North Sulawesi varies by marital status, gender, wealth, social capital and the relationship between the care-giver and the care-recipient.

Marital status

Never-married older people (3% of the sample) were vulnerable to inadequate care because they did not have a spouse, children, children-in-law and grandchildren to provide support. They lacked the entire affinal and filial support network. Never-married women were particularly vulnerable to social exclusion and destitution, because they had not complied with the cultural norms (*adat*) of marriage and raising children. Most ill nevermarried women were in unreliable care situations and depended upon insecure intra-generational kin support and non-kin assistance.

Gender

Elderly women are more vulnerable to inadequate care than elderly men, particularly in bilateral kinship societies in which they have limited power in negotiating the arrangements for their support. They also tend to have relatively few material resources of their own and sparse human capital (e.g. education, information, knowledge). Elderly widows (29%) were most exposed to inadequate care because of their low status in their families and among their spouse's kin (Eewijk, P. 2006, 'Old-age vulnerability, ill-health and care support in urban areas of Indonesia', *Ageing & Society*, vol. 26, issue 1, January, pp. 74-75 – Attachment 1).

2. What does family mean? Does it extend to nieces and nephews?

Indonesia is comprised of hundreds of distinct social groups, each of which has unique traditional laws (*adat*) and patterns of kinship. Sources, including Schröder-Butterfill and Kreager, indicate that in general, the composition of kinship networks beyond nuclear families can often depend on the nature of links established between these network members

over the elder's life course. The likelihood of nieces or nephews caring for an aunt or uncle will depend on the relationship established between these two relatives previously. According to Schröder-Butterfill, in some cases childless elders will adopt a close relative in a reciprocal arrangement of assured old-age care in exchange for inheritance (Schröder-Butterfill, E. 2003, 'Patterns of Kin and Community Support', *IIAS Newsletter*, no. 32, International Institute for Asian Studies website, November http://www.iias.nl/iiasn/32/Theme_ECI_patterns_of_kin_and_community.pdf – Accessed 22 May 2008 – Attachment 3; Marianti, R. 2002, *Surviving Spouses: Support for Widows in Malang, East Java*, PhD thesis, Universiteit van Amsterdam <http://dare.uva.nl/en/record/106171> – Accessed 22 May 2008 – Attachment 4; Kreager, P. & Schröder-Butterfill, E. 2007, 'Gaps in the Family Networks of Older People in Three Indonesian Communities', *Journal of Cross-Cultural Gerontology*, vol.22, no.1, March <http://www.soton.ac.uk/socsci/economics/research/papers/documents/gaps.pdf> – Accessed 20 May 2008 – Attachment 2 Eewijk, P. 2006, 'Old-age vulnerability, ill-health and care support in urban areas of Indonesia', *Ageing & Society*, vol. 26, issue 1, January, p. 64 – Attachment 1).

A 2007 paper by Philip Kreager and Elisabeth Schröder-Butterfill “provides the first comparative analysis of Indonesian older people's actual family networks, drawing on ethnographic and local survey data for three rural communities.” This notes that “it is normal that only a small minority of children and others who in the past have received assistance from an elder will, in turn, provide primary support to them.” The paper states:

It has often been observed that, in any given society, different sub-sets of kin are relevant to different social and economic purposes (Goody, 1972; Bourdieu, 1976; Skinner, 1997). Common examples include sub-sets participating in arranged marriages, distribution of inheritance, and the organisation of labour specific to different tasks. As far as we are aware, however, no comparative methodology has been developed specifically for collecting and analysing data on elderly support networks over time. The method proposed here is based on the *kindred*, that is, on all relations by descent and marriage of a given older person, also taking into account neighbours and others where relevant. Genealogical data are supplemented by qualitative and quantitative evidence of transfers of money, property, and services between the specified elder and other members of the kindred over his or her life course. Observation of the three communities has shown that in Indonesia, where there is no norm designating a particular child or other kin member responsible for an older person in late life, considerable heterogeneity is likely to exist in the membership of the sub-set of kin that actually take on the tasks. It is normal that only a small minority of children and others who in the past have received assistance from an elder will, in turn, provide primary support to them.

A kindred may be divided into progressively smaller sets of members, gradually narrowing the focus to the sub-set of primary support for an older person. The widest group of relevant kin may be called the *abstract kindred*, which includes the total range of kin recognised by an elderly person. This reference group is 'abstract' in the sense that very few people have the need, or even the occasion, to compile all of the kin to whom they are related, and can usually do so only after some reflection. The *proximate kindred* is a sub-set of the abstract kindred, composed of those kin with whom an older person has or had important material relations (e.g., giving and/or receiving money, labour, care, education, property etc.). The *immediate kindred*, then, is a sub-set within the proximate kindred on whom an older person expects to depend in frailty or crisis, on whom they are currently relying, or to whom they are currently giving primary support (Kreager, P. & Schröder-Butterfill, E. 2007, 'Gaps in the Family Networks of Older People in Three Indonesian Communities', *Journal of Cross-Cultural Gerontology*, vol.22, no.1, March

<http://www.soton.ac.uk/socsci/economics/research/papers/documents/gaps.pdf> – Accessed 20 May 2008 – Attachment 2).

A number of case studies are described in the paper, giving examples of the different situations and kin networks of various childless elders (Kreager, P. & Schröder-Butterfill, E. 2007, 'Gaps in the Family Networks of Older People in Three Indonesian Communities', *Journal of Cross-Cultural Gerontology*, vol.22, no.1, March

<http://www.soton.ac.uk/socsci/economics/research/papers/documents/gaps.pdf> – Accessed 20 May 2008 – Attachment 2).

A paper on widows in East Java notes that nieces and nephews are not necessarily obliged to support widowed aunts. This information states: "Both in family as well as neighbourly spheres there is differentiation between 'the close' and 'the distant' or between 'the inner' and 'the outer' circle that generally indicates *the quality of relationships*. Those who belong to one's 'close' or 'inner' circle are usually more obliged to support than those who belong to the 'distant' or 'outer' circle." (p. 221) A section on family support safety nets is also included as Chapter 8 (Marianti, R. 2002, *Surviving Spouses: Support for Widows in Malang, East Java*, PhD thesis, Universiteit van Amsterdam <http://dare.uva.nl/en/record/106171> – Accessed 22 May 2008 – Attachment 4).

Peter van Eeuwijk writes that:

In Southeast Asia in the past, it was generally kin who took care of older people with severe ill health, physical and mental disabilities that were associated with functional impairments and the need for healthcare and emotional support (Phillips 2000). Most care and support was provided by younger household and kin members, and the majority of care-givers were women (Leung 2000). Filial piety, kinship obligation, responsibility and respect towards older family members were considered integral to and normative for informal, family- and kin-based care arrangements between the generations (Eeuwijk 2003a). The combination of the progressive 'health transition', new family structures and household forms, more women working outside the home and fewer children, means that the capacity to care for frail older people is becoming increasingly circumscribed (Leung 2000). Children's readiness and ability to provide open-ended care is undergoing change (Keasberry 2002). Commenting on the current situation in Indonesia, Kreager (2003: 12) concluded that 'we should not succumb to the cosy assumption that where there are children, they can be counted upon'. Referring to this very issue, Niehof (1995 : 434) introduced the term 'negotiation' and noted that, particularly in bilateral kinship systems (i.e. where kinship is traced to relatives through both father *and* mother), care and support for older people were not and are not automatically assured or reliable : they have to be negotiated and re-negotiated in every case and from time to time. This applies all the more to extended intensive care (Eeuwijk, P. 2006, 'Old-age vulnerability, ill-health and care support in urban areas of Indonesia', *Ageing & Society*, vol. 26, issue 1, January, p. 64 – Attachment 1)

In contrast to bilateral kinship systems, Kreager and Schröder-Butterfill use the example of the matrilineal Minangkabau in Sumatra, noting that in this culture "sisters' sons and daughters are normatively enjoined to assist their maternal kin":

Variation between the communities in the way networks respond to elderly needs may be demonstrated by reference to Rao-Rao in Sumatra, where adoption never occurs – there is no need of it, as the logic of the extended family system ensures that responsibilities for, and rights in, children are shared among members of the same matrilineal *rumah gadang* (ancestral house). Sisters' sons and daughters are normatively enjoined to assist their maternal kin (Indrizal, 2004). Indeed, no terminological distinction is made between a woman's own

children and the children of her sister, both being referred to simply as *anak* (child). Children may refer to their matrilineal aunt as *mandeh ketek* ('small mother', if the aunt is junior to the mother) or *mandeh gadang* ('big mother', if the aunt is senior to the mother), but will in general simply call her *amak* (mother). A woman without children can thus take a positive and respected place in the family as classificatory mother of her sister's children (Kreager, P. & Schröder-Butterfill, E. 2007, 'Gaps in the Family Networks of Older People in Three Indonesian Communities', *Journal of Cross-Cultural Gerontology*, vol.22, no.1, March <http://www.soton.ac.uk/socsci/economics/research/papers/documents/gaps.pdf> – Accessed 20 May 2008 – Attachment 2).

3. What are the chances of an elderly/sick/frail person attending a rehab hospital or aged care facility in Indonesia? How expensive are they? Are they subsidized by the government? Is there a 'medicare' equivalent?

The available information indicates that government subsidised health care is limited in Indonesia. There are aged care homes, both state-funded and privately run, although specific current information as to prices was not found. Sources indicate that there is no medicare equivalent, although civil servants are entitled to state-provided health insurance. Kreager and Schröder-Butterfill write that "the Indonesian parliament recently debated proposals for a comprehensive social insurance system for all Indonesian workers, including old-age pensions and health care." They note that at present no universal state system of minimal old-age support exists. According to Mita Noveria, the current health insurance scheme provided by the government only covers about 13 per cent of elderly males and 4 per cent of elderly females. Eewijk describes the formal welfare services for the aged as "wholly inadequate" (Noveria, M. 2006, 'Challenges of Population Ageing in Indonesia', Paper presented at Conference on Impact of Ageing: A Common Challenge for Europe and Asia, Vienna, 7-9 June <http://www.univie.ac.at/impactofageing/pdf/noveria.pdf> – Accessed 20 May 2008 – Attachment 5; Eewijk, P. 2006, 'Old-age vulnerability, ill-health and care support in urban areas of Indonesia', *Ageing & Society*, vol. 26, issue 1, January – Attachment 1; also see: Kreager, P. & Schröder-Butterfill, E. 2007, 'Gaps in the Family Networks of Older People in Three Indonesian Communities', *Journal of Cross-Cultural Gerontology*, vol.22, no.1, March <http://www.soton.ac.uk/socsci/economics/research/papers/documents/gaps.pdf> – Accessed 20 May 2008 – Attachment 2).

According to a 2007 paper on the United Nations Population Fund (UNFPA) website, geriatric services are mostly centred in the main hospitals in capital cities of provinces especially those that have age-structured populations in the majority of major cities in Java, Sumatra and Sulawesi. The province of Bangka Belitung (where Tanjung Pandan is located) has a relatively small elderly population and little information was found on the provision of aged care health services or elderly homes. Information in this response is taken from other areas in Indonesia (Abikusno, N. 2007, *Older Population in Indonesia: Trends, Issues and Policy Responses*, Papers in Population Ageing, no. 3, UNFPA Indonesia website http://indonesia.unfpa.org/docs%20and%20reports/bkageing_indo.pdf – Accessed 22 May 2008 – Attachment 6).

Aged care homes

The UNFPA paper includes a table of care homes by province. Bangka Belitung is not included in this table. This information indicates that most elderly homes are privately run. The paper states:

A small fraction of older persons reside in care homes. However, with declining family size coupled with globalization and migration, the need for care homes is increasing. Most of the care homes are managed by the private sector. Table 20 shows that in almost all the provinces in Indonesia (which together account for a majority of older persons), care homes for the elderly are managed by the private sector, including community and social organizations, with the highest percentage in West Java (89) and the lowest percentage in South Sulawesi (33). Bali is the only exception, where all are managed by central government agencies (Abikusno, N. 2007, *Older Population in Indonesia: Trends, Issues and Policy Responses*, Papers in Population Ageing, no. 3, UNFPA Indonesia website, p. 24 http://indonesia.unfpa.org/docs%20and%20reports/bkageing_indo.pdf – Accessed 22 May 2008 – Attachment 6).

According to a 2002 study by Dr Marianti, “in many cases the right to reside in aged care homes (*panti jompo* or *panti wredha*) is based on a recommendation from the regional social affairs office (*dinas sosial daerah*). Nevertheless, there are a few private elderly homes with monthly payment for the services.” She goes on to state that the monthly payment ranges from Rp. 50,000 to Rp. 500, 000 (Marianti, R. 2002, *Surviving Spouses: Support for Widows in Malang, East Java*, PhD thesis, Universiteit van Amsterdam <http://dare.uva.nl/en/record/106171> – Accessed 22 May 2008 – Attachment 4).

A 2006 paper includes the following information on state-run institutional homes and notes that there is an insufficient number of government homes to house the needy elderly:

The Department of Social Welfare supports the elderly in the form of provision of care whether in institutional homes or non-institutional homes. The first means to support the aged who are neglected for many reasons, mainly because of the unavailability of family or relatives to care for them or although available, too poor to do so. In this scheme, the aged are placed in institutional homes established by the government and enjoy several activities such as mental and social guidance, health care, religious activities, skilled guidance in spending leisure time and recreation activities (State Ministry of Transmigration and Population, Republic of Indonesia and UNFPA 2000). Notwithstanding that placing the elderly in institutional homes is not widely acceptable among Indonesians because they place the aged in highly respected position, in some cases they have to do so since they are not able to provide support for the needs of the elderly. Therefore, it is understandable if many institutional homes are found all over the country. By 1997 there were 46 government owned institutional homes that accommodated 3,597 elderly (Department of Social Welfare 1999) and in fact, are insufficient to house the needy elderly (Noveria, M. 2006, ‘Challenges of Population Ageing in Indonesia’, Paper presented at Conference on Impact of Ageing: A Common Challenge for Europe and Asia, Vienna, 7-9 June <http://www.univie.ac.at/impactofageing/pdf/noveria.pdf> – Accessed 20 May 2008 – Attachment 5).

The paper also includes the following information on privately run institutional homes, which, it states, “apply higher charges than government owned institutional homes”:

Private institutions play an important role in elderly support through the establishment of institutional homes for the aged. The homes established by the government in fact are insufficient for the needs of the elderly. The institutions apply higher charges than government owned institutional homes, as they offer more ‘luxurious’ services. Some private institutional homes offer rooms with air conditioning. This possibly meets the needs of the aged who ask for better facilities and services, for example, the elderly of well-off families who refuse to live with their offspring (Noveria, M. 2006, ‘Challenges of Population Ageing in Indonesia’, Paper presented at Conference on Impact of Ageing: A Common Challenge for

Europe and Asia, Vienna, 7-9 June <http://www.univie.ac.at/impactofageing/pdf/noveria.pdf> – Accessed 20 May 2008 – Attachment 5).

According to information from the Indonesian government representative at a July 2007 UNESCAP seminar on ageing, the Department of Social Welfare is implementing a nursing home social welfare programme as part of the National Plan of Action for the Aged. The relevant extract follows:

Social support through Tresna Werdha (love your elderly) social nursing home is focused on neglected elderly 60 years and above who do not have family or family do not or can not support them. This includes frail elderly multiple degenerative disease.

Social support given to elderly is through Tresna Werdha (TW) that fulfils their daily needs such as food, clothing, health maintenance, pastime including recreation, social, mental and religious guidance so that they can live the rest of their life in peace both physically and mentally.

TW is an institute that substitutes the role of the family who can not take care of elderly. There are 8 functions of the family accommodated by TW namely religion, social cultural, love and affection, protection, interaction, economics and environmental protection.

Main activities of TW are :

- a). Mental and social guidance
- b). Health services.
- c). Religious activities.
- d). Developing skills to fill pastime, and
- e). Recreation.

TW is a technical unit under Social Affairs. Every TW will be developed into a social welfare institute that fulfils standard nursing home requirements. Besides government TW, the community is encouraged to establish TW through :

- a). Social organization.
- b). Social welfare organization, and
- c). Community members interested in elderly welfare.

According to the 1974 law number 6 on Social Welfare major principles, the government provides great opportunity for the community to participate in social welfare activities, specifically elderly social welfare through TW activities.

Elderly placement in TW is only the last resort taken by the family. There are many initiatives that could be taken by the family to fulfil elderly social welfare, other than TW placement.

In an effort to increase elderly quality of life, besides the TW policy, there are also other policies related to elderly social welfare. This policy is known as elderly social welfare program, objectives are to increase elderly quality of life through maintenance and increase of social welfare level as well as institutionalizing social welfare for elderly (Wibowo, S. 2007, 'Indonesia Country Statement on Government Policies and Programmes on Population Ageing', Paper presented at the Seminar on the Social, Health and Economic Consequences of Population Ageing in the Context of Changing Families, 25-27 July, UNESCAP website, 25 July http://www.unescap.org/esid/psis/meetings/Ageing_Change_Family/Indonesia.pdf – Accessed 22 May 2008 – Attachment 7).

No further information on “Tresna Werdha” was found.

Social health insurance

The above mentioned June 2006 paper by Mita Noveria provides the following information on health insurance:

the majority of elderly Indonesians are not covered by health insurance, it is their (and their family's) responsibility to provide the budget for health services. Of the whole Indonesian population, it is only slightly more than 10 per cent, including the elderly, who are covered by health insurance programs (7 per cent are government officials and army officers and their nuclear family members under the management of PT Askes; 1.3 per cent are formal private sector employees which is managed by PT Jamsostek, a government owned company; and 1.8 per cent are those who benefit from government special scheme health insurance for poor people under the social safety net (SSN) program (Arifianto 2004). The remainder have to be self reliant in obtaining health service resources.

Among those who are not under any health insurance scheme, particularly the poor and destitute elderly, provision of resources for health services is extremely hard. This is because higher expenditure is needed since they require more specialized health care. Furthermore, no discount is given to the aged for health services (Abikusno 2001) which worsens the situation, especially among those who require regular (e.g. monthly) medical examinations because of some particular disease such as blood circulatory or heart disorders. The cost of health services brings about higher burdens for the elderly and their families. It is not rare to find that they cannot afford health services and wait for charity from others or institutions that pay special attention to care for the elderly (Noveria, M. 2006, 'Challenges of Population Ageing in Indonesia', Paper presented at Conference on Impact of Ageing: A Common Challenge for Europe and Asia, Vienna, 7-9 June <http://www.univie.ac.at/impactofageing/pdf/noveria.pdf> – Accessed 20 May 2008 – Attachment 5).

A 2004 paper on the International Labour Office (ILO) website states that “60 per cent of the Indonesian population is excluded from social health protection and a large part of total health care costs is financed by out-of-pocket payments.” The paper states that the Indonesian government is “introducing a national social health insurance scheme. The new scheme intends to achieve universal coverage within a timeframe of 20 to 30 years.” The paper states the following in relation to private expenditure on health:

Surveys carried out in these districts provide evidence that user fees lead to a complete exclusion of the poor from any formal medical care (World Bank, 1995) and constitute a problem of equity. Particularly, exclusion from inpatient care is due to high financial barriers. The poorest 10 per cent of the population spend 2.3 times their total monthly household expenditure on standard inpatient care; the upper income class (Thabrany, 2003, P.39) spends about the equivalent of one month's household expenditure on standard inpatient care (Scheil-Adlung, X. 2004, 'Sharpening the Focus on the Poor: Policy Options for Advancing Social Health Protection in Indonesia', *Extension of Social Security Paper*, no. 19, International Labour Office website <http://www3.ilo.org/public/english/protection/secsoc/reports/703sp1.pdf> – Accessed 20 May 2008 – Attachment 8).

Chapter 7 of *Surviving Spouses: Support for Widows in Malang, East Java* provides details of 'state organised support' in the form of pensions and health insurance (Marianti, R. 2002, *Surviving Spouses: Support for Widows in Malang, East Java*, PhD thesis, Universiteit van Amsterdam <http://dare.uva.nl/en/record/106171> – Accessed 22 May 2008 – Attachment 4).

See also Question 5 for more information on the government and health services.

4. What are the subsistence wage and the average wage in Indonesia/ Tanjung Pandan?

The Indonesia Matters website sets out the minimum monthly wage for 2008 for most areas in Indonesia. According to this information, the minimum monthly wage in Bangka Belitung (where Tanjung Pandan is located) is IDR 813,000 ('Current Minimum Wage' 2008, Indonesia Matters website, 19 January <http://www.indonesiamatters.com/1509/minimum-wage/> – Accessed 21 May 2008 – Attachment 9).

Regarding subsistence wages, a 2006 ILO paper states: "One major feature of the minimum wage policy in Indonesia is that it corresponds to minimum living needs, which cover food, fuel, housing, clothing, transport and other needs." According to this information, "[t]he living wage rate measures the hourly pay rate full-time workers would need to earn enough to support a family of four at an acceptable minimum living standard for the country." The Indonesia Matters website also notes that "[o]n average minimum monthly wage rates have risen about 10% on 2007, and cover about 90% of estimated average living costs" (Saget, C. 2006, 'Wage fixing in the informal economy: Evidence from Brazil, India, Indonesia and South Africa', *Conditions of Work and Employment Series*, no. 16, International Labour Office website <http://www.ilo.org/public/english/protection/condtrav/pdf/16cws.pdf> – Accessed 21 May 2008 – Attachment 10; 'Current Minimum Wage' 2008, Indonesia Matters website, 19 January <http://www.indonesiamatters.com/1509/minimum-wage/> – Accessed 21 May 2008 – Attachment 9).

The following information on minimum wage fixing may also be relevant:

Minimum wages in Indonesia are set by the governor of each of the 30 provinces for their respective province. In addition to the provincial minimum wage, seven provinces also fix minimum wages at the regency or city level, which must be higher than the provincial minimum wage. There are about 100 such regency/city minimum wages. Finally, in some provinces, there are separate minimum wages by sectors, which are fixed by collective agreement. Provincial and regency/city minimum wages are reviewed on a yearly basis. (Saget, C. 2006, 'Wage fixing in the informal economy: Evidence from Brazil, India, Indonesia and South Africa', *Conditions of Work and Employment Series*, no. 16, International Labour Office website, pp. 11-12 <http://www.ilo.org/public/english/protection/condtrav/pdf/16cws.pdf> – Accessed 21 May 2008 – Attachment 10).

According to the XE Currency Converter website, IDR 50,000 equals around AUD \$5-6 at the current exchange rate. See <http://www.xe.com/ucc/> (Accessed 20 May 2008).

5. Does the Indonesian government target the provision of health for the elderly, expecting that their families should take care of them, or is it just that the government does not have enough money for the care of all Indonesians?

A number of sources were located which agree that there has been a relatively low commitment by government towards aged care despite the significant increase in aged population. Care of the frail and/or ill is largely left to families, communities and charity. As noted above, there is limited public expenditure on health, and that which there is, as well as most international funding, rarely targets the aged. Thabrany suggests that the government is unable to provide the minimum essential health services to all 220 million citizens. Abikusno writes that "the Government's view tends to be that older persons are not productive, that

they are a burden, and hence they are not given special attention in the budget” (Abikusno, N. 2007, *Older Population in Indonesia: Trends, Issues and Policy Responses*, Papers in Population Ageing, no. 3, UNFPA Indonesia website http://indonesia.unfpa.org/docs%20and%20reports/bkageing_indo.pdf – Accessed 22 May 2008 – Attachment 6; Kreager, P. & Schröder-Butterfill, E. 2007, ‘Gaps in the Family Networks of Older People in Three Indonesian Communities’, *Journal of Cross-Cultural Gerontology*, vol.22, no.1, March <http://www.soton.ac.uk/socsci/economics/research/papers/documents/gaps.pdf> – Accessed 20 May 2008 – Attachment 2; Thabrany, H. 2006, ‘Human Resources in Decentralized Health Systems in Indonesia: Challenges for Equity’, *Regional Health Forum*, vol. 10, no. 1 http://www.searo.who.int/LinkFiles/Regional_Health_Forum_Volume_10_No_1_08-Human_Resources_in_Decentralized_Health_Systems.pdf – Accessed 22 May 2008 – Attachment 12).

Kreager and Schröder-Butterfill states:

The Indonesian parliament recently debated proposals for a comprehensive social insurance system for all Indonesian workers, including old-age pensions and health care (Hari, 2004; Lloyd-Sherlock & Schröder-Butterfill, 2004; Task Force for Social Security Reform, 2004). At present no universal state system of minimal old-age support exists. The newly-passed bill envisages a step-wise extension of security coverage to all workers and their families, including those in the informal sector, by about 2025. In the interim, family and community support are assumed to provide adequate protection, although the potential of fertility decline and ‘modernisation’ to undermine informal systems of support is acknowledged (e.g., Gough, 2001: 183f.; Hugo, 2000; Tambunan & Purwoko, 2002: 38f.). The new law has already aroused controversy: in the view of critics, the plans are fiscally unsustainable and administratively impossible (International Labour Organisation 2003; Arifianto 2004) (Kreager, P. & Schröder-Butterfill, E. 2007, ‘Gaps in the Family Networks of Older People in Three Indonesian Communities’, *Journal of Cross-Cultural Gerontology*, vol.22, no.1, March <http://www.soton.ac.uk/socsci/economics/research/papers/documents/gaps.pdf> – Accessed 20 May 2008 – Attachment 2).

In relation to government and societal attitudes to the aged, the UNFPA paper states:

(a) Attitude of the government

The Government’s view tends to be that older persons are not productive, that they are a burden, and hence they are not given special attention in the budget. Regional autonomy is also a major obstacle because Central government agencies where Ageing policy and programmes have been initiated can no longer directly instruct officials at a lower tier especially District/City levels.

...(b) General attitude

“What is the use of taking care of older persons? They have only a short life to live!” This attitude reflects the prevailing negative image of ageing that the general public has on older persons that are considered as frail, sick and demented (Abikusno, N. 2007, *Older Population in Indonesia: Trends, Issues and Policy Responses*, Papers in Population Ageing, no. 3, UNFPA Indonesia website, p. 38 http://indonesia.unfpa.org/docs%20and%20reports/bkageing_indo.pdf – Accessed 22 May 2008 – Attachment 6).

General health information

According to World Health Organization (WHO) information, private health care expenditure accounts for about two thirds of total health spending, with public expenditure accounting for one third. About 10% of public health expenditure goes towards social security expenditure on health (World Health Organization 2007, *Indonesia – National Health System Profile*, last updated 6 August, p. 6 http://www.searo.who.int/LinkFiles/Indonesia_CHP-Indonesia.pdf – Accessed 21 May 2008 – Attachment 11).

A 2006 paper on the health system in Indonesia notes that mobilizing the resources to provide the minimum essential health services to all 220 million citizens of Indonesia would be a massive task (Thabrany, H. 2006, 'Human Resources in Decentralized Health Systems in Indonesia: Challenges for Equity', *Regional Health Forum*, vol. 10, no. 1, p. 78 http://www.searo.who.int/LinkFiles/Regional_Health_Forum_Volume_10_No_1_08-Human_Resources_in_Decentralized_Health_Systems.pdf – Accessed 22 May 2008 – Attachment 12).

A 2004 paper states “The situation has aggravated over the last years, since even a modest level of public health spending could not be maintained in real terms. As a result, health indicators range significantly behind the neighboring ASEAN countries and have been stagnating over the past decades.” The paper further states:

economic developments indicate that financing of social health protection will pose a serious problem in the future; even macroeconomic stability and moderate growth might not be enough for increasing public spending in the field of health protection (Scheil-Adlung, X. 2004, 'Sharpening the Focus on the Poor: Policy Options for Advancing Social Health Protection in Indonesia', *Extension of Social Security Paper*, no. 19, International Labour Office website <http://www3.ilo.org/public/english/protection/secsoc/reports/703sp1.pdf> – Accessed 20 May 2008 – Attachment 8).

State and private initiatives in aged care

The UNFPA November 2007 paper notes that policies and programs in Ageing have been established by the Indonesian government; however, implementation varies from province to province due to the current regional autonomy policy. The government is promoting home care programs which are more cost effective than nursing homes and cover a wider range of elderly. In a July 2007 paper presented to a UNESCAP seminar on ageing, the Indonesian government outlines its policies and programmes on population ageing (Abikusno, N. 2007, *Older Population in Indonesia: Trends, Issues and Policy Responses*, Papers in Population Ageing, no. 3, UNFPA Indonesia website, p. xv http://indonesia.unfpa.org/docs%20and%20reports/bkageing_indo.pdf – Accessed 22 May 2008 – Attachment 6; Wibowo, S. 2007, 'Indonesia Country Statement on Government Policies and Programmes on Population Ageing', Paper presented at the Seminar on the Social, Health and Economic Consequences of Population Ageing in the Context of Changing Families, 25-27 July, UNESCAP website, 25 July http://www.unescap.org/esid/psis/meetings/Ageing_Change_Family/Indonesia.pdf – Accessed 22 May 2008 – Attachment 7).

A January 2008 newsletter on the HelpAge International website provides details of recent initiatives and social policies in relation to aged care in Indonesia and other Asia Pacific countries (*AgeNews Asia/Pacific* 2008, issue 8, HelpAge International website, January http://www.helpage.org/Resources/Regionalnewsletters/AgeNewsAsiaPacific/main_content/AKbE/AgeNewsAsiaPacific-Jan08.pdf – Accessed 22 May 2008 – Attachment 13).

6. Is there access to pharmaceuticals for the average person in Indonesia?

According to the latest available data from WHO, 52.2 per cent of Indonesia's population have access to affordable essential drugs on a sustainable basis (World Health Organization 2007, *Indonesia – National Health System Profile*, last updated 6 August, p. 20 http://www.searo.who.int/LinkFiles/Indonesia_CHP-Indonesia.pdf – Accessed 21 May 2008 – Attachment 11).

Peter van Eeuwijk writes that “access to professional health support, including much-needed medication, physiotherapy, check-ups or specialist diet, is denied to [poor] older people because of their lack of financial means” (Eeuwijk, P. 2006, ‘Old-age vulnerability, ill-health and care support in urban areas of Indonesia’, *Ageing & Society*, vol. 26, issue 1, January, p. 75 – Attachment 1).

Indonesia's report for the October 2007 High-level Meeting on the Regional Review of the Madrid International Plan of Action on Ageing (MIPAA) states that there is “free medication for those 80 years and above” (Government of Indonesia 2007, ‘Indonesia Country Report’, paper prepared for the High-level Meeting on the Regional Review of the Madrid International Plan of Action on Ageing, 9-11 October, UNESCAP website, p. 8 <http://www.unescap.org/esid/psis/meetings/AgeingMipaa2007/Indonesia.pdf> – Accessed 21 May 2008 – Attachment 14).

WHO also states that:

Accessibility of medicines in Indonesia is through pharmaceutical wholesalers and dispensaries. From 1998 to 2002, the number of pharmaceutical wholesalers was continuously increasing. In addition, the number of dispensaries also increased from 5,471 units in 1998 to 7,139 units in 2002 (Statistical Yearbook of Indonesia 2003) (World Health Organization 2007, *Indonesia – National Health System Profile*, last updated 6 August, pp. 6-7 http://www.searo.who.int/LinkFiles/Indonesia_CHP-Indonesia.pdf – Accessed 21 May 2008 – Attachment 11).

- 7. What rent would get an elderly/sick/frail person a two bedroom place in Tanjung Pandan?**
8. How much would such a person have to spend on food a month?

Rent and food expenditure was not found in a search of the available information. See Question 4 for information on minimum living amounts in Indonesia.

9. What is the cost of the return flight from Jakarta to Tanjung Pandan?

According to Sriwijaya Airline website, a flight between Jakarta and Tanjungpandan would cost IDR 135,000 to IDR 560,000 each way (Jakarta to Tanjungpandan flight price, Sriwijaya Air website <http://www.sriwijayaair-online.com/> – Accessed 23 May 2008 – Attachment 16).

10. If an elderly/sick/frail person is in a wheelchair, are those airports friendly to wheelchairs (ramps etc).

According to the airport guide found on the Travelmedicus website, the Soekarno-Hatta Jakarta Airport has toilets and a lift for disabled passengers. Wheelchairs are also available on request ('Airport Guide' (undated), Travelmedicus website

<http://www.travelmedicus.com/english/airportguide/index.html#000000977712c5dbc> – Accessed 21 May 2008 – Attachment 15).

No information was found on wheelchair accessibility at Buluh Tumbang Airport in Tanjung Pandan.

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Immigration & Refugee Board of Canada http://www.irb-cisr.gc.ca/en/index_e.htm

UK Home Office <http://www.homeoffice.gov.uk/>

US Department of State <http://www.state.gov/>

United Nations (UN)

UNHCR <http://www.unhcr.ch/>

Non-Government Organisations

Amnesty International <http://www.amnesty.org/>

Freedom House <http://www.freedomhouse.org/>

Human Rights Watch <http://www.hrw.org/>

International News & Politics

BBC News <http://news.bbc.co.uk/>

Region Specific Links

Indonesia Matters <http://www.indonesiamatters.com/>

Topic Specific Links

HelpAge International <http://www.helpage.org>

World Health Organization <http://www.who.int>

XE Currency Converter <http://www.xe.com/ucc/>

Search Engines

Google <http://www.google.com.au/>

Databases:

FACTIVA (news database)

BACIS (DIAC Country Information database)

REFINFO (IRBDC (Canada) Country Information database)

ISYS (RRT Research & Information Services database, including Amnesty International, Human Rights Watch, US Department of State Reports)

RRT Library Catalogue

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<http://www.indonesiamatters.com/1509/minimum-wage/> – Accessed 21 May 2008.
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<http://www.ilo.org/public/english/protection/condtrav/pdf/16cws.pdf> – Accessed 21 May 2008.
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