Indonesia

Home to the eighth largest population of older persons in the world, long history of government coordinated solutions.

Long History of Government Programs

In the past few years, public policy towards the elderly has become an emerging policy issue for Indonesia. With one-third of all Indonesians predicted to be elderly (i.e. aged 60 years or older) in the year 2050, millions of citizens are vulnerable to old age poverty, since many of them will have little extra income (e.g. from savings or pension) to finance their livelihood in old age. At the same time, they will no longer be able to depend exclusively on assistance from their children/other family members as in the past, since the birth rate is declining and family relations are becoming more strained due to continued modernization and social change occuring in the country.

For more than three decades, Indonesia has made significant progress in its economic and human development. This has resulted in better health conditions for Indonesians and longer life expectancy. The country's life expectancy has increased dramatically during the last three decades, from 45 in 1970 to 66 in 2004. Consequently, the number of Indonesians aged 60 years and older has increased from 4.48% of the population in 1971 to 7.97% of the population in 2000, according the Asia Development Bank.

Existing government programmes for the elderly are limited in terms of funds and resources, rather sectoral, centralized and target oriented. They focus mainly on the poor elderly with specific problems, in particularly those who are neglected with or without families. Such programmes treat the elderly as if their needs and concerns are the same, based on standardized and centralized guidelines for implementation that do not respond to the diverse and changing needs of the elderly population.

With a real partnership among all stakeholders, along with a firm political will to improve the living standards of all elderly Indonesians and a credible mechanism to ensure that all stakeholders follow through with the above commitments, it is hoped that Indonesia can successfully develop a comprehensive aging policy that is able to effectively and sustainably improve the welfare of all elderly Indonesians, both now and in the future.

Ministry of Social Affairs Programs

Traditionally, the elderly have been taken care of by their relatives, with three to four generations of a family living together. However, there is a now a trend towards “nuclear families”, with young couples moving away in search of better jobs. Such change is “very natural”, Nuryana says, but leaves the elderly living on their own.

But now the Ministry of Social Affairs in Indonesia are creating a policy and programme to address long term loneliness and social isolation of this group of older people”, he says. The state and local governments already run a service sending social workers to provide residential care. But this kind of last resort for them is very expensive. It costs the government at least 18 million rupiah (US$1,348) annually to provide social services for each elderly. The Ministry also wants to get more people to continue working in their 60s and 70s. This will allow them to be more financially independent as their children move out.

The Ministry’s approach is threefold:

1. **Promotion and protection of the right of older people**

Protect against exploitation, violence and abuse, discrimination Promote Social, Economic and Political Rights

2. **Strengthening family and community**

First safety nets in family, then community , state as the last resort (welfare society model)

3. **Promote the establishment of commission on the older person**

At the regional, national and local level

KEMENTERIAN SOSIAL
REPUBLIK INDONESIA

Source: NATIONAL POLICY ON AGEING IN INDONESIA

Indonesia

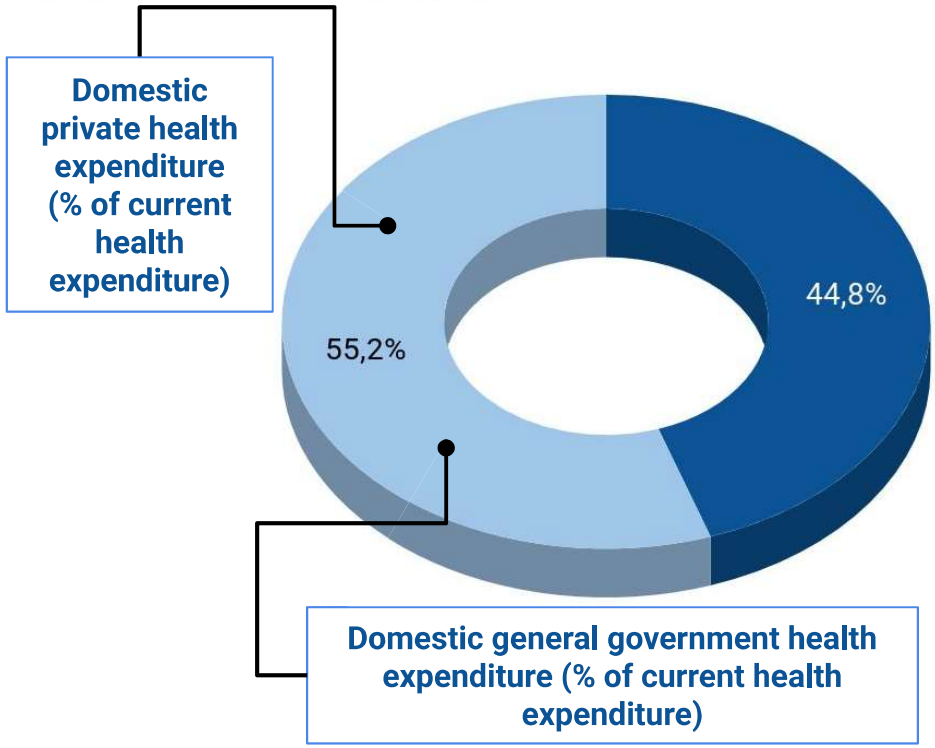
General metrics

HALE	Both Sexes HALE (2016)	61.7 years
	HALE/Life Expectancy Difference 2016	7.49
Economy	GDP per Capita, Current Prices (2016)	3.56 thousand ($)
	Annual GDP Growth (2016)	5 %
Healthcare	Current Health Expenditure per Capita (2016)	0.11 thousand ($)
	Public Health Care Expenditure 2016	3.12 % of GDP
Retirement	Age Dependency Ratio 2016	49
	Population over 65, 2016	5.2 %
	Number of WHO Age Friendly Cities and Communities	0
General Health Status	Alcohol Consumption per Capita (Litres of Pure Alcohol) 2016	0.8
	Annual Cigarette Consumption (Units per Capita) 2016	1675
	Prevalence of Overweight among Adults 2016 (Age-Standardized Estimate)	28.2 % of adults

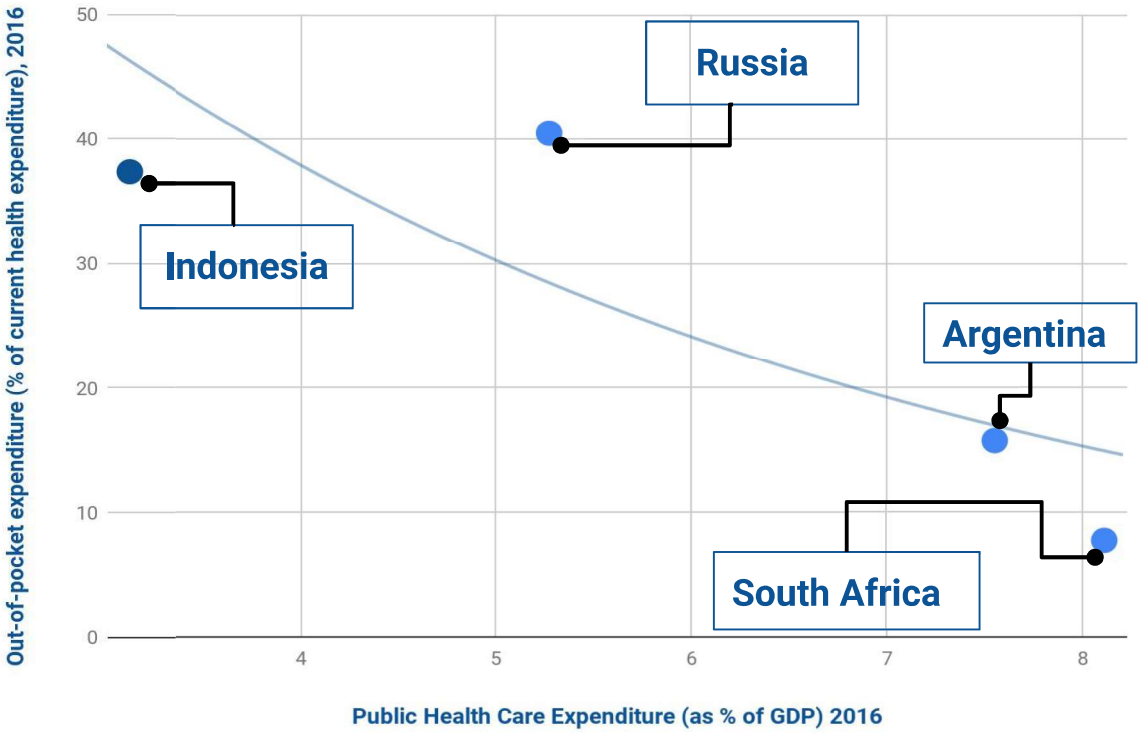
Longevity-Related Indices

- The Healthcare Access and Quality Index -2016: **44**
- Human Development Index 2016: **0.69**
- E-Government Development Index 2016: **0.45**
- Corruption Perceptions Index 2016: **37**
- Global Gender Gap Index 2016: **0.68**
- Democracy Index 2016: **6.97**

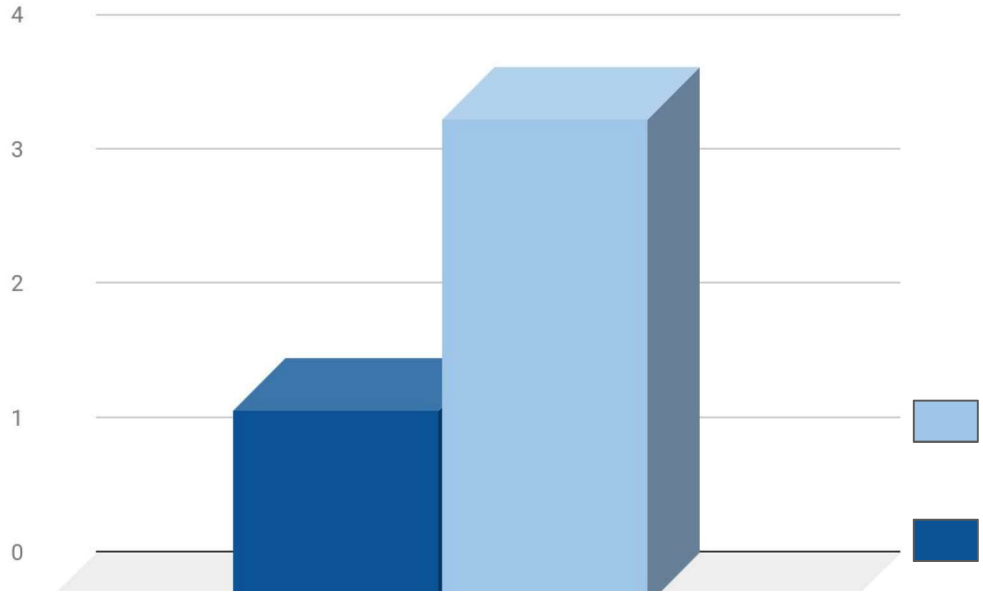
Current Healthcare Expenditure



Countries with Low HALE and Life Expectancy and Low Gap



Effectiveness ratios



There are important regional and socioeconomic inequities in the health system of Indonesia. Health financing also is low and inequitable. Government should concentrate the use of public funds on delivery of public goods and improving equity for priority health outcomes focus on improving health and on managing the whole health system, control the spread of HIV/AIDS by focusing on prevention.

HALE and Life Expectancy Difference CAGR (6 years)/Current health expenditures per capita (current US$), CAGR (6 years)

HALE CAGR (6 years)/Current health expenditures per capita (current US$), CAGR (6 years)

SWOT Analysis of Healthcare in Indonesia

STRENGTHS

- The life expectancy in Indonesia had increased by 25 years for few past decades and it was 70.2 in 2012.
- The coverage for vaccinations for measles is relatively high and is 80%.
- There was also a great decrease in the mortality rate that had fallen from 62 death to 26 death in 2012.
- There was a slight progress in reducing the spread of HIV/AIDS.
- There was a decline in deaths from tuberculosis by more than a half.

WEAKNESSES

- Total spendings on health are 3% of GDP and it is three times less than the OECD average.
- The healthcare spending per capita is $150 that is extremely below the OECD average.
- Only 40% of all healthcare costs are funded publicly that is greatly lower than the OECD average of 72%.
- Cancer and tuberculosis are the second major reasons of premature deaths in Indonesia.
- Risk factors for NCDs, such as high blood pressure, high cholesterol, overweight and smoking, are increasing.

OPPORTUNITIES

- Disease epidemiology patterns in the country have become increasingly complex in recent decades.
- The increasing demand on the health service.
- Development of healthcare tourism
- The Indonesian health system has a mixture of public and private providers and financing.
- Utilizing advanced technologies in healthcare.
- The government can initiate the Longevity plan based on successful experience of developed countries.

THREATS

- There are only 0.3 doctors per 1000 population and 1 nurse per 1000 that is the threatening situation for meeting the healthcare needs of the population.
- There is a very low coverage of vaccination for children against diphtheria, tetanus and pertussis.
- According to the data of the 2016 tobacco smoking is still the major risk factor for the Indonesian people as one fourth of the population reported to smoke daily.
- Stroke is the leading cause of death and it causes 19.2% of death in Indonesia.

Analysis of Strengths and Weaknesses of Health Care System in Indonesia

- There was a significant decrease in maternal mortality from 210 to 168 deaths per 100000 people.
- The life expectancy is growing at relatively high rate of 1.05% per year.
- The regulation for the healthcare is branched out and consists of few institutions for the effective regulation.
- Civil society actively participates in the health sector. Various nongovernmental organizations (NGOs) engage in health-related issues in Indonesia, and play an important role in promoting awareness, preventive measures, fund-raising, policy advocacy and working in 27 partnership with the government on monitoring and evaluation.
- Developed pharmaceutical industry.

- The disability-adjusted years in Indonesia are mainly caused by the dietary risks (11%), high blood pressure (10%) and smoking (9%).
- The causes for years of life lost are mainly cerebrovascular diseases, tuberculosis and road injures.
- Childhood underweight and occupational risks are the main reasons for the death among children up to 5 years old and from 15-49 years old respectively.
- 67.2% of Indonesian has tooth decay.
- Indonesia is ranked among the 10 countries with the highest diabetes and tuberculosis burden.
- 95% of ingredients for pharmaceuticals are imported that can lead to the rise of some of them.
- The access to the healthcare is unequal in different regions and HAQ index is 44.5.
- The high levels of out-of-pocket expenditure impacts access to health services for the poor.

Recommendations for Indonesia

- **Provide wider immunization coverage.** The lack of appropriate vaccinations among children can cause severe problems and spread the broaden epidemics that can lead to the young deaths.
- **Improve engagement of staff in healthcare.** Human resources for health have also grown in the last two decades, with increases in health worker to population ratios. However, the ratio of physician to population is still lower than the WHO-recommended figure, and ongoing geographical disparities exist. There is also a pronounced shortage of nurses and midwives.
- **Expand population coverage.** In response to the high levels of out-of-pocket expenditure and its impact on access to health services by the poor, the Government of Indonesia has to introduce various social insurance programmes for health.
- **Tackle environmental problems.** Bad environmental conditions contribute to poor health and inequality in healthcare status. Indonesia's large cities are prone to pollution, and this can exacerbate existing respiratory conditions like asthma. One of the most significant problems is the fact that tap water in Indonesia is not generally safe to drink.
- **Utilize AI for generating health databases of voluntary self-reported data.** Information on user experience is limited in both the public and private sectors. Requirements for informed consent are regulated but there is no national charter to describe the rights of patients in choice of provider, privacy or information. The ratio of health workers to population has improved over time, but disparities between provinces remain large.
- **Health system re-orientation towards the changing epidemiological landscape**. The increasing burden of noncommunicable diseases highlights the need to move from sick treatment to prevention of chronic conditions. It requires patients' participation and high health consciousness.