

Growing Old in the City

Research >
Indonesia

Indonesia is the fastest-ageing society in Asia. While in Western Europe and North America substantial demographic transformations took place over 100 years, in Indonesia these processes have occurred within just 25 years. The health status of a growing number of Indonesian urban elderly is increasingly being affected by rapid changes of lifestyle and adverse environmental conditions in cities. They perceive chronic illnesses as processes leading to immobility, uncertainty, and helplessness. As HelpAge International (2002: 7) sharply concludes: 'For older people in the developing world, personal health consistently ranks alongside material security as a priority concern.' Our case study shows how the urban elderly are experiencing their chronic illness in times when limited means of social and economic security are becoming gradually more unreliable and insufficient.



Monthly medical check-up for elderly citizens: patiently waiting for blood pressure reading in a health district centre (Tomohon, Minahasa, North Sulawesi, Indonesia).

ther physical and mental complications, ranging from dementia to progressive health deterioration and physical handicap (e.g. diabetes, hypertension). Finally, illnesses classed as 'worrying' are those that show indistinct causes, unclear effects, and an uncertain illness course (e.g. heart problems, lung complaints). In a second round, these categories were then used as guiding questions in the subsequent structured interview where the interviewee assessed the quality of his or her chronic illness and stated the reason for the assessment. Three-quarters of the elderly consider their chronic illnesses as disturbing, but only 50 per cent consider them 'threatening' and 'worrying'. As one elderly man with eye problems put it: 'I feel disturbed when I try to read the newspaper or a book; everything looks blurred. Also when I am walking in the street, I don't feel very safe any more. As a consequence it is difficult for me as head of neighbourhood to fulfil my duties. But at least I am still able to see enough, and therefore why should I feel afraid? After all, these are only the eyes that are shaky ... so, I don't worry about it!'

Urban elderly and the meaning of chronic illness

Interdisciplinary research involving medical anthropology and public health was carried out over a period of three years in three cities in North Sulawesi, namely, Manado, Tahuna, and Tomohon. The locations reflect different degrees of ethnic and religious heterogeneity and varying stages of urbanism. The lower age limit for inclusion in the study was 60 years. This corresponds with the official definition by the Indonesian Department of Health of *orang lansia* (an acronym for *orang lanjut usia*, 'people of advanced age').

Biomedical check-ups revealed that the 'burden of disease' of the urban elderly has actually turned into a 'double burden of disease'. They suffer from both non-communicable (e.g. hypertension, rheumatism, diabetes) and communicable diseases (e.g. acute respiratory infections, malaria, tuberculosis). The most frequently self-reported complaints were rheumatism, eye complaints, diabetes, hypertension, and stomach troubles. Furthermore, respondents complained that physicians disregarded the adverse effects of impaired vision and mobility and of hearing and dental problems on their quality of life.

By means of a first round of semi-structured interviews, in which elderly respondents made general and unspecified statements on their experience and meaning of chronic illnesses, we constructed three comprehensive categories of illness perception. Firstly, there are so-called 'disturbing' illnesses that hinder daily household tasks and most social and economic activities (e.g. rheumatism, eye complaints, asthma). Then there are illnesses perceived as 'threatening' which are related to fur-

current health disturbances to be the result of their advanced age. Rheumatism, eye complaints, and diabetes are clearly attributed to getting older. The afflicted elderly give two main explanations for this connection. On the one hand, their body is 'limp', 'weak', and 'not resistant any longer' and therefore vulnerable towards health hazards that do not harm a young and strong body. A 79-year-old rheumatic widow offers this explanation: 'You know, my old body is weak, my bones are weak, my muscles are weak, my joints are weak – because of this I have rheumatism! I am a very old person, that's why I am suffering from rheumatism.' On the other hand, 20 per cent consider their chronic ill-health to be caused by detrimental behaviour (e.g. smoking, drinking alcohol) and harmful activities and conditions in earlier stages of their life (such as hard physical work and famine). These bad habits and events result in health disturbances that appear in old age and lead to chronic illnesses.

Urban elderly persons' access to biomedical health services and professional health care including long-term care is limited due to monetary and psychological costs, transport difficulties, and lack of information. Public district health centres, prescription-only drugs sold freely in kiosks, and traditional herbal medicines are their most common therapeutic choice. The urban elderly hope for an increasing commitment on the part of biomedicine to

their persistent chronic illnesses. Their expectations clearly contradict current medical anthropology discourses on ongoing medicalization. <

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Health-related afflictions of the elderly in urban life

Urban life in North Sulawesi bears many health hazards for elderly people. They ascribe the following qualities of affliction to their illness perceptions: a disturbing illness may gradually lead to immobility and inactivity, a threatening illness to insecurity, suffering, and disability, and a worrying illness to uncertainty and helplessness. However, 'urban values' such as mobility, physical activity and ability, mental sharpness, and a degree of individual autonomy are essential requirements to make it in harsh city life. When the above-mentioned 'urban virtues' can no longer be maintained due to health disturbances, elderly people feel that their lives are greatly impaired – and only then do they consider themselves as 'old'. Along with the lack of reliable socio-economic support systems, the bodily and mental afflictions finally lead to a set of wide-ranging hardships that include dependency, poverty, loneliness, and social exclusion. In the minds of elderly respondents the ageing process and illness causality are closely connected. Eighty per cent consider their



Elderly widow (with granddaughter and neighbour) who can't walk properly is guarding the kiosk of her daughter (Tomohon, Minahasa, North Sulawesi, Indonesia).

By Peter van Eeuwijk

Growing numbers of Indonesians are reaching old age. While one would hope that this should lead to an extended lifespan in a healthy state, many elderly are in fact exposed to diseases associated with the ageing process, and their vulnerability increases in line with their age. Important epidemiological transformations in Southeast Asia mean that the health profile is gradually shifting from communicable and acute diseases to non-communicable chronic and progressive ailments, injuries, and mental illnesses.

Urbanization is also progressing rapidly in Southeast Asia. In only two decades, 65 per cent of Southeast Asians are expected to be city dwellers. Urban growth and population ageing are strongly correlated: by 2015 about 50 per cent of the elderly in developing countries will live in urban areas (World Health Organization 1998). This socio-spatial transformation goes hand in hand with rapid lifestyle changes. Most urban elderly face environmental deterioration, declining social and economic support, poverty, and a hostile physical environment. In sum, these changes and conditions have a negative effect on the health of the urban elderly, generally resulting in a low quality of life.

Graeme Hugo (2000: 318) points out that the well-being of elderly Indonesians today is framed by three essential conditions. Firstly, traditional support systems no longer guarantee security for the elderly. Secondly, the Indonesian government does not provide substitute support for the elderly. Finally, the elderly's own resources are insufficient to compensate for inadequacies in familial and state support. This 'triangle of uncertainty' turns into a 'worst case scenario' when the elderly person gets ill or is in need of long-term care. In fact, many elderly Indonesians are ailing: 75 per cent suffer from chronic diseases such as hypertension, arthritis, ulcers, and back pain (Koesoebjono and Sarwono 2003:392). In addition, many are ill with eye and ear impairments and dental problems. Yet, as Boedhi-Darmojo (2002) reveals, a great majority can neither find access to adequate health care nor afford it.