

Chapter 4

Health

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CHAPTER 4

Health



According to Law no. 36 of 2009 on Health, health is the physical, mental, and social condition that supports people's productive life in the social and economic aspects. All people, including older people, have the same right to access safe, high-quality, and affordable health services. High-quality health services will improve one's health status in terms of physical, mental, spiritual, and social aspects.

One of Indonesia's development goals, as stated in the 2020–2024 National Medium-Term Development Plan, is to develop high-quality and competitive human resources supported by healthy, intelligent, innovative, skilled, and strong human resources. All Indonesians, including older people, have the same right to take a part in the development process and reach this goal.

In response to population ageing, the government has developed a special strategy as manifested in *Strategi Nasional (Stranas) Kelanjutan* ('the Concept of National Strategy on Ageing). This document was drafted by Bappenas; to date, it is to be signed by the President as a presidential decree. However, through several forums and interviews, Bappenas has shared the concepts of this policy document with stakeholders. The vision of *Stranas Kelanjutan* is to create societies that ensure the independent, prosperous, and dignified lives of Indonesian older people. Some clauses of this policy draft focus on the well-being of older people, such as livelihood, physical and mental health, social support, etc. (Rendon and Olufemi, n.d.).

The SILANI questionnaire was developed to assess the needs of older people and to support the implementation of *Stranas Kelanjutan*. Since this phone study is

based on SILANI, the basic concept used is quite similar, with some adjustments to COVID-19 pandemic conditions. In this study, health status was measured based on the statements of respondents or proxies. Some questions aiming for the comparison between before and during the pandemic were also adopted in this phone survey.

The questionnaire also included a question on the care need of the respondents for activities of daily living (ADL), such as bathing, toileting, eating, or dressing, and another question about instrumental activities of daily living (IADL), such as shopping or using an automated teller machine (ATM). Respondents were asked if they had



**During the pandemic:
1 amongst 6 respondents
stated that their physical
health had deteriorated
and 1 amongst 8
respondents had an
increased depression
score**

been diagnosed by health professionals for several ill conditions, i.e. high blood pressure, heart disease, diabetes, lung disease, kidney disease, and stroke. The morbidity was compared between before and during the COVID-19 pandemic.

Mental health, specifically depression states, was assessed using the selected five items of the Geriatric Depression Scale (GDS). Then, the depression score derived from this study was compared with the score of the SILANI baseline survey to enable longitudinal analysis. The questionnaire

included a question on physical and/or verbal abuse which the respondents have encountered during the COVID-19 pandemic.

1. Physical Health

Table 4.1 shows the percentage of respondents who answered that their health conditions have deteriorated during the COVID-19 pandemic compared with before the pandemic. Around 16% (95%CI: 14.9%–17.4%) of the total respondents reported that their health condition deteriorated. In terms of the relationship between age and the deterioration of health condition, the older respondents were more likely to answer that their health condition deteriorated during the pandemic ($p < 0.05$, Wilcoxon rank-sum test). Another interesting fact is that the rural respondents were more likely to report that their physical health condition deteriorated than their urban counterparts ($P < 0.05$). No significant difference was found amongst the three study provinces: Bali, DIY, and DKI Jakarta.

Table 4.1 Respondents Who Reported their Health Condition Deteriorated During the Pandemic

Characteristics	Percentage	N
All respondents	16.12	3,430
Sex		
Male	16.20	1,593
Female	16.06	1,837
Age		
60–69 years	14.88	2,231
70–79 years	17.88	906
80 years and older	20.14	293
Living location		
Urban	15.70	3,171
Rural	21.24	259
Province		
Bali	16.26	781
<i>Daerah Istimewa</i> Yogyakarta	15.49	878
DKI Jakarta	16.37	1,771
Respondents' income		
Decreased	20.20	1,842
Same/Increased	11.40	1,588
Caregivers' income		
Respondents who had caregivers	16.99	2,960
Decreased	18.29	1,815
Same/Increased	14.93	1,145

The respondents whose income decreased were significantly more likely to report their health condition deteriorated than those whose income did not decrease ($p < 0.001$). The results indicate that the caregivers' income also affected the self-reported deterioration of the health status of respondents. Those whose caregivers' income decreased were more likely to report that their health conditions deteriorated than their counterparts ($p < 0.05$).

Table 4.2 shows the percentage of respondents who answered that they need support for ADL such as bathing, toileting, eating, or dressing at the time of the interview. The result shows around 8.2% (95%CI: 7.28%–9.14%) answered they needed support. The female respondents were more likely to need support than male respondents ($p < 0.001$). The older respondents were more likely to answer that they need support for ADL ($p < 0.001$, Wilcoxon rank-sum test).

The respondents in urban areas were more likely to answer that they needed support for ADL than those in rural areas even though the statistical difference is marginal ($p = 0.07$). No significant difference was found amongst the three provinces involved in this study. The respondents whose income decreased were significantly less likely to answer that they need ADL support than those whose income did not decrease ($p < 0.001$). Caregivers' income was not significantly related to the care need of the respondents.

Table 4.2 Respondents Who Had Difficulty in Activities of Daily Living (at the Time of the Interview)

Characteristics	Need Support for ADL	
	Percentage	N
All respondents	8.16	3,430
Sex		
Male	6.47	1,593
Female	9.64	1,837
Age		
60–69 years	4.53	2,231
70–79 years	9.82	906
80 years and older	30.72	293
Living location		
Urban	8.42	3,171
Rural	5.02	259
Province		
Bali	8.19	781
<i>Daerah Istimewa</i> Yogyakarta	9.11	878
DKI Jakarta	7.68	1,771

Characteristics	Need Support for ADL	
	Percentage	N
Respondents' income		
Decreased	6.41	1,842
Same/Increased	10.20	1,588
Caregivers' income		
Respondents who had caregivers	8.82	2,960
Decreased	9.09	1,815
Same/Increased	8.38	1,145

Note: *Daily activities such as bathing, toileting, eating, or dressing.

Table 4.3 shows the percentage of the respondents who answered 'no' to the question, 'Can you go shopping by yourself or can you use an ATM by yourself?'. This question was asked to indicate the IADL. About 9.9% (95%CI: 8.97%–11.0%) of all respondents answered that their IADL was impaired. Female respondents were significantly more likely to have impaired IADL than male respondents ($p < 0.001$). Older respondents were significantly more likely to have impaired IADL ($p < 0.001$, Wilcoxon rank-sum test).

No significant difference was detected between urban and rural respondents, as well as amongst the three provinces in this study. The respondents whose income decreased were significantly less likely to have impaired IADL than those whose income did not decrease ($P < 0.001$). The respondents whose caregivers' income decreased were more likely to have impaired IADL than their counterparts ($p < 0.05$).

Table 4.3 Respondents Who Had Difficulty in Instrumental Activities of Daily Living (IADL) (at the Time of the Interview)

Characteristics	Do Not Carry Out IADL Independently*	
	Percentage	N
All respondents	9.94	3,430
Sex		
Male	7.97	1,593
Female	11.65	1,837

Characteristics	Do Not Carry Out IADL Independently*	
	Percentage	N
Age		
60–69 years	4.75	2,231
70–79 years	13.80	906
80 years and older	37.54	293
Living location		
Urban	9.97	3,171
Rural	9.65	259
Province		
Bali	10.63	781
<i>Daerah Istimewa</i> Yogyakarta	10.25	878
DKI Jakarta	9.49	1,771
Respondents' income		
Decreased	8.14	1,842
Same/Increased	12.03	1,588
Caregivers' income		
Respondents who had caregivers	11.01	2,960
Decreased	11.96	1,815
Same/Increased	9.52	1,145

Note: * It means could not shop/use an ATM by themselves.

We defined 'comorbidity score' in this study as the number of respondents' chronic conditions that had been diagnosed by health professionals. We asked them about six chronic conditions: high blood pressure, heart disease, diabetes, lung disease, kidney disease, and stroke. Table 4.4 shows the change of the comorbidity scores from before the pandemic to the time of the interview. About 1.6% (95%CI: 1.2%–2.1%) of the respondents had increased comorbidity scores compared to the pre-pandemic period. However, more respondents' comorbidity scores decreased, and their percentage was about 17% (95%CI: 15.6%–18.1%).

Table 4.4 Comorbidity Score Change from Before the Pandemic

Characteristics	Increased (%)	Decreased (%)	No Change (%)	N
All respondents who answered all morbidity questions	1.60	16.80	81.60	3,424
Sex				
Male	1.30	17.10	81.70	1,592
Female	1.90	16.50	81.60	1,832
Age				
60–69 years	1.80	16.70	81.50	2,231
70–79 years	1.30	16.00	82.60	904
80 years and older	1.00	19.40	79.60	289
Living location				
Urban	1.60	16.70	81.70	3,165
Rural	1.20	17.80	81.10	259
Province				
Bali	1.00	11.60	87.70	781
<i>Daerah Istimewa Yogyakarta</i>	2.30	15.00	82.70	873
DKI Jakarta	1.70	19.90	78.40	1,770
Respondents' income				
Decreased	1.60	16.10	82.20	1,840
Same/Increased	1.60	17.50	80.90	1,584
Caregivers' income				
Respondents who had caregivers	1.50	17.00	81.50	2,954
Decreased	1.20	16.80	82.00	1,810
Same/Increased	2.00	17.30	80.70	1,144

Can this result suggest that the chronic conditions of older people had improved during the pandemic? We would like to suggest another potential reason for this result. For example, limited access to proper health services during the pandemic hindered older people from knowing their real health condition. In this study, the percentage of respondents who had postponed going to health facilities during the pandemic reached 17%. Even looking at the change of morbidity rates of each of the six items, a significant decrease in morbidity rates was detected for all six chronic conditions (Table 4.5).

No significant difference was detected in the percentage of the respondents whose comorbidity scores decreased amongst the three provinces in this study. The income of respondents did not affect the comorbidity scores significantly nor did the caregivers' income.

Table 4.5 Morbidity Rates of Six Chronic Conditions Before and During the Pandemic

Type of Chronic Conditions	Before COVID-19 Pandemic (%)	After COVID-19	N*
High blood pressure	36.33	26.93	3,424
Heart disease	8.53	6.66	
Diabetes	12.79	11.21	
Lung disease	4.32	2.34	
Kidney disease	2.22	1.14	
Stroke	4.50	3.07	

Note: *N is respondents who answered all morbidity questions.

Table 4.6 Practices to Maintain Physical Health During the Pandemic

Characteristics	Follow the Protocol to Prevent COVID-19* (%)	Exercise Outdoors	Exercise Indoors	Eat Balanced Nutrition	Reduce Smoking	Limit Time to Read the News on COVID-19	Do Breathing Exercise, Relaxation, Yoga	Read Book/Holy Book	Watch TV/YouTube	N
All respondents	34.05	53.12	17.96	15.28	0.90	0.12	1.43	3.03	19.18	3,430
Sex										
Male	35.34	60.89	16.26	14.94	1.88	0.19	1.82	2.70	17.89	1,593
Female	32.93	46.38	19.43	15.57	0.05	0.05	1.09	3.32	20.30	1,837
Age										
60–69 years	38.01	57.60	18.33	15.42	0.76	0.13	1.52	2.87	18.96	2,231
70–79 years	30.79	49.89	17.77	15.67	1.32	0.11	1.21	3.09	20.75	906
80 years and older	13.99	29.01	15.70	12.97	0.68	0.00	1.37	4.10	16.04	293
Living location										
Urban	33.68	55.06	17.57	15.74	0.98	0.13	1.45	3.06	19.80	3,171
Rural	38.61	29.34	22.78	9.65	0.00	0.00	1.16	2.70	11.58	259
Province										
Bali	26.38	43.02	22.28	8.58	0.00	0.00	1.92	1.28	8.45	781
DIY	15.03	59.34	11.16	6.61	0.11	0.00	0.80	5.01	26.08	878
DKI Jakarta	46.87	54.49	19.42	22.53	1.69	0.23	1.52	2.82	20.50	1,771
Respondents' Income										
Decrease	36.81	53.09	17.26	14.98	1.36	0.16	1.41	2.82	17.59	1,842
Same/increase	30.86	53.15	18.77	15.62	0.38	0.06	1.45	3.27	21.03	1,588
Caregivers' income										
Respondents who had caregivers	34.73	51.15	18.18	15.74	0.91	0.14	1.52	2.91	16.89	2,960
Decrease	35.65	50.36	17.41	16.36	0.99	0.17	1.10	2.42	16.03	1,815
Same/increase	33.28	52.40	19.39	14.76	0.79	0.09	2.18	3.67	18.25	1,145

Notes: * Stay at home, wear masks, etc.

The respondents were allowed multiple answers.

Table 4.6 (Continued)

Characteristics	Listen to Music (%)	Sing/ Play Musical Instrument	Express Uncomfortable Feeling and Thoughts to Others	Keep an Active Lifestyle in Daily Lives*	Sunbathe	Sleep Regularly/ Sufficiently	Take Vitamins/ Supplements/ Spices/Herbs	None	Other	N
All respondents	1.92	0.5	2.1	56.27	55.69	15.51	0.87	1.08	0.9	3,430
Sex										
Male	2.45	0.75	1.57	51.1	50.97	15.82	0.69	0.88	1.07	1,593
Female	1.47	0.27	2.56	60.75	59.77	15.24	1.03	1.25	0.76	1,837
Age										
60–69 years	1.93	0.67	2.2	58.14	55.4	15.37	0.9	0.4	0.81	2,231
70–79 years	1.88	0.22	2.32	55.19	57.28	15.78	0.88	1.32	1.21	906
80 years and older	2.05	0	0.68	45.39	52.9	15.7	0.68	5.46	0.68	293
Living location										
Urban	1.86	0.5	2.18	54.71	57.43	16.62	0.85	1.14	0.95	3,171
Rural	2.7	0.39	1.16	75.29	34.36	1.93	1.16	0.39	0.39	259
Province										
Bali	2.3	0.26	0.51	60.56	33.93	6.91	1.02	2.05	0.51	781
DIY	3.19	0.8	1.25	62.98	48.86	3.87	0	1.71	0	878
DKI Jakarta	1.13	0.45	3.22	51.04	68.66	25.07	1.24	0.34	1.52	1,771
Respondents' Income										
Decrease	1.95	0.6	2.39	56.13	55.7	16.4	0.92	0.76	0.81	1,842
Same/increase	1.89	0.38	1.76	56.42	55.67	14.48	0.82	1.45	1.01	1,588
Caregivers' income										
Respondents who had caregivers	1.82	0.54	2.2	54.49	58.24	16.82	0.88	1.15	0.95	2,960
Decrease	1.82	0.5	1.93	54.77	58.07	16.75	0.83	0.99	0.66	1,815
Same/increase	1.83	0.61	2.62	54.06	58.52	16.94	0.96	1.4	1.4	1,145

Note: * Sweep and mop the floor, clean the house, go to the rice field, etc.

The campaign to combat the COVID-19 pandemic urges people, including older people, to change behaviour into a more hygienic one to prevent transmission. Older people are encouraged to adapt to the 'new normal' habits like complying with health protocols. This requires support from all parties, especially from their families.

Table 4.6 shows the practices of the respondents to maintain their physical health during the pandemic. Almost all respondents stated that they do some practices to maintain their physical health. Only 1.1% (95%CI: 0.77%–1.50%) of the respondents answered that they did not carry out any practices to maintain physical health during the pandemic. More than half of the respondents kept an active lifestyle in their daily lives, sunbathed, and performed outdoor exercises. Thirty-four percent (95%CI: 32.5%–35.6%) of respondents stated they followed the COVID-19 prevention protocol.

The male respondents were significantly more likely to practice outdoor sports activities than females ($p < 0.001$). The female respondents were significantly more likely to be engaged in home chores actively than male respondents ($p < 0.001$). This data suggests that older people continue to carry out routine activities that promote their active lifestyle even during the pandemic.

The older respondents were significantly less likely to follow the protocol to prevent COVID-19 transmission ($p < 0.001$, Wilcoxon rank-sum test). Looking at the differences between those in the rural and urban areas, urban respondents were significantly more likely to exercise outdoors and sunbathe ($p < 0.001$ for both), whilst rural respondents were more likely to have an active lifestyle in their daily lives ($P < 0.001$).

Amongst the three provinces, the respondents in DKI Jakarta were significantly more likely to practice the prevention protocol of COVID-19 and to take balanced nutrition, whilst the Bali respondents were significantly more likely to answer they did not watch TV or YouTube to maintain their physical health during the pandemic.

The Ministry of Health, in its guidelines to maintain the health of older people during the pandemic, encourages people to sleep sufficiently and regularly, and eat balanced nutrition. About 15% of the respondents stated that they practiced these recommendations, but significant inter-provincial differences were found. The respondents in DKI Jakarta were significantly more likely to practice these two recommendations regarding sleep and nutrition.

2. Mental Health

The depressive status of the respondents was assessed using the Geriatric Depression Scale (GDS). The GDS has three versions: the full GDS which has 30 items, and the short forms of 15 items and 5 items. Previous studies in Indonesia mostly used the 15-item GDS (Pramesona and Taneepanichskul, 2018; Wada et al., 2005; Widiatie et al., 2018).

Since this study adopted the phone-survey method to avoid the risk of virus transmission through face-to-face interviews, the time per interview was limited. The study team agreed to use the five-item GDS because this is the most effective way to collect the information related to the depressive status of respondents within the short time available. Though it is the shortest version, the 5-item GDS has been validated as effective as the 15-item GDS to screen depression (Hoyl et al., 1999; Rinaldi et al., 2003). As for the Indonesian version of GDS questions, we referred to the *Petunjuk Teknis Instrumen Pengkajian Paripurna Pasien Geriatri* (Technical Instructions for Plenary Assessment of Geriatric Patients) provided by the Ministry of Health (2017). This document provides the Indonesian translation of each question of the 15-item version of the GDS. The Indonesian translation of the five-item GDS has not been provided by the authorities but its questions consist of selected items from the 15-item GDS questionnaire. We picked up five questions equivalent to the five-item GDS from the Indonesian version of the 15-item GDS.

The five-item GDS encompasses the following factors which are related to depressive status: (i) satisfaction, (ii) boredom, (iii) helplessness, (iv) reluctance to go out of the house, and (v) worthlessness. We defined the depression score in SILANI study as the sum of all items. In this first round telephone survey, however, we excluded the variable {iv} stated above because this question may confuse and tend to create ambiguity in answers during the pandemic when older people are encouraged to stay at home. Table 4.7 shows the change of 4-item depression score which was modified in this survey from the pre-pandemic period to the time of the interview.

The result shows that about 25% (95%CI: 23.0%–26.2%) of the respondents' depression scores increased compared to the pre-pandemic period. No significant difference was found between male and female respondents in terms of the change of depression scores.

Table 4.7 Change of Modified (4-item) Depression Scores from the Pre-pandemic Period

Characteristics	Increased (%)	No Change (%)	N
All respondents who answered the five-item GDS questions both in the SILANI baseline and phone survey by themselves	24.56	51.90	2,867
Sex			
Male	24.30	53.76	1,358
Female	24.78	50.23	1,509
Age			
60–69 years	25.43	52.09	2,029
70–79 years	23.83	50.92	705
80 years and older	15.04	54.14	133
Living location			
Urban	24.45	51.93	2,671
Rural	26.02	51.53	196
Province			
Bali	33.15	50.54	558
<i>Daerah Istimewa Yogyakarta</i>	17.44	63.49	734
DKI Jakarta	24.83	46.98	1,575
Respondents' income			
Decreased	27.88	47.41	1,582
Same/Increased	20.47	57.43	1,285
Caregivers' income			
Respondents who had caregivers	25.35	50.78	2,426
Decreased	27.96	47.36	1,459
Same/Increased	21.41	55.95	967

Oldest-old group of respondents was less likely to increase their modified depression scores during the pandemic compared with before the pandemic ($p < 0.01$). The depressive status of respondents in Bali was significantly more likely to increase their modified depression scores ($p < 0.001$) whilst that of the respondents in DIY was significantly less likely to increase modified depression scores ($p < 0.001$). Respondents whose income decreased or those whose caregivers' income decreased were

significantly more likely to report increased 4-item depression scores during the pandemic ($p < 0.001$).

The Badan Pusat Statistik (BPS) of Indonesia reported the increasing trend of violence against women and abuse of older people during the COVID-19 pandemic (BPS, 2020). Table 4.8 shows that about 1% (95%CI: 0.66%–1.4%) of the respondents self-reported physical and/or verbal abuse during the pandemic. No significant trend of abuse amongst older people by age was detected, nor was there a difference between urban and rural areas. In DIY, no respondents reported abuse during the pandemic.

Table 4.8 Respondents Suffering from Abuse

Characteristics	Percentage	N
All respondents	0.96	3,430
Sex		
Male	1.00	1,593
Female	0.93	1,837
Age		
60–69 years	1.08	2,231
70–79 years	0.88	906
80 years and older	0.34	293
Living location		
Urban	1.01	3,171
Rural	0.39	259
Province		
Bali	0.38	781
Daerah Istimewa Yogyakarta	0.00	878
DKI Jakarta	1.69	1,771
Respondents' income		
Decreased	1.25	1,842
Same/Increased	0.63	1,588
Caregivers' income		
Respondents who had caregivers	0.98	2,960
Decreased	0.83	1,815
Same/Increased	1.22	1,145

Table 4.9 Practices to Maintain Mental Health during the Pandemic (Part 1)

Characteristics	Follow the Protocol to Prevent COVID-19* (%)	Pray	Exercise Outdoors	Exercise Indoors	Do Breathing Exercise, Relaxation, Yoga	Take Balanced Nutrition	Keep an Active Lifestyle Indoors**	Communicate with Friends and Family	Accept Changes	Express Feeling to Others	N
All respondents	17.55	66.85	21.95	6.85	1.25	5.51	34.29	28.66	3.56	4.46	3,430
Sex											
Male	19.02	65.41	26.49	7.78	1.63	5.15	28.44	27.81	4.08	3.89	1,593
Female	16.28	68.10	18.02	6.04	0.93	5.82	39.36	29.40	3.10	4.95	1,837
Age											
60–69 years	19.00	68.67	23.35	7.17	1.43	5.87	35.86	30.79	3.90	4.44	2,231
70–79 years	17.22	64.79	21.96	6.07	1.10	4.86	33.44	25.83	3.20	4.30	906
80 years and older	7.51	59.39	11.26	6.83	0.34	4.78	24.91	21.16	2.05	5.12	293
Living location											
Urban	16.08	66.79	21.79	6.31	1.14	5.55	33.05	29.99	3.69	4.54	3,171
Rural	35.52	67.57	23.94	13.51	2.70	5.02	49.42	12.36	1.93	3.47	259
Province											
Bali	24.33	65.17	29.32	9.86	2.82	3.33	40.72	11.65	1.02	2.30	781
DIY	12.64	72.67	18.91	2.73	0.91	3.87	29.73	18.79	0.34	3.53	878
DKI Jakarta	17.00	64.71	20.21	7.57	0.73	7.28	33.71	41.05	6.27	5.87	1,771
Respondents' Income											
Decrease	19.65	66.99	23.83	7.33	1.09	5.48	35.78	29.75	3.69	4.78	1,842
Same/increase	15.11	66.69	19.77	6.30	1.45	5.54	32.56	27.39	3.40	4.09	1,588
Caregivers' income											
Respondents who had caregivers	17.64	65.54	22.53	7.09	1.22	5.64	36.42	30.41	3.61	4.56	2,960
Decrease	18.68	64.90	23.58	7.38	1.27	6.28	37.08	30.80	3.80	4.90	1,815
Same/increase	15.98	66.55	20.87	6.64	1.14	4.63	35.37	29.78	3.32	4.02	1,145

Notes: * Stay at home, wear masks, etc.

** Sweep and mop the floor, clean the house, go to the rice field, etc.
The respondents were allowed multiple answers.

Table 4.9 (Continued)

Characteristics	Limit Time to Read News about COVID-19 (%)	Read Book/Holy Book	Listen to Music, Watch TV/YouTube, Listen to Preachers	Care for Plants	Maintain Environmental Cleanliness	Spend More Time for Hobby	Keep an Active Lifestyle Outdoors ***	Sunbathe	Walk Outdoors	Others	None	N
All respondents	2.39	27.00	13.03	10.96	6.33	9.48	0.52	0.47	0.15	0.47	2.01	3,430
Sex												
Male	1.95	24.80	13.56	9.60	4.96	11.68	0.88	0.38	0.19	0.38	1.63	1,593
Female	2.78	28.91	12.57	12.14	7.51	7.57	0.22	0.54	0.11	0.54	2.34	1,837
Age												
60–69 years	2.42	27.75	13.49	11.47	6.81	10.04	0.63	0.67	0.04	0.54	1.08	2,231
70–79 years	2.43	26.60	12.47	10.82	6.07	9.27	0.33	0.11	0.22	0.33	2.98	906
80 years and older	2.05	22.53	11.26	7.51	3.41	5.80	0.34	0.00	0.68	0.34	6.14	293
Living location												
Urban	2.40	28.86	13.72	11.16	6.18	9.87	0.57	0.50	0.16	0.50	2.11	3,171
Rural	2.32	4.25	4.63	8.49	8.11	4.63	0.00	0.00	0.00	0.00	0.77	259
Province												
Bali	1.92	5.76	7.68	7.68	6.02	10.12	0.64	0.13	0.38	0.51	3.33	781
DIY	2.05	40.89	7.97	16.17	5.35	6.04	0.00	0.00	0.00	0.34	1.82	878
DKI Jakarta	2.77	29.47	17.90	9.82	6.95	10.90	0.73	0.85	0.11	0.51	1.52	1,771
Respondents' Income												
Decrease	2.17	24.65	13.52	8.31	6.73	9.17	0.81	0.49	0.05	0.33	2.06	1,842
Same/increase	2.64	29.72	12.47	14.04	5.86	9.82	0.19	0.44	0.25	0.63	1.95	1,588
Caregivers' income												
Respondents who had caregivers	2.30	23.75	12.57	10.91	6.11	9.97	0.61	0.44	0.17	0.51	2.23	2,960
Decrease	1.93	19.78	12.18	9.20	5.79	10.41	0.66	0.44	0.17	0.39	2.48	1,815
Same/increase	2.88	30.04	13.19	13.62	6.64	9.26	0.52	0.44	0.17	0.70	1.83	1,145

Note: *** Go to fields, gardens, etc.

Maintaining mental health during the pandemic is challenging because everybody is encouraged to limit in-person contacts to prevent virus transmission and to adopt the 'new normal' behaviours. Table 4.9 shows the practices reported by the respondents to maintain their mental health. Praying was the commonest practice. About 67% (95%CI: 65.2%–68.4%) stated that they pray to maintain their mental health. This was followed by 'keeping an active lifestyle in the house', 'communicating with friends and family/relatives, and 'reading books or the Holy Book'. Only around 2.0% (95%CI: 1.58%–2.55%) of the respondents stated that they did not practice anything to maintain mental health during this pandemic.

The older respondents were significantly less likely to practice the activities to maintain mental health ($p < 0.001$, Wilcoxon rank-sum test) and so do the respondents in Bali. Significantly more urban respondents read books or the Holy Book than rural respondents ($p < 0.001$). Significantly more respondents in DKI Jakarta listen to music or watch TV whilst those in Bali were significantly more likely to do breathing exercises, relaxation, yoga, or meditation even though the practising rate was not so high (2.8%, 95%CI: 1.82%–4.30%).

3. Health Services

Since the COVID-19 pandemic began, people have been strongly encouraged to stay at home, but it may have limited their chances to access health services. Older people tend to have more chronic conditions, and lesser chances for healthcare consultation could undermine their health status. Table 4.10 shows the percentage of respondents who had difficulty accessing health facilities. About 11% (95%CI: 9.77%–12.9%) who needed to go to health facilities at the time of the interview found difficulty in doing so.

The age of respondents was not significantly related to the difficulty in accessing health facilities. Urban respondents were significantly more likely to report that they had difficulty than rural respondents ($p < 0.01$). Likewise, the respondents in DKI Jakarta were significantly more likely to have difficulty in accessing health facilities than those from the other two provinces. Respondents whose income decreased were more likely to have difficulty of access ($p < 0.01$), whilst no significant difference was detected between the respondents whose caregivers' income decreased or did not decrease.

Table 4.10 Respondents Who Had Difficulty Accessing Health Facilities During the Pandemic

Characteristics	Percentage	N*
Respondents who reported that they needed consultation with health facilities	11.12	1,924
Sex		
Male	9.84	874
Female	12.19	1,050
Age		
60–69 years	10.57	1,268
70–79 years	13.26	513
80 years and older	8.39	143
Living location		
Urban	11.86	1,746
Rural	3.93	178
Province		
Bali	6.72	357
DIY	2.16	464
DKI Jakarta	16.32	1,103
Respondents income		
Decrease	13.01	1,022
Same/increase	8.98	902
Caregivers' income		
Respondents who had caregivers	12.14	1,680
Decrease	13.06	1,018
Same/increase	10.73	662

Note: * N is applied to the respondents who needed to go to health facilities.

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The answers of the respondents to the question of why they had difficulty in accessing healthcare facilities are summarised in Table 4.11. About half (45%, 95%CI: 38.6%–52.2%) answered that they were scared of being infected with COVID-19. About a quarter (28%, 95%CI: 21.8%–34.2%) stated that the health facilities were closed or services for older people were unavailable. Other reasons were 'can't afford healthcare services' (8.4%, 95%CI: 5.2%–13.2%), 'no one to accompany me to health facilities' (4.7%, 95%CI: 2.4%–8.7%), 'BPJS was not available' (4.7%, 95%CI: 2.4%–8.7%), etc.

Though the number of rural respondents who reported difficulty accessing healthcare was small, the result showed that rural respondents were significantly more likely to have a financial restriction as a cause of this difficulty than urban respondents ($p < 0.05$, Fisher's exact test). Five respondents whose income decreased reported that they had problems accessing health facilities because they were not members of the BPJS, whilst no respondents whose income did not decrease selected this answer.

Table 4.11 Reason for Difficulty Accessing Health Facilities During the Pandemic

Characteristics	Facilities Closed/Older Patients Not Accepted (%)	Do Not Have BPJS	Do Not Have Money for Services	Do Not Have Money for Transport	No One to Accompany Older Person	Staff Busy re COVID-19	Discrimination against Older People	Worried/ Scared	BPJS Not Available	Long Queue	Limited Capacity of Patients	Others	N*
All respondents	27.57	2.34	8.41	0.93	4.67	4.21	3.74	45.33	4.67	3.74	1.40	1.87	214
Sex													
Male	25.58	2.33	6.98	1.16	4.65	2.33	4.65	39.53	8.14	2.33	2.33	4.65	86
Female	28.91	2.34	9.38	0.78	4.69	5.47	3.13	49.22	2.34	4.69	0.78	0.00	128
Age													
60–69 years	28.36	1.49	8.96	1.49	4.48	3.73	3.73	44.78	3.73	3.73	0.75	2.99	134
70–79 years	27.94	4.41	8.82	0.00	5.88	4.41	2.94	44.12	7.35	4.41	1.47	0.00	68
80 years and older	16.67	0.00	0.00	0.00	0.00	8.33	8.33	58.33	0.00	0.00	8.33	0.00	12
Living location													
Urban	28.50	1.45	7.25	0.48	4.83	4.35	3.86	46.86	4.83	3.86	1.45	1.45	207
Rural	0.00	28.57	42.86	14.29	0.00	0.00	0.00	0.00	0.00	0.00	0.00	14.29	7
Province													
Bali	16.67	8.33	25.00	4.17	0.00	0.00	4.17	45.83	0.00	4.17	0.00	4.17	24
DIY	10.00	0.00	0.00	0.00	0.00	0.00	20.00	10.00	20.00	20.00	20.00	0.00	10
DKI Jakarta	30.00	1.67	6.67	0.56	5.56	5.00	2.78	47.22	4.44	2.78	0.56	1.67	180
Respondents' Income													
Decrease	27.82	3.76	9.02	0.75	6.02	3.76	4.51	41.35	3.76	5.26	2.26	1.50	133
Same/increase	27.16	0.00	7.41	1.23	2.47	4.94	2.47	51.85	6.17	1.23	0.00	2.47	81
Caregivers' income													
Respondents who had caregivers	27.94	2.45	8.82	0.49	4.41	3.92	2.45	46.08	4.90	3.43	1.47	1.96	204
Decrease	27.82	3.01	10.53	0.75	3.76	3.76	2.26	45.11	3.76	3.01	1.50	1.50	133
Same/increase	28.17	1.41	5.63	0.00	5.63	4.23	2.82	47.89	7.04	4.23	1.41	2.82	71

Note: * N is applied to the respondents who have difficulty in accessing health services.

Following the government’s recommendation (Ministry of Health, 2020), about 29% (95%CI: 27.2%–31.2%) of the respondents who needed consultation in health facilities postponed consultation to avoid COVID-19 exposure (Table 4.12). Female respondents were significantly more likely to postpone their consultation in health facilities than males ($p<0.001$).

The respondents in DKI Jakarta were significantly more likely to postpone their consultation in medical facilities than those from the other two provinces ($p<0.001$). That choice was also more likely taken by the respondents whose income decreased ($p<0.01$), whilst caregivers’ income did not affect the delay of their consultation in health facilities significantly.

Table 4.12 Respondents Who Delayed Consultation in Health Facilities During the Pandemic

Characteristics	Percentage	N*
Respondents who needed consultation in health facilities	29.20	2,048
Sex		
Male	24.87	929
Female	32.80	1,119
Age		
60–69 years	29.67	1,318
70–79 years	28.92	567
80 years and older	26.38	163
Living location		
Urban	29.74	1,883
Rural	23.03	165
Province		
Bali	17.78	388
DIY	17.46	544
DKI Jakarta	38.89	1,116
Respondents income		
Decrease	31.76	1,058
Same/increase	26.46	990
Caregivers’ income		
Respondents who had caregivers	30.75	1,795
Decrease	30.71	1,091
Same/increase	30.82	704

The government had issued a recommendation to postpone routine health checks to prevent older people from being exposed to COVID-19. It also highlighted that an adequate supply of routine medications should be ensured to maintain older people's well-being even during the pandemic (Ministry of Health, 2020). Table 4.13 shows that about 12% (95%CI: 10.2%–13.3%) of the respondents experienced a shortage of routine medicine during the pandemic.

There is no significant difference in the proportion of male and female respondents. The respondents in urban areas were significantly more likely to have a shortage of routine medicine than those in rural areas ($p < 0.001$). The respondents in DKI Jakarta were significantly more likely to have a shortage of medicine than those in the other two provinces ($p < 0.001$). Those whose income decreased were significantly more likely to experience a shortage of medicine than their counterparts ($p < 0.001$). No significant difference is evident in the percentage between the respondents whose caregivers' income decreased and those whose caregivers' income did not decrease.

Table 4.13 Shortage of Routine Medicine During the Pandemic

Characteristics	Percentage	N*
Respondents who need routine medicine	11.69	1,711
Sex		
Male	12.03	748
Female	11.42	963
Age		
60–69 years	12.13	1,088
70–79 years	11.31	504
80 years and older	9.24	119
Living location		
Urban	12.36	1,570
Rural	4.26	141
Province		
Bali	3.73	322
DIY	2.34	385
DKI Jakarta	17.83	1,004
Respondents income		
Decrease	14.60	897
Same/increase	8.48	814

Characteristics	Percentage	N*
Caregivers' income		
Respondents who had caregivers	12.65	1,478
Decrease	13.36	891
Same/increase	11.58	587

About half (46%, 95%CI: 38.5%–52.7%) of the respondents who experienced a shortage of routine medicine during the pandemic stated they did not have money to buy medicine (Table 4.14). The next commonest reason (16%, 95%CI: 11.4%–22.0%) was the closure or absence of services for older people at health facilities or pharmacies, followed by ‘no one takes them to buy medicines at health facilities/ pharmacies’ (14%, 95%CI: 9.24%–19.2%), and ‘no stock of medicine in health facilities’ (13%, 95%CI: 8.40%–18.1%).

Because of the small number of respondents who reported a shortage of medicine, a significant difference was not detected for almost all combinations between the characters of respondents and the items included in the questionnaire as the reasons for medicine shortage. However, the following factors may have significant relations.

The respondents in DIY were significantly more likely to state that the lack of someone to accompany them to health facilities or pharmacies was the reason for the shortage of routine medicine than other provinces ($p < 0.05$, Fisher’s exact test). The majority of respondents in Bali said they do not have money to buy medicines. Those whose income decreased were more likely to state that lack of money to purchase medicine caused the shortage of routine medicine than their counterparts though the statistical significance was marginal ($p < 0.05$). Such a significant difference was found even between the respondents whose caregivers’ income decreased and their counterparts. The statistical difference in this comparison was also marginal ($p < 0.05$).

Table 4.14 Reasons for Shortage of Routine Medicine During the Pandemic

Characteristics	Facilities, Pharmacies Closed/ Not Serving Older People	Do Not Have BPJS	Do Not Have Money for Medicine	Do Not Have Money for Transport	No One to Accompany Older Person	Staff Busy re COVID-19	Discrimination against Older People	No Stock	Worried/ Scared	Forgot/ Late/ No time	Other	N*
All respondents	16.00	2.00	45.50	1.00	13.50	1.00	2.00	12.50	6.50	9.00	2.50	200
Sex												
Male	16.67	2.22	48.89	1.11	8.89	2.22	1.11	14.44	5.56	8.89	2.22	90
Female	15.45	1.82	42.73	0.91	17.27	0.00	2.73	10.91	7.27	9.09	2.73	110
Age												
60–69 years	15.91	1.52	46.97	0.76	11.36	0.76	2.27	12.88	7.58	9.09	2.27	132
70–79 years	15.79	3.51	43.86	0.00	17.54	1.75	1.75	12.28	5.26	8.77	3.51	57
80 years and older	18.18	0.00	36.36	9.09	18.18	0.00	0.00	9.09	0.00	9.09	0.00	11
Living location												
Urban	16.49	2.06	45.36	0.52	13.40	1.03	2.06	12.89	6.70	9.28	2.06	194
Rural	0.00	0.00	50.00	16.67	16.67	0.00	0.00	0.00	0.00	0.00	16.67	6
Province												
Bali	8.33	0.00	50.00	8.33	16.67	0.00	0.00	0.00	0.00	0.00	16.67	12
DIY	11.11	11.11	44.44	11.11	44.44	0.00	0.00	0.00	0.00	11.11	0.00	9
DKI Jakarta	16.76	1.68	45.25	0.00	11.73	1.12	2.23	13.97	7.26	9.50	1.68	179
Respondents' Income												
Decrease	13.74	3.05	51.15	0.76	11.45	0.76	2.29	13.74	6.11	6.11	2.29	131
Same/increase	20.29	0.00	34.78	1.45	17.39	1.45	1.45	10.14	7.25	14.49	2.90	69
Caregivers' income												
Respondents who had caregivers	16.04	2.14	46.52	1.07	12.83	1.07	1.60	12.83	5.88	8.56	2.67	187
Decrease	12.61	3.36	52.94	0.00	14.29	0.84	1.68	12.61	5.88	5.88	1.68	119
Same/increase	22.06	0.00	35.29	2.94	10.29	1.47	1.47	13.24	5.88	13.24	4.41	68

Note: *N is applied to the respondents who experienced a shortage of needed medicine.