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THE WELFARE OF ELDERLY PEOPLE IN RURAL WEST JAVA: ECONOMY, HEALTH AND VERNACULAR CARE

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Abstract

The universal health social security program in Indonesia began in 2014, and as of the present day, many people are now covered by it. However, many weaknesses in the system have been pointed out. Significantly, many people do not possess the necessary health cards to take advantage of the program due to the complicated process one must go through in order to obtain them. Even now, 60 million people have not joined the program. Many people do not rely solely on the universal social security program but may be supported primarily or additionally by the vernacular care system, whereby support is provided by their family, friends and community. This study intends to understand and analyze the vernacular care system found in rural West Java, Indonesia, with particular focus being given to the elderly's engagement with it. This study is mainly based on field work that surveyed 64 households with a socio-economic household survey being conducted alongside in-depth interviews with elderly people who received medical check-ups in 2003. This study shows the importance of care; not only that which is provided by the children of elderly parents, but also the grandchildren. In cases where children migrate from their family homes, elderly family members are supported not only through remittance, but also by having their grandchildren live with them. Otherwise, the characteristics of the informal sector occupations enable people to continue living in and around the village that their families are based so that their children, children-in-law, and grandchildren can care for the elderly.

Keywords: vernacular care; elderly people; children; grandchildren; informal sector

1. Introduction

In January 2014, the Medical and Social Security Agency (BPJS Kesehatan) launched a program aimed at achieving universal national health insurance. In July 2015, the Labor Force Social Security Agency (BPJS Ketenagakerjaan), which has jurisdiction over non-medical insurance schemes, including vocational accidents, death allowance, old-age lump-sum payments, and pensions, was launched. Together with the Medical and Social Security Agency and the Labour Force Social Security Agency, we will aim for universal health insurance in Indonesia (Gatra, 2014).

The most important aspect of institutional reform since 2014 is that, from the Suharto period onwards, farmers and people in the informal sector, who have hardly been covered by social security systems such as medical insurance, have otherwise been covered by social

security systems in institutional terms. The long history of the social security system in Indonesia started with the form of protection put in place for bottom-level workers and contract coolies who had been subjected to abuse and poor working conditions (Pastor, 1927; Tjoeng, 1947; Said, 1977; Breman, 1992). Of further relevance are the policies that gave rise to the system, including those that affected *becak* drivers after independence (Mizuno, 2018a). However, during the Suharto period, policy-making bowed down to prevailing corporatism, whereby civil servants, members of the armed forces and workers for large-scale private companies were prioritized in the social security system (Hadiz, 1997; Ramesh, 2000). People in the informal sector were excluded from the system as a result of this. Social security targeting the informal sector began in 1998 with the social safety net program that was established after the Asian financial crisis. This scheme continues to cover many poor people in the informal sector. As a result of the institutional change in 2014, universal health insurance was aimed at all informal sector workers, as well as housewives and retired elderly people (Suryahadi, Febriany, & Athia, 2014; Kunarti, Sudrajat, & Handayani, 2018). It took a long time to pass the bill in parliament due to the long and circuitous negotiation furnished by a political tug-of-war in which parties in opposition to each other acted to further their own interests (Ayuningtyas, 2014). The passing of the universal health care bill in parliament was promoted by the strong political commitment of certain politicians (Mboi, 2015) and by the pressure that civil society applied (Tjandra, 2014, Jung, 2016). When the direct elections for local leaders were introduced in 2005, the case made for a popular health scheme led to success at the polls. Universal health coverage became an electoral asset used to aid political agendas (Pisani, Kok, & Nugroho, 2016).

Challenges to the universal health insurance program have been made, with there being questions surrounding financial sustainability, as well as the need for intensive investment by the government to ensure supply-side readiness for the sake of achieving equitable health care unification and health attainment (Trisnantoro, Marthias, & Harbianto, 2014). Furthermore, issues were raised concerning the improvement of hospitals' financial performance (Ambarriani, 2014), BPJS card holders' dissatisfaction with the speed of the BPJS card-making process, the freedom in choosing where one would be admitted to hospital, and the structure of medical bureaucracy (Kholis, Ratnawati, & Farida, 2018). There is no significant difference in satisfaction between BPJS health insurance patients and those without insurance regarding the health services at Negara Public Hospital, for example, as the service provided by the hospital has been unanimously far below the patients' expectation (Dewi & Ramadhan, 2016). Other concerns include the plethora of problems embedded in the administration system of BPJS (Widjaja, 2014); most notably the time-consuming administration process between registration and payment, which has resulted in widespread patient dissatisfaction and, subsequently, poor quality hospital service (Handayani, Hidayanto, Sandhyaduhita, Kasiyah, & Ayuningtyas, 2015). Syah pointed out the need to promote the concept of primary health care (Syah, Roberts, Jones, & Trevena, 2015), Bernschot took note of the widespread involvement of brokers facilitating access to health care services (Berenschot, Hanani, & Sambodho, 2018). Another topic that has been covered is that of disbursement claims that have not been implemented. (Rahman, Pujianti, Yulia, Ayu, & Sari, 2015). Even though the BPJS scheme systematically neglects those below or close to the poverty line, it is still largely utilised by this population (Rolindrawan, 2015). Rasyid & Alfina proposed a model to evaluate the quality of an e-

government service (Rasyid & Alfina, 2017). The existence of the BPJS card can be considered beneficial for the poorer population, but a decrease in the quality of health insurance services previously received by civil servants and the armed forces (Effendi & Komalasari, 2018), as well as pension reform was discussed under the scheme of the BPJS program (Muliati, 2013).

Until the establishment of BPJS, or universal health coverage, social security systems had not included the majority of those people working within the informal sector, which most rural people belong to, as well as the majority of people below the middle class line living in urban settlements (Arifianto, 2004; Wisnu, 2011; Joedadibrata, 2012; Mizuno, 2012). However, it cannot be stated that this population was generally without possession of a safety net as far as healthcare is concerned. In other words, there would have been some networks of assistance among family members, neighbours, friends or even religious groups. This form of assistance is what we refer to as vernacular care. Abikusno points out that there are definite family roles and responsibilities practiced by sons and daughters toward their elderly parents. Health-seeking behaviour begins in the immediate family followed by external local health providers (Abikusno, 2002). A study conducted by Ng et al. reveals the existence of geographic pockets of vulnerable older people in Purworedjdo District. The lack of care and services for older people has to be addressed and the Indonesian health system should aim to increase the balance between ‘curing sick older people’ and ‘caring for healthy older people and promoting their health and well-being’ (Ng, Hakimi, Byass, Wilopo, & Wall, 2010). Support for the elderly has been provided by both governmental and non-governmental institutions. However, the number in need is significantly larger than what can currently be accommodated. As the government cannot provide the support entirely, the private sector and communities are expected to take a more active part in fulfilling the needs of the elderly (Noveria, 2006). Ochiai (2009) analysed the welfare regime in East and Southeast Asian societies as a combination of actors comprised of the state, market, community, family (nuclear family) and extended relatives (including nieces, nephews and grandchildren) based on studies conducted in Japan, Korea, Singapore and Thailand.

Numerous recent studies on the BPJS or universal health care system in Indonesia mentioned above limit themselves to the sole consideration of formal institutions, thereby neglecting the role of the family or vernacular care in general. Even now, 60 million people are not covered by the BPJS program. Under the current situation where the weaknesses of the BPJS program are so apparent, people continue to make plans to combine their reliance on both formal institutions and informal institutions for healthcare. It is therefore quite important to understand informal institutions and vernacular care more generally. In order to think about these problems, we must first clarify exactly what vernacular care is and how it is being performed. This paper discusses vernacular care in Indonesia, using the results of a survey conducted in 2003 within the Karawang district in the West Java province. Particular attention will be given to the elderly, with the impact of government programs on this demographic being very low. Geographically, the province is a wide, northern, flat area located on Java island. It has good irrigation and has developed rice-growing areas since the colonial era. On the other hand, since the 1990s, this region has been allocated as an industrial estate, along with the district of Bekasi, which is adjacent to Jakarta, with dynamic deployments in both agriculture and industry. In 1998, the government's social safety net program had been launched in response to the impact that policies implemented to mitigate the Asian financial

crisis had on people. Around 2003, the manufacturing sector accounted for 29% of the national GDP – the highest level in Indonesia's history. Since then, "de-industrialization" has continued, with the ratio of the manufacturing sector having fallen to around 20% of the GDP at present (Mizuno, 2018b). In other words, the level of industrialization around 2003 was never lower than what it is today, with there being no universal national medical insurance at the time and the impact of the government's social safety net program being of minimal significance. In 2003, societies in the surveyed rural area of Java island, which was affected by industrial and economic growth, could be considered a good object of research to understand the degree to which vernacular care is not affected by the formal social insurance system, or "genuine" vernacular care in the industrialized area of West Java.

Hildred Geertz was the first to carry out a study on the care of the elderly in Indonesia. In Javanese society, Geertz claimed that the youngest children, especially daughters, tend to live with their parents and they continue to live together after marriage, thereby ensuring that the care for older parents is provided by those children (Geertz, 1961). In contrast, Andrews et al. noted that as a result of social change, such as urbanization and industrialization, female caregivers are not always close to their parents, and they are increasingly unable to rely entirely on traditional care systems such as those described by Geertz. Andrews et al. explain further that it has become more common for families to live at a distance from each other, provoking uncertainty around the issue of whether Indonesians can rely on future support from their children (Andrews, 1992; Mason, 1992; Keasberry, 2002). Keasberry's study on elderly care and other intergenerational studies show that most elderly people in the surveyed villages live closer to (at least some of) their children, and hence could still receive support from them. Elderly people from a village more frequently lived with one of their children and had at least one other child living in the same village. Keasberry concluded that the shift to a market economy and the international labor migration of children increased monetary support for older people. However certain groups of people are vulnerable. Women are more likely to live alone and be childless. The oldest elderly people are also more likely to live alone or to be widowed (Keasberry, 2002). On the other hand, in urban Indonesia, the older people who are most vulnerable to inadequate and inappropriate care provisions are unmarried women and poor widows (Eeuwijk, 2015).

Previous studies tend to always focus on the role of children who stay with their parents or stay in the village to care for their elderly family members. This paper will pay attention to the role of actors who provide care to elderly people more generally. This topic concerns not only children who care for their parents but also the roles of extended family members and the wider community. In addition to the care provided by children, this paper broadly examines the networks of care for neighbours and others as factors that have an important impact on the welfare of the elderly. The impact of the migration of children has been studied with remittance being the primary form of measurement. However, this paper seeks to consider other circumstances alongside remittance. Questions considered include: How does living with/without the child in the household have an impact on the welfare of elderly people?; How does the migration of children have an impact on the welfare of elderly people or the care given to elderly people?; How do people compensate for the migration of children?; If many children stay with the elderly or support the elderly living in the village, then what factors enable the

children to continue living in the village? This paper tries to answer these questions with empirical data and qualitative explanation.

Chapter 2 discusses the methodology of the survey on vernacular care in Karawang district. Chapter 3 discusses the various facts obtained from the research project and presents the results of the analysis on the welfare of the elderly. The final chapter provides a conclusion.

2. Methods

2.1 The Selection of the Survey Site

The survey site of Karyasari village (*desa*), Rengasdengklok sub-district (*kecamatan*), Karawang district (*kabupaten*), West Java province (*provinsi*) is located on the western boundary of the Citarum River, which is one of the main rivers of West Java province, flowing from Bandung district to the Java Sea. Tanjung Pula, which has a terminal for small people carriers (*angkot*) and faces the main road connecting Jakarta to Cirebon, Semarang, is 15 kilometers south of the village. There is a paved road from Tanjung Pula to Rengasdengklok running north to the village of Karyasari. The traffic between Tanjung Pula and Rengasdengklok is not congested, making it easy for villagers to travel to these cities. The area of the village is 553.5 hectares, of which 424.6 hectares are paddy fields with good irrigation. Rice productivity is high, with 5–6 metric tons of dry rice per hectare gained per crop and an annual yield of nearly six metric tons of hulled rice from the bi-annual harvests. There are large paddy fields in the village, with many farmers, tenants, and agricultural workers active in them. Economic activities in the non-agricultural sector are also present, as described later.

According to the statistics available at the village office, in 2003 there were 11,505 residents in 3,070 households, the population density being 2,075 people per square kilometer. According to the village statistics, of the 11,505 villagers, 537 were elderly (aged 60 or older), making up 4.67% of the population.

There are five wards (*dusun*) in the village: two on the west side of the village road and three on the east side. The majority of the village's inhabitants are Sundanese people who speak Sundanese in their daily lives and so the survey was mostly conducted in Sundanese. This is also the case for the results of studies in this village in 1985–1986, such as Mizuno (1990a), Mizuno (1990b), Mizuno (1992), and Mizuno (1997).

2.2 Outline of the Survey

The survey was conducted from March to May 2003 using three methods. We conducted the first stage of the survey on all households in Babakan Jati Ward, whose occupants were 65 years of age or older, as well as in the northern Babakan Tengah Ward and the northern Babakan Lio Ward, primarily focusing on conditions such as household composition, land ownership, and expenditure for the previous month. According to the first stage of the survey, there were 958 household members in 224 households surveyed, 267 of whom were elderly (aged 65 or older). The average number of household members was 4.1, of which 1.2 were elderly. Subsequently, a socioeconomic household survey was conducted as the second stage in approximately 64 households within Babakan Lio ward, in order to ascertain in finer detail information regarding care and assistance to the elderly people. According to the second stage of the survey, the total number of household members was 283, of which 142 were men and 141 were female, with 4.4 being the average number of members per household. There were

74 elderly people in these 64 households. In the third stage, medical research was conducted by medical teams for all elderly persons in the Babakan Jati ward, the northern area of Babakan Tengah and its Babakan Lio district. The results of the medical survey were published in [Wada et al. \(2005a\)](#) and [Wada, Wada, et al. \(2005b\)](#). The vast quantity of data collected from the above socio-economic survey formed the basis of this paper.

3. Results and Discussion

3.1 Care for the Elderly by Children–Type of Households

A detailed investigation was conducted of 64 households containing elderly people aged 65 or older as the second stage of the survey. The 74 elderly members of these households had a total of 228 children. Of these, 13 households had three children, the average number of children in these households was 3.6 and the maximum number was eight. Two of the household heads had no children. Of the children, 55 lived with their elderly parents, with an average of 0.9 children per household. On the other hand, 26 households contained elderly people that did not live with their children. Meanwhile, 152 children did not live with their elderly parents but did live in the village, while 51 households containing elderly people had seven children or fewer living within the village. The average number of children in households who did not live with their parents yet lived in the village was 2.4. There were 21 children who did not live with their parents and did not live in the village and were therefore migrants who lived elsewhere. However, it is worth considering that among these were children who lived in the neighboring villages as well as in more remote places such as Jakarta, or even as far afield as Sumatra or Japan.

In these cases, if the spouses of their children are included, there was a total of 407 children with 78 elderly people in 64 households which included elderly people. The average number of children per household was 6.4, the median was 6, and the maximum number was 16. Of these, 80 children lived with elderly persons, so on average, 1.3 children lived with elderly persons and 25 elderly persons did not live with their children. In addition, there was a total of 266 children and sons/daughters-in-law who did not live with the elderly but who lived in the village, and the average number of these children per household was 4.2. From the point of view of the elderly, there were 39 elderly people who lived with those children, 19 who did not live with them but had children in the village, 4 elderly people who did not live with them but had children outside the village, 1 elderly person who had no children or sons/daughters-in-law and one household comprising elderly people who had no sons/daughter-in-law, but had grandchildren in the household and also in the village. The number of children and sons/daughters-in-law who lived outside the village was 61, or 0.95 per household.

From these data we can see that there were many combinations of circumstances among the elderly people's households: those who have children or sons/daughters-in-law in the household, outside of the household but in the village, outside of the village but nearby, or outside the village and living in a remote area, and we developed classifications according to these differences. The reason why we consider whether children live outside the village, and in such cases whether they live nearby or remotely, is to understand the impact of children's migration on the welfare of elderly people.

Table 1. Classifications of the elderly people's households*

Type	Household with children and/or grandchildren	Household with elderly people only	Child/children in the village	Child/children outside of the village but nearby	Children living outside of the village in a remote area	Number of households
I	○ (1)	-	-	-	-	5
II	○ (5)	-	○	-	-	22
III	○ (3)	-	○	○	-	9
IV	○ (1)	-	○	○	○	3
V	○ (2)	-	○	-	○	7
VI	○ (2)	-	-	○	With/without ○	7
VII	-	○ (1)	-	-	-	1
VIII	-	○ (8)	○	With/without ○	With/without ○	8
IX	-	○ (3)	-	○	With/without ○	3

*Notes: (1) child or children always includes the sons/daughter-in-law; (2) areas considered nearby include neighbouring villages, areas within the same district and areas within 20 kilometers of the surveyed village which are outside the district; (3) numbers in the parenthesis is the number of households without children

3.2 Care for the Elderly by Children, Grandchild and Neighbours

The figures for households according to their relevant classifications are presented in the final column of Table 1. From this, we can identify that the number of households in the type II category was the largest. Households belonging to types III, IV, V, and VIII also included children in the village and this points to the importance of children in these elderly people's households. In order to understand the composition of each household according to these types, Table 2 shows the number of family members with each characteristic for each type.

Table 2 also demonstrates the large number of children who lived in the village and shows that the number of grandchildren is significant, and is generally more than the number of children in the elderly people's household. As Table 1 shows in parenthesis, many households did not have children, and in such cases, it was often the grandchildren who lived with the elderly people. In many cases, these grandchildren were not particularly young themselves. For example, an elderly person aged 83 lived with their 35-year-old grandson and 33-year-old granddaughter-in-law. A widow aged 70 lived with her granddaughter, aged 21, while the widow's four children lived separately in the village. The four children claimed that they visited their widowed mother almost every day.

We can imagine that elderly people within the Type I and II categories, amounting to 27 households, were mainly supported by the children and grandchildren living in the household and the village. Types III, IV, V, and VIII amounted to 27 households which also had many children and grandchildren in both the household and the village.

Table 2. Number of household members, children, and grandchildren living within each household, and the number of children living outside the household, whether nearby or remotely

Type	Average number of household members	Average number of children at the household	Average number of grandchildren at the household	Average number of great-grandchildren at the household	Average number of children who live in the village	Average number of children who live outside of the village but nearby	Average number of children who live outside of the village in a remote area
I	5.00	1.50	1.67	-	-	-	-
II	5.33	1.71	1.81	-	3.95	-	-
III	5.88	0.88	2.25	1.50	1.44	1.89	-
IV	5.00	1.67	1.67	-	3.33	2.67	1.67
V	4.86	1.14	1.86	0.57	4.00	0.29	2.14
VI	5.43	1.71	2.43	0.14	-	2.00	1.00
VII	1.00	-	-	-	-	-	-
VIII	1.50	-	-	-	2.00	2.14	0.43
IX	1.67	-	-	-	-	3.33	0.33

In response to the question of whether children and children-in-law provided them with financial support, 41 answered that they would receive financial support for food and medical care, 11 responded that they would receive money directly from their children when they visited, while 22 gave no answer. Of these 22, 12 lived with one or more children, and financial support (including support from parents to children) could therefore be considered natural. Of the 28 elderly people with no children living with them, 14 answered that their children and their sons/daughters-in-law would provide basic financial assistance for food and medical care, while 6 answered that they would supplement their income whenever they came to visit.

3.3 Impacts of Children's Migration to Other Areas on the Welfare of Elderly People

Although many children and grandchildren tended to stay at the village where elderly parents or grandparents lived, some of the children lived in a nearby area or a remote area. Among the Sundanese people, the idea of *merantau* is common so many young people have tried to seek fortune and experience in distant places. Among those people who migrated at a young age, some of them have returned to the village.

Table 3 shows the average number of children who have moved to a nearby area or remote area from the type III, IV, V, VI, VIII, and IX households. Those children who lived in different areas were expected to support the elderly. To what extent did their support contribute to the elderly people's household economy?

Within Types III, IV, V, VI, VIII, and IX, there were children who lived outside the village. Many of the children contributed remittance, however not in every case. Actually there was quite a large variation among the households, with some households' incomes being supplied wholly by remittance. However, there were some elderly people's households whose income

from remittance was relatively small. If we view the composition of remittance or financial support beyond that which the children, sons/daughters-in-law, nephews and nieces and even the neighbours had paid, then one can ascertain why the ratio of total remittance and financial support was larger than the ratio of remittance and financial support given by children in Table 3. A widow that belonged to Type VII was supported by a neighbour who had the title of “*Hajar (hajah)*”, which refers to females who take the pilgrimage to Mecca with rice once a year. Her occupation was an agricultural laborer who collects the scattered paddy following the harvest, earning an income equivalent to only 21.7 percent of the poverty line threshold.

Table 3. Remittance and financial support provided by children in relation to the income of elderly people’s households and their general economic position *

Type	Ratio of total financial support or remittance to household income (%)	Ratio of financial support or remittance provided by children (%)	Average yearly income per-capita of elderly people’s households (Rp.)	Average agricultural land holding (m ²)	Percentage of households whose income was below the poverty line (%)
I	0	0	1,215,271	2,000	60.0
II	10.17	8,88	1,451,984	6,377	22.2
III	4.78	0	1,410,649	0	14.3
IV	41,69	19,77	915,333	0	66,7
V	33.33	33,86	1,365,373	7,142	71.4
VI	12.23	0	1,831,542	13,671	42.8
VII	5.88	0	195,500	0	100
VIII	23.36	23,36	862,062	250	50.0
IX	33.33	0	2,242,667	0	0

*Notes: (1) children in this table does not include the sons/daughters-in-law; (2) poverty line was Rp, 900,000 per capita per year, the income of 360 kilograms of rice per annum was considered to be on the poverty line according to the Sayogyo's conception (Sajogyo, 1977), while the price of rice in the village at the time of the survey was 2,500 rupiah per kilogram

If we see the income per capita according to the type of the household, we can see the tendency that the household that had the children who stayed outside the village had somewhat higher income. However actually there was much variation among the households within the category of each type, that why the percentage of households whose income was below the poverty line varied. In general, children’s migration had brought somewhat higher income for the elderly households; however, this was not always the case. One of the households that fell within Type IV consisted of a widow and their nine-year-old grandson. The majority of the household’s income was secured by remittance and financial support from the household-owner’s children, as well as a neighbour. The household income was only 36.7 percent of the poverty line threshold, with 5 of the 8 children and children-in-law being based in the village. Many of them answered that they supported her with food and money.

Remittance or financial support was important for the elderly people’s households when the children stayed outside the village. Besides that, the existence of grandchildren was important. Table 2 shows that the grandchildren filled vacancy at the household because the children live outside the household, both in the village and outside the village (Type II, III, IV, V, and VI).

3.4 Dependency at Times of Illness

We need to consider who in the family would usually take care of elderly people if they became sick. Of the 74 people surveyed, 30 answered that their children would do so, while 23 replied that they would depend upon their wives and husbands. Looking at the relationship with children, out of the 46 elderly people surveyed whose children were living with them, 21 answered that their children would look after them and 15 answered that their wives/husbands would. Of the 23 elderly people whose children live independently in the village, 8 answered that their children would look after them, six responded that wives/husbands would do so, and four replied that their grandchildren would be responsible. Of the four elderly people who did not live with children and had no children within the village, two responded that their grandchildren would take care of them and two responded that either their husband or wife would do so. Older people without any younger relatives answered that they would take care of themselves at times of illness.

Furthermore, when asked about how the family had coped with the past year's medical expenses, 20 responded that the total amount was handled by their children, and 4 responded that their children had paid for half of the expenditure. Of the remainder, 32 answered that they did not receive any support for medical expenses and 18 chose not to respond. Asked whether there was financial support outside of the family regarding medical costs, 9 respondents said yes and 29 answered no, with the remainder choosing not to provide an answer. Meanwhile, 9 respondents confirmed that they had access to health insurance and 8 responded that they were in possession of a health card. Looking at the economic status of these 8 people, 5 were below the poverty line, but one of them was within the top four wealthy groups, and the income of 2 respondents was roughly twice that of the poverty line, thus positioning them as members of the village's middle class. The older childless woman who lived alone did not have a health card. This malpractice was found in many places relating to the health care system within the social safety network program in Indonesia at the beginning of 2000s (Mizuno & Machfud, 2003).

3.4 Dependency at Times of Illness

People in the surveyed village tend to continue to live in the same village or the surrounding areas. People who had migrated elsewhere also attended to family residing in their home village by making frequent visits or providing remittances. The lifestyle of families living nearby is reminiscent of the Sundanese proverb "*Benkung ngariung bongkok ngaronyok*" ("families prefer to live nearby rather than remotely, despite this making them poorer than they could be"), or the Javanese proverb "*mangan ora mangan asal kumpul*" ("families prefer to live together whether food is available or not").

What factors kept children and grandchildren living in the village? First, we considered the availability of work opportunities for those who remained in the village. Looking at the occupations of 326 people who were employed according to the first-stage survey of 225 households, the largest number of workers were merchants (57), followed by agricultural workers (47), transportation workers (34), farm owners (32), factory workers (31), and private enterprise employees (21). In addition, there were 18 tenants, 20 self-employed people in the wall-wood manufacturing industry, 17 in the miscellaneous informal sector such as the sewing and repair industries, 4 security guards, and 4 civil servants. This data demonstrates the make-

up of informal-sector businesses, formal-sector jobs and agriculture-related businesses. Especially important was the existence of many jobs within the informal sectors, with the self-employed taking on the occupations of traders, working in transportation, rural industries, and miscellaneous businesses and jobs. These self-employed businesses tended to create job opportunities which enabled people to maintain the norm of families living together in the same area. Table 4 shows the ratio of people whose main occupation belonged to the informal sector.

Table 4. The ratio between the locations of people whose main occupation belongs to the informal sector in relation to their home village (%), and the index of ADL for elderly people*

Type	People who lived in the village	People who lived outside but near the village	People who lived in an area remote from the village	ADL for elderly people
I	81.82	-	-	21.0
II	76.84	76.9	-	20.4
III	80.0	44.44	33.33	19.6
IV	63.63	100	83.83	18.7
V	90.63	77.77	0	20.7
VI	75.0	-	-	20.8
VII	100	-	-	21.0
VIII	95	90	n.a.	20.8
IX	100	84.1	n.a.	20.6

*Notes: (1) ADL is the activity of daily life index. For ADL assessment, each subject rated his/her independence in accordance with seven criteria (walking, ascending and descending stairs, feeding, dressing, going to the toilet, bathing and grooming); (2) each ADL factor was evaluated using four different levels: 3 = completely independent, 2 = requires some help, 1 = requires a great deal of help, 0 = completely dependent; (3) the seven basic ADL scores were then aggregated into one total score (0-21) representing overall welfare

Table 4 shows that the majority of people living in the village were engaged in the informal sector. Their occupations had the characteristics of self-employment, affording the flexibility to adjust to situations, allowing some children to act upon their preference to live remotely from their parents, while other family members attempted to stay in the village or at the households of older parents or grandparents. Another reason why people could afford to stay in the village was that agricultural activity was dynamic, while an industrial estate was also established not far from the village, allowing many young people also to stay in the village and commute to the factory.

This character of the informal-sector occupations enabled the elderly to continue working. According to the first-stage survey, among the 267 elderly people within the surveyed 958 households, members in the 224 households surveyed, 46.1% were employed. Labor participation was rare for 65- to 69-year-olds, at 52.8%, while for those aged between 70 and 74, the percentage was 48.7%. The percentage was also 48.7% for those aged 75 to 79 years and 31.7% for those aged 80 or older. Almost all occupations were in the informal sector. This employment condition for elderly people may correlate to some extent with the relatively good ADL scores shown in Table 4.

The condition of elderly people in this village was relatively healthy according to the ADL index (Wada et al., 2005a; Wada et al., 2005b), however the households within the Type IV

band achieved the average score of 18.7, meaning that there were elderly people within this population that were in need of some assistance. To demonstrate the variation observed, the elderly widow mentioned on page 108 achieved the score of 15. She said that she suffered from rheumatism but did not require extensive daily physical support. 5 of her children and children-in-law (2 of whom were female) said that they visited her house every day, while the widow reported that a neighbour also visited her every day. When in need of assistance, she claimed that she would primarily ask her children. Yet a widow belonging to Type VII band of households fared significantly better, maintaining a score of 21, which denotes the highest possible living condition according to the index.

4. Conclusions

The universal health and social security program commenced in January 2014. Many studies have been conducted demonstrating the challenges that the new social security system faces. People are still forced to wait for a long time for medical consultations with doctors and at the hospital. The system has not covered all people, while the financial sustainability of the program has already been questioned.

Many people, especially those working within the informal sector, both in rural and urban areas, had yet to join the security system in 2013, and even now 60 million people have not yet joined the BPJS system. These people are thought to retain their own safety nets to care for those around them, especially elderly people. It is assumed that people have maintained extensive networks, mainly among children, relatives, their community and even religious groups, for the sake of maintaining their health. Care among these networks can be referred to as vernacular care. Actors in the welfare regime are the state, the market, family (nuclear family), relatives, and the community, all of which are expected to collaborate to support the welfare of people, especially the elderly.

The many recent studies of the BPJS tend to neglect vernacular forms of care. This study investigates this type of care for elderly people using the data collected by the authors in 2003 when the impact of formal social security was minimal. The level of industrialization was not lower then than at the present time, and this data is therefore appropriate when considering “genuine” vernacular care in industrialized West Java.

This study attempts to classify elderly people’s households by considering those with/without children in the household, with/without children in the village, with/without children living outside the village but nearby and with/without child living remotely, in order to clarify the role of children in maintaining the welfare of the elderly.

Contrary to the previous study, this paper clarifies the real situation of care toward the elderly; not only is it carried out by their children and the spouses of their children, but also by grandchildren, especially in the households where no children live with their parents. The migration of children is accompanied by the remaining of grandchildren in the household alongside the remittances that the elderly person receives from their migrated children.

This study shows that the households with children that have migrated elsewhere tend to have a somewhat higher income, although there is much variation. Although some of the children migrated elsewhere, the majority of children, their spouses and grandchildren tend to stay in the village, or in nearby areas. From this we can see that the traditional culture of Sundanese people has held fast in adherence to the proverb: “*Benkung ngariung bongkok*”

ngaronyok” (“families prefer to live nearby rather than remotely, despite this making them poorer than they could be”) or the Javanese equivalent: “*mangan ora mangan asal kumpul*” (“family prefer to live together whether food is available or not”).

This social value can be maintained in conditions where the availability of occupations in the informal sector is plentiful. Dynamic agriculture and the development and growth of industrial areas support the availability of occupations in and around the village.

Ultimately, the existence of flexible networks and combinations of formal- and informal-sector activities enables people to continue caring for the elderly. This conclusion proves itself to be more accurate than the reductive interpretations that previous studies have focused on, which rely purely on the definitive role of the youngest daughter. These flexible networks and combinations of activity in the formal and informal sector are at the core of genuine vernacular care in industrialized West Java. The formal security system, it would seem, is expected to be combined with vernacular forms of care.

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