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SOCIAL SUPPORT SYSTEMS AND ITS IMPLICATION FOR HEALTHCARE PROVISION FOR THE ELDERLY POPULATION

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Abstract

The aging population structure creates a fundamental mismatch between traditional social support systems and contemporary healthcare provision. Family based care arrangements weaken due to urbanization, female labor participation, and declining multigenerational households. Formal healthcare systems designed for acute diseases face difficulty managing chronic multimorbidity in older adults. This qualitative literature study examines how social support system transformation affects healthcare delivery for elderly populations. Analysis reveals fragmented care coordination, inadequate geriatric competence among health professionals, physical accessibility barriers, and financial protection gaps. Family caregivers experience substantial burden without adequate systemic support. Age based stigma influences clinical interaction quality and resource allocation. Community based approaches and health social service integration show promise as reform directions. Policy coordination across ministries, financing mechanism redesign, and mandatory universal design standards represent practical implications. Educational curricula revision for health professionals requires urgent attention.

Keyword: elderly population, social support, healthcare delivery, multimorbidity, community care

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Introduction

The elderly population is experiencing a proportional increase in the demographic structure across various countries. This demographic shift occurs due to a decline in birth rates and an increase in life expectancy (Kohli et al., 2020). The phenomenon of epidemiological transition shifts disease patterns from acute infections to chronic degenerative diseases. The consequence of this shift is the need for sustainable long-term health services. This indicates that society needs to prepare itself to face new challenges in social life to remain harmonious (Darmawan et al., 2021). Current health systems are designed to respond to the needs of young and adult populations with acute disease patterns. The mismatch between system design and the needs of the elderly population creates various gaps in service provision. Elderly care needs are multidimensional, covering medical, psychological, social, and functional aspects. Therefore, public policies adopted must be able to balance various interests for the sake of the sustainability of the wider community (Mardikaningsih & Hariani, 2021). Each of these dimensions requires a different approach in service governance. This change in the population age structure is progressing rapidly without being balanced by adequate adjustments to social support systems.

The capacity of the health system to absorb the surge in service demand from the elderly population faces structural limitations (Asadzadeh et al., 2022). Primary and secondary health care facilities are not yet fully adaptive to the needs of elderly patients. This condition demands an organization or institution to be more agile in managing crises amidst uncertain situations (Arifin & Darmawan, 2022). The availability of professional staff with geriatric competence is still limited in number. Medical and nursing education curricula often do not include geriatrics as a core component. As a result, health workers are less trained in handling multimorbidity conditions in the elderly. In addition to medical personnel factors, public awareness regarding the use of environmentally friendly health products is also an important concern in the future (Fachrurazi et al., 2022). Multimorbidity refers to the presence of two or more chronic diseases in one individual simultaneously. Handling multimorbidity requires coordination between specialists and complex medication management. Medication patterns in

the elderly are also prone to side effects due to physiological changes related to aging. Furthermore, there is limited access to rehabilitative and palliative services which are highly necessary. All these factors emphasize the gap between real needs and the available system capacity.

Social support for the elderly is experiencing erosion along with changes in modern family structures (Rashidi et al., 2022). The extended family model, which traditionally served as the main support for elderly care, is starting to be abandoned. This shift is often felt heavily because old values must confront the demands of life in the fast-paced modern era (Amri & Khayru, 2022). Urbanization and labor mobility cause geographical distances between the elderly and family members. Women, who culturally play the role of primary caregivers, now participate heavily in the formal workforce. Consequently, the availability of informal caregivers within the family environment is decreasing. This issue becomes even more complicated when combined with poorly organized living environments and sharp differences in social status (Fauzi, 2021). Formal social support systems such as nursing homes and home care services have not developed evenly. Negative stigma toward elderly care institutions still persists in society. Families often feel guilty if they place the elderly into institutional care facilities. On the other hand, the family's ability to provide care at home is limited by time and knowledge. This condition creates a dilemmatic situation for families in fulfilling their caregiving responsibilities toward the elderly.

Health financing for the elderly population is becoming a burden that continues to increase significantly (Bagus et al., 2022). Per capita health expenditure for the elderly is much higher compared to younger age groups. Chronic diseases such as hypertension, diabetes mellitus, and osteoarthritis require long-term treatment. The need for these medicines and medical treatments sometimes makes people look back at traditional medicine as an alternative in the midst of globalization (Khayru, 2022). Hospitalization costs are also higher due to longer lengths of stay. National health insurance systems in various countries face fiscal pressure due to population aging. Capitation-based payment mechanisms in primary care do not encourage preventive care for the elderly. To overcome such widespread problems, more disciplined rule enforcement and environmental management are required (Nuraini et al., 2021).

Meanwhile, fee-for-service payment systems encourage an increase in service volume that is not always necessary. The imbalance between premium income and financing claims is a common problem. The elderly from low economic groups face the greatest difficulty in accessing quality services. Inclusive financial protection schemes for the elderly have not yet been adequately realized.

Intersectoral coordination in the provision of health services for the elderly shows systematic weaknesses (Rusdi, 2019). Health services for the elderly should involve the health, social welfare, housing, and transportation sectors. However, the referral and communication mechanisms between these sectors generally do not function optimally. Good cooperation between the government and citizens is highly needed so that community aspirations in a democracy can run hand in hand (Rojak et al., 2021). Disruptions in the care chain often occur when the elderly move from home to a hospital or rehabilitation facility. Medical information is not always fully conveyed between different service providers. The absence of an integrated information system for recording the health history of the elderly exacerbates the situation. This is where the active role of the local community is very important to help unify modern knowledge with local wisdom (Nurmalasari & Nuraini, 2021). Health workers at the primary level do not have access to elderly care data at the secondary level. Similarly, social workers do not obtain information about the medical conditions of their elderly clients. As a result, the interventions provided become uncoordinated and potentially overlap. The burden of this coordination often falls on the elderly themselves or their families. This is an additional burden that should not occur in an organized system.

Changes in functional capacity in the elderly affect the way they interact with the healthcare delivery system. Decreased physical mobility and mild to severe cognitive impairment require modifications in the service delivery process. Many elderly people eventually feel depressed due to the difficulty of adapting to changes in their body conditions and environment (Issalillah & Aisyah, 2022). Health facility designs that are not elderly-friendly hinder access to the required services. Heavy doors, stairs without handrails, and inadequate lighting become physical barriers. Administrative staff who lack patience in serving elderly people

with hearing impairments or slow understanding also become an obstacle. Therefore, assistance activities such as the *Posyandu lansia* (integrated service post for the elderly) program in villages become very beneficial to bring services closer to them (Darmawan et al., 2022). Long waiting times in emergency units or polyclinics are burdensome for the elderly with physical limitations. Complicated registration procedures based on digital technology make it difficult for the elderly with low digital literacy. Ideal health services for the elderly require comprehensive procedural and physical modifications. Unfortunately, these changes require significant investment and clear development priorities. Without serious attention to these accessibility aspects, the gap in service reception will continue to widen (Guzman-Castillo et al., 2017).

The main problem faced is the disruption in the traditional social support system that previously guaranteed the continuity of elderly care. The transformation of family structures and intergenerational relationship patterns has resulted in the reduced availability of informal caregivers. When family caregivers are unavailable, care responsibility automatically shifts to a formal system that is not yet ready to receive it (Cheng, 2017). The formal health system is designed to respond to acute conditions rather than provide long-term care. The absence of a smooth transition mechanism between informal and formal care creates a service vacuum. Elderly individuals who do not have supportive families face the risk of exclusion from access to decent care. On the other hand, families trying to maintain care at home experience physical and psychological exhaustion. All these challenges ultimately require us to care more for one another so that social life continues to function well (Darmawan et al., 2021). This double burden creates an unfavorable situation for all parties involved. This problem is universal, but its manifestations differ depending on local policies.

Another problem relates to the inability of the healthcare system to respond to the specific needs of the elderly with multimorbidity. Conventional medical approaches that focus on one disease at a time are ineffective for the elderly. An elderly person with hypertension, diabetes, and osteoarthritis requires integrated management that considers the interactions between these conditions. However, daily clinical practice remains fragmented according to the specialization of the doctors the

patient visits. Polypharmacy, or the use of many medications simultaneously, becomes a serious risk without prescription coordination. In the future, health system management must be more organized and pay attention to the balance of many aspects in order to survive (Mardikaningsih & Hariani, 2021). A cardiologist prescribes medication without knowing the medication prescribed by a neurologist. The elderly themselves do not have the ability to integrate all the treatment information they receive. Hospitals rarely provide comprehensive geriatric consultation services for outpatients. Electronic medical record systems are not yet interconnected between different service facilities. Consequently, the elderly receive uncoordinated care with significant potential medical hazards (Navickas et al., 2016).

Every year, there is a consistent increase in the proportion of the elderly in the population (Dmitrieva, 2022). The consequence of the slow adaptation of the system is preventable human suffering. The elderly experience a decline in quality of life because they do not receive services that meet their needs. Families experience stress and financial burdens due to care that is not supported by the system. The health system bears greater costs because inappropriate care actually worsens the condition. Delays in reforming the system will accumulate increasingly complex problems. Ultimately, we all need to work together to create a more supportive environment for our parents in the future (Nurmalasari & Nuraini, 2021). Normative research like this is necessary to map the direction of the changes that must be made. A strong theoretical understanding of the relationship between social change and elderly healthcare needs becomes the foundation of policy. Without this mapping, policy interventions risk being undirected or even counterproductive. Therefore, studies on social challenges in providing health services for the elderly are becoming very urgent.

The purpose of this writing is to construct a theoretical understanding of the relationship between the transformation of social support systems and the capacity to provide health services for the elderly population. This writing aims to identify critical points where traditional social support systems fail to transition into formal systems. The theoretical contribution of this paper is the refinement of the analytical framework regarding the gap between elderly care needs and

the available system capacity. Practically, this writing provides a foundation for the formulation of elderly care policies based on contemporary social realities.

Method

This writing uses a qualitative literature study design that focuses on the conceptual exploration of the social phenomena underlying the provision of health services for the elderly population. The qualitative approach was chosen because of this method's ability to capture the complexity of social relations that cannot be reduced to numbers alone. Lampard and Pole (2015) explain that qualitative research excels in uncovering the processes and mechanisms underlying social phenomena. The exploratory nature of qualitative methods allows researchers to delve into various dimensions of a problem without being restricted by rigid quantitative categorizations. In a literature study, data are obtained from academic texts such as books, journal articles, and relevant policy documents. Henn, Weinstein, and Foard (2005) assert that literature research is a valid strategy for developing a theoretical understanding of a topic. All sources used were selected based on criteria of relevance, credibility, and the currentness of the information. The document selection process was carried out systematically by searching trusted academic databases. No primary data were collected through interviews or field observations in this research. All arguments constructed are based on the author's interpretation of the available literature.

The analysis in this research was conducted through a thematic analysis method adapted to the characteristics of literature data. Qualitative data analysis involves the process of data reduction, data display, and drawing conclusions (Kalof & Dan, 2008). The initial step taken was to read all the collected documents repeatedly to build a holistic understanding. Analysis categories were developed inductively based on the patterns emerging from these repeated readings. Adler and Clark (2011) state that category development in qualitative research is iterative and reflective. The main categories in this research include the transformation of family support, the capacity of health institutions, and service coordination mechanisms. Each category was then broken down

into more specific sub-categories to deepen the analysis. Data from various sources were compared against each other to identify consistencies or differences in views. The process of drawing conclusions was carried out gradually by constantly referring back to the original data. The validity of the findings was maintained through a process of triangulation between different sources. This overall analytical procedure ensures that the resulting conclusions have a solid foundation in the documentary evidence.

Result and Discussion

The structure of the social support system operates in two main forms, namely informal support originating from family and relatives, and formal support provided by the state and institutions. Informal support has long been the primary foundation of elderly care in various societies because of its nature based on emotional bonds and moral obligations. This system has advantages in terms of flexibility, responsiveness to individual needs, and costs that are not charged to the public budget. However, the socio-economic transformations that have occurred since the twentieth century have fundamentally changed family structures and intergenerational relationship patterns (Vaziri et al., 2021). These changes are deeply felt in daily life, where the way people interact with one another is no longer the same as it used to be (Irfan & Al Hakim, 2022). Urbanization causes the movement of the productive-age population to urban areas while the elderly remain in rural areas. Women's participation in the formal workforce has increased significantly, thereby reducing the availability of time for family care. The nuclear family has replaced the extended family as the dominant social unit, so the number of family members who are potential caregivers has decreased. The result of these changes is the weakening capacity of the informal support system in providing adequate care for the elderly. The gap arising from the weakening of informal support should be filled by formal support systems. However, formal support systems in most regions have not developed adequately to fill that void.

The imbalance between the declining capacity of informal support and the limited capacity of formal support creates a condition of vulnerability for the elderly population (Puraya et al., 2021). Elderly

people who do not have family or relatives capable of providing care face the highest risk of having their needs unmet. This condition is exacerbated by policies that often still assume the existence of the family as the main pillar of elderly care. This problem is often rooted in social structural injustices that have existed for a long time and are difficult to change easily (Gani, 2022). These assumptions no longer reflect contemporary social realities but remain the basis for formulating various programs. Consequently, elderly people who are not integrated into a functional family network become invisible to the policy system. They do not meet the criteria for family-based programs but are also not included as priorities for institutional services. The group of elderly living alone or only with an equally elderly spouse experiences the greatest difficulty. Therefore, it is very important for the government to adjust regulations to keep up with the times and the current needs of society (Halizah & Mardikaningsih, 2022). This condition indicates a systemic failure in detecting and responding to fundamental changes in social support patterns. Transformations in family structure should be responded to with a reconfiguration of the formal support system to be more responsive. Without such reconfiguration, the gap in access to health services will continue to widen as the proportion of the elderly increases.

Social support has a direct influence on the utilization of health services by the elderly population through several different mechanisms (Zapata-López et al., 2015). The first mechanism relates to the facilitation function, where family members assist the elderly in accessing health services. This assistance includes transportation to health facilities, accompaniment during medical consultations, and help in understanding medication instructions. The quality of service received by patients at community health centers greatly determines whether or not they feel satisfied with the assistance provided (Darmawan et al., 2022). Elderly people without adequate family support often fail to attend routine check-up appointments or access services that are actually needed. The second mechanism relates to the advocacy function, where family members play a role in ensuring that the elderly receive services according to standards. Families can question doubtful medical decisions or request referrals to more competent specialists. Elderly people living alone do not have this advocacy agent, thus risking receiving substandard

services. The third mechanism is the medication adherence monitoring function, where the family reminds and ensures medication consumption according to the schedule. Non-adherence to treatment in the elderly often occurs due to memory impairment or a lack of understanding regarding the benefits of long-term treatment. This makes us realize that education and providing information to the public are very important to change their habits for the better (Gautama & Mardikaningsih, 2022). With the weakening of the family support system, these three functions become unavailable to a large portion of the elderly. The formal health service system must recognize the loss of these functions and develop appropriate compensatory mechanisms.

Multimorbidity, as a primary characteristic of the elderly population, presents specific challenges to healthcare organizations that are monospecialistic in nature (Guadalupe & Vicente, 2021). An elderly person with hypertension, type two diabetes mellitus, osteoarthritis, and mild cognitive impairment requires at least four different types of interventions simultaneously. However, the healthcare system is organized based on the division of diseases into separate departments according to organs or body systems. Heart patients are referred to cardiology, diabetes patients to endocrinology, and joint pain patients to orthopedics or medical rehabilitation. This situation is sometimes exacerbated by changes in the urban environment that increasingly marginalize low-income groups from existing facilities (Fauzi, 2022). There is no natural mechanism within this system to integrate all treatment plans from these various specialists. Consequently, the elderly receive recommendations that may contradict each other, such as medication prescribed by one specialist worsening a condition being treated by another. Polypharmacy becomes a serious issue when an elderly person consumes five or more types of medications simultaneously without adequate coordination. The risk of adverse drug interactions increases exponentially with the increase in the number of medications consumed. Hospitals and clinics rarely have automated warning systems regarding potential interactions between drugs from different prescribers. In fact, the well-being of the officers who serve the community also greatly influences how well that service is provided (Gautama et al., 2021). The burden of integrating all this information falls on the elderly themselves or their families who do not have medical

competence. This condition is inherently unsafe and requires fundamental reform in service organization for populations with multimorbidity.

Coordination between service levels is a critical element in providing effective care for the elderly population, yet it is precisely the weakest point in the system (Grover, 2019). Ideally, elderly care moves seamlessly between primary, secondary, and tertiary levels, as well as between the health and social sectors. An elderly person might start with a visit to a public health center, then be referred to a hospital, then moved to a rehabilitation facility, and finally return home with home care support. At each of these transition points, a transfer of responsibility occurs from one service provider to another. Without an effective information transfer mechanism, every new service provider starts from scratch without knowing what has been done previously. As a result, the same examinations are repeated multiple times, medication history is unknown, and conflicting recommendations may be given. We need to realize that all these problems are interrelated and require serious attention from all of us so that there are real solutions (Gautama & Mardikaningsih, 2022; Halizah & Mardikaningsih, 2022). A well-functioning referral system requires medical records that are accessible to all involved service providers. These medical records must include not only medical data but also information about the patient's social and functional conditions. However, in most regions, health information systems have not reached the level of integration necessary to support this kind of coordination. The absence of this integrated system results in elderly care becoming fragmented and inefficient. Ultimately, sincere cooperation among all parties is the key to creating better change for our collective life (Rojak et al., 2021).

Health professionals who handle the elderly population require specific competencies that differ from handling young adult patients. Aging is accompanied by physiological changes that affect responses to medications and medical procedures. Renal clearance decreases, so a drug dosage that is safe for a young adult can become toxic for the elderly. Blood vessel elasticity decreases, so blood pressure must be managed more carefully. Sensitivity to drug side effects also increases, necessitating more intensive monitoring. Beyond medical aspects, the elderly also often face psychosocial problems such as loneliness, depression, and

social isolation that affect treatment outcomes. We must realize that maintaining good relationships and harmony among family members is very important amidst these changing times (Sulistyo, 2022). Health workers need to have the ability to detect and respond to these psychosocial problems because they impact treatment adherence (Sarafino & Smith, 2014). However, medical and nursing education in many institutions has not yet made geriatrics a core component of the curriculum. Lessons on elderly care are often very limited and taught as peripheral topics. Consequently, graduates enter practice without adequate preparation to handle the population that will become the majority of their patients. This competency gap is a structural barrier to providing high-quality health services for the elderly.

The distribution of health personnel with geriatric competence shows a significant geographical disparity between urban and rural areas (Carvalho et al., 2017). Geriatric specialists and gerontological nurses tend to be concentrated in large hospitals in metropolitan cities. Rural areas, which often have a higher proportion of elderly people due to the migration of youth to cities, conversely lack trained personnel. This is closely related to the urban lifestyle, which greatly influences the general health conditions of its residents (Warin, 2025). As a result, the elderly in rural areas must travel long distances with high transportation costs to obtain services that meet standards. Many elderly people eventually choose not to access services at all because of these barriers of distance and cost. This condition widens the health gap between urban and rural elderly that has existed from the beginning. Moreover, with increasingly expansive urban development, the daily mobility of residents often makes relationships between neighbors less close (Wisnujati & Mardikaningsih, 2021). Policies for the equal distribution of health personnel through placement incentives in remote areas have not yet succeeded in addressing this issue adequately. Financial incentives alone are not enough because professionals also consider access to children's education and other supporting facilities. On the other hand, developing the capacity of local personnel through training and distance education shows potential that has not been optimally tapped. Telemedicine could be a partial solution to overcome distance barriers but requires technological infrastructure that is not yet evenly distributed. A

combination of various strategies is needed to address this distributional imbalance systematically.

The financing of health services for the elderly faces dual pressure from both the demand side and the supply side simultaneously. On the demand side, the number of elderly people requiring services continues to grow along with population aging (Galera et al., 2017). On the supply side, the cost per unit of service for the elderly is higher due to the complexity of cases and longer lengths of stay. Capitation payment mechanisms commonly used in primary care encourage efficiency but do not encourage preventive care for the elderly. Public health centers (*puskesmas*) that receive capitation payments per capita per year have no incentive to provide services beyond the minimum required. In such difficult situations, support from the surrounding environment and the active participation of citizens are highly needed to help one another (Zulkarnain et al., 2021). Meanwhile, the elderly with multimorbidity require longer consultation times and more frequent visits compared to young adult patients. The mismatch between real needs and existing financial incentives results in the elderly receiving inadequate services. On the other hand, fee-for-service payment systems encourage an increase in the volume of services that are not always medically necessary. Hospitals have incentives to extend the length of stay or perform unnecessary procedures because every action generates income. The quality of service provided by medical personnel is indeed the main key to ensuring patients feel satisfied and comfortable (Khayru & Issalillah, 2022). Mixed payment systems that combine capitation for basic services and fee-for-service for complex services have not been widely implemented. Designing the right payment mechanism remains an unresolved technical challenge in most health systems.

Financial protection for the elderly from low economic groups is a fundamental issue of justice in the provision of health services (Pannarunothai, 2021). The elderly with fixed incomes and limited assets face the risk of financial catastrophe if they experience serious illness. Hospitalization costs, routine medication purchases, and transportation costs to health facilities drain savings that should be for basic needs. Many underprivileged families living in densely populated areas often struggle to meet their daily food needs (Mahmudah, 2021). Many elderly

people decide not to seek treatment even though their health condition requires intervention due to fear of costs. This decision often results in a worsening of the condition, which actually requires greater costs later on. Social insurance-based health financing schemes are designed to protect against such financial risks through mutual cooperation mechanisms. Sometimes, mental health issues are still viewed negatively by some families, so legal protection is highly necessary (Zahid et al., 2022). However, elderly participation in insurance schemes is often hampered by complicated registration procedures or a lack of information. Elderly people who are not registered in health insurance must bear all service costs independently from their limited income. The poorest groups of elderly often qualify for premium assistance but do not know the procedures to access it. Even among those registered in insurance, out-of-pocket cost reductions remain a significant burden. Comprehensive financial protection requires the elimination of out-of-pocket costs for essential services for the poor elderly.

The physical design of health facilities often ignores the specific accessibility needs of the elderly population with mobility limitations (Mustofa & Rinawati, 2020). Doors that require significant strength to open, narrow hallways, and stairs without handrails are common physical barriers. Bathrooms without grab bars and slippery floors create a high risk of falling for the elderly with balance issues. Environmental problems like these often affect community groups living in less healthy places (Issalillah & Mardikaningsih, 2022). Parking areas far from the facility entrance make it difficult for the elderly who use walkers or wheelchairs. Registration desks that are too high make it difficult for elderly people in wheelchairs to communicate with staff. Waiting chairs that are too low or without armrests make it difficult for the elderly to sit and stand safely. Signage with small letters or low color contrast is unreadable by the elderly with declining visual function. Patient satisfaction levels highly depend on how good the service they receive is and how easily the location can be reached (Mardikaningsih, 2022). Inadequate lighting increases the risk of tripping or losing orientation for the elderly with visual impairments. Universal design standards that ensure accessibility for all age groups and abilities are widely available. However, the application of these

standards in the construction and renovation of health facilities is still very limited. The additional cost for design modifications is often cited as the main reason for non-compliance with accessibility standards. This argument is weak because modification costs at the planning stage are much lower than renovations after the building is standing.

Administrative procedures in the healthcare delivery system are often unfriendly toward the elderly with cognitive and sensory limitations (Oyekola et al., 2021). Registration forms with small print and complicated language are difficult to understand for the elderly with low education or visual impairments. Identity verification processes that require multiple stages and different documents confuse the elderly with memory impairments. Long waiting times without clear information regarding the cause of delays cause anxiety in the elderly. Queue systems based on sequence numbers announced through loudspeakers are inaccessible to the elderly with hearing impairments. We need to understand that everyone has different ways of facing problems, especially when dealing with public services (Darmawan et al., 2021). Administrative staff who are rushed and impatient with elderly people who respond slowly worsen the negative experience. The digital transformation of administrative services through smartphone applications further marginalizes the elderly with low digital literacy. Online registration mandated by several health facilities assumes that all patients own and are capable of operating a smartphone. This assumption is unrealistic given the low adoption rate of digital technology among the elderly, especially those from low economic groups. These complicated and unfriendly administrative procedures serve as significant non-medical barriers to service access. The elderly may decide not to access services at all rather than face administrative complexities. Simplifying procedures and training staff in communication with the elderly are simple yet high-impact interventions. Hopefully, with more attention, the quality of life of our community can become even better in the future (Khayru & Issalillah, 2022; Mardikaningsih, 2022).

Stigma against aging and the elderly internalized within society and the healthcare delivery system affects the quality of clinical interaction (Saif-Ur-Rahman et al., 2021). The elderly are often treated with a paternalistic attitude that underestimates their capacity to make their own decisions about healthcare. Health workers may not explain

treatment options fully, assuming the elderly will not understand them. We need to remember that every public policy made must have a strong legal foundation so that community welfare is truly guaranteed (Rizky & Udjari, 2021). Medical decisions are sometimes made without involving the elderly in meaningful discussions about risks and benefits. This attitude is a form of age discrimination or ageism that reduces the autonomy of the elderly as patients. The elderly with mild cognitive impairment still have the capacity to participate in decision-making with appropriate support. Paternalistic treatment can reduce adherence to treatment plans because the elderly feel unvalued as individuals. On the other hand, elderly complaints about pain or other symptoms are often dismissed as a normal part of aging that does not need to be taken seriously. As a result, conditions that are actually treatable go unaddressed because they are ignored by health workers. Stigma also affects resource allocation, with elderly care often viewed as a less valuable investment. This perspective ignores the fact that many elderly people still contribute socially and economically in various capacities. Therefore, the government must demonstrate good leadership and truly care about public services oriented toward the interests of citizens (Rojak, 2021). Changing stigma requires simultaneous interventions at the individual, institutional, and policy levels.

Families striving to provide care for the elderly at home face significant physical, psychological, and financial burdens (Rosnu et al., 2022). Physical burdens arise from caregiving activities such as assisting with mobility, bathing, dressing, and eating, which require physical strength. Psychological burdens stem from the stress of witnessing the suffering of a loved one and concerns about the inability to provide optimal care. Life in big cities is indeed often full of challenges and striking differences in economic levels, which make this burden feel even heavier (Mardikaningsih, 2021). Financial burdens originate from medical costs not covered by insurance, the purchase of assistive devices, and loss of income due to reduced working hours. The combination of these burdens often leads to a condition known as caregiver burnout. Family caregivers experiencing burnout are at high risk for depression, sleep disturbances, and other physical health problems. The quality of care provided also declines when the family caregiver is in a state of

exhaustion. The healthcare delivery system rarely provides adequate support for these family caregivers. Training on correct care techniques, psychological counseling, and respite care services are very limited in availability. Respite care is a temporary care service that allows family caregivers to take a break from caregiving duties for a while. Without this support, many family caregivers are eventually forced to place the elderly in institutional care because they can no longer cope. This issue shows how important it is for us to support each other so that the burden of life feels lighter (Rizky & Udjari, 2021; Rojak, 2021). This phenomenon demonstrates that support for family caregivers is a crucial intervention to delay or prevent institutionalization.

The availability of institutional care services such as nursing homes is very limited and unevenly distributed in most regions. The number of beds in long-term care facilities is far below the actual needs of the elderly population. Existing facilities are also often concentrated in urban areas, making them inaccessible to the rural elderly (Frimpong et al., 2019). The quality of service between facilities also varies greatly, with most operating below minimum standards. Amidst the bustle of the city, people usually form groups based on similar hobbies or interests to stay connected (Rejeki, 2021). Many nursing homes are managed by religious or philanthropic organizations with very limited resources. The shortage of trained staff in institutional facilities results in inadequate care quality. The ratio of staff to residents is often too low to provide the necessary individualized care. The negative stigma toward nursing homes as places for "discarding" parents reduces the interest of families in using them. Families feel guilty if they place the elderly in a nursing home because it violates the norm of filial obligation. On the other hand, the elderly themselves often refuse to enter nursing homes for fear of losing independence and social contact. This serves as a reminder for all of us to always maintain togetherness within our living environments (Mardikaningsih, 2021; Rejeki, 2021). Alternatives such as senior housing groups with mutual support or co-housing have not developed widely. Community-based care models that combine independence with access to support when needed show great potential. However, the development of these alternative models requires investment and regulatory changes that are not simple.

Digital technology offers opportunities to overcome several challenges in elderly care but also creates new ones. Telemedicine enables remote consultations, thereby reducing the transportation needs for elderly people with mobility limitations (Lotfalinezhad et al., 2021). Remote health monitoring devices can provide early detection of changes in clinical conditions, thus preventing deterioration. The use of modern technology such as artificial intelligence is now beginning to significantly change the way the health world works (Khayru, 2022). Automated medication reminder systems can improve treatment adherence in elderly individuals with memory impairments. Video communication applications allow the elderly to stay connected with family members living geographically far away. However, all these technological solutions assume that the elderly have access to hardware, an internet connection, and digital literacy. This assumption is not met for the majority of the elderly, especially those from generations who did not grow up with digital technology. Elderly people with cognitive or sensory impairments also face greater difficulties in using digital interfaces. The lack of interface designs that consider the needs of the elderly exacerbates these accessibility issues. The digital divide between the elderly and younger age groups can widen the inequality of access to health services. Solutions relying on digital technology must be accompanied by digital literacy programs for the elderly and non-digital options. Although technology is very helpful, we must still ensure that the way we work remains efficient and does not waste time (Radjawane et al., 2022). A hybrid approach that combines technology with direct human interaction is the most realistic middle ground.

Elderly care policies are often scattered across various ministries without adequate coordination mechanisms. The Ministry of Health is responsible for the medical aspects of elderly care but lacks authority over social aspects (Yusran & Sabri, 2020). The Ministry of Social Affairs manages social assistance programs for the poor elderly but is not linked to health services. The Ministry of Housing regulates public housing policy but does not consider the need for modifications for the elderly. Many workers in the city who have precarious jobs also feel anxious about their future in this fast-paced environment (Mahmudah, 2022). The Ministry of Transportation manages public transport which is often

unfriendly toward the elderly with mobility limitations. This fragmentation of authority results in no clear "problem owner" for comprehensive elderly care. Each ministry works in its own silo with different priorities and budgets. There is no mechanism that compels these various ministries to sit together and formulate an integrated plan. Consequently, the interventions carried out are partial and often do not support one another. The establishment of special agencies for elderly affairs at the ministerial level has been implemented in several countries. These agencies function as coordinators between ministries and ensure that elderly care policies are integrated. We all must learn to work more neatly and in an organized manner so that all plans can run according to expectations (Radjawane et al., 2022; Mahmudah, 2022). The experience of various countries shows that institutional coordination is a critical factor for the success of elderly care policies.

Individual care planning is an essential instrument for managing the complexity of elderly needs. This document contains a comprehensive assessment of medical conditions, functional capacity, social support, and the personal preferences of the elderly (Haimi & Gesser-Edelsburg, 2022). Based on this assessment, a care plan is formulated that includes goals, necessary interventions, and the party responsible for each intervention. Individual care plans are dynamic and must be reviewed periodically as the elderly person's condition changes. The implementation of individual care plans requires coordination among the various service providers involved in elderly care. Unfortunately, the practice of developing individual care plans has not yet become a standard in most service systems. This document is often non-existent or exists only informally in non-standardized notes. The absence of individual care plans results in care that is reactive rather than proactive. Every time a new problem arises, management starts from scratch without considering the broader context. Ultimately, the main goal of all these efforts is so that we can live more peacefully and comfortably with our loved ones (Khayru, 2022; Radjawane et al., 2022). The systematic application of individual care plans requires investment in health personnel training and documentation systems. However, the benefits of this investment are significant in terms of improving the quality and

efficiency of elderly care. Countries with advanced elderly care systems have made individual care planning a standard practice.

Aspects of spirituality and the meaning of life are often overlooked in discussions regarding the provision of health services for the elderly (Asadzadeh et al., 2022). Yet, for many elderly people, spiritual health is just as important as physical health in determining quality of life. Elderly individuals approaching the end of life often grapple with questions about the meaning of the life they have lived. Spiritual support can help the elderly find peace and acceptance toward the physical limitations they experience. This indicates that good policy must always prioritize health and justice for everyone without exception (Issalillah, 2021). Health personnel rarely have training to detect and respond to the spiritual needs of elderly patients. Health service systems generally strictly separate medical and spiritual aspects for reasons of secularism. However, this separation ignores the fact that for many elderly people, these two aspects are inseparable. Pastoral services or spiritual counseling should be standard components of comprehensive elderly care. Collaboration between health personnel and religious leaders can ensure that the spiritual needs of the elderly are not neglected. Elderly individuals who receive adequate spiritual support show better overall health outcomes. Mechanisms and infrastructure to integrate spiritual support into health care need to be developed systematically.

The involvement of the elderly in planning policies related to their own lives is very limited (Ho, 2022). Elderly care policies are generally formulated by policymakers who are relatively young without direct experience as elderly people. Assumptions about what is good for the elderly often do not align with the preferences of the elderly themselves. The elderly desire independence and control over their own lives as much as possible. In carrying out their duties, decision-makers must possess honesty and integrity so that justice is maintained (Saktiawan et al., 2021). However, policies are often designed based on the assumption that the elderly are a passive group in need of protection. This approach ignores the agency capacity of the elderly and their right to determine their own life path. Public consultation forums on elderly policy are rarely attended by the elderly due to accessibility barriers. The timing and location of meetings often do not consider the mobility limitations of the

elderly. Discussion materials are presented in formats that are difficult for the elderly with sensory limitations to access. Consequently, the voices of the elderly are not represented in the policy processes that determine their lives. The principle of "nothing about us without us," which originates from the disability movement, is also relevant for the elderly population. Elderly care policies must be formulated with meaningful participation from the elderly as primary stakeholders.

Gender differences in the elderly population have important implications for health service needs (Carvalho et al., 2017). Women have a longer life expectancy compared to men, so the number of elderly women is much larger. Elderly women are also more likely to live alone due to the higher mortality rate of male partners. This condition of living alone makes elderly women more vulnerable to social isolation and a lack of support. In this highly individualistic age, we need to re-strengthen our sense of togetherness and social responsibility (Saputra & Darmawan, 2021). Elderly women also face a higher risk for conditions such as osteoporosis and arthritis that affect mobility. On the other hand, elderly men have a higher risk of heart disease and stroke. These different disease patterns require specific prevention and treatment approaches according to gender. However, most clinical guidelines do not differentiate recommendations based on gender for the elderly population. Elderly women also face double discrimination due to factors of age and gender in accessing services. The average pension income for women is lower due to work histories interrupted by caregiving roles. As a result, the financial ability of elderly women to access health services is more limited compared to elderly men. Therefore, every legal step and advocacy must be based on good intentions to defend the truth (Saktiawan et al., 2021). Elderly care policy must be sensitive to these gender dimensions in program formulation and resource allocation.

Community-based approaches to elderly care show better results compared to purely institutional approaches in various studies. This approach allows the elderly to remain in familiar surroundings while still accessing necessary services. The elderly can maintain social networks that have been built over many years in their living environment. A sense of belonging to the community contributes positively to the mental health and well-being of the elderly. Efforts to improve the quality of life

of the community must indeed start from policies that support equal rights (Issalillah, 2021). Home care services allow medical and non-medical care to be provided at the elderly person's home by professional staff. Senior activity centers provide a place for socializing and participating in meaningful activities on a regular basis (Wiles et al., 2012). Home visit programs by trained volunteers reduce social isolation for the elderly who rarely receive visitors. *Posyandu lansia* (integrated service posts for the elderly) driven by community health cadres have proven effective in the early detection of health problems. All components of this community-based approach require good coordination between various local stakeholders. Local governments are in a strategic position to develop and manage this community-based approach. Flexibility in tailoring programs to local conditions is a major advantage of the decentralized approach. However, this approach requires a sustainable budget commitment from local governments that often face fiscal constraints.

The integrated elderly care model between the health and social sectors is the most promising direction for reform. The separation between health services and social services in practice is often artificial because both needs are closely interrelated (Choudhary, 2019). An elderly person hospitalized for pneumonia cannot be discharged if there is no social support at home. Delays in discharge due to social problems are referred to as "bed blocking," which harms the system as a whole. It is very important for us to remain united and care for one another for the collective good in the social environment (Saputra & Darmawan, 2021). Similarly, elderly people with unmet social needs will experience preventable health declines. Service integration means that both types of services are planned, funded, and delivered in a coordinated manner. A single point of responsibility for both types of services eliminates coordination issues between different agencies. Integrated budgets allow for a shift of resources from expensive services like hospitalization to preventive services. Success measurement must also change from sector-specific indicators to outcome indicators for the elderly as a whole. The implementation of this integration faces challenges due to differences in professional traditions, financing schemes, and regulatory frameworks. However, various countries such as Japan and the Netherlands have

successfully implemented integration models with positive results. We all hope that every public service can be carried out with full integrity and responsibility (Saktiawan et al., 2021; Issalillah, 2021). Their experience provides valuable lessons for other countries embarking on a similar reform path.

Conclusion

The transition of social support for the elderly faces a fundamental shift from family-based informal patterns toward a dependency on formal systems that are not yet prepared. The weakening of family care capacity due to demographic structural changes, urbanization, and women's participation in the workforce creates a service vacuum that is not filled by the formal system. The health system demonstrates structural inability in responding to the specific needs of the elderly with multimorbidity because the organization of services is fragmented based on disease specialization. Coordination between service levels and between the health and social sectors does not function optimally, resulting in elderly care that is non-integrated. The physical design of health facilities, administrative procedures, and the competency of health personnel are not yet adaptive to the functional limitations of the elderly. Stigma against aging affects the quality of clinical interaction and the allocation of resources for elderly care. Families striving to provide care at home face an excessive burden without adequate system support. Community-based approaches and the integration of health and social services represent the most promising reform directions to overcome the identified challenges.

The theoretical implication of this discussion is the need to reformulate the concept of social support systems to no longer assume the existence of the family as the main pillar of elderly care. A new analytical framework must acknowledge the structural gap between the declining capacity of informal support and the limited capacity of formal support. Practically, the government needs to develop integrated elderly care policies across ministries with clear coordination mechanisms. Health financing systems must be reformed to create incentives that encourage preventive and coordinated care for the elderly. Universal design standards for health facilities need to be strictly enforced in every

construction or renovation. Health personnel education curricula must include geriatrics as a core component with adequate instructional hours. Support programs for family caregivers, such as training, counseling, and respite care, need to be expanded in reach. The development of community-based care models and the integration of social health services must become long-term reform priorities.

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