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Waiting for "Good Care". Biomedicine and the Elderly in North Sulawesi, Indonesia

Dans l'attente de « bons soins ». Biomédecine et personnes âgées en Sulawesi du Nord, Indonésie

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Waiting for "Good Care"
Biomedicine and the Elderly in North Sulawesi, Indonesia

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Older Indonesians' Encounters with Biomedicine

Health and illness denote inherent features and phases when a person grows old. In old age, being healthy and becoming ill both represent meaningful conditions and dynamics where the entanglement and coalescence of human biology and culture intrinsically shape our aging (Lock 1993; Manderson, Cartwright & Hardon 2016; Sokolovsky 2020). Hence, health practices that consciously and necessarily maintain and restore health in advanced age have gained in importance in most societies. Health in old age has become an increasingly precious value, an indispensable resource, a significant outcome, and an essential right (UNFPA & HelpAge International 2012; WHO 2015). Consequently, medical cultures, their medicines, and their practices, contribute to the shaping of health landscapes that advocate and engage with the comfort and well-being of older persons as well as their materialities of cure and care.

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Older persons recognize biomedicine as a potential performer and transformer in such health landscapes. Yet, the Indonesian case of urban North Sulawesi reveals significant fields of incompleteness as regards provided curative services in the healthcare system from the perspective of elder citizens. Moreover, the current demographic, epidemiological and social transformations in Indonesia manifest a further major shortcoming of the built healthcare system, namely the provision of eldercare on local level. This paper looks at the experiences and hopes of older Indonesians with regard to a more complete delivery of both biomedical cure and care, and illuminates a biomedical system that only slowly recognizes elder people as part of an emerging "health market" but until now has failed substantially to figure out the health needs of the elderly and so keeps them excluded and invisible.

The general historicity of health and medicine in Asia, and particularly in Island Southeast Asia, shows biomedicine as "late-comer" in the wake of European and American colonial expansion. The seminal works of Leslie (1976) and Leslie and Young (1992) on Asian medical systems and their relevant knowledge delineate a vivid scientific medical pluralism including Chinese medicine, Ayurvedic medicine, Islamic humoral medicine, and many local or regional medical traditions, where cosmopolitan or allopathic medicine (or contemporary biomedical) encounters and faces different health epistemologies, varying understandings, and thus new practices of how to interpret, explain, and decode health and illness and act on them. In Indonesia, too, biomedicine came late with the Dutch expansion into this huge archipelago (Boomgaard 1993; Boomgaard, Sciortino & Smyth 1996)—and it encountered socially well rooted, culturally widely accepted and complex medical systems with partly long-standing traditions such as the Javanese *Jamu* phytopreventive and -therapeutic medical culture with its local health specialists (Afdhal & Welsch 1988).

The role of biomedicine in Indonesia after Independence (1945) was strongly shaped by the politics and ideologies of the first two presidents, namely Soekarno ("Father of the Republic of Indonesia": Old Order) and Soeharto ("Father of Development": New Order), whose length of rule encompassed more than half a century. In these 53 years under the two presidents, biomedicine acted as a nationalist vehicle of decolonization, statehood, and nation-building (in the Old Order), and functioned as depoliticized, top-down applied logical framework for development, modernization, and progress (in the New Order). It represented a rather narrow biomedical concept with vertical programmes of infectious disease control and eradication, based on curative-clinical hospital medicine and basic technical practices of Primary Health Care (Harper & Amrith 2014; Neelakantan 2017; Pols 2018). "However, the legacy of the colonial era was a health system focused primarily on diagnosis and treatment, and for government personnel and the military" (Agustina et al. 2019: 77). These healthcare services were mainly provided and thus available in sufficient quantity in urban areas of Java and Bali, but much less or not at all in the remote areas of the so-called Outer Islands such as Sulawesi, Moluccas, and Nusa Tenggara (Koesoebjono-Sarwono 1993). "Aside from this, the health and welfare of the elderly should become a public policy

concern in themselves. This will necessitate shifts in public health research and facilities" (Niehof 1995: 427). Hence, it is a self-evident reality in early national health policy created after independence in Indonesia that special health services and programmes for older persons were not yet established or in name only until the beginning of the 21st century (Mujahid 2006).

The period of "awaiting biomedicine" thus covers a large part of the life course of today's older Indonesians aged 60 years and more. Yet, biomedicine is not a completely foreign phenomenon for most of them: In their childhood, adolescence, and early adulthood they experienced medical interventions such as malaria, tuberculosis, measles, and hookworm reduction programs as well as Primary Health Care programs including growth monitoring, immunization, nutritional programs, and family planning initiatives (Berman, Ormond & Gani 1987; Gish, Malik & Sudharto 1988). Furthermore, for most Indonesians who reach 60 years today the introduction of community health centers (*Pusat Kesehatan Masyarakat: PusKesMas*) in every subdistrict (*Kecamatan*) in the 1970s and of integrated community health service posts (*Pos Pelayanan Terpadu: PosYanDu*) in every village (*Desa*) in the 1980s epitomized a first successive approximation and substantiation of the above mentioned biomedical health provision at a regional and local level—a structural, material, and administrative state that remained in place for decades until the end of the presidential era of Soeharto in 1998 (Agustina et al. 2019).

The first twenty years of the 21st century reveal distinctly that Southeast Asia, including Indonesia, is undergoing a very significant demographic, epidemiological, and social transformation (Hugo 2000; Kinsella 2000; Arifianto 2008; Lutz et al. 2009; Schröder-Butterfill 2012). One particular outcome of this multifaceted dynamics is a rapidly growing aging society in Indonesia: (1) whose older people increasingly suffer from non-communicable illnesses, aging impairments, and old and newly emerging communicable diseases; (2) whose systems of care no longer ensure the provision of expected normative social and psychological eldercare; and (3) whose financial and material support can no longer be guaranteed for its aged members. In the light of this "triangle of uncertainty" (Eeuwijk 2006a: 63) it is hardly surprising that frail older Indonesians develop high hopes in biomedicine which they presently consider not yet fulfilled. "Awaiting biomedicine" in these rapidly changing times thus represents not only the expectation of older Indonesians regarding a much more intensive commitment by the current healthcare system for their health concerns, but also the quest for an appropriate, reliable, just, and equitable provision of biomedical cure and care for older persons.

In this article I shed light on the vision of the "right biomedicine and good care" developed and held by older persons in North Sulawesi Province in Eastern Indonesia. My case study, which indicates how aged Indonesians critically encounter and appropriate biomedicine—and, finally, biomedicine in turn starts to appropriate their health—, is set in Tomohon Municipality where I examine the (dis-)juncture between biomedical health providers and older persons at community and household level.

Exploring Older Persons' Experiences of the Municipal Healthcare Landscape

Tomohon, a city in the cool and fertile Minahasa Highlands, was formerly a small but important subdistrict (*Kecamatan*) within the extensive Minahasa District (*Kabupaten*) in North Sulawesi Province, before it officially became a municipality (*Kota*) in 2003 in the wake of national decentralization policy. Such a detachment from a district level entails the challenging task of upgrading, as soon as possible, all existing public services and infrastructures to match those of other administrative districts at what is known as Level II (*Daerah Tingkat II: DaTi II*). The first step includes, for instance, the provision of an operative biomedical health infrastructure, including hospitals, polyclinics, maternity facilities, nursing schools, health centers in all subdistricts, as well as a district administrative office. In Tomohon, however, such a decentralization process—especially in the education and health sectors—also means a gradual shift from decades-old healthcare services provided by faith-based organizations to state-delivered and -run health services.

Both religion and religious institutions play a significant role in health provision in the "City of Flowers." The 107,000 inhabitants of Tomohon belong predominantly (90 percent) to one of the Christian denominations, either Protestant, Roman Catholic, Pentecostal, or Seventh Day Adventist (BPS Kota Tomohon 2020). Furthermore, the Christian Evangelical Church in Minahasa (*Gereja Masehi Injili di Minahasa: GMIM*), the largest denomination in North Sulawesi Province, has its synod center in the city. For many decades, the two faith-based organizations (*GMIM* and Roman Catholics) have run most healthcare services in Tomohon—except for two state-run community health centers (*PusKesMas*)—which include two hospitals, three maternity clinics, and pioneering outreach Primary Health Care programs in several villages in the Tomohon area (Eeuwijk 1999). Many of the older inhabitants only know either one or the other of these two hospitals as a first entry point to the biomedical healthcare system: Protestants seek medical advice in "their" Bethesda Hospital, Roman Catholics in "their" Gunung Maria (Mountain of Holy Mary) Hospital. Located on the slopes of active volcanos in the Minahasa Highland, most villages (*Desa*) on the outskirts of Tomohon only enjoyed very basic public infrastructure facilities, including bad roads, no or an unreliable electricity supply, and no permanent biomedical health facility at the local level in the 1980s and early 1990s. Thus, most residents lacked the capacity to afford biomedical services in distant regions of North Sulawesi Province. Hence, people left their villages only very rarely during an illness episode and preferred to rely on local health provision which encompassed freely available kiosk drugs and traditional healers (*dukun, tonaas*) (Eeuwijk 1998). These local healing specialists were widely accepted and were prominent social actors. In general, one or two healers per village ward existed in each village (*Dusun, Lingkungan*), prompting the health services of the Christian faith-based organizations to launch a statewide program known as "Integration of Traditional Healers into Primary Health Care" (*Pengobat Tradisional sebagai Motivator PosYanDu*) in the field of preventive and

promotive medicine (Obrist & Eeuwijk 1993-1994). Moreover, the Protestant and Roman Catholic health services established a village-focused, yet hospital-driven, network of trained voluntary health cadres (*kader kesehatan*) or Village Health Workers (VHW), who ran the village dispensary (*pos obat*) and assisted the external biomedical staff from the nearby hospital in Tomohon who, once a month, worked the integrated community health service posts on their "doctor tour" (*torney dokter*) (Supit 1986; Eeuwijk 1998). This caderization of local lay helpers—in most cases young married women with one or two children—occurred in the wider, depoliticized New Order concept of top-down decreed "community participation" with the purpose of effectively delivering preventive and basic curative services at the local level within the biomedical framework of Primary Health Care (Berman 1984; Stark 1985; Koesoebjono-Sarwono 1993). Still, health provision especially for older persons was never part of such community participation programs at that time in North Sulawesi Province (Eeuwijk 1998). Not until the mid-1990s did a state-run, urban community health center in Tomohon—namely the one in Lansot—provide a few health activities to ill older people who attended the facility (Eeuwijk 2003). Moreover, by the start of the 2000s none of the two faith-based hospitals in Tomohon had yet established a geriatric ward (Eeuwijk 2006b).

In contemporary Tomohon Municipality, with its five subdistricts (*Kecamatan*) and 44 political communities (*Kelurahan*), 13.45 percent of the population are 60 years and older (BPS Kota Tomohon 2020). It indicates that Tomohon is rapidly progressing from an aging community (approximately 8 percent in 2000; Eeuwijk 2003) to an already aged society (*penduduk tua*); in Indonesia, the latter represents a demographic benchmark as soon as the proportion of older persons has reached 10 percent and more in a given population structure (Kementerian Kesehatan Republik Indonesia 2019; Utomo et al. 2019). The Office of Social Services (*Dinas Sosial*) in Tomohon Municipality applies the lower age bar of inclusion of 60 years for older people which corresponds with the National Aging Policy of 2003 and the official Indonesian age definition of *lansia*, the acronym for [*orang*] *lanjut usia*: [person in] advanced age (Department of Social Affairs 2003; Kementerian Kesehatan Republik Indonesia 2019).

In 2019, the biomedical infrastructure of Tomohon Municipality consisted of three hospitals (two faith-based organization-owned and one state-run since 2018), one polyclinic, eight community health centers (*PusKesMas*), 27 sub-public health centers (*Pusat Kesehatan Masyarakat Pembantu: PusTu*), and 17 mostly privately run pharmacies (*apotek*) (BPS Kota Tomohon 2020). Every subdistrict (*Kecamatan*) in Tomohon has at least one community health center and almost two-thirds of all political communities (*Kelurahan*) have their own sub-public health center. The formerly very prominent and popular local community health posts (*PosYanDu*) have become less important over the last ten years due to their replacement by sub-public health centers as well as to the improved availability and accessibility of the above-mentioned urban health facilities (including enhanced transport and communication) in this rapidly urbanizing environment. This significant restructuring of municipal healthcare services, which demand physical mobility

and cognitive agility on the part of their users, affects health practices of older, ill-health urbanites in particular ways (Eeuwijk 2020).

The political community of Lahendong in Tomohon Municipality and its government-registered "elderly association" (*kelompok lansia kelurahan*) take center stage in this article. Here this organization for older persons was founded in 2001 as an informal club of voluntary, active, aged people in Lahendong, regardless of gender, religious denomination, ethnic origin, socio-economic status, and marital status. In 2014 the group transformed into a formal association of older people and was consequently legally recognized by the community, sub-district, and district authorities. This political acceptance provided the permission, among other entitlements, to request biomedical assistance from the health services of Tomohon Municipality and to ask for financial and material support for older persons in need from district authorities. A year later, in 2015, the association became a member of the national network Organization for the Coordination of Social Welfare (*Lembaga Koordinasi Kesejahteraan Sosial: LKKS*), a private-public corporation with representation at all administrative levels. The two occurrences resulted in a broader and tighter horizontal and vertical interconnectedness of the association. Primary targets of this body which, since its beginning in 2001, has been managed and chaired by older women, include quite tangible, practical purposes such as social gatherings twice per month, the setting up of regular biomedical services, organizing eldercare at home by local voluntary cadres (*kader lansia*), lending (*pinjam*) of small amounts of cash to its members, cultural and religious activities in and outside the village, and social and emotional support in case a member falls seriously ill (Eeuwijk 2014, 2017, 2020).

My initial study of health issues in North Sulawesi Province in the mid-1980s included a broad survey on treatment practices and traditional medicine in different rural and urban areas. From 1990-1994, I conducted extensive field research in three remote villages in North Sulawesi Province which also encompassed older persons and related health problems. The main phase of my aging research in North Sulawesi Province lasted four years (2000-2004) and covered three urban sites including Tomohon. The study setting involved different societal levels: a community study, a household study, an age cohort study, and a tracer illness study (Eeuwijk 2003, 2005, 2006a). After 2005, I continued my aging research with a few related older persons and their families in the three above urban areas, with one to two face-to-face meetings per year and retrospective memory studies. From 2001 on, I started accompanying and studying the older person's association in Lahendong (Tomohon Municipality), and in 2013 applying a "Homecare Assessment Tool," a semi-structured interview guideline to qualitatively explore issues of health, cure, and care of 15 of the overall 120 association members and people from their household once per year (except in 2020 due to Covid-19 implications). For this contribution, I draw mostly on the annual interviews with older people from the association in Lahendong, from the intensive exchange—including discussions and direct observations—with many of its members, and

from the previous age-cohort and tracer illness study with chronically-ill older people in Tomohon in the early 2000s.

Biomedicine and its Appearance for Older Persons: A Local Case Study

The political community Lahendong with its roughly 2,600 inhabitants (in 2019) adjusts and aligns its provision of local biomedical facilities and services to the availability of secondary and tertiary biomedical care infrastructure in the city center of Tomohon. The three hospitals are a 20-30 minutes' drive away (by public bus) from Lahendong. This fairly good accessibility to important biomedical healthcare providers at any time outside the community leads to the medical reality that there is no private doctor's, nurse's and midwife's office, no pharmacy, and no polyclinic in Lahendong. Moreover, the main community health center (*PusKesMas*) in nearby Lansot closed the local integrated community health service post (*PosYanDu*) in 2012 and dismissed the remaining five health cadres who had operated this facility since 1995. Yet, in the same year (2012), a sub-public health center (*PusTu*) was established in the local public hall (*balai desa*); it is run by alternating staff from Lansot health center once a week on Thursday. Owing to the successful lobbying by the elderly association's chairwomen, an integrated community health service post for older persons (*PosYanDu Lansia*) was inaugurated in 2014. The public health center of Lansot with its professional staff also operates this local health post event once a month; it is assisted by ten local cadres for older persons (*kader lansia*). It is particularly this last-mentioned local healthcare facility—staffed by biomedical professionals and operated by well-acquainted voluntary female cadres—that the older Lahendong inhabitants have been waiting for a long time.

The schedule of the health center staff from Lansot and thus the operation of the local health post events for older persons are announced at the two monthly meetings of the elderly association as well as by word-of-mouth among the households with an elderly person. In Lahendong, this health post session is always held on the 24th of the month (except on a Sunday). It is strictly reserved for people aged 60 years and more, and only in emergency cases can ill or injured persons attend the facility. Pregnant women and mothers with under-fives are sent away to the sub-public health center, with the remark that they do not fit this age group and thus disrupt the health post's procedure and timing. Yet, many elderly ill people prefer to attend this facility with persons of the same age in order not to have to expose their suffering or disability to younger inhabitants: being ashamed (*malu*) and afraid of rumors (*kabar angin*) are their main reasons.

The local health post for older persons starts operations as soon as the staff—usually a physician, one nurse, two auxiliary nurses, and a driver/technician—have arrived from Lansot in their ambulance around 8.30 a.m. The venue is generally a spacious, stilted and thus sheltered private house in the middle of the long-

stretched village. 25-30 chairs are arranged in front of three laid tables so that every patient has the administrative, diagnostic, and treatment setting in sight—and is ready when a nurse calls his/her name. Privacy is not provided, but neither demanded by the older patients. After the medical equipment, the boxes containing drugs and plastic bags, the stationery with forms, paper, and pencils, and a glass jug for voluntary donations are placed on the tables, one of the association's chairwomen or a board member of a local Christian congregation opens the church mass (*ibadah*) which lasts for about 20 minutes and is completed with a common prayer. Following this, the host and members of the association offer some baked goods (*kukis*) and sweet tea or black coffee to all present. At that time, about 60 older persons are present; women and men sit separately. Before the consultations start, the physician and the nurse stand up and provide bits of important health information such as symptoms of lung tuberculosis, preventive measures against dengue fever, nutritional advice in case of hypertension, or changes in health insurance matters. In the meantime, a local cadre compiles a list of the names of all those waiting and hands it to the nurse.

When the first patient is called, he/she proceeds to the first table to settle administrative matters such as registration, verification of health insurance status (for instance, the Indonesia Health Insurance Card, *Kartu Indonesia Sehat: KIS*), examination of biomedical documents such as the Health Card for Older Persons (*Kartu Menuju Sehat Lansia: KMS Lansia*), and search for the patient file from a large carton on the table. From the first call on, every patient is accompanied physically and mentally by a local cadre for older persons who assists him/her during the entire process at the three tables. The diagnostic procedure at the second table, which is staffed by the nurse and two cadres, includes the recording of basic body data (such as weight and height) and of the current health condition along with person's comments. The nurse takes the patient's blood pressure and his/her pulse and, if indicated, listens to his/her chest with a stethoscope. These collected data are noted on paper which is passed on to the physician at table three. This third and final part relates to the biomedical curative measures which belong exclusively in the physician's realm. The general practitioner takes a short look at the paper with the patient's medical diagnostic data and his/her current health status. In nine out of ten cases, the physician issues a drug prescription, not least because many aged patients need nothing more than their medication for the next thirty days owing to their chronic disease(s). This "health encounter" between the biomedical professional and the lay patient at table three lasts no longer than three to four minutes. The drugs are either available immediately and handed over in a small plastic bag by the nurse or, if currently not available, they are obtainable for free from one of the drug stores in the city center in Tomohon. In general, and following this "health post stage", the local cadre explains to the patient the correct use of the medication in their common ethnic Minahasa language, Tombulu. Aged individuals who have other age-related complaints such as dental, hearing, visual or locomotive impairments can address the physician during this rather short medical round who can then issue a letter of referral to

a biomedical specialist in Tomohon. At around 12.30 p.m., health post activities come to an end after all patients have left. After a short mealtime blessing, the host family serves lunch for the association's administrative women, the health center staff, and any political community personnel present. The health center staff then return back to their health center in nearby Lansot at about 1.30 p.m.

The above-described setting, structure, and procedure of such monthly local health post meetings assume the symbolic nature of a biomedically informed ritual. Older persons who regularly attend these health post activities emphasize the formalized procedure ("it is always the same") based on replicable rules and comprehensible norms—and on recurrent identical practices. They are embedded in an almost solemn atmosphere of trust in technologies of high symbolic value and recognition (such as stethoscopes, sphygmomanometers, and pharmaceuticals), and into administration as a strengthening of competent disease management and control (such as measuring, reporting, and prescribing). Based on Luhmann's understanding of trust as a "mechanism of reduction of social complexity" (1968), trust in "health care as social institution"—represented, for instance, by such local health post sessions for older persons—supports older patients in minimizing systemic complexity objectified by biological changes, biomedical technology, and expert knowledge, and by the ritualistic characteristics of such an entity (Endress 2002; Gilson 2003). Moreover, the health post session as a healthcare ritual represents a closed, non-instrumental institution that emits a high degree of predictability. The recurrent use of formula-like wordings and portrayal-like gestures by health professionals strengthen not only the old persons' trust, but also their firm belief and conviction in biomedicine as a bearer of hope or as a just savior in times of crisis. Persons in advanced age not only increasingly experience the existential liminality of life and death (Eeuwijk 2017), but also an illness episode as a severe life crisis. For older persons, disease as a calamity that gets managed, diagnosed, treated, and finally controlled through biomedicine available at a health post, amounts to both a biological and a cultural transition in terms of van Gennep's understanding of rites of passage (1909): The described health post activities represent such a biosocial transition from a diseased and unruly and thus deviant body, through a phase of uncertain, but well monitored change, to a cured safe condition. Administration, diagnosis, and treatment symbolize such important transformative passages by overcoming uncertain liminality and reconfiguring societal order (Turner 1969) which is threatened and challenged, for instance, by sickness and health impairment.

Older persons experience "their" monthly health post meetings in Lahendong definitely as a meaningful social event that is linked with a biomedical routine check-up. The ambience at the gatherings encourages them to exchange information not only about their individual complaints, but also about general health issues—and, of course, talk about local occurrences and rumors. Moreover, this artificial social space of older people is widely used for the exchange of experiences with respect to a particular chronic disease or old-age impairment. For instance, a small group suffering from diabetes (*sakit gula*) or hypertension (*darah*

tinggi) might discuss their beneficial experiences with certain nutritional recommendations and physical exercise regimes, another group might exchange hints regarding the purchase of new cheap glasses, yet another talk about experienced side effects of a drug against gouty arthritis (*asam urat*), while some of the aged persons debate about the use and effect of a local medicinal plant against nocturnal spasms. In sum, such a health post exemplifies that a biomedical institution can induce a meaningful social space for older persons and even extend it.

Finally, the local voluntary health cadres for older people (*kader lansia*)—actually the important "silent helping hands" at these health posts—act as a kind of social, cultural, and psychological "glue" between the biomedical professionals and the older patients. They ceaselessly move among the elderly and commute between the health staff and their aged charges. Whether they translate oral specifications from Manado Malay into the ethnic language, physically support a frail grandmother, or weigh an aged patient—they act as practical go-betweens or brokers in support of both health providers and users. Nevertheless, the health cadres know the social, economic, emotional, and health situation of each older person in Lahendong very well, not least because they are often involved in the provision of quality eldercare at home. This means, they also go back and forth between the realm of care and the realm of cure. As a result, the health cadres are absolutely in the picture with regard to the older patients who attend the monthly health post. Yet, the transfer of health knowledge flows almost exclusively from biomedical professionals to health cadres, often in a fairly authoritative way. A favorable occasion for a common production of geriatric or gerontological knowledge (or its co-production)—for the benefit of frail, ill and/or disabled older persons—is thus forfeited.

Older Persons' Quest for Cure and Care

The above exploration of the local monthly health post meetings for older persons in Lahendong reveals that patients of advanced age experience only very short encounters with biomedical curative practices, which in almost all cases exclusively include the administration of drugs after a brief basic diagnosis. This short active stage of cure at a biomedical facility is followed by a much longer and rigorous period of care at home—a sphere in which biomedicine signifies no intention of being intensively involved. Accordingly, older persons in Lahendong express their distinct wish that both cure and care be biomedically assisted. They emphasize their hope that both cure and care become a genuine concern of the current biomedical health system in Tomohon Municipality—and not only cure. Referring to Janzen's seminal work on the "quest for therapy" (1978), cure and care for older persons encompasses not only the individual sufferer, but also his/her broader social, economic, and psychological environment, and in our case the existing biomedical health system. This quest for cure and care is implicitly and ideally associated with a process of augmenting the quality and quantity of

provided biomedical cure and of intensifying the biomedical interest and efforts in eldercare. In a more general way, Helman concludes that rapid aging resulting in an increasing number of chronically ill older people "will require a major shift in the medical paradigm [...], a shift from 'cure' to 'care'" (2007: 11).

Such a paradigmatic change in biomedicine is undoubtedly triggered by the rapid demographic and epidemiological transformations and, concomitantly, by the swift social restructuring in North Sulawesi Province: An increasing number of older persons suffer from non-communicable diseases and aging impairments and therefore need long-term care. Yet, such normatively expected, appropriate long-lasting eldercare provided by family, kin, and community is no longer ensured by the present social pattern of care assemblages (for Yogyakarta: Keasberry 2002; for East Java, West Java and West Sumatra: Kreager & Schröder-Butterfill 2007). In addition, current health profiles in our old-age studies in urban North Sulawesi provide ample evidence of such rapidly changing health conditions within the last twenty years. Our first research findings from the early 2000s show (in order of frequency) upper respiratory infections, hypertension, gastroenteritis, eye problems, diabetes mellitus, and dental problems as the most common diseases reported by older people (Eeuwijk 2003, 2005). About seventeen years later, in the late 2010s, aged persons reported hypertension, diabetes mellitus, upper respiratory infections, rheumatism, gastritis, and eye problems as their most frequent ailments (Eeuwijk 2017, 2020). Infectious diseases still remain high in frequency (such as respiratory infections and gastritis), but chronic illnesses (particularly hypertension, diabetes, and rheumatism) and aging impairments (for instance, vision deficiency) are on rapid increase and presently in the forefront of this health profile list. One can, therefore, speak empirically of a potential "triple burden of disease" for older people in North Sulawesi due to "unfinished agendas of health transition," when communicable diseases (the "old" agenda), non-communicable illnesses (the "new" agenda), and aging impairments (the "hidden" agenda) become concomitant sicknesses in an aging body. Most above-mentioned chronic diseases and aging impairments are of progressive-degenerative nature and thus leave little hope for complete health recovery on the part of the older sufferer. Therefore, the hope in biomedicine—ranging from regular medical check-ups at home to effective palliative care and to professional first aid in emergency cases—is still very much alive in the mind of Lahendong's older inhabitants.

All the more, quality and quantity of eldercare gain in importance—a care which is, up to now, provided primarily by family members at household level. The staff of the community health center does not make house calls, and even during the local health post meetings in Lahendong they do not visit older patients at home but, at the same time, bedridden, disabled and less mobile older persons cannot make it to the monthly meetings. Consequently, the most seriously ill and frail older patients pass up on the local health facilities and have to go and see a health professional in one of the three hospitals or in a private surgery in the center of Tomohon for which they again are dependent on the support of a spouse and/or children for transport. Furthermore, older persons suffering from

co-morbidity complain that the doctor at the local health post diagnoses and treats them only for one disease even if the patient lists more than one disorder, such as hypertension and rheumatism (Eeuwijk 2020). Among other things, this combination of diseases "interact[s] in complex ways with each other and with the social conditions in which they occur, and these relationships change over time" (Weaver & Mendenhall 2014: 104). This practice causes in older persons not only feelings of uncertainty and structural ageism—revealing that the problem is not their age, but the age-based discrimination (or invisibility they feel) inherent in the healthcare system (WHO 2015), and the need to urgently seek treatment beyond the community. Having to miss out on the local health system represents an important part of the caregivers' burden in terms of social, economic, psychological, and physical strain.

The true representatives of community-based eldercare are the voluntary local health cadres. In Lahendong, ten female cadres are still active. They all went through a two-week training course at the training center of the Protestant Bethesda Hospital in Tomohon. They live in the community, visit bedridden and frail older people at home at regular intervals, and act as liaisons between the households and the health authorities at the community health center. The cadres provide valuable and useful non-material services for older people and their caregivers such as health advice, information about preventive practices, and psychological assistance in care provision (for urban West Java: Azana, Gondodiputro & Didah 2019). As trained laypersons, however, they are not allowed to administer drugs or use syringes. They advise on dieting and on the right position for bedridden patients, take blood pressure, measure blood sugar, demonstrate physical exercises, and explain the intake of medication—but refuse to provide intimate care and sick-nursing. Moreover, they counsel caregivers about the biomedical referral system at district and provincial level—and, by this, they are also called in emergency cases such as hypoglycemia, falls, or heart attacks. Their close guidance and supervision of older patients in need of care at home leads to their growing understanding of health conditions and their development, patterns of drug utilization, visits by local traditional healers, lifestyle and caregiving circumstances with respect to an aged care-receiver. The cadres are also present during the gatherings of the old people's association and the local health post meetings even though the professional staff does not really consider them as part of the biomedical domain. Still, they play a meaningful role as mediators, not only between external health professionals and the older patients and their families, but also between an older care-receiver and his/her family caregiver(s) (for urban South Sulawesi: Sumardi, Seweng & Amiruddin 2020). Yet, they do not fully replace family and kin eldercare which, were this the case, would put in question the centrality of family in North Sulawesi societies (Eeuwijk 2020). I would rather speak of a "kinning the cadre" by an older person—in reference to Carsten's creation of kin-like relatedness through care (2000) and Thelen's "kinning the state" in volatile care relations (2014)—which entails the establishment of a pragmatic alliance or "partnership" with an individual cadre as a reliable and trustworthy care-provider which also

diminishes curative uncertainties such as drug shortage. In sum, from an older person's perspective "his/her" cadres in Lahendong are the central agents of biomedicine due to the high degree of cultural acceptance, social credibility, and familiarity with eldercare, which in turn creates trust in the existing healthcare system on the part of the aged person.

A critical reflection on the biomedical services for older persons provided at community level in Tomohon cannot get around noticing the minimal medical equipment at health posts, over-pharmaceuticalization in old-age treatment, denial of therapy in case of co-morbidities, certain modes of structural ageism, abandonment of home visits, and the health professionals' lack of respect for lay cadres. Aged persons suffering from chronic diseases and aging impairments make the point that they actually attend this health post because they are looking for good care but receive nothing but limited materialized cures. It seems that eldercare is definitely beyond the scope of the biomedical activities at a health post and tacitly transferred to the realm of family, kin, and a few non-kin at household level (for East Java and West Sumatra: Schröder-Butterfill & Fithry 2014; for urban and rural East Java: Pratono & Maharani 2018). The older persons' vision of "good care"—and with it of the "right medicine"—is strongly associated with the appropriate good cure and a reliable good care which are ideally provided by the biomedical health system in an equal, safe, effective, patient-oriented, and context-adapted way. Yet, the powerful image of biomedicine by means of objectification of old age and older persons' well-being held by health professionals leads increasingly to a social, cultural, and emotional disconnection between health providers and older persons—this invisibility of the elderly also applies to Lahendong.

Older Indonesians and Biomedicine: Who Appropriates Whom?

The history of biomedicine in Indonesia and the above analysis of a localized biomedical health system in Eastern Indonesia start from the conjecture that older Indonesians will appropriate biomedical practices and notions step by step. Such an appropriation of a "global good" "is fundamentally suited to understand the process of changes in consumption" (Hahn 2006: 229). Appropriation as transformation is in reference to Hahn (2014) a tiered process that consists of six stages: 1. acquisition; 2. material reshaping; 3. naming; 4. cultural reconfiguration; 5. incorporation; and 6. traditionalization. The success or failure of this process with respect to social acceptance can only be assessed after many years, which requires a high degree of willingness for internal societal change, and a delineated power structure that determines the agency of individuals and groups in accessing global goods and modes of consumption. Moreover, such an adaptive transformation can lead to the commodification as well as singularization of a particular object or practice—an ambiguity in societies which, simultaneously, construct both objects as goods and people as their buyers and sellers (Kopytoff 2005). In other words,

aged persons buy and sell at the same time "health" as a very unique and precious commodity as well as an alienable and purchasable good. They appropriate their "health" through biomedicine—and biomedicine appropriates the "health" of older persons. Particularly the latter process—biomedicine's appropriation of elderly health—gains increasingly in importance in rapidly aging societies such as Indonesia. The following four domains substantiate the reversed gaze on this mode of medical appropriation in Tomohon Municipality, namely (1) pharmaceuticalization of old age; (2) impact of formal health insurance; (3) biomedicalization in eldercare; and (4) elderly health as an emerging commodity and market.

Pharmaceuticalization of Old Age

Pharmaceuticals are considered to be the spearhead of older persons' encounter with biomedicine. Long before permanent health facilities were launched in Lahendong, its inhabitants could buy synthetic drugs at kiosks and small shops in the village or in drug stores and hospital pharmacies in the center of Tomohon. In the early 1990s, a drug post was established in Lahendong and run by voluntary health cadres who dispensed essential medications at a low price. Over the past decades, older villagers have increasingly held high hopes for the availability and accessibility of safe, effective, and affordable pharmaceuticals. Up to now, in Tomohon Municipality, drugs are usually sold freely over the counter, including many medications that are officially only obtainable by prescription. Nevertheless, pharmaceuticalization of physical and mental health already starts at the local health post where almost every older person obtains drugs that play a fundamental role in this monthly ritual. Biomedicine, by means of its medication, thus penetrates not only the realm of cure, but also that of care which occurs exclusively at home. Drugs consumed by ill older people in North Sulawesi Province comprise (in order of frequency) analgesics, cardiovasculars, and anti-inflammatory drugs due to being easily available, directly effective, and persistently preventive (against relapse) (Eeuwijk 2012). Moreover, vitamins, tonics, stimulants, energy drinks, and mineral supplements are increasingly and routinely consumed by elderly persons—and many Indonesian pharmaceutical companies actively promote the appeal of such life-style medicines for the elderly, such as PT Kalbe Farma, which sets up a booth during the monthly health post meetings in Lahendong to promote its nutritional, calcium-rich, high-energy formula Entrasol. Thus, elderly persons become a target of being appropriated by medicines, in this case by pharmaceutical companies, but, ironically, the healthcare system is still impermeable for most ill aged people (in Indonesia) where they yet remain an invisible, highly vulnerable age group. Older persons actually welcome synthetic drugs because they epitomize the power of a modern, advanced, professionalized, and scientific medical system—and with every swallow of a tablet such positive and powerful qualities are readily appropriated in a process of metaphorical embodiment of energy and strength. These "technologies of self and being" (Lyon 2005: 14) not only change the degree

of accessibility and availability of medicines and their modes of consumption, but they have also a direct impact on relations of appropriative medical authority (Petryna & Kleinman 2006). In particular, they have an impact on the management of an older person's therapy by pharmaceuticals and the control of the prescribed degree of his/her drug adherence. Such an implicit process of pharmaceuticalization as a biomedicalized form of authoritative control over particular sufferings stands for the medicinal commodification of aged person's physical experiences, health practices, and understandings by "attributing power to medicines beyond their active ingredients" (Whyte et al. 2002: 88). In sum, appropriation of older persons' health, "whereby problems—and therefore solutions—are framed in pharmaceutical terms, as conditions to be managed through drugs" (Lock & Nguyen 2018: 301), means to a large extent an optimistic dynamic in healthcare provision which older persons in Tomohon are definitely striving for. Pills and tablets distinctly represent an intensified commitment of biomedicine to be more concerned with old-age health and well-being.

Impact of Formal Health Insurance

Current schemes of health insurance for older persons and the biomedical health system are inherently intertwined in both mutual support and dependency—a constellation which prevails also in Indonesia (WHO 2017; Agustina et al. 2019; World Bank 2020). The introduction of the Social Insurance Administration Agency for Healthcare (*Badan Penyelenggara Jaminan Sosial Kesehatan: BPJS Kesehatan*)—established in June 2015 in North Sulawesi Province—as the main implementer of the current Indonesian National Health Insurance System (*Jaminan Kesehatan Nasional: JKN*) finally provided a big lift and sudden access to a formal health insurance scheme and thus to biomedical health care for millions of older Indonesians (Kaasch, Sumarto & Wilmsen 2018; Mizuno et al. 2018). Hence, elderly inhabitants in Tomohon "invested" high expectations in the introduction of health insurance in the hope that this will provide solutions for many of their health problems and related constraints by means of "a comprehensive benefit package with minimal user fees or co-payments" (WHO 2017: 10). Our study of the insurance situation in Lahendong reveals that in 2019 the large majority of older persons, namely between 85 and 90 percent, are insured BPJS members. Yet, 75 percent of the monthly insurance premium of these elderly people are paid by the local government because their families are not yet self-reliant (*belum mandiri*)—nota bene, the elderly can join this insurance only as a family member. The remaining 25 percent of premiums are covered by children or by the aged persons themselves as pensioners of a formal public or private corporation. Since the introduction of this state health insurance in this province in 2015, a rapid increase in attendance at all healthcare services by older persons has been reported. In Lahendong, the health post for elderly persons exemplifies such an evident growth, namely from 5-10 aged attendees per month in 2014 to 50-70 individuals in 2019. Older people name two biomedical services (at the health post) which they appreciate

most as BPJS members: firstly, the monthly medication for chronic diseases (most commonly hypertension, diabetes mellitus, and rheumatism), and, secondly, the doctor's referral letter to a community health center or a hospital in case of aging impairments (most frequently visual, hearing and dental problems). Non-orthodox medical systems provided in North Sulawesi Province such as complementary and integrative medicine (for instance, homeopathy, kinesiology, touch for health, massage, yoga, reiki), Javanese *Jamu* phytotherapy, traditional Chinese medicine, and the many forms of local traditional medicine are excluded from the scope of BPJS. This stringent structural regulation restricts the ill older persons to biomedicine and thus provides the strategic baseline for biomedicine to appropriate the health of aging Indonesians. In the parlance of critical medical anthropology, such a politically backed hegemonic position of biomedicine grounds on a favorable political economy of health—particularly through the structural interconnectedness of national health insurance, biomedicine, and legislative laws—so that any pluralistic features of health care (for instance, for the elderly) are denied (Singer 1990; Baer, Singer & Susser 2003). Without this plurality (and its concomitant access to inexpensive medicines and non-orthodox treatments), unequal and unjust social and economic conditions within health structures result for older persons needing care.

Biomedicalization in Eldercare

Older people in Tomohon certainly appreciate a higher commitment to biomedicalization in eldercare. Yet, such medicalization—depicted traditionally as a process in which "the medical community attempts to create a 'market' for its services by redefining certain events, behaviors, and problems as disease" (Lock 1988: 44)—is already taking place if only in invisible, implicit, and indirect ways of exercising control. This dynamic of biomedical appropriation of eldercare is most evident in three fields: 1. pharmaceuticals; 2. cadres for older persons; and 3. caregiving.

The first field, drug administration by biomedical health professionals, provides the elderly sufferer the social agency to justify his/her sick role and legitimate (costly) treatment for his/her chronic "silent killers" (for example, medical check-ups and medication) and to request appropriate care from close family members (Eeuwijk 2012). Most diabetic, hypertonic, and rheumatic older persons in Lahendong complain that these "diseases without illness" (Kleinman 1980) and the concomitant "chronification of uncertainty" (Mol 2008) lead to a permanent burden of proof: growing old with a biomedical diagnosis and affective ups and downs but without clearly visible symptoms. Therefore, the open display of pills and drugs discloses that he/she does not feel comfortable and will take leave of certain obligations and responsibilities within and outside the household, but without waiving any required treatment (Eeuwijk 2012, 2020).

If pharmaceuticals provide a certain social agency for older people in care arrangements, then the local cadres for older persons, the second field mentioned

above, exert a more immediate impact on elderly ill persons, if not necessarily in a coercive manner. The cadres are actually considered to be at the forefront of biomedicine, not least through their basic training, their proximity to the supralocal healthcare system, and their access to scientific knowledge: thus, they indirectly foster and promote the appropriation of elderly health by biomedicine. Their personal involvement and daily activities in cure and care of older sufferers make them the person who "carries" biomedicine into the household—by means of advice, manual support, first aid, and ultimately personal control over older individual's caregiver(s).

The last field mentioned above, elder caregiving as societal phenomenon, is centered on care as morality and ethics (Tronto 2009). Contemporary social science perspectives understand "care" as medical work (such as tangible interventions and technical operations), and as social practice (such as emotional-affective assistance and everyday help in the household). A further component of this perspective is to see care as a cultural norm (such as filial piety and kin obligation) and as a human virtue with individualized characteristics (involving commitment to other persons' impairment) (Kleinman & Geest 2009; Buch 2015; Drotbohm & Alber 2015; Eeuwijk 2017, 2020). In North Sulawesi society, too, medicalization by way of discursive power about the "right" caregiving enters the sphere of eldercare provision. Lay caregivers increasingly become the target of health professionals, local health cadres, and mass media (for instance, newspapers and social media) in order to hold them responsible and liable to provide medical measures for their older care-receivers compliant with biomedical standards. For example, with regard to the use of medication, observing a diet and physical exercise are required. Referring to Foucault (1976) and Brijnath and Manderson (2008), the medicalization of eldercare thus employs moral obligation, social pressure, hegemonic scientific knowledge, and state body politics to control the aged person as patient by disciplining first his/her caregiver(s) as the main provider of such curing power (Eeuwijk 2007). In a second stage, the caregiver him-/herself exercises substantial power on the older patient in order to ensure strict adherence to biomedical instructions. As a result, caregivers and ill elderly persons alike face growing pressure from authoritative health professionals to comply with biomedical prescriptions. Caregivers are thus given the responsibility—but not necessarily the competence and skills—to implement what is essentially a biomedical task (Eeuwijk 2007).

Therefore, the notion of "good care" and the current appropriation of eldercare by biomedicine has not yet been experienced by older persons in Tomohon. Biomedicine's concern and control of eldercare only extends as far as the medical work, but has no effect on the constraining social, cultural, affective, and financial care efforts, whose "healing" is fully delegated to lay caregivers.

Elderly Health as New Market

Older people's health as a medical market is rather a new phenomenon in North Sulawesi Province. Yet, the rapid increase in elder persons, their new health profiles, and the transformation of their socio-economic sphere lead to a growing trend of biomedicine appropriating elderly health, as both commodity and consumption with regard to an aging urban middle class—along the lines of "health sells well" (Eeuwijk 2014). Current biomedical discourses address older persons not only as patient or care-receiver, but increasingly also as potential consumers, customers, and clients of their services with (apparently) free choice in a neo-liberal, free-market health economy (Biehl 2011; Kehr, Dilger & Eeuwijk 2018; Lock & Nguyen 2018; Sokolovsky 2020)—or in other words: a growing "consumer citizenry […] of a greying cohort" (Samanta 2018: 93). In fact, biomedicine is steadily "discovering" the age-group "60 plus" and, in particular, the older middle-class urbanites who have access to daily newspapers, internet, and social media where most of the ads concerning elderly-specific health services and products are currently posted in North Sulawesi Province. The given frame of the political economy of health in Indonesia in fact excludes most non-biomedical health methods from (health economic) competition on equal terms with biomedicine. However, economic competitiveness in the health sector occurs particularly between public and private biomedical health providers, in North Sulawesi Province between government (including the Armed Forces), regional faith-based and national private hospitals. The latter is represented in Manado, the provincial capital, by the high-level hospital of the Indonesian Siloam Hospitals chain. It also offers geriatric medicine; a few diabetic older people in Tomohon know the Siloam Hospital from medical interventions due to renal failure and subsequent blood dialysis. In sum, biomedicine's appropriation of elderly health will certainly open up a new profitable market in Eastern Indonesia, thanks to expanding global gerontological models such as "healthy aging" or "active aging"—however, the older inhabitants of Lahendong are focused on a "biomedicalized local health market" that ensures, first of all, good quality in cure as well as active support in all spheres of care.

Older Persons, Biomedicine, Covid-19, and the Vulnerability of the Health System

The initial narratives in this article about appropriation of biomedicine take up the general, widely accepted assumption—at least in studies on aging and health—that older Indonesians strive increasingly for an appropriation of biomedical health-care provision (Eeuwijk 2012; Kadar, Francis & Sellick 2013; Agustina et al. 2019; Widayanti et al. 2020). The argument is based on the premise that biomedicine epitomizes a modern-day, efficient and therefore persuasive health system which is fairly compatible with (1) increasing chronic morbidity, (2) longer life expectancy, (3) changing household compositions, and (4) the transformed educational and

economic level of older Indonesians, and thus meets their fundamental physical and mental health needs (Eeuwijk 2006a; Gupta 2016). In sum, biomedicine's appeal to elderly people is reasonable and coherent. Yet, these narratives are also subject to temporality, which implies both transformation and disjuncture in such appropriation processes. The "reversed gaze" on biomedicine that embarks on the appropriation of elder health is based also on four previous basic domains and on a Global Health-induced realignment with enhanced commodification of (elder) health. This evolution toward inverted health appropriation, however, does not lead to an irreconcilable antagonism of two different directionalities of appropriation, but in some degree to a complemental mutuality. Starting from older persons' health experience in North Sulawesi Province it makes perfect sense when both appropriative directions place elder health at the center of their particular concerns in the near future. The case of the elderly persons in Lahendong reveals that, from their perspective, the two modes of appropriation should ideally aim at providing and utilizing an adjusted quality and quantity of health care as well as of social care.

More than twenty years ago, the "Asian Crisis" drove the Indonesian biomedical health system of the New Order to the brink of collapse. The sharp and all-embracing economic and financial decline at the national level in 1998 led, among other things, to a major breakdown of the Indonesian healthcare system, including established Primary Health Care with existential consequences on household health and the well-being of older persons (Koesoebjono & Sarwono 2003). Most families in North Sulawesi Province had to renounce regular access to biomedical healthcare due to its unaffordability and subsequent unavailability, and local traditional medicine, in particular herbal medicines, became a vital medical option (Eeuwijk 2000). Older persons still have strong memories of this multiannual period of drastic medical scarcity and resulting health impairments during adulthood at the turn of the millennium. Whereas particularly monetary reasons badly affected the Indonesian health system during the "Asian Crisis," the Coronavirus pandemic (Covid-19) in 2020 is severely hitting the communities in North Sulawesi Province due to the epidemiological situation which has turned out to be much more severe than the previous SARS (severe acute respiratory syndrome, in 2003) and the subsequent avian influenza outbreaks (in 2004-2005) (Davies 2019). Yet, physically and mentally, the older inhabitants of Lahendong have experienced the weeks of total lockdown in the first and partly the second half of 2020 as much more disruptive, constricting, and despairing than the hard times of the "Asian Crisis". The Covid-19 pandemic distinctly reveals the unreliability and fragility of the current healthcare system, and especially of the biomedical services for aged persons: no local health post and thus no dispensing of medical drugs, no visits of community health center staff, no home visits of cadres for older people, no supporting structure for (mostly female) caregivers, no immediate referral of severe cases to hospitals, no cheap kiosk drugs available, no health insurance premium payments possible—and no social gatherings of the "elderly association" to share health experiences and information. The long

absence of biomedical infrastructure, the sudden disruption of home visits and outreach programs, and the forced immobility of elderly people in need of care and their relatives disclose both the high degree of aged persons' care dependencies and the low degree of sustainability of biomedical activities at community level during the current Covid-19 pandemic. In sum, "Covid-19 reveals structures of vulnerability" of the national health system which have an "impact on individuals, families and communities" (Team & Manderson 2020: 671).

The administrative-geographical location of Lahendong within Tomohon Municipality significantly exacerbates the structural vulnerability of its biomedical healthcare provision in the age of Covid-19: Lahendong is located at the municipality's periphery, bordering on Minahasa District. This "invisible frontier" was suddenly and completely closed and therefore impermeable for the adjacent community of Lahendong, and the only road leading to the city center of Tomohon was impassable because of roadblocks at which non-residents were turned back due to tight social control. The week-long isolation of Lahendong affected especially those elderly persons who desperately needed their drugs once per month and medical check-ups in the case of non-communicable diseases, and who were dependent on regular supportive home visits by the local cadres. Yet, also minor matters such as the purchase of special dietary foods or of dressing material for diabetes-related wounds could not be attended to and consequently resulted in the deterioration of some older people's health. "Caregiving continues in environments of lack. The networks of care shrink in some cases, while blowing out in others," as Manderson and Levine (2020: 137) delineate eldercare in times of Covid-19. Moreover, the growing economic hardship in most households in Lahendong due to tight Covid-19 measures has resulted in the cancellation and non-payment of the monthly health insurance family premium which leads to elderly people's ongoing exclusion from free or low-cost treatment, including pharmaceuticals. The Covid-19 pandemic has distinctly shown that in North Sulawesi Province the appropriation of elder health through biomedicalization and particularly pharmaceuticalization feigns a certain degree of autonomy and release for an older person, for instance, in the case of diabetes; yet, it also creates a new form of coercive subjection and strong addiction, for instance, as far as insulin injections and medication intake are concerned. If this healthcare regime for frail and ill elderly people can no longer be maintained and even disintegrates in times of crisis—such as during the current Covid-19 pandemic—, this type of false independence for older persons clearly points to a growing vulnerability of the existing biomedical health system. In the end, this system-inherent, structural vulnerability makes older people even more vulnerable and thus demystifies their idea of "good care" in old age.

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Abstract: Older persons in North Sulawesi (Indonesia) shared a long experience with biomedical health interventions during Soeharto's New Order administration. These vertically and top-down structured development activities in health no longer fit current demographic, epidemiological, and social transformations in Indonesia. The rapidly aging communities, the sharp increase in non-communicable diseases, and aging impairments along with rapidly changing household assemblages call for a biomedical public health that ideally covers cure and care in equal shares. This understanding and vision of "good care" leads to a dynamic appropriation of biomedical services initiated by older persons. Here the monthly local health post sessions for elderly people occupy center stage of this appropriative process: a highly formalized and ritualized medical check-up based on the administration of drug which covers basic curative needs. In addition, the local cadres for aged persons play a significant role as intermediary and broker between an elderly patient, his/her caregiver(s), and the health professionals. Yet, except for the cadres' home visits, the existing biomedical health system is not very concerned with eldercare (or social care) at household level—for ill older persons fully dependent on kin care truly a "missing link." Biomedicine in turn increasingly attempts to appropriate elder health as its new market commodity. Thereby, the four fields of pharmaceuticalization, national health insurance scheme, biomedicalization as control and exercise of power in care, and commercialization of elder health support biomedicine in its pursuit of the hegemonic appropriation of older persons' health and illness. However, dislocations and disjunctures due to the Covid-19 pandemic clearly reveal the structural vulnerability of this biomedical health system: Its sudden unreliability and unsustainability leads not only to a loss of trust in it, but also to a higher degree of vulnerability on the side of older persons in need of cure and care.

Dans l'attente de « bons soins ». Biomédecine et personnes âgées en Sulawesi du Nord, Indonésie

***Résumé** : Les personnes âgées en Sulawesi du Nord (Indonésie) ont partagé une longue expérience des interventions sanitaires biomédicales pendant l'administration du Nouvel Ordre de Soeharto. Ces activités de développement de structure verticale et du sommet vers la base dans le domaine de la santé ne correspondent plus aux transformations démographiques, épidémiologiques et sociales actuelles en Indonésie. Le vieillissement rapide des communautés, la forte augmentation des maladies non transmissibles et des handicaps liés au vieillissement, ainsi que l'évolution rapide de la composition des ménages, exigent une santé publique biomédicale qui, idéalement, couvrirait à parts égales les remèdes et les soins. Cette compréhension et cette vision des « bons soins » conduisent à une appropriation dynamique des services biomédicaux à l'initiative des personnes âgées. Ici, les sessions mensuelles au poste de santé local pour les personnes âgées occupent la scène centrale de ce processus d'appropriation : un contrôle médical hautement formalisé et ritualisé basé sur l'administration de médicaments qui couvrent les besoins curatifs de base. Par ailleurs, les cadres locaux pour les personnes âgées jouent un rôle important d'intermédiaires et médiateurs entre un patient âgé, son ou ses soignants et les professionnels de la santé. Pourtant, à l'exception des visites à domicile des cadres, le système de santé biomédical existant ne se préoccupe guère des soins aux personnes âgées (ou des soins*

sociaux) au niveau des ménages – ce qui représente, pour les personnes âgées malades et dépendantes des soins de la famille, un véritable « chaînon manquant ». La biomédecine, à son tour, tente de plus en plus de s'approprier la santé des aînés comme sa nouvelle marchandise. Ainsi, les quatre domaines de la pharmaceuticalisation, du plan national d'assurance maladie, de la biomédicalisation en tant que contrôle et exercice du pouvoir dans les soins, et de la commercialisation de la santé des personnes âgées soutiennent la biomédecine dans sa quête d'appropriation hégémonique de la santé et de la maladie des personnes âgées. Cependant, les bouleversements et les déséquilibres dus à la pandémie de Covid-19 révèlent clairement la vulnérabilité structurelle de ce système de santé biomédical : son manque soudain de fiabilité et de durabilité entraîne non seulement une perte de confiance à son égard, mais aussi une plus grande vulnérabilité des personnes âgées qui ont besoin de soins.

Keywords: Indonesia, aging, health, eldercare, appropriation, biomedicine, pharmaceuticalization, Covid-19.

***Mots-clés**: Indonésie, vieillissement, santé, soins aux personnes âgées, appropriation, biomédecine, pharmaceuticalisation, Covid-19.*