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Analysis of Health Disparities Among Different Socioeconomic Groups in Indonesia: Implications for Health Policy

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| **ABSTRACT**The unequal distribution of economic resources can result in disparities in access to health services, particularly in lower-income communities where the lack of resources may limit the ability to obtain services that meet their specific needs. As is often the case in communities with lower economic status, individuals tend to prefer traditional medicine, facilitated by village shamans, over seeking care at nearby health facilities. In some literature, the factors contributing to the difficulty of accessing healthcare in communities with low economic status are attributed to two primary factors: internal factors and external factors. This lack of agency on the part of the community then gives rise to a middle ground in the form of a national health insurance program, commonly referred to as BPJS, which is accessible to people from a range of economic backgrounds. This study employs the descriptive qualitative research method, which involves a systematic and comprehensive examination of a given phenomenon or subject matter, with the objective of providing a detailed account of that phenomenon or subject matter in a way that is both accurate and insightful. The findings indicate that economic status continues to exert a significant influence on the manner in which health services are provided to the Indonesian population.**Keywords:** Health, Disparity, Socioeconomic, Policy  |

**INTRODUCTION**

Economic disparity is an imbalance in the distribution of economic resources, affecting individuals and groups. The existence of a gap between those who have more and those who have less inevitably creates an injustice in the distribution of those resources, which are considered important in a society. The socio-economic gap is an imbalance in the fulfillment of economic needs between groups, and thus indirectly reveals the existence of a gap.

The socio-economic status of the community is highly diverse, which has a significant impact on the overall health of the nation. This discrepancy in economic status is a primary factor influencing the ease and difficulty of access to health services, despite the fact that As stated in the 1945 Constitution, Article 28 H, paragraph (1), "All individuals have the right to live in a state of physical and mental wellbeing, to reside in a healthy environment, and to receive health services."

In order to actualize the ideals of the nation set forth in the fifth point of Pancasila on the principle of justice, the government is endeavoring to implement a health program targeting the middle to lower class population, with the objective of facilitating their access to health services. However, despite these efforts, many individuals continue to encounter challenges in receiving adequate attention through this government program.

The primary objective of health services is to enhance public health and prevent the onset of disease through community counseling, with the ultimate goal of reducing the prevalence of the targeted illness. In Indonesia, these health services are typically delivered by community health centers (Röhr *et al.*, 2023).

Subjectively, certain groups of people experience inequality in obtaining the right to health services. Some elderly individuals perceive a lack of attention from health services, which they feel are designed with a focus on younger, more productive populations. Women report that their role in determining contraceptive use is undervalued compared to that of men. Those from lower socioeconomic backgrounds also report limited access to education, which they believe negatively impacts their ability to make informed decisions about their health.

In quantitative terms, inequality can be defined as a difference in numbers, which is referred to as "inequality." When this difference pertains to health issues, it is classified as health inequality. To provide an illustration, there might be a discrepancy in life expectancy between region A and region B. Alternatively, there might be a disparity in the number of BPJS participants between city A and city B.

As demonstrated by Bambi et al. (2024), inequities in health services are a prevalent phenomenon within community settings. For instance, individuals diagnosed with HIV/AIDS may encounter disparities in the quality of health services provided at local health centers. Similarly, residents of specific areas, predominantly of a particular ethnic origin, frequently confront injustices in the distribution of health services (Bambi et al., 2024).

These differing perspectives lead to ongoing debate about the nature, extent, and implications of inequality or injustice in health care. The concept of injustice, in particular, is inherently subjective, making it a challenging subject to address. Reid and Robinson (2006) argue that health injustice is particularly difficult to address because it encompasses notions of justice, equality, and human rights. Similarly, the distinction between health injustice and health inequality rests on two different ideologies regarding the distribution of wealth or income.

**METHODS**

This study employs the descriptive qualitative research method, which involves a systematic and comprehensive examination of a given phenomenon or subject matter, with the objective of providing a detailed account of that phenomenon or subject matter in a way that is both accurate and insightful. This method comprises a comprehensive account of the disparities in health outcomes based on socioeconomic principles at Puskesmas Medan. In contrast, analytical analysis involves a systematic and logical examination of the data collected with the objective of drawing more in-depth conclusions. This study will employ a descriptive qualitative approach to analyze data gathered via diverse research methodologies, including desk research, case studies, comparative approaches, and interpretative approaches. The analysis will yield a description of health disparities related to socioeconomic factors. Consequently, the research method utilized in this publication can be described as descriptive qualitative, as it integrates comprehensive descriptions and in-depth data analysis to fulfill the stated research objectives.

This section outlines the approach that will be employed in the research. The preliminary phase involves a review of the relevant literature. This entails a systematic examination of sources pertaining to the research topic, including books, journals, and articles that address disparities in the health sector. The process allows researchers to identify and analyse a comprehensive range of related sources on the topic under discussion.



**Figure 1.** Qualitative Research Method

**RESULT AND DISCUSSION**

The disparity in access to services refers to the discrepancy experienced by a particular community in terms of obtaining a comprehensive range of health services, including both primary (promotive and preventive) and tertiary (curative, rehabilitative and other specialized services). This gap may be subjective (perceived by the community) or objective (deliberately designed or implemented by health service providers). The objective of this research is to identify examples of health service access gaps at Puskesmas Medan. In the field of health promotion, residents in Medan reported difficulties in obtaining information on health services. In the area of preventive health care, residents lacking a local KTP reported obstacles in accessing information on health services. Finally, in the domain of curative health care, residents who are not members of BPJS Kesehatan reported challenges in receiving treatment.

Furthermore, from the rehabilitative perspective, individuals with limited financial resources and those living below the poverty line may encounter challenges in bearing the economic burden associated with their illnesses.

As an illustration of deliberate or structured disparities in access to health services, the government has identified vulnerable groups, including infants, pregnant women, and the elderly, as priority recipients of vitamin supplementation in the promotive sector. In the preventive sector, vaccinations and immunizations are given priority in some cases. For instance, the vaccine for the novel coronavirus (Covid-19), which is intended for health workers, is one such example. In the rehabilitative sector, a company may implement a policy that makes it easier for workers who have been injured at work to return to work if they are still productive or under the age of 40.

The question arises as to why this is occurring. It would appear that patient safety has not yet become a culture that must be considered by hospitals in Indonesia. Furthermore, the paradigm shift in healthcare institutions that is currently turning to patient-centered care has not been carried out properly.

As Mrs. MA stated, she is unable to obtain information or promotions from the health service because she does not possess an ID card that corresponds with her place of residence. Consequently, she was unable to access information about health activities on several occasions. Mrs. MA's economic status is classified as lower middle class. There are certain services that are inaccessible due to her economic circumstances. For instance, immunization for Mrs. MA's child, there are several immunizations that are not included in the government's mandatory program and are not available to individuals in the middle to lower class category. Consequently, they are required to bear a significant financial burden.

Some hospitals remain oriented towards the interests of management, which can result in a neglect of patient safety. In accordance with the stipulations set forth in Law Number 36 Year 2009 on Health, hospitals are now required to prioritize patient safety above other interests. Consequently, he asserted, hospitals are obliged to implement a patient safety culture. There is no longer any justification for any hospital to refrain from implementing a culture of patient safety, given that the consequences extend beyond mere material losses and encompass the potential loss of the patient's life.

According to Mr. JF's statement, the public has lodged numerous complaints about doctors, the majority of which pertain to the provision of incomplete information, inaccurate disease diagnoses, and unfriendly attitudes. There are even instances of doctors exhibiting unprofessional behavior towards patients. In the event that hospitals and healthcare workers continue to disregard patient safety, it is imperative that severe sanctions be imposed on both parties. However, numerous cases in Indonesia have demonstrated that hospitals and even healthcare workers have not been subjected to any form of penalty, which underscores the persistently weak enforcement of health laws in Indonesia.

In cases where negligence or even intent on the part of the hospital results in a threat to patient safety, it is imperative that not only internal sanctions be imposed but that the matter also be referred for criminal prosecution. This is the current situation, whereby the community is being harmed due to weak law enforcement, which ultimately results in cases being dismissed. There are several factors that contribute to the failure of patient safety cultures to be truly implemented in various hospitals. Primarily, the low level of concern of health workers for patients is evident in the continued occurrence of discriminatory incidents experienced by patients, particularly those from impoverished communities.

The workload of health workers remains excessive, particularly that of nurses. Nurses are responsible for nursing care to patients, yet in some hospitals, the number of nurses is limited, thereby increasing their workload.

In addition to nurses, there is currently a shortage of doctors, especially specialists, in Indonesia. This is coupled with an uneven distribution of medical professionals, which has an impact on the quality of service provided in hospitals. Third, there is a tendency among health workers to prioritize pragmatism, which can result in a lack of attention to patient safety.

This was the experience of Ms. WS, who received suboptimal care due to her BPJS insurance being classified as only Class III. The inadequate inpatient room conditions resulted in unsatisfactory health services. Socioeconomic factors contribute to the disparities in health services among patients.

The lack of robust supervision by the health department of health workers is a significant issue. The lack of supervision can be attributed to a number of factors, including the limited personnel available within the health department and the department's relatively low bargaining position. The aforementioned four factors represent significant obstacles to the establishment of a patient safety culture in hospitals. If this issue is not promptly addressed, Ahid warned that cases that endanger patient safety will persist, necessitating significant efforts to establish a patient safety culture. Accordingly, the implementation of the revised accreditation standards in 2012 represents a promising opportunity to advance the implementation of a patient safety culture across all hospitals in Indonesia. Furthermore, it is essential to enhance the awareness and understanding of healthcare providers regarding the significance of integrating patient safety culture into every aspect of healthcare practice.

Ahid asserts that a comprehensive public awareness campaign is imperative to inform the general public, particularly those who utilize healthcare services, about the significance of patient safety culture and the importance of responsible behavior in healthcare utilization.

These efforts must be made immediately to prevent further instances of alleged malpractice that could harm the community and to enhance the quality of health services in hospitals. By prioritizing patient safety, a patient safety culture can be effectively implemented. "It is imperative not to allow a few isolated incidents at a hospital to result in irreparable damage to the hospital's reputation on the global stage," he said. (ODPHP, 2020)

The BPJS program is beneficial for the community in terms of accessing health services. However, over time, there has been a discrepancy in the quality of health services provided by BPJS. The program, which was introduced in 2014, has received considerable criticism from the community due to the perceived inadequacy of its services compared to those provided to individuals who seek treatment using public services at their own expense. Despite having a BPJS card, individuals are still required to pay a monthly fee. Furthermore, this payment is also what was previously considered a significant burden for those in lower socioeconomic groups. Health workers are increasingly overwhelmed, and it is likely that the community will attribute the performance of health services and health workers on duty to this burden, despite the fact that it should be acknowledged that the disbursement of BPJS funds is challenging and subject to regulations that must be adhered to by health service providers. Failure to comply with these regulations could ultimately harm the health service institution itself (Spencer *et al.*, 2019).

Indeed, hospital services tend to favor high-income groups, residents in proximity to facilities (cities), and economically privileged groups. Many public hospitals vie to offer VIP class services. Consequently, greater attention is directed towards those with greater financial resources, rather than services classified as Class III, which are perceived by many residents as being of little value and of poor quality (Alfiyyah A, 2022). This has led to a situation where even those with relatively limited financial resources are inclined to seek services in expensive private hospitals. The government's bureaucratic structure, staffing system, and payroll system have resulted in public hospital services being perceived as unresponsive to popular demand and of inadequate quality.

Consequently, a significant proportion of the population is compelled to utilise the services of private hospitals. In order to generate profit, these institutions provide services that are perceived as beneficial, despite the exorbitant costs associated with them. The general public has no alternative but to accept this situation. Private hospital owners generate substantial profits, whereas not-for-profit private hospitals, which aim to assist the government or underprivileged individuals, face challenges due to inadequate funding and limited government subsidies. Private for-profit hospitals are subject to fewer obligations to serve the poor than not-for-profit hospitals, despite the fact that tax incentives and government assistance for not-for-profit hospitals (such as Islamic hospitals, Catholic hospitals, and other religiously oriented hospitals) are largely similar. This policy encourages individuals to seek profit from inappropriate and unregulated hospital services in Indonesia, which may result in harm to patients or clients.

By Survey Kesehatan Indonesia, The existence of health disparities is not a mere coincidence; rather, they are the result of a complex interplay of factors that give rise to differences in health outcomes between cities or between areas within the same city. The challenge of understanding and addressing these disparities is further compounded by the fact that they are not solely contingent on the healthcare system, but also on a multitude of other social, economic, physical, and environmental factors, including education, quality of life, and social issues. In light of this complexity, the World Health Organization (WHO) has identified these interrelated elements as the Social Determinants of Health (SDOH) (WHO., 2023).

Urban communities exhibit income disparities due to their heterogeneous population, which encompasses individuals with disparate levels of education, skills, and attitudes towards their work. Individuals with higher education and skills are more likely to earn higher incomes. Additionally, individuals with positive attitudes towards work, including those in self-employment roles, are more likely to be active and productive workers, which in turn contributes to higher earnings. Spencer (2019) further asserts that income directly contributes to child health inequities (Spencer *et al.*, 2019).

A higher income level is associated with greater access to resources, which in turn facilitates the utilization of health services and improves health outcomes. In the aggregate, income is expressed as gross regional domestic product (GRDP), which is a measure of the total value of goods and services produced by a region in a given period of time. A study by Alfiyyah and Hasibuan revealed that GRDP factors contribute to disparities in access to outpatient services for JKN participants. Low income and high dependence on parents result in low access to mental health services among adolescents, as stated by informants involved in a qualitative study conducted by Setiawan et al. (2023) (Setiawan *et al.*, 2023).

The advancement of a city in terms of industrialization and business activities indirectly contributes to the emergence of health disparities. In urban communities, the prospects for earning or increasing income from the industrial and business sectors vary in accordance with social status. Individuals with superior education, skills, and competencies are more likely to secure income through employment in industry. Those with robust social networks and the resilience and persistence to become entrepreneurs tend to earn higher incomes.

The geographical conditions in Indonesia are highly variable, with significant differences observed between cities. These geographical factors include altitude, area, length of highway, number of islands, climate, temperature, and wind speed. The unequal distribution of health services across different urban areas is largely shaped by geographic factors. As demonstrated by Alfiyyah and Hasibuan (2022), the disparity in access to basic outpatient care for JKN participants is influenced by two primary geographic variables: the number of islands and the size of the city area. In general, the greater the number of islands and the larger the area of a city, the lower the access for JKN participants (Alfiyyah A, 2022).

As both the perpetrator and subject of health problems, the population factor exerts a profound influence on health disparities within communities. When discussing population, the factors taken into consideration are the number, density, composition, and socio-cultural or cultural context. A study of 34 provinces in Indonesia revealed that population density exerts an effect on disparities in access to outpatient visits at primary health care facilities by JKN participants.

Education is a significant factor in an individual's cognitive abilities, enabling them to learn and gain insights from diverse experiences. Individuals with higher levels of education tend to demonstrate enhanced abilities to conceptualize health issues. Consequently, regions with a highly educated population are more likely to exhibit superior public health outcomes. Spencer (2019) posits that educational factors directly contribute to health inequities in children. Additionally, Hastoety, et al., (2018) indicate that the quality of maternal education plays a role in differences in nutritional problems in toddlers in a city (Hastoety *et al.*, 2018).

Individuals' consumption and expenditure patterns contribute to the disparities observed at the individual and population levels with respect to health problems. Alfiyyah and Hasibuan (2018) have stated that these consumption and expenditure behaviors serve as key determinants of disparities in access to FKTP outpatient services among JKN participants.

High consumption and expenditure patterns are indicative of a superior economic status. At the population level, research conducted by Sari et al. (2017) demonstrates that the prevalence of overweight individuals in Indonesia at the provincial level is associated with the economic disparity of the community. An increase in the economic gap is correlated with a rise in the prevalence of overweight individuals within a region. Economic disparity also influences the disparity of Cesarean section delivery services in Indonesia (Sari *et al.*, 2017).

Theoretical frameworks or perspectives or community-based approaches to health problems can be classified into two distinct categories: (1) a traditional approach that perceives the community as lacking sufficient understanding of health issues, leading to a tendency to ascribe blame, and (2) a contemporary approach that views the community as having a grasp of health concerns, positioning them as partners in the effort to overcome disease.

Health insurance is a policy initiative introduced by the government with the objective of facilitating access to comprehensive health services or universal health coverage. The implementation of health insurance enables individuals to receive direct services at primary health facilities, eliminating the need for out-of-pocket payments. According to Istiqomah et al. (2023), the guarantee of health services for economically disadvantaged individuals through the Penerima Bantuan Iuran (PBI) program also contributes to reducing disparities in access to superior quality health services (Istiqomah *et al.*, 2023).

The advancement of a region and the dedication of local leaders to regional health concerns significantly influence the accessibility of health facilities within an urban setting. These facilities encompass hospitals, clinics, laboratories, pharmacies, and Posyandu. The quantity of health facilities serves as an indicator that plays a role in regional disparities.

The government formulates health policies with the objective of determining appropriate courses of action and programs to enhance the quality of health services. However, the resulting health policies often have an adverse impact on other groups. In a policy brief prepared by Juanita (2021), the disparity in access to heart disease services is attributed to government governance in the form of placement policies (prioritizing cardiologists who receive educational assistance), incentives, availability of facilities, and availability of services. Consequently, the distribution of heart specialists is uneven across regions due to a shortage of medical personnel (Juanita, 2021).

Access to government-provided services is considered equitable if it is distributed evenly across geographical, social, economic, and community boundaries, as well as in accordance with community needs for health issues. However, the distribution of health facilities between urban areas is not uniform.

The role of health workers in reducing health problems and improving access to health services is a central factor in this context. The literature indicates that the availability of health workers is a significant determinant of urban health disparities. For example, a 2023 study by Setiawan et al. demonstrated that the scarcity of mental health professionals is a primary driver of unequal access to mental healthcare services among adolescents. Additionally, disparities in the distribution of health workers across health centers in eastern Indonesia are evident between regions with differing population densities, poverty rates, and urban/rural settings (Setiawan *et al.*, 2023).

The number of health workers in any given area is indicative of their role in providing community services; areas with a greater population utilizing the services provided by health workers tend to exhibit superior health outcomes. As demonstrated by Nurrizka &amp; Wahyono (2018), districts and cities with lower coverage of delivery by health workers demonstrate a heightened likelihood of maternal deaths during childbirth (Nurrizka and Wahyono, 2018).

The limitation of this research is that the research location is constrained to a single region with a multiplicity of cultural conditions and community life. Consequently, the research is confined to an examination of the conditions of health service injustice in the region. It should be noted that conditions in each region and area will be markedly disparate, contingent upon the cultural conditions and the availability of health services.

**CONCLUSION**

The issue of healthcare disparities across Indonesia is a multifaceted one, with numerous factors contributing to its persistence. Subjective and objective disparities, including imbalances in the distribution of health facilities and personnel across different regions, frequently manifest in remote and less developed areas, where access to fundamental health services remains severely constrained. This is evidenced by the continued scarcity of access to fundamental health services. Furthermore, disparities in the availability and quality of human resources in the health sector have been identified as a contributing factor at the community level. As a consequence of the unequal distribution of health workers, some regions are experiencing a shortage of qualified personnel, including doctors, nurses, and other medical personnel. This has a direct impact on the region's capacity to provide adequate and equitable health services to all levels of society. Socioeconomic factors also contribute to this disparity. Those who are economically disadvantaged are more likely to have restricted access to quality health services. Furthermore, this disparity is frequently exacerbated by inadequate levels of education and a dearth of awareness regarding the significance of health and disease prevention. The complexity of this issue necessitates the implementation of policies founded upon a comprehensive analysis of the disparities. The aim of these policies should be the reduction of disparities by optimizing the distribution of health facilities and personnel, as well as improving accessibility to health services for all socioeconomic strata. Potential strategies for advancement include the enhancement of health infrastructure in remote and underserved areas and the introduction of incentives to encourage health workers to engage in service in disadvantaged communities. Moreover, health services should be provided irrespective of the socioeconomic status of the community.

**RECOMENDATION**

The following recommendations and suggestions for research are intended to expand the subject matter and objects of study with the goal of obtaining results regarding disparities in health services, thereby providing a potential means of implementing these findings into the provision of health services themselves.

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