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by Ratno Adrianto

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The Accessibility of Health Services for Multiethnics Community Towards Universal Health Coverage in Samarinda City: A Qualitative Study

Ratno Adrianto[1], Amran Razak[2], M. Alimin Maidin[3], Darmawansyah[4]

[1]Department of Administration and Health Policy, Faculty of Public Health, Mulawarman University; [2] Department of Administration and Health Policy, Faculty of Public Health, Hasanuddin University; Department of Hospital Management, Faculty of Public Health, Hasanuddin University, [4]Department of Administration and Health Policy, Faculty of Public Health, Hasanuddin University

Introduction

Since January 1, 2019, Indonesia has entered the era of Universal Health Coverage (UHC) that is sustainable. This success is considered an innovation in the coverage of almost all communities to be able to access available health services. In some districts / cities, the membership of the National Health Insurance System (NHIS) does not cover 100 percent, such as Samarinda. This has an impact on the low universal coverage of NHIS, so that citizens experience obstacles to accessing the health services they need.

Methods: There are four focus group discussions (FGD), which are made according to large ethnic groups in Samarinda, namely the Banjar, Javanese, Bugis and Dayak ethnic groups. The discussion participants were almost all housewives, they were considered to have a high level of concern for their household health problems, and eight main informant interviews. Content analysis was used to explore the phenomena that emerged in this study.

Results: Findings show that approachability dimensions (distance traveled, travel time, and transportation costs), including health insurance coverage, are a problem for some multi-ethnic communities. Although there was no discrimination in vulnerable groups such as the elderly and pregnant women, it was revealed that other patients felt different treatment when receiving services. Available health facilities are considered adequate. However, the number of health workers (doctors and paramedics), is considered lacking. The low level of government attention and lack of socialization from the Social Security Agency of Health (SSAH) are considered as obstacles to achieving UHC in Samarinda City.

Conclusion: There are still obstacles to access for ethnic groups who are located far from the city center. Revealed the existence of 'discrimination' patients when using health care facilities.

Keywords: *accessibility, multiethnic community, universal coverage, samarinda city.*

Introduction

The National Health Insurance System (NHIS) is a part of the National Social Security System (NSSS) which was implemented since 2014, using a mandatory social health insurance mechanism based on Law Number 40 of 2004. The law is concerning the NSSS with the aim of meeting the basic needs for decent public health, given to everyone who has paid contributions or fees paid by the government.[1]

NHIS management carried out by the Social Security Agency of Health (SSAH) based on Law Number 24 of 2011, aims to realize the implementation of guarantee, fulfillment of basic needs for a decent life for each participant and/or family members.[2]

Decentralization of government since 2001 has increasingly increased health system heterogeneity and worsening equity disparity.[3] The UHC system in Indonesia initiated in 2014 focused on accommodating

diversity with flexible and adaptive implementation features and quick evidence-driven decisions based on changing needs. UHC is one way to reduce disparity in access to health services.[4]

Since January 1, 2019, Indonesia has entered an ongoing era of UHC. This success is assessed as an innovation in the coverage o f almost all communities to be able to access available health services.[3] Some districts/cities in Indonesia, SSAH membership coverage has not reached 100 percent including Kota Samarinda.[5] This has caused people experiencing difficulties in accessing health services that they need.

This study employed qualitative research on the accessibility of health services to multi-ethnic communities, in Samarinda City supporting UHC. This study aims to explore dimensions that affect the accessibility of multi-ethnic communities to support UHC and the achievement of Sustainable Development Goals (SDGs) 2030.[6]

Theoretical framework

The theoretical concept of the five accessibility dimensions of Levesque, et. al.[7] was modified as a conceptual framework for this study. Access is defined as an opportunity to achieve and obtain appropriate health services in situations that are deemed necessary for care.[8] Access is seen as a result of interactions between the characteristics of people, households, physical and social environment and characteristics of health systems, organizations and providers.[9]

The concept of five dimensions of service accessibility includes Approachability; 2) Acceptability; 3) Availability and accommodation (Availability and accommodation); 4) Affordability; 5) Appropriateness.

Conceptual definition used

In this study, the concept of five dimensions of health service accessibility was modified to explore the dimensions of accessibility of health services to multi-ethnic communities in the city of Samarinda to utilize health facilities.

1) Approachability is the distance to get health services in the form of mileage, travel time, and travel costs (geographical access), including health insurance coverage.

2) Acceptability is that services provided do not conflict with customs, needs, beliefs, public trust, there is no discrimination in providing services, especially for vulnerable groups (not capable) and how people perceive service quality.

3) Availability and accommodation is that all types of health services needed by the community are not difficult, as well as their presence in the community at any time needed (availability of infrastructure, adequate health equipment, pharmaceuticals (medicines) and health human resources (doctors, midwives and nurses).

4) affordability is the financial capacity of the community to utilize health services (description of community work, socio-economic status and income picture).

5) Appropriateness is the need for health services with services provided in accordance with community demand; and community perceptions in accordance with services provided by providers (health care providers)

This dimension of accessibility allows individuals or households to plan, choose, utilize and feel satisfaction with the health services they obtain.

Materials and Method

Selection of participants

The selection of Focus Group Discussion (FGD) participants was purposive sampling with the following criteria; they have or are currently using health facilities; always be alert and responsive to maintaining the health of his family; influential in making decisions on the utilization of health facilities; and willing as a participant. Key informants are selected purposively based on their relevance to health service policies; community leaders, and traditional leaders.

The target population for this study was 4 ethnic communities (Banjar, Javanese, Bugis, and Dayak etnhic groups). The number of discussion participants was 8 people each group (n=32). Key informants were 4 people from service providers, and 4 people from community leaders and traditional leaders (n=8).

Data collection and analysis

Accessibility of Health Services in the Multi-Ethnic Community Towards UHC in Samarinda City was explored through 4 Focus Group Discussion

(FGD) groups and 8 key informant interviews. FGDs are conducted in open spaces and halls where communities usually gather. In-depth interviews were conducted at the office or at the key informant's home. FGDs and in-depth interviews were conducted after obtaining informed consent from participants and key informants. Interviews and discussions focused on the 5 dimensions of accessibility of health services including: approachability, acceptability, availability and accommodation, affordability and appropriateness.[7] Data analysis used content analysis[10] to analyze the phenomena found in the study.

Results

Focus group discussions of 32 participants (n=32), as many as 30 people (93.75%) were women. Therefore, almost all participants were housewives. There were 8 key informants of which 4 key informants were heads of the community health center and 4 other key informants were community leaders and traditional leaders (n=8).

This study uses the accessibility model of Levesque et.al. which has been developed according to the context of local communities and the policies of the Indonesian government. There are 5 dimensions of accessibility including approachability, acceptability, availability and accommodation, affordability, and appropriateness.

Approachability

Accessibility of proximity includes distance, travel time, transportation costs and ownership status of health insurance.

Mileage to health care facilities, especially hospitals, each ethnicity is different depending on its geographical location, but can be accessed by public transportation or private vehicles, and motorbikes. For ethnic communities that are close to urban areas (Javanese, Banjar and Bugis), they are relatively not constrained by the distance. Unlike the Dayak ethnic group, having difficulty accessing health center and hospitals, it takes around 30 kilometers.

Travel time to health service facilities for ethnic communities domiciled around Samarinda city (Javanese, Banjar and Bugis ethnic group) between 6-18 minutes using a motorcycle or car. Whereas with the Dayak ethnic group, it took almost 1 hour to get to the hospital.

In focus discussions, participants argued that travel costs were perceived as an economic obstacle due to extra expenses, although these costs varied according to the distance traveled and transport facilities used. For the Banjar, Javanese and Bugis ethnic group, because they live around the center of Samarinda, the average cost is Rp. 10,000, up to Rp. 20,000, - one way. Unlike the Dayak ethnic group who have to spend around Rp. 50,000, one way.

Regarding the ownership status of NHIS, in 4 discussion groups it turned out the participants were very diverse. Those who have been included as NHIS participants, most feel happy to have used their cards to meet their medical needs. Unlike the participants who have not been included in NHIS membership, they feel the cost constraints if they want to use health services.

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On the other hand, the population of Samarinda City itself, the coverage of NHIS participation has not yet reached the Universal Health Coverage (UHC) target, still 81 percent.[5]

Acceptability

Acceptance accessibility includes perceptions of service quality and discrimination in health services.

Public acceptance of the presence of modern health services is quite good. There are no significant obstacles to enjoying the medical needs of all ethnic group, both indigenous and immigrant ethnic group. Dayak ethnic group who still take good care of their culture and customs, have apparently relied on modern health services.

In the discussion it was revealed that participants were almost totally not familiar with the treatment system and care of their ancestors. Knowledge and traditional medicine systems are no longer an option, except occasionally using herbs such as betel leaves for the efficacy of reducing certain diseases. Even so, several cases of childbirth were handled by TBAs. Actions carried out by TBAs such as umbilical cord are

given powder, umbilical cord given coffee which finally festering.

Availability and accommodation

Some key informants from the service providers, stated that the condition of the infrastructure, the completeness of health equipment, the availability of medicines and the number of health workers (doctors and paramedics), were adequate. However, they admit that they still need an increase in the quantity and capacity of the availability of health facilities to be able to provide quality services.

Affordability

Accessibility of the user›s ability can be observed from the description of the work and income of the family head.

Job descriptions for the Javanese ethnic group are generally building coolies, Bugis ethnic group as fishermen and farmers, Dayak ethnic group as a farmers and Banjar ethnic group as farmers and traders.

The income picture of the multi-ethnic community is closely related to the type of work, so it is very varied, daily workers such as construction workers are around Rp. 75,000 / day or Rp. 180,000 per month. Fishermen can reach Rp. 100,000, - per day or Rp. 3,000,000, - while farmers are around Rp. 5,000,000 / month. Farmer's income is around Rp. 3,000,000 per month. Those who work as traders earn an average of Rp. 4,000,000 per month.

Appropriateness

Accessibility in the form of suitability demand with health services; and perceptions of services provided in accordance with health service providers.

The comments of several discussion participants stated that the service provided was good enough, hopefully this will continue. They do not doubt the professionalism of health workers who provide services. Meanwhile, several key informants said that they were in line with the operational standards of the minister of health regulations

Discussion

Affordability of health care facilities for multi-ethnic communities in Samarinda City is closely related to the problems of distance, travel time, and transportation. This will effect the economic burden of the household, due to the costs that must be spent from their pockets to access the health services. The transportation costs comes from their daily expenses. This obstacle has an effect on the delay in achieving UHC. Potentially, health service needs are influenced by distribution, distance, and means of transportation.[12-13]

This study revealed the complexity of managing and utilizing NHIS, among participants who were not the member of NHIS, they chose to pay for themselves because they did not want to be involved in the complexity due to uncertainty waiting for NHIS cards to arrive, and other administrative problems.

The emergence of ‹discriminatory› treatment when receiving health services. This will cause patient discomfort. Participants for this study argued that every health problem should be treated equally. Experience in Cape Coast, Ghana showed that the main obstacles to subscribing to health insurance include; long queues and waiting times, and negative attitudes of service providers. [14]

In East Kalimantan province alone, there have been 5 districts/cities won UHC awards.[15] This is different from Samarinda city which has not yet reached the UHC target.[6] Whereas the city government of Samarinda has improved the SSAH management counter facilities in each sub-district and sub-district, socialization of SSAH to all levels of society and every citizen who comes to the location must be informed, as well as door to door socialization. The ineffectiveness of SSAH outreach was also revealed in discussions that participants were still not covered by NHIS, there were also dropouts. The multi-ethnic approach model as carried out in this study can be used to help in socializing UHC achievements in Samarinda City.

One sensitive issue that emerged among discussion participants, i.e. the health service users still had to pay from their pocket when receiving the services, this would be an economic burden.[16] Many patients purchased drugs in the private pharmacy because they were not available at the health facilities, especially for those who are not easy to have cash. The same case occurred in Addis Ababa when the beginning of the Economic Basic Health Insurance (EBHI) implemented.[17] This condition shows that there are still obstacles to the use of health services.

This study emphasizes the need for intensive

socialization to foster positive perceptions of SSAH management. This is expected to increase the participation of NHIS, thus supporting the achievement of UHC in Samarinda City. Health center as the leading gate-keeper of health services is expected to optimize the Mobile Health Center as an effort to glue the imbalance of health services due to obstacles to geographical access especially to ethnic Dayak communities.

Conclusion

The accessibility of health services to multi-ethnic communities in Samarinda City was adequate. Although there was no discrimination in health services for vulnerable groups, other patients felt different treatments when receiving health services. The overall coverage of NHIS participation had not yet become a barrier to achieving UHC in Samarinda City.

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