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Potential Barriers to Utilizing Health Services among Multi-Ethnic Communities in Samarinda City: A Qualitative Study

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Abstract

Background: Users of multi-ethnic services are sometimes faced with barriers when using health services. However, health care providers are sometimes not aware of these barriers, even though they may share a little more responsibility for them. To enlighten service providers, such as potential pitfalls that may exist, will be explored by various factors that trigger these barriers.

Objective: This study aims to explore and identify potential barriers to the utilization of health services among multi-ethnic communities in Samarinda city.

Method: There were 28 informants from 4 ethnic groups (Javanese, Buginese, Banjar ethnic, and Dayak ethnic) who were selected by purposive sampling according to the criteria set (n-28). Key informants from the community leaders and traditional leaders of each ethnic group (n = 4). Data analysis used content analysis to analyze the phenomena found in the study

Results: Potential barriers occur at three different levels: service user level, provider level, and system level. Barriers at the service user level were related to the characteristics of service users: socioeconomic conditions, heritage lifestyle, family support, income of the family head, entry to NHIS member, transportation and travel time. Barriers at the provider level were related to provider characteristics: attitudes, communication dan information style, ethnic matching program. System-level barriers were related to system characteristics: referral system.

Conclusion: Several potential barriers have been found but are more related to the level of service providers and the level of the health systems.

Keywords: *Potential barriers, utilization of health services, multi-ethnic, Samarinda city.*

Introduction

Indonesia is an archipelago consisting of 17,774 islands, where is the largest island of Borneo. Indonesia's population reaches 262 million, has 300 ethnicities and 730 language groups[1,2] The island of Borneo has 5 provinces, one of the largest provinces in East Kalimantan with its capital Samarinda. The ethnic groups in East Kalimantan are mostly Javanese, Bugis, Banjar, and Dayak ethnic group. Based on the 2016 Population Census, the Javanese (29.55 percent), the Bugis (18.26 percent), the Banjar ethnic group (13.94 percent) and the Dayak ethnic group (9.91 percent).[3]

Decentralization of government since 2001 has increasingly increased health system heterogeneity and worsening equity disparity. The Universal Health Coverage (UHC) system in Indonesia initiated in 2014 seeks to accommodate a diversity of potential and different health constraints. Since 1 January 2019, Indonesia enters the era of sustainable UHC. This success was assessed as an innovation in coverage of almost all of its population able to access health services.[2] However, several districts/cities in Indonesia National Health Insurance System (NHIS) membership coverage has not yet reached the UHC target, such as Samarinda city.[4] The low coverage of NHIS has resulted

in community barriers to accessing health services they need.

This study aims to explore and identify potential barriers to the utilization of health services among multi-ethnic communities in Samarinda city.

Method and Method

Selection of Informants: The selection of informants by purposive sampling with the following criteria; they have used or are currently using health facilities; always alert and responsive to maintain the health of his family; and influential in making decisions on the use of health facilities; and willing as participants. Key informants were selected by purposive sampling based on the influence of their figures (community leaders and traditional leaders).

The target population for this study was 4 multi-ethnic community groups (Javanese, Buginese, Banjar ethnic, and Dayak ethnic) each of 7 people per ethnic group (n = 28). Key informants consisted of 1 person in each ethnic group (n = 4).

Data collection and analysis: Potential barriers to the utilization of health services in multi-ethnic communities in Samarinda city were explored through in-depth interviews with 4 Javanese, Banjar, Bugis and Dayak ethnic groups (n = 24). Key informant interviews are conducted in the office or in their home. In-depth interviews are focused on behavioral models of Andersen's theory which include four main components: population characteristics; environment; health behavior; and health outcomes.[7] Data analysis usedcontent analyzes to analyze the phenomena found in study.[5-8] This study also included decision-making factors and socio-psychological factors that were judged to be missed in the behavioral model of Andersen.[9]

Results

There were 32 informants in this study, consisting of 24 service user informants, all (100.0%) housewives who were considered to have high attention, were always alert and dominant in making decisions to use health services. Informants were taken from 4 ethnic communities (Javanese, Bugis, Banjar, and Dayak ethnic groups), every 7 people (n = 28). Generally, housewife informants do not work. Key informants were traditional community leaders/figures taken by 1 person from every ethnic group (n-4). Their education is high school average, and there are still some informants who are not covered by health insurance.

Table 1. Informant Characteristics

Characteristics	Housewife Informants	Key Informants
Gender:		
Woman	28 people (100,0 %)	-
Man	-	4 people (100,0%)
Age (Year)	24 - 68 year	34 – 57 year
Ethnic Group:		
Javanese	7 people (25,0 %)	1 person (25,0 %)
Buginese	7 people (25,0 %)	1 person (25,0 %)
Banjar ethnic	7 people (25,0 %)	1 person (25,0 %)
Dayak ethnic	7 people (25,0 %)	1 person (25,0 %)
Jobs		
Civil servants	-	1 person (25,0 %)
Privates/private entrepreneurs	6 people (12,5 %)	2 people (50,0 %)
Farmers	-	1 person (25,0 %)
Not working	22 people (87,5 %)	-
Education:		
University/Institute/	-	-
High school	20 people (71,4%)	3 people (75,0 %)
Middle high school	6 people (21,4 %)	1 person (25,0 %)
Elementary school	2 people (7,2 %)	-
Health Insurance:		
Have	23 people (82,1 %)	4 people (100,0%)
Do not have	5 people (17,9 %)	-

A number of potential barriers identified refer to the characteristics of service users in the form of predisposing characteristics, enabling characteristics and needs characteristics; health behavior in the form of the use of health services; health outcomes in the form of provider and environmental characteristics, namely organizational factors and health care systems.

Barriers are presented in three groups of barriers: (1) potential barriers at the service user level; (2) potential barriers at the provider level and (3) potential barriers at the system level.

Potential Barriers at the service user level:

Socio-economic conditions: Socio-economic conditions that are vulnerable to some multi-ethnic communities can act as barriers to utilizing health services.[10] The existence of differences in social status between users and service providers allows for communication disruptions. These problems are not favorable to the user's perception of the use of the services provided.[11]

Heritage lifestyle: For example, eating habits in Bugis ethnicity, diets that do not conform to medical recommendations, such as serving traditional foods, can also act as a barrier. Bugis people like to use high fat and high sugar in traditional diets may not accept a diet that is low in fat and low in sugar when they find it not tasteful because it tastes tasteless.[12]

Family as a 'healer': Lack of family and social support can act as a barrier to health care. Family support is beneficial in providing emotional support to service users.30 In eastern culture, the presence of a family in a hospital is considered part of the patient's healing process.[13]

Ineffective communication: Ineffective communication is another major barrier in the partnership that should exist between patients and practitioners. The relationship between an ethnic minority patient and a physician is essentially vertical due to social differentials forced by unevenness on linguistic, cognitive and institutional levels. This gulf separates patients and physicians and invariably benefits the physician more than the patient.[14] Still found, elderly patients from Dayak ethnicity were still being escorted by their children to the Community Health Center because of language difficulties.[15]

Perception and attitude towards health services and personnel: Denying perceptions and attitudes regarding health services and personnel can act as a barrier. This is particularly evident when the Dayak ethnic patients doubt the benefits of health services or do not see benefits. Some elderly Dayak ethnic patients may see service providers as strangers or a new group of people and growing too much respect for medical staff and paramedics. As is known, these Dayak ethnic patients have been known as protectors and healers in their communities. In turn, this can hold them back from asking important questions about their medical conditions and this form of abstract subordination prevents them from questioning authority as they see it.[16]

The income of the family head: Lack of the financial resources can be a barrier because economic conditions affect people's lives and their ability to get care that does not have NHIS. The lack of finance and being in the poverty line is problematic for the multi-ethnic community because they are in a vulnerable position.[11] The multi-ethnic community income picture is very varied, construction workers are around Rp. 1,800,000 per month. Fishermen are Rp. 3,000,000 per month, shrimp farmers are around Rp. 5,000,000 per month. Farmer's income is around Rp. 3,000,000 per month, and traders earn Rp. 4,000,000 per month. Based on the East Kalimantan Provincial Minimum Wage (PMW) in 2019, it is set at Rp. 2,747,561, - per month. This means that only shrimp farm workers and traders are relatively above the East Kalimantan PMW. [17]

Entry to NHIS membership: The inability to obtain health insurance can act as a barrier to using health services.[10] Complexity in the management of NHIS membership, makes service users choose other alternatives by becoming a private patient even though it is considered to be very unfair, unequal as a fellow citizen. Nearly a quarter of the informants from this study claimed not to have an NHIS card. The administrative impression is complicated, the incompleteness of the requirements file makes them delay the administration of the NHIS card.[11]

Transportation and travel time: Irregular public transportation on the outskirts of the city, combined with long travel times and transportation costs is another barrier to getting needed health services, especially ethnic Dayaks who live in the suburbs. The distance to the hospital is around 30 kilometers, if using a public

vehicle the one-way fee is around Rp. 45,000. Their transportation costs are likely to be taken from the cost of their household's daily consumption needs.[18]

Potential barriers at the provider level:

The behavior of providers: The attitude of health care staff is another significant barrier in the use of multi-ethnic health services, especially those who are vulnerable and tend to be discriminatory.[15] There is a feeling of being treated differently from other service users, for example when queuing at the registration counter, the queuing for patient examinations in community health centers will upset them, and have a detrimental effect on the image of the public health center.

Communication and information style: Authoritative communication from the style of service providers can act as a barrier. That is a confrontational way in which health workers sometimes approach service users can produce shame and discomfort, for example when routine references are made about missed appointments and other forms of non-compliance. The prognosis of the disease delivered directly and the use of medical terms can cause inconvenience to users of health services.[19]

Ethnic matching program: Treatment programs that serve certain ethnic-inhabited suburbs, where the absence of ethnic matching (users and service providers) have the potential to be a barrier. Our view is that ethnic Dayak ethnic matching programs can make care more accessible to users of the same ethnic service.

Potential barriers at the system level

Consumerist approach: The dispassionate consumerist approach can act as a barrier, particularly the impersonal and technical attitude of the physician. Patient multi-ethnic feel physicians forego their responsibility for patients' health. To some multi-ethnic patients, the consumerist approach to medical services is a novelty. The patient is encouraged to be a more assertive patient, but this often runs against the grain of older, more vulnerable patients. There are complaints too that the physician treats his patients in a matter-of-fact formal manner. This is contrary to the warm and sympathetic way some patients are used in their hometowns such as on the islands of Java and South Sulawesi where the hospitals are bigger and more advanced.[15]

Referral system: The referral system can act as a barrier because some service users feel uncomfortable with monitoring procedures that prevent them from getting adequate care.[20] Sometimes they bypass the referral system using services that have been accepted in the previous system.

Discussion

Daily barriers and consequences: Universality and specificity. Many problems are 'universal' barriers that can befall us all. Long queues at the registration counter, the inspection queue, for example, prevents all service users from using the services they are entitled to. In addition, they can take their time to take care of their daily needs (household needs). Ethnic groups which can be hampered due to distance and transportation costs such as ethnic Dayaks who live on the outskirts of Samarinda. A barrier that only afflicts some of the other multi-ethnic communities is participation in the NHIS. For those who have not been included in the NHIS with vulnerable economic conditions, they can act as a barrier. Economically vulnerable ethnic groups were found in almost all ethnic groups from the monthly average income that coincided with the East Kalimantan Provincial Minimum Wage (PMW) range.

The specificity of the situation: A complicated and established reference system by the Social Security Agency of Health (SSAH) can hamper further use of health services. Users of certain ethnic services may see health care as a luxury rather than what we consider a necessity. In this case, the use of the gatekeeper, who must refer to more forms of special services, is seen as a barrier. Also, the waiting list for promises creates barriers, as we explained earlier. Therefore, it is important to consider the specific context we face when identifying barriers to the use of health services.

The specificity of service users and time: Many phenomena that are increasingly blurred in the perspective of service users (health care users) in multi-ethnic commissions are likely due to the shifting of their cultural values and belief systems, where they are 'second generation' who have rapid acculturation. This has an impact on their increasing trust in modern medicine and the existing health care system.

As a result, even barriers that prevent them from using health services may also change

Conclusion

This study aims to raise awareness about various potential barriers so that the problem of barriers in health services among multi-ethnic communities becomes transparent. Some potential barriers have been found but are more related to the level of service providers and health systems.

Limitation: There are limitations to this study. The review is more than the utilization of community health center facilities compared to hospital use. In fact, the phenomenon of officer behavior and the nursing system will be more commonly found in hospitals because of the more complex problems.

Further Research: There is a need for further research. One of them is implementation studies reduce barriers from user service interactions with providers, especially multi-ethnic communities with service providers in hospitals.

Conflict Interests: There is no possibility of conflict interest.

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Ethical Clearance: The study has passed through The Health Ethics Commission of Public Health Faculty of Hasanuddin University, No. 2383/UN4.14.8/TP.02.02/2019.

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