Sehat Yogyakarta!

Access to Health Care for People with Different Ethnical Derivations in the Urban Tugu Area

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Human Geography
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Pictures

All pictures are made by the author, unless stated otherwise.

Front page: Indonesian woman treated by a doctor in the health care centre
Executive Summary

Access to health care services is essential when people have the benefit of health care. Other elements of access are also relevant besides physical access. Different factors and dimensions play a role in determining the nature of the concept of access, the ‘5A’s’: Availability, Accessibility, Affordability, Adequacy, and Acceptability. Provision of and access to health care are not always equally distributed. This can be the result of several reasons. Access to health care can pave the way for advancement in the quality of people’s lives, regardless of people’s background. In Indonesia, it is relevant to focus on health care access from the perspective of ethnicity as it is a country with a heterogeneous ethnic population. Besides, Indonesian cities are rapidly growing, which creates challenges which are often handled with limited resources. For this reason, it is more than interesting to focus on access to health care in an Indonesian urban area where there are several health care providers in the first place and an ethnical diversity in people in the second.

Yogyakarta is a city with a multicultural society. The role of ethnicity in health care in Indonesia is still underexposed in literature. A central point of this research is the way the inhabitants of Yogyakarta have access to health care which is compared with their ethnical derivation. Although there are other factors that might influence access to health care as well, it would be too extensive to include all possible factors. For this reason, the focus of this research lies, besides ethnicity, on the following personal characteristics: gender, religion, and income. Gender may be a relevant factor because of the majority of male doctors. The religious backgrounds of hospitals may play a role in this matter. Income may be relevant because of the universal health insurance, which depends on a person’s income.
This study focused on people of varied ethnic derivations in the urban Tugu area of Yogyakarta (Pasar Kranggan and Mungkubumi), on Java, island of Indonesia. The aim of this research is therefore formulated as follows:

*The aim of this master thesis is to acquire an in-depth understanding of how the inhabitants of Tugu area in the city of Yogyakarta with different ethnical backgrounds have access to health care focusing on Availability, Accessibility, Affordability, Acceptability, and Adequacy.*

Several theoretical concepts were used to understand the reach the aim of this study and to answer the main question. The theories includes the 5A’s of Access, Spatial and Social (In)justice, the Entitlement Approach, and the Livelihood Approach. In addition, ethnicity in theory is being discussed.

A qualitative research method is being used to acquire an in-depth understanding of how people experience the access to health care. The participants consisted of the inhabitants of Tugu area in the city of Yogyakarta. A qualitative type of research was the most adequate way to acquire more insight of the health care access of people with different ethnic derivations. A case study was performed in Yogyakarta in order to have more insight into this theme. This study made use of a thorough qualitative approach. The people living in Tugu area, Yogyakarta, were the case of this study. As the experiences of the respondents were central, going in-depth was the most appropriate way to do research. Data was collected using (semi-)open interviews with twenty inhabitants of the research area. The respondents were partly found by walking through the neighbourhood and asking inhabitants to participate. Others were found using snowball sampling. It was important to keep the distinctions between different kinds of respondents in mind during the research. Eventually, the group of respondents consisted of eight Javanese, seven Chinese, three Sumatran, and two Sundanese people. A second interview took place with eighteen of them. The first interview had a more describing character whilst the second interview was more explanatory in nature. Observations in the research area and interviews with both informants and experts were gathered as additional data. Another important source was literature by other scholars. The obtained data has been analysed.
The thesis has three empirical chapters. The first empirical chapter sketches six portraits of inhabitants of the Tugu area. Those portraits are based on a division in six capital assets groups. The chapter showed that people make choices in health care in accordance with their capital assets. It seems that this depends predominantly on people’s financial and physical assets. People who have more money to spent on health care go less often or not at all to the puskesmas services for primary health care and usually visit private general practitioner or a doctor in a hospital. Also, someone’s social environment and personal background play a role. People with low assets predominantly make use of the puskesmas services while people with higher assets use private doctors more.

The second empirical chapter centres on the experiences of having access to health care of the inhabitants. Although the quantity of health care providers in and around the urban Tugu area seems high, all the respondents had experienced or knew that the waiting lines at certain health care providers can be very long. This can be seen as part of availability. The access to the health care provider can sometimes be limited by accessibility, e.g. transport, or affordability, e.g. regulations. The most recurring aspect was the financial capital asset when the respondents’ stories were listened to. Ethnicity does at first sight not seem to be of large influence on the access to health care in Tugu area. The Chinese seem to be more often entrepreneurs and to have more financial capital. In that sense, affordability does not seem to be an obstacle for the Chinese to acquire health care. The adequacy and acceptability of health care seem to be adequate for all respondents.

However, the last empirical chapter in which the personal characteristics gender, religion, income, and ethnicity were discussed put forward some issues. All can play a role in having access to health care. Most of these aspects are not visible on the surface but seem to be present underneath. Ethnicity, does not play a role at all on the one hand, since Yogyakarta is a multi-ethnical city for centuries. On the other hand, ethnicity does play a role in ostensibly small things like languages and people’s habits and traditions. Stereotyping can also play a role in this. These elements make ethnicity or ethnicity-related issues meaningful in people’s access to health care in the urban Tugu area of Yogyakarta.
Akses terhadap pelayanan kesehatan sangat penting bila orang mendapatkan manfaat dari pelayanan kesehatan. Elemen akses lainnya juga relevan selain akses fisik. Berbagai faktor dan dimensi yang berbeda berperan dalam menentukan sifat konsep akses, '5A': Availability (Ketersediaan), Accessibility (Aksesibilitas), Affordability (Keterjangkauan), Adequacy (Kecukupan), and Acceptability (Akseptabilitas). Penyediaan dan akses terhadap pelayanan kesehatan tidak selalu merata. Ini bisa terjadi karena beberapa alasan. Akses terhadap pelayanan kesehatan dapat membuka jalan bagi kemajuan dalam kualitas kehidupan masyarakat, terlepas dari latar belakang orang lain. Di Indonesia, itu menarik untuk berfokus pada akses pelayanan kesehatan dari sudut pandang etnisitas karena ini merupakan daerah dengan populasi etnis heterogen. Selain itu, kota-kota di Indonesia berkembang pesat, yang menciptakan tantangan yang sering ditangani dengan sumber daya terbatas. Ini juga sesuatu yang harus dihadapi kota Yogyakarta.

Penelitian ini difokuskan pada orang-orang keturunan etnis yang beragam di daerah Tugu urban Yogyakarta (Pasar Kranggan dan Mungkubimi), di Pulau Jawa, Indonesia. Oleh karena itu, tujuan dari penelitian ini adalah sebagai berikut:

_Tujuan dari tesis master ini adalah untuk memperoleh pemahaman mendalam tentang bagaimana penduduk daerah Tugu di kota Yogyakarta dengan latar belakang etnis yang berbeda memiliki akses terhadap pelayanan kesehatan yang berfokus pada Ketersediaan, Aksesibilitas, Keterjangkauan, Penerimaan, dan Kecukupan._


Observasi di wilayah penelitian dan wawancara dengan informan dan pakar dikumpulkan sebagai data tambahan. Sumber penting lainnya adalah sastra oleh ilmuwan lain. Data yang diperoleh dianalisis.

Tesis ini memiliki tiga bab empiris. Bab empiris pertama membuat sketsa enam potret penghuni kawasan Tugu. Potret tersebut didasarkan pada sebuah divisi di enam kelompok aset modal. Bab ini menunjukkan bahwa orang membuat pilihan dalam pelayanan kesehatan sesuai dengan aset modal mereka. Tampaknya hal ini sangat bergantung pada aset finansial dan fisik orang. Orang yang memiliki lebih banyak uang untuk dibelanjakan untuk perawatan kesehatan jarang pergi atau tidak sama sekali ke pelayanan puskesmas untuk perawatan kesehatan primer dan biasanya mengunjungi dokter umum swasta atau dokter di rumah sakit. Lingkungan sosial dan latar belakang seseorang juga berperan dalam hal ini. Orang dengan aset rendah lebih memanfaatkan layanan puskesmas sementara orang dengan aset lebih tinggi lebih banyak menggunakan dokter pribadi.


Etnisitas, sama sekali tidak berperan di satu sisi, karena Yogyakarta adalah kota multi-etnis selama berabad-abad. Di sisi lain, etnisitas memainkan peran dalam hal-hal kecil yang tampak seperti bahasa dan kebiasaan dan tradisi orang. Stereotip juga bisa berperan dalam hal ini. Unsur-unsur ini membuat etnisitas atau masalah yang berkaitan dengan etnisitas bermakna dalam memiliki akses terhadap perawatan kesehatan di kawasan Tugu urban Yogyakarta.
Sehat Yogyakarta!
Preface

This master thesis has been written as a completion of the Master Human Geography at the Radboud University of Nijmegen. It is the result of my research, for which I did fieldwork in Yogyakarta, Indonesia. After several months of working on this project, this is the final product.

I am thankful for those who helped me and motivated me during my fieldwork period in Indonesia and during the time I wrote this thesis, when I was back in The Netherlands. First of all, I would like to thank all the interviewees who agreed to conducting an interview with them for the purpose of this research. It was interesting to hear people’s experiences and opinions. I want to thank Lothar Smith, my supervisor, for his ideas to find an internship and his guidance and critical comments during the process from the beginning until the end. This study was embedded in the Centre of Population and Policy studies at the Gadjah Mada University in Yogyakarta. They gave me the opportunity to do the actual fieldwork in this city. For that and arranging my stay, special thanks to professor Pak Sukamdi and to professor Pak Made. Also thanks to Ali and Veronika who helped me during the interviews by translating the conversations. Next to that, thanks to my family and friends. But above all I want to thank God, who gives me strength and blessings all the days of my life:

*I will call upon Your name*
*Keep my eyes above the waves*
*My soul will rest in Your embrace*
*I am Yours and You are mine*

(From the song: *Oceans*, Hillsong United, 2013)

I wish Yogyakarta and all her citizens a good health and when necessary a good access to health care. For that reason, I raise my glass with *es teh* (= ice tea) and toast on the future: *sehat!* (= healthy/cheers)

*Sehat Yogyakarta! Sehat* to you, my reader.

Jurgen Hartman, April 2017
Indonesia’s diversity is formidable: some thirteen and a half thousand islands, two hundred and fifty million people, around three hundred and sixty ethnic groups, and more than seven hundred languages.

– Pankaj Mishra

*Indian essayist and novelist*
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Introduction

The provision of health care, and access to it, seems quite normal in the northern hemisphere. When there is need for a doctor, you find one and get medicines in the anticipation that you will be better. Being in good health is a great thing, but it is not a given. People can get sick because of unhygienic or unhealthy habits or because they are living too close together with too much people. These are sources for pathogens which result in a greater chance of getting a disease.

Because health is something to cherish, the United Nations drew up the Universal Declaration of Human Rights after the Second World War. The right to health care was also incorporated in that declaration: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services” (UN, 1948, n.p.). It resulted in attention for primary health care centres supported by the World Health Organization (WHO). These kind of services mainly focus on the most common problems in a community (Starfield, 1992). They are services on a small scale, with the idea to provide equal health to everyone and tackle “politically, socially and economically unacceptable” health inequalities in all countries (WHO, 2010, p.XII). These primary health care services increase the physical access to health care, in the sense that people can reach a health care centre more easily. However, as access to health care is more than only the physical side of it, it may still be inadequate in other ways.

1.1 Access to Health Care

Access to health care can be seen from a wide range of angles. Different factors and dimensions play a role in determining the nature of this concept. Several researches have tried to define the concept of ‘access’ describing these factors and dimensions. Levesque, Harris and Russell (2013) performed a synthesis of the published literature on the conceptualisation of access. In their article they give an overview of the most cited definitions and dimensions. According to them, the term access is often used to describe the first contact or the first use of a health care provider. However, opinions differ on which aspects are part of access, and where the emphasis should lie. Of particular
importance was the definition by Penchansky and Thomas (1981) who conceptualized access more explicitly. Both the health care services and the clients are central according to their explanation. This definition makes use of five dimensions in which access emerges (Levesque et al., 2013). Those dimensions include the availability of health care services, the physical distance, the costs, and language. On this definition of access, as well as the definitions of the several dimensions, will be elaborated later.

1.2 Inequalities in Access to Health Care

When it comes to access to health care, there can be differences between people. For example, one person lives close to a hospital and another’s house is further away. Or in an urban area the amount of health care services might be higher than in a rural area. Although the UN declaration is almost seventy years old, there are still examples of inequalities in health care, which is manifested in various forms.

Many studies focus on inequalities due to different socio-economic status. The various aspects of the relationship between poverty and health inequality were central in the research of Peters et al. (2008). They argued that people in poor countries tend to have less access to health care services than those in better-off countries. This results in, for example, a high infant mortality rate in low and middle income countries (Setiawan, 2016). But also within countries, the poor seem to have less access to health care services. Other studies focus more on people’s origins and looked at disparities between the ethnic majority and minority groups, for example. Egede (2006) concluded in a study done in the United States that minorities tend to have less access to health care services. Besides, minority groups tend to receive a lower quality of health care than non-minorities (Smedley, Stith & Nelson, 2003). The health and health care of migrants and refugees, groups that are seen as vulnerable, have been studied as well. A Spanish researcher concluded that Spanish migrants made the same or less use of health care services as the native population (Villarroel & Artazcoz, 2016). Nevertheless, these examples are general pictures. It is not applicable to all vulnerable ethncal groups and diseases (Uiters, 2007).

The outcome of these studies shows that the provision of health care, and the access to it, is not always equal. Health care services can favour certain groups of people and neglect others. People can be hindered getting the health care they need. Even in a
densely populated area with a lot of health care providers, access can be limited. Especially in such urban areas the ethnicity aspect can play a role. A city is often a melting pot where several cultures and ethnicities come together (Aharon-Gutman, 2014). People from other parts of the country or from abroad are living, sometimes for ages, next to the indigenous population. Therefore, it is very interesting to focus on access to health care regarding ethnicities in an urban area.

1.3 Ethnicities in Indonesia

A good example of a country with a heterogeneous population is Indonesia. The archipelago with over 240 million inhabitants is one of the most ethnically diverse countries in the world (Utomo & McDonald, 2016). Here, ethnicity is ‘everywhere’, as observed by Bruner in the 1970s:

*Indonesia has a national culture in that there are national symbols and such national institutions as a civil service, a military organisation, and other agencies of the central government but every Indonesian is also a member of an ethnic group in that he is either Javanese, Malay Balinese, Minangkabau, or something else. The national language, Indonesian, exists side by side with various local languages. Home territories on one or another island are ethnically homogenous; the mixing of people occurs primarily in border areas and in such modern contexts as army camps, government offices, and cities.* (Bruner, 1974, p.252)

Although this observation was done more than four decades ago, Utomo and McDonald (2016, p.29) acknowledge that ‘ethnic identities have continued to thrive, and shape a visible, though in most cases non-exclusive, boundary in the everyday social interactions of Indonesians’. With still a few hundred ethnic and sub-ethnic groups Indonesia is a plural society. The Javanese are the ethnic majority in Indonesia, although there are also other larger and smaller indigenous groups. Besides, some non-indigenous groups have been living in Indonesia for many years, like the Chinese (Utomo & McDonald, 2016). An ethnic group or ethnicity can therefore be defined as a sense of group belonging with the following important features: a common origin, history, culture, language, experience, and values (Baumann, 2004).
To create equal access in health care, the Indonesian government has invested in establishing *puskesmas* in every sub district (Wirawan, 2010). A *puskesmas* is a public health development centre. It is not only about giving health care, but they also provide comprehensive and integrated services to the community. They are building community participation to promote healthy life behaviours. This community-based health care has been a cornerstone of the public health system in Indonesia. In 2013, the Indonesian government enacted the implementation of Universal Health Coverage (*Jaminan Kesehatan Nasional*) by law to improve the health care in both urban and rural areas (Plummer & Boyle, 2016). This fits into the plan of the Indonesian government to create access to health care for all citizens. Not only government health services, also foreign aid, non-profit health organisations (NGOs), religious organisations and the private sector are involved. In Indonesia, the rapid urbanization creates more demand for higher supply of health care services, but together these organisations can tackle the problems and make health care in Indonesia sustainable (Plummer & Boyle, 2016; BPS Indonesia, 2012). Access to health care can pave the way for advancement in the quality of people’s lives, regardless their ethnicity.

### 1.4 Research Problem

Together with the right to get health care, as formulated by the UN (1948), it is necessary to create and maintain the access to it. Access to health care is a major health development issue, due to the growth of Indonesia’s population and her economy. As a result of the rapid urbanization, the ratio of doctors/inhabitants has been getting smaller in the last decennia (BPS Indonesia, 2012). These demographic changes, which also take place in Yogyakarta, might form a threat to the provision of and access to health care.

There must be space to go to the health care provider, when there is need to. However, that space – the access – is not always clear and lucid. The concept of access can be approached using different factors and dimensions (Levesque et al., 2013). Those underlying issues together determine people’s access to health care. Access is not always seen as a multi-dimensional concept. Especially in a urban area, where there are generally speaking more health care providers, the access to health care is considered to be high. This way of looking at access, however, only includes the spatial side of the concept,
thereby omitting other dimensions and making a large proportion of the concept of access insignificant.

An Indonesian study which only approached access as a spatial concept, was done by Suryadarma, Widyanti, Suryahadi and Sumarto (2006). As they explained, little research has been done on the influence of ethnicity as a variable in access to health care in Indonesia. For that reason they included this issue into their research and concluded that there were no significant differences in access to health care regarding ethnicity (Suryadarma et al., 2006). However, the different studied groups in this quantitative research were based on the different islands people live. For example, they compared the access to health care on Java with that on the neighbouring island Bali. They did not look at ethnical diversity within an urban or rural area, although people who live and work close to each other may experience the access to health care differently, due to their background. These differences within places were not taken into account in that study.

Therefore, it is more than interesting to focus on access to health care in an urban area where there are, in the first place, several health care providers and, in the second place, an ethnical diversity in people. Yogyakarta is a city with a multicultural society. In this area, where there is a system of health care with hospitals, clinics and other services, it might be relevant to focus on the experiences of the inhabitants. A central point in this research will be how these people have access to health care, with a special focus on their ethnical derivation. Although there are other factors that might influence access to health care as well, it would be too extensive to include all possible factors. For that reason, the focus of this research will, besides ethnicity, be on the following personal characteristics: gender, religion, and income. Gender may be a relevant factor because of the majority of male doctors. Religion may be relevant, because of the religious backgrounds of the hospitals. Income is relevant, because of the universal health insurance, which depends on your income.

1.5 Research Objective and Research Questions

As mentioned above, access to health care can be understood from different angles. Therefore, a multi-dimensional definition by Obrist et al. (2007) will be used in this study, which will be discussed in Chapter 2. It is important to understand the idea of ‘access’
better and to focus on the stories of people. These experiences cannot be measured with a questionnaire or other quantitative methods. A qualitative study gives more insight in how people have access to health care and why they make certain choices.

As described before, the declaration of the UN (1948) states that everyone has the right to health care. The access to health care is of great importance to actually enjoy this right. The right and access to health care are therefore intertwined: with the right to health care, the access to it should not be obstructed. If people cannot access health care services, then they also do not get the health care they need.

Because Indonesia knows several ethnicities, it might be insightful to shed light on the ethnical aspect of access. Especially because in research there has been a lot of attention to financial assets and less to the aspect of ethnicity. It is worth doing research on it, because what if there is an obstacle for somebody to go to a health care centre because of the language of the doctor and he is afraid of misunderstandings because the spoken language is different than he is used to speak? Such elements can be of great importance in taking action and going to a doctor.

This study will focus on people of varied ethnic derivation in the Tugu area of Yogyakarta (Pasar Kranggan and Mungkubimi), on Java, island of Indonesia. As discussed earlier, the role of ethnicity in health care in Indonesia is still underexposed in literature.

The research objective can be formulated as follows:

*The aim is to acquire an in-depth understanding of how the inhabitants of Tugu area in the city of Yogyakarta with different ethnical backgrounds have access to health care, focusing on Availability, Accessibility, Affordability, Acceptability, and Adequacy.*

To reach the aim of this research, the research question will be as follows:

*What role does ethnicity have in the access to health care in Tugu area, Yogyakarta, and how is this influenced by gender, religion, and socio-economic status?*
In order to formulate an answer to this question, the main question will be supported by three sub-questions:

1. **How do inhabitants of the Tugu area use health care?**
   
   In Chapter 6 the respondents will be introduced. Several persons will be portrayed to describe how the inhabitants of the Tugu area are using the health care in different manners, based on their capital assets. The portraits will be used in the subsequent empirical chapters as well.

2. **How do inhabitants of the Tugu area with a different ethnic derivation experience their access to health care?**
   
   The second sub-question will focus specifically on the inhabitants of the Tugu area. Their access to health care is being described according to the five A’s of access: Availability, Accessibility, Affordability, Acceptability, and Adequacy. There will be shed light on this sub-question in Chapter 7.

3. **What do inhabitants of the Tugu area specifically say about differences in their access to health care?**
   
   This last sub-question follows the second sub-question, but has a more explanatory character. It sheds light on specific differences regarding access to health care. Gender, religion, income, ethnicity, and related issues will be discussed. This question is central in Chapter 8.

In Box 1 this research is depicted briefly:

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Ethnicity >> Access to Health Care in Tugu Area << Personal Characteristics

Access to health care in Tugu area, Yogyakarta is the central element in this research. The role of ethnicity will be discussed and light will be shed on specific personal characteristics.
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Box 1: Brief overview of this research
1.6 The Importance of this Research

This research is relevant for both societal as scientific reasons. This relevance is described below.

1.6.1 Societal Relevance

Health care is both an international and a national issue. Not only in Indonesia, but also in other countries health is ‘booming business’. Due to globalization, there is more exchange between and within countries in knowledge, skills, and capital. Right then, it is also important to focus on the access to health care. In a world with health care for all people, the possible obstacles to having access to health care should be made as small as possible:

Moving towards health for all requires that health systems respond to the challenges of a changing world and growing expectations for better performance. This involves substantial reorientation and reform of the ways health systems operate in society today: those reforms constitute the agenda of the renewal of PHC [primary health care]. (WHO, 2008, p.XII)

This citation explains the need to rethink the health care systems and adapt them if there is need to. In doing so, it is relevant to focus on the access. If people experience limitations in access, the threshold is higher to take action and go to a health care provider. When these limitations are absent, sicknesses may be identified earlier, which benefits the overall health. There has been substantial progress in health over the recent decades, but that progress has been deeply unequal. On the one hand, a large part of the world profits from the improved health care, while on the other hand a considerable number of countries is lagging behind or experiencing a decline in the quality and quantity of health care (WHO, 2008).

Already in 1975, Aday and Andersen (p.14) suggested that ‘it is perhaps most meaningful to consider access in terms of whether those who need care get into the system or not’. Especially poor and/or excluded people have less accessibility to health care. Health is an important aspect in poverty eradication and one of the sustainable development goals (UN, 2015). Facilitating access to health care means focusing on
helping people by providing them appropriate health care services in order to preserve or improve their health care (Gulliford et al., 2002). Therefore, improvements in access to health care can result in a better quality of people’s lives.

1.6.2 Scientific Relevance
Cities in Indonesia have been growing rapidly during the last thirty years (Divigalpitiya & Handayani, 2015; Fahmi, Hudalah, Rahayu & Woltjer, 2014). Due to urbanization, they are expanding more and more and population numbers are increasing. This is especially the case for small and medium-sized cities (Fahmi et al., 2014). Cities are important in the way that they can be seen as the engine of national development. In south-east Asia, the cities provide economic progress and contribute to large shares of the national output (Divigalpitiya & Handayani, 2015).

Yogyakarta has also been changing as an urban area, both in the number of inhabitants and the percentage of the total landscape area. While in 2002 18 percent of the total area was urbanized, in 2013 this was already 27 percent (Divigalpitiya & Handayani, 2015). The city of Yogyakarta grew from more than 392,500 inhabitants in 2011 to a total of approximately 412,700 inhabitants in 2015 (BPS Yogyakarta, 2016). Because of the increase of urban area, cities are facing enormous challenges in various fields of governance, including education, mobility, and health. This is not only the case for cities on Java, but also for fast growing cities elsewhere in the world. They all have to deal with challenges on how to make or keep the city healthy and how to provide health care to all citizens – often with limited resources.

Achieving equitable access for all ethnicities is a complex challenge to health care practitioners and policy makers (Szczepura, 2004). In most health care systems, it is acknowledged that minority ethnic populations have, until now, experienced poorer health as well as barriers in the access to health care. Closing the health gap for people in these population groups has now become a priority. There is increasing interest for the role of ethnic diversity in health care, but more research still has to be done in order to get a complete view of it. That is why this empirical study will contribute to the academic literature about the link between ethnicity and accessibility to health care.
Access is an arguably complex concept which many scholars (e.g. Gulliford et al., 2002; Aday & Andersen, 1975) have tried to give an appropriate definition of. The definition of ‘access to health care’ is still disputable. This study can help to unravel the complexity of this concept and attribute to the discussion. Moreover, this study will contribute to the existing knowledge about social justice, the entitlement approach, and the sustainable livelihood approach. However, this research does not only have the intention to add to the current literature, but also to connect the aspects of accessibility, health care, ethnicity, and related issues such as gender, religion, and income with each other. In that way, this study is a relevant comparative analysis.

1.7 Thesis Structure

This thesis has been structured as follows: in Chapter 2, hereafter, the theoretical framework will be described. Different concepts will be set out. ‘Access’ will be described as a multi-dimensional concept, which is a perspective in this thesis. Concepts that have to do with people’s circumstances like endowments, entitlements, and capital assets are crucial in having access to health care. Furthermore, the used qualitative methods will be described in Chapter 3. Herein, the case study and the research area will be discussed. The limitations of the used methods and the challenges of doing fieldwork are also part of this chapter. The described research design is used to structure the research. Moreover, it shows how all of the steps taken during this project work together to address the main research question in this study.

The health care system in Indonesia will be discussed in Chapter 4. To understand people’s access in the Indonesian city of Yogyakarta, it is relevant to focus on possibilities of getting health care. This can be in a formal way at a hospital, or in a more informal way by buying medicines from a vendor outside the rules of the health care system. The information provided in this chapter will be used to give an overview of the health care providers in Yogyakarta in Chapter 5. Prior to this, a description of the local context of Yogyakarta will be given. Both Chapter 4 and Chapter 5 will describe the environment and background in which the inhabitants of Yogyakarta live and where they use health care. The provided information in those two chapters helps to understand the empirical chapters.
In Chapter 6, the respondents will be introduced. They will be portrayed to describe how the inhabitants of the Tugu area in Yogyakarta use health care in different manners, based on their capital assets. Thereby, the respondents will be portrayed in six groups. In this chapter, the first sub-question will be answered. The portraits will be used in the two following empirical chapters as well. Chapter 7 specifically focuses on the inhabitants of the Tugu area. Their access to health care is being described according to the five A’s of access: Availability, Accessibility, Affordability, Acceptability, and Adequacy. This last empirical chapter, Chapter 8, sheds light on specific differences and personal characteristics regarding access to health care. Gender, religion, income, ethnicity, and related issues will be discussed.

The empirical chapters will be followed by a conclusion in Chapter 9, in which the main question will be answered. A description of how the theory discussed in Chapter 2 is applicable to the given results is incorporated herein as well. In the second part of Chapter 9, a critical view on this research will be provided. Also, recommendations for further studies will be given.
APOTEK

PRAKTEK DOKTER BERKELOMPOK

Drg. A. EDIE SUSANTO
DOKTER GIGI
SIP. No: 503 / 3233
Praktek : Senin s/d Sabtu,
Hari Besar / Minggu Tutup
Jam : 17.00 - 19.00

Dr. BOWO W, Sp. PD
SPESIALIS PENYAKIT DALAM
SIP. No: 503 / 4240
Praktek : Senin s/d Jumat
KECUALI HARI BESAR TUTUP
Jam : 19.00 - 21.00

Dr. Yohan Budi Hartanto, Sp.S
NEUROLOG
SIP. No: 503 / 2953
Praktek : Senin, Rabu, Jumat
KECUALI HARI BESAR TUTUP
Jam : 17.00 - 19.00

Dr. FLORETTA RATNA M.
DOKTER UMUM
SIP. No: 503 / 3402
Praktek : Senin s/d Jumat
KECUALI HARI BESAR TUTUP
Jam : 17.00 - 19.00

SIP. No: 503 / 8076
PRAKTEK
DENIN, SELASA, KAMIS
JAM 17.00 - 19.30
RABU, JUMAT
JAM 09.00 - 21.00
(Minggu Tutup)

D不吃...
Access to Health Care Theory

According to Harris, Harris and Roland (2004, p.21) “access can be defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their need”. Access is equitable when it “does not vary in quality because of personal characteristics, such as gender, ethnicity, geographical location, and socio-economic status” (Millman, 1993; as cited in Szczepura, 2005, p.42). In other words, equal access to health care means it is open for everyone, without looking at someone’s background. Unfortunately, this is not always the case, like in Indonesia. In this chapter, several theories will be described to acquire an in-depth understanding of the place of ethnicity in the access to health care of people in the Tugu area of Yogyakarta. First, the concept of access will be discussed. This concept is leading in this thesis. Then, the theory of justice will be discussed briefly to show the judicial sight of access to health care. Thereafter, the entitlement approach will be discussed, followed by the livelihood approach. These two approaches can be used in this context to show that people’s backgrounds and, in particular, what they have or do not have play a role in having access to health care. At the end of this chapter, the concepts will be displayed in a conceptual model.

2.1 5A’s of Access

Levesque, Harris and Russell (2013) start their article on the concept of access with an apparently easy definition from the dictionary: “Etymologically, access is defined as a way of approaching, reaching or entering a place, as the right or opportunity to reach, use or visit” (Canadian Oxford Dictionary, 1998; as cited in Levesque et al., 2013, n.p.). According to this definition, access is both about the act of entering and the right to do so. But it is not as easy as it seems. In the article by Levesque et al. (2013), who synthesized the concept, a variety of researchers’ interpretations of the concept of access is given. Because access can be seen from a broad perspective, it is hard to give a precise definition. Guagliardo (2004, p.2) stated that “the most basic problem [of defining access to health care] is that it is both a noun referring to potential for health care use, and a verb referring to the act of using or receiving health care.” This might create confusion or
misunderstanding people, because it is both about physical presence and the (non-
physical) ability and willingness of people to take action.

A common work in theorizing and defining access is that of Penchansky and
Thomas (1981). They were the first to develop a taxonomy for the definition of access.
The researchers defined access to health care as “the ‘fit’ between the patient and the
health care system” (Penchansky & Thomas, 1981, p.128). They made a distinction
between five dimensions: availability, accessibility, affordability, acceptability, and
accommodation. These five dimensions of access influence the course of the health-
seeking process (Obrist et al., 2007). The first two dimensions are more spatial and related
to the presence and the distance of health care. The last three A’s are more non-spatial,
related to costs, cultural and social factors, and service quality. This study by Penchansky
and Thomas (1981) was one of the foundations of the conceptualization and definition of
the term access. Many researchers have afterwards build their work about access on
these ‘pioneers’. Obrist et al. (2007) also did this in their study, but they replaced
accommodation with adequacy, as adequacy is more appropriate when it comes to
people’s expectations. The concept of the 5A’s of access and its definitions can be seen in
Box 2.

- **Availability is about the relationship between the volume and time of the health
  services and that of the clients’ need.**
- **Accessibility is about the location of the services and that of the clients.**
- **Affordability refers to the financial component of access.**
- **Acceptability is about social and cultural values of people.**
- **Adequacy is about the expectations of the clients to the organization of health care.**

Box 2. The 5 A’s of Access and its definitions (source: Obrist et al., 2007)

There are some ethical issues concerning access (Daniels, 1982). The first one we already
discussed. Access is a complicated concept, because it is composed of many factors. Equal
access is even more difficult as equity is a questionable term. People can have a lot of
different views on what is equal and, just like access, equity is composed of many factors.
Another ethical issue is that health care services are not homogeneous. They have many
functions, some urgent, some less important. When it is about access to health care, it is important to question what kind of access to health care is needed. The last ethical issue that Daniels (1982) mentioned is the most fundamental one and more about the distribution of justice, which also come back in theories about spatial and social justice.

2.2 Spatial and Social (In)justice in Health Care

Equitable access has both a spatial component and a judicial component. ‘Is the need to health care a human right, or is it a privilege?’, people might wonder. An important work on equality is John Rawls’ *A Theory of Justice* (1971), in which the philosopher focuses on the distribution of power, knowledge, and money. He describes what justice is according to him and how a just society could work. In this theory, the concept of ‘social justice’ is central. This is a relevant issue regarding equal access – also in access to health care. Social justice is a complex phenomenon, but it has generally been described as both a process and a goal that is mutually shaped to meet the needs of all people (Bell, 2007). Also, social justice can be seen as the pursuit of social change or service to disadvantaged and vulnerable groups, particularly people living in poverty (Witkin, 1999).

According to Knight and Albertsen (2015), John Rawls’ theory of distributive justice is perhaps the most prominent theory. In it he discusses the distribution of primary goods, which according to him are: ‘Things which it is supposed a man wants whatever else he wants’ (Rawls, 1971, p.79). Thereby, he focuses on rights, liberties, opportunities, income and wealth and ‘the social bases of self-respect’. He argues that liberty and equality are essential for a well-ordered society (Banai, Ronzoni & Schemmel, 2011).

Health care is seen as a human right and therefore it also has to do with justice. Institutions and policies are also important, as they can have a huge role in (non-)access to health care. Moreover, social justice is about the fair and just relation between the individual and the society. Herein, fair distribution and social privileges are essential. Concerning this research, social tensions or feelings of inferiority should not hinder people in their access to health care.
According to Soja (2010), a political geographer, justice has a geography in which the equitable distribution of resources, services, and access is a basic human right. In Rawls’ book (1971) about the theory of social justice, he discussed ‘Justice as Fairness’, which is more about the distribution. He did not explicitly include health or health care as one of the basic social goods which should be distributed equally. However, the influence of Rawlsian arguments is such that they have subsequently been applied to health care.

2.3 Access to Health Care and the Entitlement Approach
Access to health care is multi-dimensional and dependent on assets people have. However, the endowments and entitlements of people also play a role, as the entitlements analysis shows. This approach was developed by Amartya Sen (1981). In his work about food security, he focuses on the concern of access to food and argues that it is not sufficient to ensure the presence of food in the economy or in the market, because it does not directly ‘entitle’ food to an individual. He describes entitlement as follows: “A set of alternative commodity bundles, over which a person can establish command, given the prevailing legal, political and economic arrangements” (Sen, 1981, p.156). In other words, his work is an explanation of how it is possible that people have no access to food in the midst of food plenty. According to him, this can be seen as a result of a collapse in their means of command over food (Maxwell, 2000).

The entitlements analysis is useful in explaining how it is possible that people do not have access or do not have full access to health care. This research focuses on the access of health care in an urban area, where there are proportionally a lot of health care facilities. This does not necessarily mean that people have access to those services. The same reasoning Sen (1981) uses to talk about food security is also applicable to issues around access to health care. The entitlement analysis helps to explain how it is possible that people have no access to health care in the midst of health care services, which might be a result of a collapse in people’s means of command over food.

This approach by Sen (1981) uses three interrelated basics: the endowment set, the entitlement set and the entitlement mapping (Nayak, 2000). The endowment set is defined as “the combination of all resources legally owned by a person” (Nayak, 2000, p.60). Resources include both tangible assets, such as land, and intangible assets such as
knowledge, skill or membership of a particular community. The entitlement set is defined as “the set of all possible combinations of goods and services that a person can legally obtain by using the resources of his endowment set” (Nayak, 2000, p.60). The entitlement mapping is simply the mapping of the endowment set on the one hand and the entitlement set on the other.

This approach concentrates on ownership and exchange. Sen (1999, 1981) argues that when analysing the food sector, the focus should lie on access and entitlement, instead of on supply, as is done in the traditional analysis of famines. Availability does not guarantee the prevention of famines and starvation; inequalities in distribution and accessibility in particular are other important factors.

The approach has been used in different contexts to explain access issues, such as the access to health care (Ergler, Sakdapolrak, Bohle & Kearns, 2011). It helps to understand the links between poverty, health, and access to health care, which has been made visible in Figure 1. Just as the mere availability of food cannot prevent famine, the presence of health care services cannot guarantee good access to health care. Although health care

Figure 1. Entitlement approach and access to health care (source: Ergler et al., 2011)
facilities are concentrated in cities, the geographical availability and physical proximity of facilities do not necessarily imply better access for poorer residents as other factors also play a role (Ergler et al., 2011). The five factors outlined by Penchansky and Thomas (1981) are influencing access to health care and are potential entitlement barriers (Ergler et al., 2011).

2.4 A Livelihood Focus

According to Chambers and Conway (1991, p.6) “[a] livelihood in its simplest sense is a means of gaining a living”, in which capabilities, assets, and activities are included (Serrat, 2008; Chambers & Conway, 1991). The livelihoods approach emerged during the 1990s, after the structural perspectives of neo-Marxism and the dependency theory in the 1970s and 1980s (De Haan & Zoomers, 2005). In both approaches, the inequalities in the distribution of power and poverty was central, but they predominantly dealt with the economic part. The influence of people themselves was also not included. Because of the incompletion and shortcomings of these theories, the livelihoods approach emerged (De Haan & Zoomers, 2005). It captures how people build their livelihood, using different kinds of capital asset. Important in this is the ways in which people combine and transform those assets in the building of livelihoods. Moreover, the ways in which people are able to expand their assets and the ways in which people are able to use and enhance their capabilities are of great importance (Bebbington, 1999):

A person’s assets, such as land, are not merely means with which he or she makes a living: they also give meaning to that person’s world. Assets are not simply resources that people use in building livelihoods: they are assets that give them the capability to be and to act. Assets should not be understood only as things that allow survival, adaptation and poverty alleviation: they are also the basis of agents’ power to act and to reproduce, challenge or change the rules that govern the control, use and transformation of resources. (Bebbington, 1999, p.2022)
In the livelihood approach, a distinction is made between five different types of capital assets, as shown in Box 3. Different livelihood assets are possible, which can be tangible for example land or tools, but may also be intangible, think of access to education or access to health care.

<table>
<thead>
<tr>
<th>Capital assets (source: Obrist et al., 2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural capital: Land, water, and livestock</td>
</tr>
<tr>
<td>Human capital: Knowledge, education, and skills</td>
</tr>
<tr>
<td>Financial capital: Cash and credit</td>
</tr>
<tr>
<td>Physical capital: Infrastructure, equipment, and means of transport</td>
</tr>
<tr>
<td>Social capital: Social networks and affiliation</td>
</tr>
</tbody>
</table>

A livelihood is sustainable when it can cope with and recover from stresses and shocks and maintain or enhance its capabilities, assets, and activities both now and in the future (Serrat, 2008). This approach is people-centred, which means that the people are central. It is also holistic which means that it is not restricted by boundaries and recognizes multiple strategies, multiple actors, multiple influences, and multiple outcomes. The approach is dynamic, because it tries to understand the fact that the things that influence the livelihood are always changing.

2.4.1 Health Access Livelihoods Framework
The British Department for International Development (DFID) developed a tool to improve our understanding of livelihoods: the sustainable livelihoods framework (GLOPP, 2008; DFID, 1999). This framework was adjusted by Obrist et al. (2007) to put access to health care in it (Figure 2, next page). It situates access to health care in the broader context of livelihood insecurity and combines both health service and health-seeking approaches (Obrist et al., 2007). In this sub section, the framework will be discussed in more detail.
Access to health care becomes important once an illness is recognized and treatment seeking has started. As discussed in Section 2.1, five dimensions of access influence the course of the health-seeking process: Availability, Accessibility, Affordability, Adequacy and Acceptability. According to Obrist et al. (2007), the health-seeking process depends on the 5 A’s of access, wherein the livelihood assets play a huge role:

*What degree of access is reached along the five dimensions depends on the interplay between (a) the health care services and the broader policies, institutions, organizations, and processes that govern the services, and (b) the livelihood assets people can mobilize […] Whether people actually recognize an illness and seek treatment in pharmacies or through other health care services depends to a large extent on their access to livelihood assets of the household, the community, and the wider society. (Obrist et al., 2007, n.p.)*

The availability of the livelihood assets is influenced by forces over which people have little control, for example technology, economy, or climate change. Obrist et al. (2007) refer to these factors as people’s vulnerability context. These elements influence the utilization of health care and its quality. They may take no action at all or make use of several service providers. However, if people gain and have access to health care and use
it, the outcomes are positive in terms of health status, patient satisfaction, and equity (Obrist et al., 2007).

In this research, the assets of people are central. These are: natural capital, human capital, financial capital, physical capital, and social capital. But it is important to keep in mind that these assets are influenced by a bigger story. For example, people can be hindered in making full use of their capitals, since some capital is so-called dead capital. This term, introduced by De Soto (2000), is about property which is informally held and what is not legally recognized. It means a decrease of the value of the asset and cannot easily be bought, sold or used for an investment. These lost forms of value are dead capital. Therefore, it cannot create value for the people with less capitals. Besides this, livelihoods are formed within different contexts. Moreover, different policies and processes affect the ability to access. The way in which ethnicity affects the livelihoods of different groups within a community also has an influence. Access to livelihood assets of the household, the community, and the wider society are important aspects in recognizing and taking steps to go to a health care provider (Obrist et al., 2007).

2.5 Ethnicity in Theory
Ethnicity has long been a widely described subject in theories. Different paradigms have formulated answers for questions about the nature of ethnicity and why ethnicity emerges. It depends on the spirit of the age which one is popular. One of these paradigms is primordialism, which argues that “ethnic groups and nationalities exist because there are traditions of belief and action towards primordial objects such as biological factors and especially territorial location” (Gryosby, 1994, p.168). Fixed ethnic boundaries and the importance of biological and/or cultural inheritance are central elements. Within a society, there are certain fundamental, irrational commitments between human beings which are based on religion, culture, language, and so on. The fact that someone is born in a certain community already gives a connection with this community (Yang, 2000). Based on the primordialist school, or comparable theories, ethnicity matters in the sense that people feel connected or at least have connections to people they originally belong to.
An ethnical theory exposes differences and distinctions between people based on where they are born and their further background. That is why ethnicity in getting health care and the access to it cannot be ignored, although the role is not always clear. A survey of antibiotic use of individuals visiting public health care facilities in Indonesia showed that antibiotic use was higher among individuals with the Javanese ethnicity than non-Javanese respondents (Hadi et al., 2008). The researchers, who admit that this is difficult to explain, concluded that “cultural factors might play a role” (Hadi et al., 2008, p.628).

The largest studies in this field were done in the United States in which they found disparities in health status compounded by reduced access to health care between several ethnic groups, which often has to do with having a health insurance or not (Brown, Ojeda, Wyn & Levan, 2000). However, another American study stated the following:

*Racial and ethnic disparities in health care even exist when insurance status, income, age and severity of conditions are comparable. [...] These differences in health care occur in the context of broader historic and contemporary social and economic inequality and persistent racial and ethnic discrimination [...].* (Nelson, 2002, p.666)

Here, issues such as bias, stereotyping, prejudice of health care providers, and language of patient or physician (mastering and interpretation) play a role and may be points of attention and recommendation for improving access to health care for individuals of all ethnicities (Nelson, 2002).

### 2.6 Conceptual Model

The concepts described in this chapter relate to each other, becomes clear in the conceptual model on the next page (Figure 3). As explained earlier, access is considered as a multi-dimensional concept and includes the 5A’s: Availability, Accessibility, Affordability, Adequacy, and Acceptability. This will be helpful in deciding which dimensions specifically play a role in whether people have access to health care or not and in understanding people’s choices regarding access to health care in the Tugu area in the city of Yogyakarta. Equitable access has both a spatial component and a judicial component in it, which is why the theory of social justice also plays a role in this theme.
Even though Tugu is an urban area where there are health care services, the entitlement approach will be helpful to acquire an understanding that only those 5 A’s are not enough. The approach by Sen (1981) helps to understand the links between poverty, health, and access to health care. The livelihood approach will be useful in showing the importance of the context: a livelihood is influenced top-down. The livelihood assets in particular will be helpful to categorize the inhabitants.

![Conceptual Model](source: Author)

In order to address ‘access’ in this conceptual framework the idea of the five dimensions of access are integrated in the framework. Following the model set by Ergler et al. (2011) the 5 A’s are considered as potential entitlement barriers. A problem can be transport: someone can be entitled to go to a hospital, but the accessibility is in this example a barrier.
In this research also the livelihood assets are an important concept. Herefor, the model as been made by Obrist et al. (2007) is used. According to them, the health-seeking process depends on the 5 A’s of access, wherein the livelihood assets play a huge role as discussed in Section 2.4. The livelihood assets can be seen as a forerunner in having access to health care. For example, for getting medicines people have to pay (financial capital). If someone’s financial capital is high, the affordability of access would be high too. Another example is having a motorcycle (physical capital). This can help to reach the hospital, which increases the degree of accessibility. These examples show that livelihood assets determine to a certain extent the degree of access. In this sense the livelihood assets and the 5 A’s are together potential access barriers.

However, the entitlement approach and the livelihood approach are not isolated systems. As came forward in both the model of Ergler et al. (2011) and the model of Obrist et al. (2007), the health care providers, the broader policies, and institutions have also their influence in having access to health care. The same applies to the ‘vulnerability context’: forces over which people have little controle. Since this research considered the experiences of the respondents as very important, this study purely focus on this ‘micro level’. Moreover, this study is exploratory. The role of both institutions as external forces cannot simply be ignored, but this study should be too broad to focus on the ‘macro level’ as well.
Methodology

In order to make sure the data is useful to answer the research question, a clear methodological approach is needed. In this part, the methodology of my research will be discussed. The aim of this study is to get an in-depth understanding of how people experience the access to health care. A qualitative research method is the best applicable here. The participants are the inhabitants of Tugu area in the city of Yogyakarta. The research area will be discussed shortly in this part, but will be described in more detail in Chapter 4.

3.1 Case Study in Yogyakarta

A qualitative type of research is the most adequate way to get more insight in how people with different ethnic derivations experience accessibility to health care. This kind of research has various valuable advantages, especially in health care research where qualitative research is relatively uncommon (Al-Busaidi, 2008). To get more insight into this theme, a case study was done in Yogyakarta.

3.1.1 Case Study

A case study is a form of research which attempts to gain a thoroughgoing understanding of an object or processes (Verschuren & Doorewaard, 2015). Creswell (2007, p.73) explains a case study as follows:

A case study research is a qualitative approach in which the investigator explores a bounded system (a case) [...], through detailed, in-depth data collection involving multiple sources of information (e.g., observations, interviews, audiovisual [sic] material, documents and reports), and reports a case description and case-based themes.

This study made use of a thorough qualitative approach. The case in this study were the people living in Tugu area, Yogyakarta. Going in-depth was more relevant for this research than for example a survey research, as the experiences of those respondents are central, which is an underlying strength of doing a case study. Moreover, the objects or processes
are studied in their own environment and less distance will be experienced in comparison to surveys, for example. On the other hand, a case-study can be challenging in terms of external validity and giving generalizing statements (Verschuren & Doorewaard, 2015). However, the outcomes of this type of research may still point in a certain direction and prove to be valuable.

3.1.2 Research Area

This study focused on Tugu area in Yogyakarta and took place in the area of Pasar Kranggan (north part) and Mungkubumi (south part). This research area (Map 1, next page) was chosen because this neighbourhood is in the heart of Yogyakarta city (Map 2, next page), which made it possible to do research on access in an urban environment. It is generally assumed that services are close-by in a city, making the access to those services fine. But this might not be the case.

Besides, the Tugu area is home to different ethnicities. In this area Yogyakarta citizens who are originally from outside Java are living next to the Javanese people. Different religions also live together in this area, of which the presence of several mosques, churches, and a Confucian temple is evidence. More about the local context will provide in Chapter 5.
Map 1: Research area between green lines (source: Google Maps, 2016; adapted by Author)

Map 2: Tugu Jogja, central in the inner city (source: Google Maps, 2016)
3.2 Data Collection
Data was collected using (semi-)open interviews with people living within the research area. Because this was a case-study, a triangulation of methods was desirable to minimize the probability of coincidence. For that reason, observations – both at people’s homes and health care services – and interviews with informants and experts were part of the data collection. Another important source was literature by other scholars. The first sub-question, focusing on the health care system, especially made use of literature supplemented with information from the informants and experts. The chapters about the second and third sub-question were mostly based on the interviews with the inhabitants. Observations were done for all the sub-questions. Together, these methods were used to answer the main question.

3.2.1 Interviews
The first group of interviews were those with the inhabitants of Tugu area. To acquire an understanding of people’s experiences of having access to health care, two kinds of interviews were conducted. The first interview session had a mostly descriptive character. According to Verschuren and Doorewaard (2015), describing is the most primary and basal activity in doing scientific research. During this interview, I asked the respondent questions about the 5 A’s: Availability, Accessibility, Affordability, Adequacy, and Acceptability; based on the idea of Thomas and Penchansky (1981) as discussed in the previous chapter. The second session, with the same respondent, took place after at least one week. This session was more explanatory in nature and issues such as ethnicity, income, and religion were discussed. Both interview sessions were analysed and used to answer the research question. Chapter 7 was predominantly based on the first sessions of these interviews and the explanatory interviews were mainly used for Chapter 8.

To be able to focus on ethnicity in the access to health care twenty people with different backgrounds were interviewed. The original idea was to focus on the four largest ethnical groups in Yogyakarta: Javanese, Sundanese, Malay, and Chinese. Of each of these groups, five persons would be asked to be part of this research. However, during the collection of data, it was difficult to find people from Sundanese and Malay origin in the research area. However, there were people from Sumatran origin, who were able to be
interviewed. For that reason, the focus on the different groups now included a Javanese, Chinese, and ‘others’ group. The others were people from Sumatra and Sunda origin.

The respondents were partly found by walking through the neighbourhood and asking people to join. Others were found using snowball sampling, by asking the respondent for other potential participants. During the search for respondents, it was important to keep the distinctions between different kinds of respondents in mind. The participants were asked about their ethnicity, so they had the opportunity to categorise themselves. Eventually, the group of respondents consisted of eight Javanese people; seven Chinese – generally they prefer to call themselves in Indonesia: Zhōnghuá/Tiong Hoa which comes from the Chinese word for ‘Chinese’ –; and five others: three people from Sumatra and two Sundanese people. Beside including respondents with different ethnicities, I also aimed to have a variation in gender, age, and income. However, that proved to be difficult for a group of twenty respondents. In total, eleven men and nine women were interviewed, with an age ranging from 26 to 77 years (average age: 50 years). It was easier to find older respondents, since they had more time for an interview. A list of the respondents, with the date of the conducted interview, can be found in Appendix I. For the purpose of clarity and readability, these dates are not given in the running text.

Almost all respondents had two interview sessions: a descriptive and an explanatory one. Two of the respondents did not have the opportunity to have a second interview session later and data for these respondents is limited. In the end, there was a total of thirty-eight interviews. These interviews were semi-structured and done with the use of interview guides (Appendices II and III).

It was not always easy to communicate with the respondents because of the language. Nineteen of the twenty respondents did not speak English fluently. In those cases, an interpreter was used. Although the presence of a translator was good, it was sometimes hard to react on a certain answer. The questions and answers also had to be translated twice, because English was not the mother tongue of both the interviewer and the interviewees, which made it easier to have translation mistakes.

The second group of interviews were with three informants and three experts. Those included one professor from the Gadjah Mada University (UGM), who is part of the health policy department, a doctor, a nurse, and a future nurse who are all acquainted.
with Yogyakarta and know the situation in the health care sector there. Those interviews were used for background information. A list of this group can be found in Appendix I. The questions during the interviews were adapted to the different interviewees. A semi-structured interview guide were used during the interviews with the doctors and nurses (Appendix IV), to ask them about their experiences, their opinions or what they knew about a certain aspect.

3.2.2 Procedure
The interview guide of the first session with the respondents (Appendix II) started with an introduction of the researcher, the research objective and the aim of the interview. After the opportunity to ask questions and a clear consent to participate in this research, the session started with some general information about the respondent, including asking their ethnicity. If their ethnicity was not clear, then the question was how they would describe their ethnicity. Thereafter, the interview followed a path with questions along several components of access. This approach tries to let the respondent talk about their situation and stories (descriptive). There was made use of the 5 A’s from the theory of Thomas and Penchanky (1981) as written down in Chapter 2. In the following order those were: Availability, Accessibility, Adequacy, Affordability, and Acceptability.

For the second session another interview guide (Appendix III) was used. These interviews started with a recap of the first session, to discuss the term ‘access’ and ‘equal access’. After the interviewee had gotten the opportunity to specify differences in health care (if present) based on their experiences or what they knew, he was asked to explain potential factors for it (explanatory). The following factors were discussed in all cases: gender, income, ethnicity, and religion, because they might be relevant and were also mentioned by some respondents in the first session. In the end, there was the opportunity to tell something else about access to health care that had not yet been mentioned.

3.2.3 Observations
Also observations were part of the data collection. Besides body language and expressions of the respondents during the interviews, there was also observation of the house/environment of the people. This was done in order to determine their socio-
economic status and to place their story in a context. During these observations some notes were made and some pictures were made of the neighbourhood. These pictures underpin stories of people and can be seen as complementary.

A visit to a health care service was also part of the observations in this research. In that way, the health care system could be understood better, not only by spoken words, but also by observation. These observations were made by taking pictures in the *puskesmas*. Pictures say a lot about a place: “Photographs can convey a great deal of information about the appearance of a place far more succinctly than words” (Rose, 2008, p.51). When there is a picture, it can be easier to imagine the situation described. Furthermore, observations (making a picture) can make clear what an interviewee could not completely describe in words.

### 3.3 Data Analysis

Analysing data is a challenging task. A qualitative researcher is moving more in ‘analytic circles’ instead of using a fixed linear approach (Creswell, 2007). A data analysis spiral is depicted below (Figure 4). In those ‘loops’ the researcher undergoes various processes. The idea is to identify major organizing ideas.

![Data analysis spiral](source: Creswell, 2007)
This study followed the several steps in this data analysis spiral. The first procedure was ‘data managing’. It consisted of preparing and organizing the given information for analysis. After that, but also simultaneously – it overlaps each other – the procedure ‘reading and memoing’ started. This phase was meant to reflect on the data. After that, all the data was reduced into themes and codes to focus on the meaningful material (Creswell, 2007). Important quotes were, for example, highlighted. In this research, the data of the interviews was reduced by the researcher; by highlighting significant segments and separating them into themes the data was ordered.

The questions during the interviews were open questions and the interviews were semi-structured. The answers on the questions were mainly descriptive and give an image of health care access. They are people’s own experiences and opinions. Sometimes they are supported by observations, in the form of a picture and a description of it, in order to underpin the respondents’ experiences. Those pictures were added to the empirical chapters.

To focus on the ethnicities and take gender, religion, and income into account, different combinations and comparisons were made. This was part of the ‘Describing, Classifying and Interpreting’ loop. In combining all those different views from respondents and informants with the observations, a general image was formed. Because this is a case study, a more detailed description of the local context, the particular case and its setting will be provided in Chapter 4 about the health care system and Chapter 5 about the local context.

The interviews with the informants and experts were also analysed in order to find useful information. Important quotes were highlighted. Those interviews were semi-structured. The information the informants and experts gave is mostly about background information of the health care system or experiences in the hospital. The most important information of the interviews is captured in this research.
3.4 Reflection on Methods

In almost all interviews, the help of an interpreter was made use of. As already mentioned, this brings some difficulties with it. It is important to keep in mind that a translator can influence the context of an interview. He or she can add his or her own perspective to the translated information or omit relevant issues. This was also discussed beforehand with the interpreter concerned, to make this influence as small as possible. For both the translator and the researcher, English is not the mother tongue, which made it difficult for both to apply nuances in the spoken word. An interview guide for the semi-structured interviews and definitions, translated beforehand, were also helpful as a guideline for conducting the interviews. In this way, efforts were made to make the translation problems as small as possible.

A recommendation for a next research would be to conduct the interview in the language of the respondent by an interviewer who knows the language, and translate it afterwards with an language expert who can also explain more about nuances. The background and interpretations of the researcher are important as well. The researcher gives his direction to a conversation, draw his conclusions during the interview and can interpret words in a different way than is meant. In this research, there is one researcher, so for a large part the interviews with the respondents were formed by my thoughts and opinions. For that reason, it would be better to have several researchers working on one project who all give their opinion and interpretation.

Health care and health are personal issues. It is possible that people did not tell me everything about their health care situation. Although this research did not focus on the personal health of the specific respondents, this might have been a reason for the respondents to not be totally open when it came to giving examples. It was also challenging to find enough respondents for each ethnicity. Javanese and Chinese respondents were more easy to find, but it was harder to find Sunda and Malay people. The original idea of focusing on four ethnicities with each the same number of respondents has therefore not been reached. Since this research focuses on ethnicity as an aspect in the access to health care in general and not on specific ethnicities this was not a problematic situation. For that reason, the research continued interviewing people
with a Javanese, Chinese, Sundanese or Sumatran background who were available in Tugu area to a greater or lesser extent.

The reader should bear in mind that this study approached almost all respondents on the street or in the neighbourhood. Because of this method of snowball-sampling, a community bias is lurking: within a community people know each other and they suggest other people they know. People who are more introverted or less socially active in the research area had less chance to be suggested or addressed for an interview. Another important aspect is that the people who were interviewed were all at home or in their own shop, which is why they could be approached. But there were also people living in the area, who were not at home during the time of approaching possible participants and were therefore not included in this study. A less diversified group may be a consequence of this. People in the Tugu area were maybe working in another place or could not being interviewed due to another reason. It was tried to approach people during the evening, but also on Saturday – both during the day and in the evening. Besides, it was hard to interview young people, which should be taken into account for a next research.
Overview of the Indonesian Health Care System

This chapter is an overview of the health care system in Indonesia. To understand people’s access to health care it is relevant to understand the system first. This part will focus on the different health care providers and elaborates on important developments of the last decades. These developments include the government decentralisation and the implementation of a universal health insurance system. All those who provide health care are grouped under the term of health care provider. This term is very broad, because there are many types of health care providers. The most important health care providers will be addressed in this part.

4.1 Health Care Providers

The health care providers include hospitals, puskesmas services, posyandu, lansia, private doctors, and traditional health care providers. Below a description of each will be given.

4.1.1 Puskesmas

The Indonesian national health development program is built on a primary health care concept (Adashi et al., 2013). The primary health care centres are basic health facilities. In those ‘puskesmas’ (acronym of Pusat Kesehatan Masyarakat: Community health centre), they provide primary health care and at the same time function as referrals to hospitals (interview Hasan Basri, UGM; 16-06-2016). At least one puskesmas is supposed to be headed by a doctor, although sometimes the sub health care centres are headed by nurses. Because the (regional) governments do invest in such centres in the whole of Indonesia, this concept is a common understanding among Indonesian people (Adashi et al., 2013). Even when people have never been to it, they know how it works there, because a lot of people go over there and talk about it. People use the puskesmas because in the city of Yogyakarta they are often close by. In each kecamatan (district) a puskesmas is available, which provide service for primary health care and prevention programs (Adashi et al., 2013). People are appointed to the puskesmas in their own district. As long as they are registered in the area of the puskesmas they will be free of charge. Without the right documents, people have to pay for the service.
Health care centres focus on health promotion, sanitation, mother and child health and family planning, community nutrition, disease prevention, and minor emergencies (Ministry of Health, 2004; as cited in Adashi et al., 2013). Also, they focus on health development which means “the implementation of health programs by all Indonesia people to increase awareness, willingness and ability of healthy life for every person to realize the optimal level of public health” (Ministry of Health, 2014, p.27). They provide several programs for people to attribute to the public health of Indonesian citizens.

There are several kinds of puskesmas services. In the first place, there is just the normal one, but besides that one there are puskesmas pembantu (helper). These are in general smaller puskesmas services that are a branch of a bigger puskesmas and built to increase physical accessibility. There are also puskesmas keliling (roving). These health care centres are movable, for example by car, and are driving around in remote areas (Ministry of Health, 2014).

The number of puskesmas services is increasing and so is the ratio of the service per head (Ministry of Health, 2014). In West Papua there are relatively speaking the most primary health care services, while this number is lowest in Banten (West Java). In the province of Yogyakarta, the ratio is 1.02 puskesmas for 30,000 citizens, which is a little bit under the national level. However, this ratio does not say everything:

The ratio does not describe real conditions of accessibilities to basic health services. For example, three provinces with the highest ratios are all located in the eastern region of West Papua, Papua, and Maluku. This is due to small number of inhabitant despite of vast working area. (Ministry of Health, 2014, p.27-28)

4.1.2 Hospitals

A puskesmas can be seen as having the function of gatekeeper for the hospitals. The government sees the hospitals as care provider for referral services, curative and rehabilitative services (Ministry of Health, 2014). According to the Ministry of Health (2014, n.p.) the definition of a hospital is the following (next page):
A hospital must provide basic services such as general medical service, emergency unit, nursing service, outpatient, inpatient, surgery, pharmacy, nutrition, sterilization, medical documentation, administration and management service, health education for the community, mortuary, ambulance.

A great distinction in hospitals in Yogyakarta can be made on the background of a hospital. There are hospitals financed by the government and hospitals run by institutions. Those institutions are mostly religious. Another distinction can be based on the type of the hospital. Two different types exist: Umum (general) and Khusus (special). The definition of a general and a special hospital is described in Indonesia as follows: “A general hospital is a hospital which gives health care services for all kind of specialties and diseases. A special hospital is a hospital which provides health care treatment for a particular kind of disease, which is based on major, age, part of body or type of disease” (Klassifikasi Rumah Sakit, 2010). The special hospitals can also be divided, based on the specialty they offer: maternal, surgical, eye, psychic or ENT (ear/nose/throat) (interview Hasan Basri, UGM; 16-06-2016). Besides this, there is a kind of hierarchy in the health care facilities in Indonesia. There are type A, B, C, and D facilities:

Type D is only one specialist doctor; type C is with a minimum of 4 specialists. Type B is for education and type A is for national referral. That last one is owned by the ministry of health, they put it in specific provinces. In Yogyakarta is that Sardjito Hospital. Everyone there is employer of the national ministry of health. (interview Hasan Basri, UGM; 16-06-2016)

This hierarchy is not only in size or specialism but also in responsibility: “Type A is national, type B are owned by the province government. Type C and D are from the district governments” (interview Hasan Basri, UGM; 16-06-2016).

Some people use the hospitals for primary care. They have a doctor in the hospital who they know and who is their general practitioner. There is a strong influence of family traditions and habits. According to Hasan Basri (UGM; interview 16-06-2016) this is changing because of the implementation of BPJS. Unless in case of emergency, people
need to have a letter of referral from a *puskesmas* or, in some cases, from a private doctor if they want to be part of the Indonesian health insurance system (see: Section 4.2, p.44).

Another distinction is that of government and private hospitals. The traditional private hospitals are religious and were already there before the independence of Indonesia (interview Hasan Basri, UGM; 16-06-2016). Because people are not satisfied with the government hospitals, there was a growth in private ones. Quite recently, in 2005, the JIH (Jogja International Hospital) was founded. They also stand for profession, as they present themselves as ‘the ultimate values health care’. According to Hasan Basri (UGM; interview 16-06-2016) that is what private hospitals feel: the need for profession. People want to have quicker service and good health care and private hospitals respond effectively to these demands. But also vice versa: doctors and policy makers of the governmental hospital feel that the service there is not good enough.

4.1.3 *Private Clinics*

The private health sector has grown a lot over the last decades due to several developments in this sector. The use of it is increasing, as is the amount of private hospitals and clinics. This is not surprising when you consider that between 65% and 80% of specialist doctors’ income derives from their work in non-governmental hospitals or private clinics (Meliala, Hort & Trisnantoro, 2013). This is probably the reason that dual practice in state and private services is common and well established in Indonesia. The predominance of doctors’ income from private sources is becoming problematic for the government. They are afraid that in the future there will be no doctors working in state hospitals and afraid of a decreasing quality for the patients there. They try to limit the private practices with regulations, but those are ineffective.

4.1.4 *Posyandu and Lansia*

A *posyandu* (acronym of *Pos Pelayanan Terpadu*: integrated service post) is a community service for primary health, which can be supported by the *puskesmas* (Nirwana, Utami & Utami, 2015). The community based service is to secure local well-being, especially for conceiving mothers and young children. Also, they can provide small medicines and take care of elderly people. The activities are run by and for the community. In almost all
villages in Indonesia, a posyandu is available. There are several posyandu in Yogyakarta, one of which is located in the research area.

In Indonesia, there are also lansia (acronym of lanjut usia: advanced age). These are services for elderly people and part of the Indonesia Elderly Institute (Do-Le & Raharjo, 2002). Those services are self-reliant and independent. They are managed and funded by the communities themselves. In the research area, there are several groups that are part of lansia. They come together in the building of the posyandu, for example once every two weeks.

4.1.5 Traditional Health care and Self-Treatment

Some Chinese respondents used the old traditional Chinese medicine, abbreviated in scientific literature to TCM. The ancient version of TCM is Huangdi Neijing which was written 2000–3000 years ago (Unschuld, 2003; as cited in Xu & Yang, 2009). It is based on the Chinese philosophy of ‘Yin and Yang’ and on the ‘Five Elements’. Both emphasize harmony with the universe. Not only acupuncture and massage are main treatments in TCM, there is also an extensive Chinese herbalism which includes plants, but also medicinal uses of animals and minerals (Xu & Yang, 2009). Because of the significant Chinese group in Yogyakarta, there are several Chinese medicines you can buy in the shops. There are also traditional Indonesian medicines, the so-called jamu (herbal medicines). Those are medicines with several ingredients from natural materials like spices, flowers, seeds, leaves. People use these medicines for self-treatment, besides the regular medicines provided at the pharmacy.

The availability of medicine is changed by regulation. You can buy medicines only for small problems now. However, the traditional health care is getting more attention from the government:

*Traditional health care programs continue to grow and get special attention from the government. Traditional health care is the treatment or care and based on inherited experience and skills from generation to generation, which is empirically accountable and applicable based on norms in the society.* (Ministry of Health, 2014, p.33)
4.1.6 Other Health Care Providers

Not only the hospitals, puskesmas services, and private (traditional) doctors and clinics are the health care providers. People cannot only buy medicines at the pharmacy, but they can often get advice from the pharmacist or a medical specialist as well. Besides, some traders passing through the streets of the neighbourhoods sell their medicines and advices. People’s blood pressure, for example, can be measured for a small amount of money. These traders can base their practice on scientific standards, but also on traditional, spiritual, and religious ideas.

Health care providers can operate outside the rules of the health care system. Vendors and traders are especially this group of ‘informal health care workers’:

_in situations where formal health facilities are not available nearby or easy to access, this group of informal health workers [vendors and traders] is the first and most important point of call for people in search of health services._ (Omaswa, 2006, p.83)

However, also formal health care workers can operate outside the rules of the health care system. For example, when they practice outside the limits of their skills. Informal health care workers are found in every health system. When the strength of the formal sector weakens, the impact of the role of the informal one increases (Omaswa, 2006).

4.2 Two Major Transitions

Recently, there have been two major transitions in health care in Indonesia (Plummer & Boye, 2016). The first one is the implementation of government decentralisation. The other transition is the launch of a universal health insurance.

After the fall of the Suharto regime, which was authoritarian, the government authorities became increasingly decentralized, including the health care sector. The provinces and districts were given more authority (Plummer & Boyle, 2016; Kristiansen & Santoso, 2006). The development of those two transitions is partly intertwined as Aspinall (2013, p.806) described (next page):
The origins of Indonesia’s social security and welfare system lie, as in most countries, with early introduction of health insurance and pension schemes for civil servants and soldiers, followed by gradual expansion to, first, workers in the formal sector and, eventually, all citizens. By the end of the Suharto period (1966 – 1998), however, only the politically strategic groups of civil servants, soldiers, and formal sector workers were covered by compulsory health insurance and pension schemes; the vast majority of the population had access only to rudimentary state health care.

Traditionally, Indonesian health care has been fragmented. There is private insurance for those who can afford it and basic state provision for the very poorest. Besides that, there are NGOs present in some areas to provide support for the poor and the in-between. With the decentralization and expansion of the welfare system, there came ideas about a new health insurance system. This resulted in several help institutions from different governmental layers.

Figure 5: BPJS as an umbrella term (source: bpjs-kesehatan.go.id, 2016)
Because of the difficulty and the unclearness of this system, the government started with a new national health insurance system for the whole of Indonesia in January 2014. This public health insurance is called BPJS (abbreviation of Badan Penyelenggara Jaminan Sosial: Social Security Agency) and aims to cover all Indonesian people. This is a kind of umbrella term for several regulations and options (Figure 5, previous page).

Within BPJS, there are three health care accommodation classes: first, second, and third class. There are different regulations for each class, for example for those who are covered by the insurance scheme or free BPJS for the poorest people. In general, the monthly premium for BPJS in 2016, were 30,000 Indonesian rupiah (2 euro) for the first class, 51,000 rupiah (3.50 euro) for the second class, and 80,000 rupiah (over 5 euro) for the first class (Jong, 2016). An average monthly wage is hard to give, but in comparison, 1,572,200 Rupiah (105 euro) is the official minimum monthly wage in the city of Yogyakarta in 2017 (Kota Jogja, 2016).

The goal of the implementation of the BPJS is to have all Indonesian people covered by 2019. This idea is in line with goals from the United Nations (Plummer & Boyle, 2016).
The Local Context: City of Yogyakarta

This chapter gives a small overview of the context of this research. Some information about the city Yogyakarta and the research area in specific will provide a better understanding of the situation in which the respondents live.

5.1 Location of Yogyakarta Province and City

Yogyakarta is a city in Indonesia, situated in the province with the same name, which is officially ‘The Special Region of Yogyakarta’, in Indonesia abbreviated to DIY: Daerah Istimewa Yogyakarta. The province is located on the south side of Central Java Island (Map 3). It is one of the smallest provinces surrounded by the province of Central Java and by the Indian Ocean in the south.

Map 3: Yogyakarta on Java in Indonesia (source: Worldatlas.com, n.d.)

The region has four regencies or districts: Kulonprogo, Sleman, Bantul, and Gunung Kidul and one city. The city is called Kota Yogyakarta (‘city of Yogyakarta’; Map 4, next page). All have their own capital with administrative offices.
The region is special for its pre-colonial sultanate, which is still embedded in the administrative structure.

5.1.1 Government
The capital of the province is Kota Yogyakarta, situated in the centre of the province. It is the administrative part of the Yogyakarta Special Region. It covers over 30 km² which is just one per cent of the total province surface (3,133 km²). Yogyakarta city is divided into fourteen kecamatan (sub districts), that are all divided into kelurahan (larger neighbourhoods). All sub districts have their administrative leader. Each larger neighbourhood has their own leader called RW (abbreviation of Rukun Warga: Citizens Association). The smallest administrative Javanese division (e.g. a kampong – a demarcated village in a bigger neighbourhood) has their own voluntary, elected leader, called RT (abbreviation of Rukun Tettanga: Neighbourhood Association).
5.1.2 History of Yogyakarta city

People in the area of today’s Yogyakarta have been living under several regimes and monarchs for centuries. However, it was not until 1756 that the Yogyakarta Sultanate was officially created after years of wars. Since that time, the city has always been a symbol of resistance to colonial rule and maintained its position as sultanate. After the independence of Indonesia, officially in 1949, it was determined that this area would be part of the new republic. Because of its important contribution to the independence conflict, the region has received a special provincial status in the republic of Indonesia.

5.1.3 Population

The population of the city area was 388,627 inhabitants at the 2010 census. Due to urbanization the population had increased to a total of 412,704 inhabitants at the 2015 census (BPS Yogyakarta, 2016). Yogyakarta has the highest population density of the province, which is around 12,700 people per km2. The huge growth in a short time has resulted in a very high human development index in the city centre. By contrast, Gunung Kidul in the east covers half of the province, but only has a density of 482 people per km2. This shows the contrasts within the province, in which Yogyakarta is the urban area and the surrounding provinces are rural.

The citizens of kota Yogyakarta are divided over 144,137 households (BPS Yogyakarta, 2015). Of the total population there are over 200,000 men and 210,000 women. The population in the city is young, due to urbanization of mostly younger people, the presence of several huge universities and institutions and a relatively low life expectancy. Less than fifty percent of the whole region is older than 35 years and approximately 8 per cent of the total population is older than 65% (BPS Yogyakarta, 2015). Of the citizens living in the centre of Yogyakarta, more than 8.5 per cent lives below the poverty line (BPS Yogyakarta, 2014).
The province has a diverse ethnic composition (Table 1). Javanese people are by far the largest group. Followed by Sundanese, an ethnic group native to the western part of the island of Java, and Chinese descendants among others. In all economic sectors, a variety of ethnic groups are represented. A few sectors are dominated by one or two ethnic groups. The restaurant sector is dominated by either Javanese or Chinese, the security sector by the Javanese and the computer sector by Chinese people.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Javanese</td>
<td>3,331,355</td>
<td>96.54</td>
</tr>
<tr>
<td>2. Sundanese</td>
<td>23,572</td>
<td>0.68</td>
</tr>
<tr>
<td>3. Malay</td>
<td>15,430</td>
<td>0.45</td>
</tr>
<tr>
<td>4. Chinese</td>
<td>11,545</td>
<td>0.33</td>
</tr>
<tr>
<td>5. Batak</td>
<td>9,858</td>
<td>0.29</td>
</tr>
<tr>
<td>6. Madurese</td>
<td>5,289</td>
<td>0.15</td>
</tr>
<tr>
<td>7. Minangkabau</td>
<td>5,152</td>
<td>0.15</td>
</tr>
<tr>
<td>8. East Nusa Tenggara</td>
<td>4,238</td>
<td>0.12</td>
</tr>
<tr>
<td>9. Dayak</td>
<td>3,790</td>
<td>0.11</td>
</tr>
<tr>
<td>10. Other South Sumatra</td>
<td>3,629</td>
<td>0.11</td>
</tr>
<tr>
<td>11. Papua</td>
<td>3,567</td>
<td>0.10</td>
</tr>
<tr>
<td>12. Balinese</td>
<td>3,495</td>
<td>0.10</td>
</tr>
<tr>
<td>13. Others</td>
<td>29,924</td>
<td>0.87</td>
</tr>
</tbody>
</table>

Table 1. Ethnic composition of Yogyakarta Special Region in 2010 (source: BPS Yogyakarta, 2011)

5.1.4 Religion

That Yogyakarta is home to diverse ethnicities also means that it is home to several religious groups, since ethnicity and religion are in many cases connected to each other (Pamungkas, 2015). During the last centuries those different ethno-religious groups have lived together harmoniously it has always been a relatively peaceful region (Sumartana et al., 1999; as cited in Pamungkas, 2015). However, since the start of this millennium, when there was the transition to a new political system, some fundamentalist and radical Islamic groups have become active in the city (Pamungkas, 2015), with the necessary tensions. In daily life, the social distance between Muslims and Christians is beginning to appear more and more.
The religion that people follow is listed by the government and is also on the passport of the Indonesian citizen, for example. People who are listed as Muslim are, with more than 90 percent, the biggest group in Yogyakarta. Christians are the second religious group, with 5.75 percent Catholics and 3.23 percent Protestants. These groups are followed by Hindus and Buddhists (BPS Yogyakarta, 2011).

5.1.5 General Health Information
According to the statistic institute of Yogyakarta, the city has two governmental hospitals with a capacity of 304 beds (BPS Yogyakarta, 2015). Furthermore, there are eighteen private hospitals with a capacity of 1,590 beds. However, these numbers can give a distorted picture, since the distinction of what the area of the city is and what not is not always clear. For example, the central state-owned university hospital ‘Dr. Sardjito’ is close to the city and many citizens make use of it, but it is not part of the administrative district of the city centre of Yogyakarta.

5.2 Tugu Area
This research focuses on the Tugu area in Yogyakarta and takes place in the area of Pasar Kranggan and Mungkubumi. It is the sub district of Jetis and a smaller part of the sub district of Tegalrejo. This area in the heart of Yogyakarta city is home to different ethnicities. Tugu is an iconic monument in the middle of a busy intersection. This three centuries old construction has a very deep meaning for people of Yogyakarta. There is a tradition to hug and kiss this monument after getting a university degree (Yogyes, 2007). North of the Tugu area Pasar Kranggan is situated. The pasar (means ‘market’) is partly indoors, where they mainly sell fish, chicken, vegetables, and spices. Several colours and odours come together here. In front of the market, the Chinese temple is established, which is still a religious place for rest, out of the bustle of the market. Behind the market streets there are several other streets with some shops, restaurants, and schools, but mainly houses. South of the Tugu area is Mungkubumi. This area knows some busy streets with shops, but deeper into the neighbourhood there are more houses with small streets.
5.2.1 Health Care Providers in Yogyakarta

The health care providers described in Chapter 4 are also present in the city of Yogyakarta. Some can be found in or around the Tugu area. Those health care providers were named by the respondents. Below some notable hospitals of Yogyakarta are described.

- Dr. Sardjito Hospital

This hospital is the central governmental hospital in the regency of Sleman, but close to the city centre of Yogyakarta. This general hospital is connected to the Gadjah Mada University, a reputable state university of the country.

- Jogjakarta International Hospital (JIH)

A large, relatively new, private hospital located in the north of the city. It is part of the regency of Sleman, but well-located along the ring road. The lowest classes of service are not represented in this hospital. Below, a picture of this hospital is shown (Figure 6).

Figure 6: Jogja International Hospital (source: kreatifia.blogspot.nl, 2013)
- **Panti Rapih Hospital**

A private hospital, located near Gadjah Mada University. The hospital was founded in 1929 by catholic sisters. Nowadays, Panti Rapih (Figure 7) provides its services in the spirit of the Catholic faith (Panti Rapih Hospital, 2017). They have beds in several classes, from low to very very important person (VVIP).

![Panti Rapih Hospital](akperpantirapih.ac.id, n.d.)

- **Bethesda Hospital**

This hospital is the oldest one in the city and also one of the biggest private ones. It was founded in 1899 as a protestant Christian mission hospital. Despite its original protestant Christian character, it serves patients in need regardless of race, religion of class, according to the mission of the hospital (Bethesda Hospital, 2017). They have beds in several classes, from low to very very important person (VVIP). The location of the hospital is between UGM and city centre.
- **Muhammadiyah Hospital**

Another big hospital in Yogyakarta is the Muhammadiyah hospital in the southern part of the city (Figure 8). This hospital is part of an Islamic organization Muhammadiyah, which owns several hospitals through the country. It is an Islamic hospital, based on Islamic values.

Figure 8: Muhammadiyah Hospital (source: pusatpengobatan.com, 2015)
Below, a map of a part of Yogyakarta is depicted (Map 5). In this map, the research area is circled with a red colour, while the notable hospitals are circled with a blue colour. The two puskesmas services in and near the Tugu area are circled with a green colour. In the West of the research area, there are no hospitals, which is the reason for the research area not being the centre point of the map.

Map 5. Research area with notable hospitals and puskesmas services (source: Google Maps, 2016; adapted by Author)
Portraying the Inhabitants by Assets Groups

Each respondent has his or her own story regarding access to health care. This chapter sheds light on six portraits of inhabitants in the Tugu area. Those portraits are based on the groups in which they belong. Because it is assumed that people’s assets are important in access to health care, the respondents will be divided in six groups. Each group is based on their capital assets, which is part of the Sustainable Livelihood Approach as discussed in Chapter 2. In the next two chapters (Chapter 7 and Chapter 8), there will also be made use of those groups with the corresponding assets. It can be helpful to place statements, experiences or opinions of respondents in a certain context. This will be done in order to answer the next sub-question:

*How do inhabitants of the Tugu area use health care?*

**6.1 The Importance of Portraits**

To get an in-depth understanding of how the inhabitants of Tugu area have access to health care, it is important to focus on how they use the health care. As seen in Chapter 4, there are multiple options and ways to get health care. In this maze, people make choices to go to one health care service and to leave another behind. So in order to grasp the bigger picture of access to health care, the current use of health care is central. For that reason, six portraits will be sketched, based on the in-depth interviews. In that manner, different situations and backgrounds of the people will be presented.
6.2 Capital Assets

To make clear who the twenty respondents are, they are divided into six groups. Each group is based on their capital assets. Access to livelihood assets of the household, the community and the wider society are important aspects in recognizing an illness and taking steps to go to a health care provider (Obrist et al., 2007). The assets are: natural capital, human capital, financial capital, physical capital, and social capital (Box 4).

- Natural capital (N): Land, water, and livestock
- Human capital (H): Knowledge, education, skills
- Financial capital (F): Cash and credit
- Physical capital (P): Infrastructure, equipment, and means of transport
- Social capital (S): Social networks and affiliations

Box 4: Capital assets (source: Obrist et al., 2007)

The diverse groups have been made visible by webs (Figure 9). Each angle in those pentagons is a certain capital. The first letter of each capital is written down. For each group a coloured line will show to what extent a certain capital is present. The further away from the centre, the greater the asset. The webs give a little insight in the differences between groups. The natural capital is the same for each group, because there is not much difference the natural capital that people in an urban area have. This capital will therefore be ignored.

Figure 9: Capital assets web – each angle corresponds to a certain capital
6.3 Sketches of the Portraits

The situations of the twenty respondents have been reduced to six portraits. These portraits are based on the capitals people have. The capitals came forward during the interviews and observations made at the respondents home. People with similar assets were put in the same assets group. Using this system, six groups have been made, which resulted in the following division (Table 2):

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Javanese woman J1I</td>
<td>Javanese man J2I</td>
<td>Javanese man J3I</td>
</tr>
<tr>
<td>Javanese woman J1II</td>
<td>Javanese man J2II</td>
<td>Javanese man J3II</td>
</tr>
<tr>
<td>Chinese man C1III</td>
<td>Sumatran man Sr2III</td>
<td>Sumatran man Sr3III</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sundanese man Sd3IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sundanese man Sd3V</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 4</th>
<th>Group 5</th>
<th>Group 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Javanese woman J4I</td>
<td>China man C5I</td>
<td>China woman C6I</td>
</tr>
<tr>
<td>Javanese woman J4II</td>
<td>China woman C5II</td>
<td>China man C6II</td>
</tr>
<tr>
<td>Sumatran woman Sr4III</td>
<td>China man C5III</td>
<td>China woman C5IV</td>
</tr>
</tbody>
</table>

Table 2: Six capital assets groups

Behind each respondent a code is shown. This represent the corresponding respondent. The first letter is assigned to the ethnicity of the respondent: J = Javanese; C = Chinese; Sr = Sumatran; Sd = Sundanese. The Arabic numerals refers to the capital assets group the respondent belongs to. The Roman numerals refers to the unspecified, arbitrary place in the group, based on the sequence in Table 2. A brief overview of the respondents can be found in Appendix I.
6.3.1 Group 1

The first group scores quite low on the several capitals. Imagine a Javanese woman who is low-educated. She is more than 60 years old, living in the middle of the kampong. She looks older than she is, marked by the hard work during her life. She has a few children, who all live elsewhere. Since her husband passed away, she is alone in her one-room house, which also serves as a small shop for citizens of the kampong. She is Muslim like a lot of people in her environment. Besides her family, the people in the kampong are those who she has contact with. Although she has some health issues, she is not complaining, but happy and thankful with her house and her place in the kampong.

Because this woman has low financial capital, she makes use of BPJS. She goes to the puskesmas, which she is content about. The services there are good and the staff is nice. She walks to the puskesmas by herself or people in her kampong help her to go there. When there is need for a hospital, she goes to the traditional non-governmental hospitals with a referral from the puskesmas. Her health care is free, because she uses only the lowest service level of health care.
6.3.2 Group 2

The second group has the same web as the first group. Imagine a Javanese man who works hard for himself and his family. He is trying to do the best with the things he has. He is low-educated and has worked as a tailor his whole life. Now he is more than 50 years old and will work until he cannot anymore. Traditionally, he is Islamic. He sees himself more as a blue-collar worker and does not want to be involved with white-collar people. He is married and has some children. He lives in a small house in the kampong. He is healthy and not very talkative. He has a motor cycle, but prefers to walk in the city.

The difference with the first assets group is that the people in this group are rarely using health care. Self-treatment is important. If the Javanese man in this group has health problems, he prefers to treat it by himself or some (traditional) medicines, which he buys in a shop or at the pharmacy. The man is part of BPJS, which he is not paying for, but how it works he is not sure and has less attention for it. When there is need for health care, he will probably go to the puskesmas.
6.3.3 Group 3

Figure 12 and Box 7: Capital assets group 3

The people in the third group are in general more educated and thoughtful in making choices. They belong to the low-middle class. Imagine a thirty-year-old man who is working hard for himself and his family. Originally, he comes from Sumatra. Since he finished his education a few years ago, he has been working for the government at an office with low wages. He lives in a nice small house and feels responsible for his environment. He is protestant Christian. He has a motorcycle.

Because this group is less tied to the place where they live, their social capital is higher than the previous groups. Due to their human capital, the people in this group are more critical regarding health care. Although they are satisfied with their health care to a certain extent, they definitely know some huge improvements could be made. Due to their low income, they have the right to BPJS, but have to pay a certain amount of money each month. They are using the puskesmas and go to the traditional public hospitals.
6.3.4 Group 4

Figure 13 and Box 8: Capital assets group 4

Group 4 covers the middle class more. This group is critical. Imagine a Javanese woman who is forty years old. She is Muslim. She has studied when she was younger and now has a job that is not study-related a few days a week. Her husband is the main breadwinner. Besides her work, she raises their children and is active in several committees of her neighbourhood. She lives in a house with a nice garden and a veranda. She has all that she and her family need and can save some money for her children when they go to the university later.

This group is critical about the BPJS and the Indonesian health care system. For that reason, they barely use the puskesmas. Instead, they prefer a private doctor. Some have the highest level of BPJS for their access to the private doctor.
6.3.5 Group 5

![Diagram of Group 5 assets]

- Using private doctors and private services
- Having a health Insurance
- Critical about Indonesian health care system

Figure 14 and Box 9: Capital assets group 5

Group 5 has more financial and physical assets than the fourth group. They are part of the middle/higher income group. Imagine a Chinese 70-year-old woman. She owns her own shop and has some staff. She is selling groceries, medicines, and household items. She is proud of her origin and also sells Chinese products. She and her Chinese husband live behind the shop, which is spacious. They have several children, who do not live in their house anymore. This friendly, hard-working woman is Catholic. She goes to church regularly, but usually stays at home.

This group is critical about the public health care. They only go to private health care services. They have their own health care assurance.
6.3.6 Group 6

Figure 15 and Box 10: Capital assets group 6

The respondents in the sixth group are wealthy. Imagine a 30-year-old man, who is co-owner of the company of his and his family. He is not married and because of that, he lives with his parents in a huge house. He is works long days in his office at his company. He wears suits all the time. He has done several business studies in Indonesia and has gone to Europe to study. He sees Indonesia as a low-income country.

The respondents in this group are wealthy. They can afford health care outside Yogyakarta, for example services in Jakarta or Singapore. They are very critical about the Indonesian health care.
6.4 Concluding Remarks: Using Health Care

The six portraits described in this chapter give insight in the different lives and circumstances of people. The portraits are not complete, but only a sketch showing a glimpse of how inhabitants of the Tugu area use health care. In this manner differences and similarities are visible in how people using health care. At the end of this chapter, we are able to answer the first sub-question:

*How do inhabitants of the Tugu area use health care?*

In Yogyakarta there are various health care services and levels of service within a health care provider. This means that there is a broad range of possibilities, from which people can choose. It is possible for people to live next to each other in the same area but have different trajectories in health care. Based on peoples capital assets, they use different health care services. It seems that this depends predominantly on people’s financial and physical assets. The choice for a health care centre depends largely on how much money people want to spend on their health care – and the underlying question of how much money they can spend. When people have more money to spend on health care, they go less often or not at all to the *puskesmas* services for primary health care, but straight to a private general practitioner or a doctor in a hospital.

The choice for a health care provider depends also on the environment. What do they know, what kind of advices can they give? This human capital, e.g. family or neighbours, can be of great importance in going to a health care centre. Family in particular can be decisive, for example if there is a family doctor. This can be connected to family traditions, which is fed by people’s ethnicity and religion. It seems that people make use of their background, consciously or unconsciously, to make choices regarding health care.
The Experiences of Access to Health care

The availability of health care services in a place can say a lot about, for example, the level of welfare within an area. But it does not tell the complete story. There are regional differences in availability, also within Indonesia. There are less services and doctors in remote areas, which cause severe shortages there. This is partly due to the preferences of health care workers to serve in urban areas (Efendi, 2012). On the other hand, the geography of Indonesia is difficult. The archipelago and wilderness make it a great challenge to deliver health care, especially on small islands and deep in rainforests. In those areas, the lack of availability and accessibility to health care may result in deploring situations. However, this does not necessarily mean that the access to health care is better in an opposite situation. Even on the large islands with many people and in urbanized areas, access to health care can be disappointing. Access is more than only the components availability and accessibility. Other ‘ingredients’ of equal and full access have to be taken into account as well: affordability, adequacy, and acceptability.

Nevertheless, statistics show a higher concentration of doctors in and around cities (BPS Indonesia, 2015). However, those statistics are quantitative, focusing on numbers of people, hospitals, puskesmas services, and doctors. The stories and opinions of people are not captured in those data. For that reason, it is relevant to focus on people’s own stories and opinions about access to health care in all its facets. In this chapter this will be done by answering the next sub-question:

*How do inhabitants of the Tugu area with a different ethnic derivation experience their access to health care?*

As discussed in Chapter 2 (p.13), access consists of five dimensions. Based on these dimensions, the experiences of the respondents will be discussed. First, the aspect of availability will be focused on and, in succession, accessibility, affordability, adequacy, and acceptability.
7.1 Availability

*It is about the relationship between the volume and time of the health services and that of the clients’ need* (Obrist et al., 2007).

In the Tugu area of Yogyakarta, there are several facilities, as described in Chapter 5. The more extensive hospitals, such as the Sardjito hospital, are relatively close by. In such hospitals people can be helped for numerous complaints. That is also what all respondents mentioned. They know where the several hospitals are and can mention the general differences between them. In every district, a *puskesmas* service is available. Those are open five days a week, both in the morning and in the afternoon, even on holidays. In contrast to the *puskesmas*, the several hospitals are open 24 hours a day (Respondent Sd.3.IV). Some smaller parts of the area do not have a health care facility directly close by. This can be a problem in the access to a health care provider (Respondent Sr.3.III). But still, in the city centre of Yogyakarta, a health care facility is not that far. This is also shown in Map 5 in Chapter 5, part of it is shown on the next page (Map 6).

Besides the hospitals surrounding the area and the *puskesmas* services, are there also several private doctors in Tugu area. These doctors are usually open during weekdays, where you can make an appointment. The respondents know that there are also private doctors, but not everyone can mention them, depending on whether they use them. This could have several reasons. They might be satisfied with their own doctor or it is further away from their house. That there are several options for health care providers does not direct imply that there are enough health care facilities. However, according to the biggest part of the respondents, there are sufficient health care facilities in their environment, as shown in Table 3 on the next page. Still, some people think that the health care facilities are insufficient.
Map 6: Health care facilities around Tugu area (source: Google Maps, 2016; adapted by Author)

<table>
<thead>
<tr>
<th>Ethnicity (No. of Respondents)</th>
<th>Sufficient</th>
<th>Insufficient</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Javanese (8)</td>
<td>63% (5)</td>
<td>37% (3)</td>
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<tr>
<td>Chinese (7)</td>
<td>42% (3)</td>
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<td>29% (2)</td>
</tr>
<tr>
<td>Others (5)</td>
<td>80% (4)</td>
<td>20% (1)</td>
<td>-</td>
</tr>
<tr>
<td>Total (20)</td>
<td>60% (12)</td>
<td>30% (6)</td>
<td>10% (2)</td>
</tr>
</tbody>
</table>

Table 3: Perceived sufficiency of health care facilities

There are a lot of options for people with regard to health care. However, this is only true when they have access to it and have the right to choose their own doctor, for example. It seems that in this urban area there are a lot doctors, but there are still some improvements to be made.
Availability is not only about the sufficiency of the number of services and medical staff, which can be seen as the ‘volume’ of the health services and that of the clients’ need (Obrist et al., 2007), but also includes the aspect of ‘time’. In this context, think about the procedures – when are you being served – and the time in general: the waiting times. For some people it is all the same, for others this really matters. For example, respondent J1I goes to the puskesmas service, but for her it is fine to wait in line. She explains how it works with the several steps in a puskesmas:

There are five general practitioners. Two are especially for the elderly people. Other patients are treated by three doctors. The idea is first come, first serve. So, for example there are three doctors, if there is one doctor free, and a number comes up the patient will be treated by that doctor. If people have a preference, for example if they are more comfortable to a specific doctor, they can wait until this doctor is available. Then they have to wait longer. There are specials days for services. On Monday there are services for babies until five […] On Tuesday and Wednesday, it is for the pregnant check-up. On Thursday it is for contraception […]. Tests in labs, like cholesterol or blood tests, can every weekday but only in the morning. All the services are provided in the morning. Only in the morning is there these service times from 8.00AM until 10.00AM. The afternoon service time is especially for the sick people, while in the morning are these consultations.

People have to wait twice. First, just for the registration (Figure 16, next page), later on for waiting for the doctor (Figure 17, next page). These registration cues is also what people mention as a point of concern:

There are not enough services in this area. I know a lot of people have troubles in there, because of the cue for the registrations and the waiting lines. It is very crowded. I think that is a problem. (Respondent C5I)
Another woman (Respondent C5IV) sighed when it was about the puskesmas services: “No, puskesmas! [...] There are a lot of people there, waiting in line.” She is going to a private doctor where there is not such a waiting line. For her, time is money, also because she is an entrepreneur. This is an example of opportunity costs: the value of choosing the best alternative opportunity. The woman has the willingness to finance a private doctor to minimalize the time spending on visiting a health care provider. The same is applicable to respondent C5II, who cannot leave her commerce. Respondent C6II experienced the same. She has problems with her kidneys, but she cannot leave her store at all times. Even with her problem, she does not want to drink a lot. Then her need to go to the toilet – and
so leaving her store – would be bigger. There are no complaints of respondents about private doctors concerning volume or time. Some doctors can be quick, but that is not at the expense of the service.

**Capital Assets**

When focusing on people’s capital assets, a number of things draw attention to them. Predominantly, the three groups with the lowest capital assets say that there are sufficient health care services in the area. They know several and think, based on the knowledge they have, that it is enough to cover the area. Perhaps, when people have fewer assets, they find pleasure less important and accept the long waiting time at the *puskesmas*, for example. They have lower financial capital (Figure 18), resulting in them being satisfied easier with what they get. Linked to the same capital asset, those people have less (financial) ability to go out of their area for health care and are therefore more likely to make use of health services close to them.

![Figure 18: Three lower capital assets groups (first, second, and third group)](image)

This can imply several things. The first point is that people with more assets have probably more freedom to go to a health care service of their own choice. For example, because of their financial assets they can afford more expensive medical help. Another point is that people with fewer assets are less critical concerning health care. They go to the nearest health care centre and trust the service provision there.
All respondents – with the exception of the second assets group – go to a health care provider regularly. People with few assets go to a *puskesmas*, while people with more assets usually go to a private doctor. The second assets group is mainly using self-care, making own medicaments, for example.

*Focus on the Ethnicities*

It is notable that the Chinese respondents mentioned several times that they have less time to go to a health care service. This is mainly because of their job. Most of them are entrepreneurs, so they are busy with their own shop or company, whereby they have less time. Furthermore, these respondents are mainly part of the higher assets groups, which makes them more critical about the availability of health care. The Chinese respondents know where the public services are, but five out of seven Chinese respondents had never been to a *puskesmas*, for example (Respondents C5I; C5III; C5IV; C6I; C6II). They prefer to go to their ‘own’ doctors who meet their expectations (Respondents C5II; C6I). These doctors are private ones in hospitals, who they or their family knows for many years. Sometimes they even have a designated general (family) doctor (Respondents C5I; C5III; C5IV; C6II). Three of the Chinese people mentioned using traditional Chinese health care, which is seen as good (Respondents C1III; C6I; C5II). They buy, for example, Chinese medicines or take a traditional Chinese massage against back pain.

Of the Javanese, only two respondents mentioned the traditional health care (Respondents J4I; J3II). All the Javanese respondents were using or had used the *puskesmas* services. The public hospitals (Wirosaban and Sardjito), Panti Rapih and Muhammadiyah were the hospitals they mentioned going to.
7.2 Accessibility

*It is about the location of the services and that of the clients.* (Obrist et al., 2007)

When there are several health care providers in the research area, it is expected that a health care provider is always relatively close by. Because of the population density, the city centre of Yogyakarta seems well-covered: in the Tugu area is one and close to it is another *puskesmas* service. The respondents think that the *puskesmas* services in and around the Tugu area are situated in a strategic place:

*There are many hospitals and puskesmas services in Yogyakarta now. So I think it is good now, even people from central-Java come here. [...] Furthermore, the puskesmas service is on a two-way street. So anyone can go inside. Emergency response can go quick.* (Respondent J2II)

Because Tugu area is situated in the city centre, the location of the different services are close by. For that reason, people here have the freedom and possibility to go to the service they want to go to. “The services are on strategic places. All the hospitals are close by, and you can easily reach them by bejak [a three cycle taxi] for around 10.000 Rp” (Respondent Sd3IV).

<table>
<thead>
<tr>
<th>Ethnicity (No. of Respondents)</th>
<th>Walk</th>
<th>Motorcycle</th>
<th>Car</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Javanese (8)</td>
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<td>88% (7)</td>
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<td>13% (1)</td>
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<td>Chinese (7)</td>
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<td>71% (5)</td>
<td>43% (3)</td>
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<td>15% (3)</td>
<td>85% (17)</td>
<td>25% (5)</td>
<td>5% (1)</td>
</tr>
</tbody>
</table>

Table 4: *Transport*

Table 4 shows the several possibilities people mentioned of how they go to a health care service. Most of the respondents used a motorcycle or a car. Other alternatives are walking or going by *bejak*, the three cycle taxi. For none of the respondents, the use of a motorcycle was a problem. However, some respondents cannot drive by themselves or do not own a motorcycle. When there is no motorcycle available
they can borrow it from others, although it may be a threshold to ask someone, especially when you want to have an unseen doctor visit. It is even more difficult when you cannot ride a motorcycle by yourself. For example, there was a woman (Respondent J1Il) who goes to the hospital or the puskesmas several times a month and is supported by her son who picks her up and brings her to the service.

Besides walking, going by motorcycle or going by car, Yogyakarta citizens do have the possibility to go by public transport. A car taxi or a bejak taxi are options to move, but there are also several bus services that stop at hospitals. None of the respondents mentioned this, but it is possible to use them. However, all those transports, with the exception of walking, cost money. If you have money, you can go by public transport. Thereby, it is important to realize that it can be hard for ill people, disabled persons, and elderly to use public transport. Think about the embarkation and debarkation when boarding a bus. This makes the public transport less accessible for those people.

The same applies for the area itself. Some parts are better accessible than others. Respondent Sr3Ill said that there are enough health care providers in the district. However, he called the kampong where he lives problematic. In the kampong ‘Jogoyudan’ is just one small road, which is quite passable to walk and to ride by motorcycle. Furthermore, there are small side roads and short cuts with stairs where it is only possible to walk:

*The main problem is the access inside this kampong, [...] it is hard for vehicles to go in and out of this part of the area. The road is too narrow, and ambulances for example are hard to go through.* (Respondent Sr3Ill)
Figure 19 shows the situation in this kampong. On the map, it looks like a thoroughfare, without sideways. But along this road, there are several small paths going to the houses more close to the river. These paths are inaccessible for cars, and so for ambulances.

This is a situation in which the accessibility of the kampong is limited. This can cause dangerous situations, but also make it difficult to reach patients when there is an emergency, or vice versa when patients need to go to the hospital as quickly as possible. The area here makes use of a ‘emergency team’.

*They have a lot of equipment like a stretcher. But it is not enough. There are still some cases in which people are getting ill and where it is difficult to move them up on the road.* (Respondent Sr3IIII)
**Capital Assets**

Because Tugu area in Yogyakarta is an urban area with health care services scattered around the environment, the services are in the vicinity. This means that people can reach them easily by walking, provided that people are able to walk. In case people are unable to reach the service by foot or other transport, then their access to health care will be low. This has to do with the capital assets people have, which can influence people’s accessibility.

![Image](image_url)

**Figure 20**: Low capital assets group (red line). Social capital can help to enlarge other capitals for a moment (blue line)

A good example of how low assets are an obstruction in the distance between someone’s house and the health care service is that of Respondent J1II. She often need other people to help her to go out of the kampong, only she walk to the puskesmas. But once her condition was too poor, so the doctor gave her money for the transport. She does not have any transportation like a bike or a car (physical capital), she does not have a driver license (human capital) and not has the financial ability to invest in transport (financial capital). However in this case, the social capital helps her out of the distress (Figure 20).

Of the respondents in this research, those with higher assets have more possibilities to be picky and to move: “If it good, it does not matter for me if it is far or not” (Respondent C6I). For this reason, respondents also went to Jakarta or Singapore (Respondents J3II, C5III), because of the more ‘Western standards’. So the distance between the location of the services and that of the clients is not really an issue, but more the costs: “If it about the distance, people can still manage. But when it is about the costs, it is harder” (Respondent Sr3III). Before the section about affordability, the focus will first lie on the ethnicities.
**Focus on the Ethnicities**

Regarding the relation between accessibility and respondents’ ethnicity, the location of the place the respondents live is telling. Four out of the twenty respondents live in the less accessible ‘Jogoyudan’ kampong described in one of the previous paragraphs. Of those four respondents, three are Javanese (Respondents J1I, J1II, J2II, Sr3III). All of them belong to the first three assets groups. The other respondents live in less traditional kampungs and five out of the seven Chinese respondents live on one of the main roads, where the shops and restaurants are.

Based on where the respondents are found and live, there seems to be a relation between someone’s ethnicity and the place they live. In that sense there is a link with accessibility. However, this issue is also connected to affordability, because it seems that people with higher assets live in better houses that are better accessible and less far away from health care services. The next A will be discussed in the following section on affordability.

**7.3 Affordability**

*It refers to the financial component of access.* (Obrist et al., 2007)

For the respondents, the affordability issues seemed to a big part, or the biggest part, of their access to health care. This is also confirmed by the informants*, who emphasised the affordability part in particular. When you are in a higher service class of a hospital, the service is different compared to the lower classes. However, according to the informants, when you are in a higher class the differences in services and the use of (non-)generic medicines is the only thing that is different.

A lot of the respondents are using BPJS, the national health care insurance for all Indonesian people (see: Chapter 4.2, p.44). It is important to mention that these insurances are not especially meant for people who cannot afford health care, although it can be very helpful for them. There are several classes in BPJS. The lowest class is free of charge when they go to the puskesmas. This group makes use of generative medicines and uses the lowest class in the hospital. Other groups pay an amount of money and can claim higher classes with better service at the health care providers.

* Personal communication: Tugu Doctor 10-06-2016; Nurse Diana 17-06-2016; Nurse Veronika 08-06-2016
All respondents knew about the existence of BPJS, but not everyone knew the intention of the government for the implementation of it. A woman (Respondent J1II) told me how she became involved in the BPJS:

*Someone of the government came in this neighbourhood. Then I got interviewed by a surveyor. Later on I got the KISS [precursor of the BPJS]. I do not know why they came, even the chief of this area did not know about it. It was from the government and they just came by themselves, I do not asked for it.*

Normally, people need to register themselves to be part of the BPJS system. The idea of the system is to get all Indonesian citizens involved in the BPJS program. However, according to respondent Sr4III it can be hard to get into the lowest, free, class of BPJS, because of a quota. That is why they are surveyed first. They have to be verified when they sign a form of it. There are criteria for BPJS: they use a so called Standard Operation Procedure. But according to respondent Sr3III the parameters are quite vague:

*Some of the requirements of being poor are a house without a fundament, so a soil floor, and an income less than 500.000 rupiah per month. But even people with an income of two million rupiah per month have a hard time each month. [...] The parameters for poorness are unclear and blurry.*

It is also possible that people get no help because of inheritance, or because they have gotten help by a charity organization to rebuild their indecent house to a house with stones. In such cases, people will not pass the verification because they have a house which is too good. This happens, even when their condition is hopeless: unemployment for example. Also, the people of the survey sometimes ask the neighbours to verify. The question is whether it is always true what they say: “If people do not like their neighbours, they can talk bad. In such a case the neighbours will not complete the verification process” (Respondent Sr3III).
Sometimes, people want to have benefits from BPJS, even though they can afford health care. One respondent (C5III) is trying to get into the BPJS for another operation, which is less expensive when she and her husband are part of the insurance. Another respondent (C6I) is part of the BPJS and sees it as something extra:

*I have BPJS but I never use it. It is safety mature and because it is cheap, so why not? It is a way cheaper than the insurance I have. I want the highest service of BPJS, but that is still very cheap. So you just never know. That amount of money is not significant for me. In case anything should happen, maybe I can get extra treatment from the BPJS.*

In Table 5 below, the insurances of people are shown. Some people only have BPJS or only another health care insurance; some have a combination.

<table>
<thead>
<tr>
<th>Ethnicity (No. of Respondents)</th>
<th>Only BPJS</th>
<th>BPJS + other health care insurance(s)</th>
<th>Other health care insurance(s) (No BPJS)</th>
<th>No insurance at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Javanese (8)</td>
<td>87% (7)</td>
<td>13% (1)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Chinese (7)</td>
<td>29% (2)</td>
<td>14% (1)</td>
<td>43% (3)</td>
<td>14% (1)</td>
</tr>
<tr>
<td>Others (5)</td>
<td>60% (3)</td>
<td>40% (2)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total (20)</td>
<td>60% (12)</td>
<td>20% (4)</td>
<td>15% (3)</td>
<td>5% (1)</td>
</tr>
</tbody>
</table>

*Table 5: BPJS and/or health insurance*

Besides BPJS, other health care insurances which were mentioned are: Prodential (Respondents C5I; C5II; C5IV), Sinar Mas (Respondent C5II), and InHealth (Respondent Sr3III). Those are all commercial, private insurances. Two respondents (J3II; Sd3V) mentioned ASKES, which is a health insurance from the government for civil servants and their family. In general, people think the access to health care regarding affordability is getting better now. Health care seems more affordable for people. BPJS can be helpful and a lot of treatments are covered by it. However, it is people's own responsibility to get involved in the BPJS.
**Capital Assets**

The three lowest assets groups are all registered in BPJS. They do not have to pay a monthly fee. When they use it, they have to go to the puskesmas and need a referral letter to be helped at the hospital. Some respondents of the other groups do also have BPJS, but they have to pay a monthly fee, due to their higher (financial) assets (see: Section 4.2, p.44). The higher capital assets group have more financial space to go to more specialized doctors and hospitals.

**Focus on Ethnicities**

As already mentioned, the Chinese respondents are part of the higher assets groups. The majority of this group are not registered in the BPJS system. They choose a private health care insurance more often. All Javanese respondents were part of the BPJS, as well as the Sumatran and Sundanese respondents. This means that all of them have a certain financial access to get health care. However, those with more financial space, often the Chinese respondents, can be more picky and get more specialized and non-generic help.

**7.4 Adequacy**

*It is about the expectations of the clients to the organization of health care.* (Obrist et al., 2007)

This ‘A’ was not always clear for the respondents, partly due to translation issues. The expectation of the respondents is the general agreement that health care needs to be good. The views differ about what good health care is. These opinions depend more on people’s personal characteristics and experiences. Some aspects in the health care system of Yogyakarta are inadequate. The crowds and the long waiting time in especially the public health care services is one of those issues mentioned, as also discussed earlier in this chapter. That is also the reason why some respondents will not go to a puskesmas service. Respondent C5I said the following about it: “I think it is inadequate, because it is crowded. They have to serve a lot of people in the district. And especially after the BPJS was implemented, a lot of people went to the puskesmas [...], but it is hard to serve all those people at once.”
The BPJS is, according to some respondents, also a point of inadequacy. Some respondents call it a difficult and confusing system. There is a lot of ‘bureaucracy’ and requirements that have to be met (Respondents J3I; Sr4III; C5III; C6I):

*When you have the letter of referral it is valid for month. So within a month you have to go to the hospital. When you are in the hospital, there are also steps to take for BPJS, to register again. Why do they make it so difficult?* (Respondent C6I)

Yet, the general idea is that the health care system in Yogyakarta is getting better. The organization of it has been subject to change: “Back then, good health care was only for the rich, nowadays there is not really a distinction anymore” (Respondent C5I). Other positive reactions were for example: “Health care system in Yogyakarta is good enough” (Respondent C6I), “Here, everyone has entrance to the system of health care” (Respondent C5IV).

It seems that adequacy is connected to the financial component of access. When people pay for the service, they expect more. That is also what respondent C6I mentioned. He said that there are no poor people anymore in Indonesia. Money is important, according to him, so everyone can have entrance to the health care system. If people spend more money to health care, the public hospital does not have the quality they expect of a hospital: “In Sardjito hospital, I am afraid to go there. It is a huge building and it is haunted” (Respondent C5I).

*Capital Assets*

When the inhabitants of Tugu area have more capital assets, it seems that people have more expectations as to the organization of health care. As also emerged discussing the previous ‘A’s’, it seems that people with more (financial) capital assets, can be more picky. If people have to pay for their health care services by themselves, people expect more of the health care services.
Focus on Ethnicities
There are not really differences in adequacy based on peoples’ ethnicity. The expectations of the respondents concerning the organization of health care is based more on peoples’ experiences. When they are used to better services in health care, their expectations are higher.

7.5 Acceptability

It is about social and cultural values of people. (Obrist et al., 2007)

Discussing acceptability, people started to talk about the friendliness of the doctors and staff. This has also something of hierarchical distance in it and a respect for doctors. When the respondents have the choice, they choose a doctor who they trust. In a puskesmas service, you can give your preference for a certain doctor. There is also a complaint box in the health care centre. If anyone is uncomfortable with the service, you can put a letter of complaint in there. In general, the respondents think that the acceptance of the patients is good. The doctor will just accept the patients, when they focus purely on doing the service as respondent CSIV mentioned. For measuring blood pressure and asking general questions, you go to the doctor at a desk in an open area. For more specific examination, there are private rooms, where you can have a private conversation with the doctor.

Acceptability is not only about acceptance by the medical staff, but also about feeling accepted by other patients, for example in the waiting room. It has happened that people were approached by other patients because of their derivation. A Sundanese man (Respondent Sd3V) told: “Before they asked to me: ‘You are not from here?’ ‘You are not from the city?’ But nowadays it is for me the same as the people from here.”

There are differences between people in how accepted they felt at different hospitals. These differences are, for example, based on the hospital (religious or not) or their ethnicity. These will be discussed in the next chapter, where the focus lies on the more personal characteristics. Acceptability can be coherent with that.
Capital Assets
In general, the respondents from all the capital assets groups feel accepted. They share certain social and cultural values which are applicable to the whole country. It is difficult to place acceptability in the patterns of the capital assets. However, social capital is relevant in the sense that it is about social networks and affiliation. All the respondents feel themselves connected to others.

Focus on Ethnicities
It is also hard to determine the relation between acceptability and ethnicity. The Javanese respondents felt accepted without a doubt, but also the Chinese, Sumatran, and Sundanese respondents felt accepted by the hospital or doctor they go to.

7.6 Experiences of Access to Health Care
At the end of this chapter, we are able to answer the sub-question:

*How do inhabitants of Yogyakarta with a different ethnic derivation experience their access to health care?*

The availability of the quantity of the health care providers in the city centre of Yogyakarta seems high at first sight. Yet all the respondents had experienced or knew that the waiting lines at certain health care providers can be very long. For some people, this is a thing which shows that there are not enough health care facilities. People with low assets predominantly use the puskesmas services, while people with higher assets use the private doctors more.

When it is about accessibility, the transportation for the respondents in the city centre of Yogyakarta is not really a problem. People have their own car or motorcycle – or can barrow it or they walk. However, transportation can be difficult in health care emergency situations within kampongs which are not designed for larger vehicles.
When it is about the financial component of access, people make choices based on the BPJS, if they use that. To meet the requirements, people have to appoint to a certain health care service. The general idea is that the organization of the health care in Yogyakarta is getting better, although respondents could still name some improvements.

In general, people do feel accepted, because of the friendliness of doctors, and comfortable because of the time a doctor takes to treat the patient. This has also to do with respect to an authority, the doctor in these cases. There are exceptions, in which people do not totally feel accepted. Reasons for that can be ethnicity, religion or gender. This will be discussed in further detail in the next chapter.

**Capital Assets**

To get direct access to health care in Tugu area, the natural capital, human capital, physical capital, and social capital seems to be of less importance. However, social capital can be relevant in, for example, helping people to go to a health care provider. But in general, listening to the stories of the respondents, the most recurring aspect is the financial one. The financial capital asset is important in the sense that when people have money to spend on health care, they can easily have access to whatever health care provider. Money also comes back in availability (more freedom to choose your health care provider/medicines) and accessibility (money for transportation). To a lesser extent, this can also be the case in adequacy (more money to health care, possibly higher expectations) and acceptability (possibly feeling more accepted because of better service).

**Focus on Ethnicity**

In an urban area as Tugu, ethnicity does not seem to be of large influence on the access to health care – especially focusing on the availability part (the presence of health care services) and the accessibility part (reaching the health care services). A health care service in this urban area is easily accessible when it is about traveling time, especially when you compare it to a non-urban area. Basically, to go to a health care provider does not cost that much money, time, and energy. However, ethnicity and access in the urban area definitely makes sense when you focus on where people live. In general, it seems
that the Chinese live in better accessible houses, while Javanese, Sumatran, and Sundanese people live in kampongs more often, which are less accessible.

This also seems connected to the affordability part of access to health care. The Chinese seem to be entrepreneurs more and to have more financial capital. In that sense, affordability is not really or less of an obstacle for them to get health care.

Adequacy and acceptability seem to be okay, according to the respondents. Ethnicity does not really play a role in this. However, in the subsequent interviews, when the personal characteristics gender, religion, income, and ethnicity were discussed, some issues came up, that had not been discussed before. These personal characteristics will be focused on in the next chapter.
Focus on Personal Characteristics

As seen in Chapter 6, there are differences in assets that people have. Based on those assets, people make choices, which also comes forward in Chapter 7. In the previous chapter, the experiences of the inhabitants of Tugu area in having access to health care were central. This chapter builds upon the previous chapter. Certain differences between the respondents will be discussed. As seen in the previous chapters, money is an important aspect in access to health care in Yogyakarta. Although it is definitely relevant, it does not say everything. For that reason, this chapter focuses on several personal characteristics. Those issues possibly play a role in access to health care. Specific factors addressed in this chapter are gender, religion, income, and ethnicity. It is possible that these factors are not the only characteristics explaining differences in health care. These four characteristics, however, are mostly visible for the respondents and the people surrounding them, and for that reason easily recognizable. In Tugu area, men and women from different religions and ethnicities live and work next to each other, all with another socio-economic background. Those characteristics are manifested in the assets people have. To focus on these personal characteristics, the next sub-question is as follows:

*What do inhabitants of the Tugu area specifically say about differences in their access to health care?*

Access to health care in Tugu area, Yogyakarta is the central element in this research. The role of ethnicity will be discussed and light will be shed on specific personal characteristics. This last sub-question will focus on these personal characteristics regarding access to health care. Subsequently, gender, religion, income, and ethnicity will be discussed.
8.1 Gender

In general, the respondents say there are no differences in how men and women have access to health care. They do not see gender as an obstacle as seen in the following tables (Table 6 and Table 7). You go to a health care service or hospital and will be treated according to the number you take or when you have an appointment, you go there.

<table>
<thead>
<tr>
<th>Ethnicity (No. of Respondents)</th>
<th>No obstacle</th>
<th>Maybe</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Javanese (8)</td>
<td>75% (6)</td>
<td>12.5% (1)</td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>Chinese (7)</td>
<td>86% (6)</td>
<td>-</td>
<td>14% (1)</td>
</tr>
<tr>
<td>Others (5)</td>
<td>100% (5)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total (20)</td>
<td>85% (17)</td>
<td>5% (1)</td>
<td>10% (2)</td>
</tr>
</tbody>
</table>

Table 6. Gender as an obstacle by ethnicity

<table>
<thead>
<tr>
<th>Gender (No. of Respondents)</th>
<th>No obstacle</th>
<th>Maybe</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman (8)</td>
<td>87.5% (7)</td>
<td>12.5% (1)</td>
<td>-</td>
</tr>
<tr>
<td>Man (12)</td>
<td>83% (10)</td>
<td>-</td>
<td>17% (2)</td>
</tr>
<tr>
<td>Total (20)</td>
<td>85% (17)</td>
<td>5% (1)</td>
<td>10% (2)</td>
</tr>
</tbody>
</table>

Table 7. Gender as an obstacle by gender

However two women (Respondents J4I, J4II) would prefer women doctors. For one woman (Respondent J4I) it is because of religious reasons. She is Islamic, and thinks that it is not good to be treated by a man if it is not necessary. Such difference is also present in Islamic hospitals. That is also what respondent J4II mentioned:

*In some hospitals there is a difference. When women go to that hospital, the nurse or doctor needs to be the same gender. For men it does not matter, only for women. It depends to the person if gender is an obstacle or not. As a woman, I am feeling myself uncomfortable being treated by a male doctor.*

Head covering also has to be taken into account as a gender-religious reason to want to be treated by a woman specialist, as respondent J4I also mentioned.
In Yogyakarta, there are several private doctors, both male and female. So if you choose a private doctor, you can choose a male or a female one. This is harder in a puskesmas service or with a more specialist doctor in a hospital. The majority of the doctors are male. In that case, waiting in line for another doctor does not make sense if all are men. However, in some cases it is possible to get a female doctor, as respondent J2I experienced himself: “My wife, when she was pregnant, she was wondering why there were men at the gynaecology department. We said that and asked for a female doctor. Then we had to wait for a female doctor.”

One other woman (Respondent J1I) mentioned that there are difference in how male or female doctors approach you. The male doctors explain more about the sickness, while the female doctors talk with more empathy. However, it is acknowledged that, in earlier times, it was more of an issue, according to respondent Sd3IV: “Back then people from the villages they used traditional medicines and traditional systems. So also gender was like that”.

The respondents say that gender does not play a role in access to health care. However, while discussing it, some issues came forward, especially when talking with women. Some gender issues are relevant in going to a health care provider – so those issues are also important in access to health care.

8.2 Religion
As slightly discussed in the previous section, religion as a personal characteristic can be an aspect in access to health care. As gender and religion can be intertwined, so are ethnicity and religion sometimes. Religion is part of the culture of an ethnicity. Roughly speaking, you can make a distinction in religion and where somebody comes from. Most of the Batak ethnic groups in North Sumatra are predominantly Christians. Sundaland (West Java) is predominantly Islamic, while the rest of Java is more moderate Muslim. These differences in religions can make sense in access to health care. An important footnote of religion in Indonesia is the obligation to be part of a religion. This means you are born with a certain religion. For some people, their faith is of great importance. For others, it is less important, or only as a family tradition.
In Tugu area are several mosques, churches, and a Confucian temple. Also, there are various religious health care providers. This diversity indicates that there people living together with different religious backgrounds. That Yogyakarta is multi-ethnic and multi-religious makes that there according to most of the respondents that there are no differences in health care divided by religion. In Table 8 is seen if religion play a role or not according to the respondents.

<table>
<thead>
<tr>
<th>Ethnicity (No. of Respondents)</th>
<th>No role</th>
<th>Yes</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Javanese (8)</td>
<td>75% (6)</td>
<td>12,5% (1)</td>
<td>12,5% (1)</td>
</tr>
<tr>
<td>Chinese (7)</td>
<td>72% (5)</td>
<td>14% (1)</td>
<td>14% (1)</td>
</tr>
<tr>
<td>Others (5)</td>
<td>100% (5)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total (20)</td>
<td>80% (16)</td>
<td>10% (2)</td>
<td>10% (2)</td>
</tr>
</tbody>
</table>

*Table 8. Role of religion*

The most respondents believe that religion does not play a role in their access to health care. Reasons for people why it does matter is their faith. For respondent C5IV, who is Catholic, her religion plays a role. When she is ill and has to go to a hospital, it is very important for her to pray. She will ask for assistance in her praying and performing her rituals. For respondent J4II it is of great importance that the hospital is Christian. For her it is about the acceptance that she is Christian:

*If I go to the puskesmas or hospital, Christian or Catholic, that is okay for me. But if I go to the Islamic hospital that is a problem. [...] It is very Islamic, the doctors need to be Muslim. Bethesda hospital and Sardjito hospital is more mixed. For example at Bethesda it is only the rule that you cannot wear head covering.*

Several Muslim respondents mentioned that some Islamic people have the preference of an Islamic health care provider:

*For me religion does not matter in access to health care. But sometimes Muslim people prefer to go to Muhammadiyah hospital, so then plays religion a role. They are not comfortable with other religions in the hospital, so more orthodox Muslims will prefer that hospital. (Respondent J1I)*
None of the Muslim respondents in this research were that strict in their religion that he or she only goes to a Islamic hospital. However, three respondents (Sr4III, J2I, Sd3IV) mentioned that they know people who are strict in that. Respondent Sr4III said that it is important for her Sumatran mother: “She is fanatic, but also in Sumatra religion plays more a role than in Yogyakarta.” The brother of respondent J2I is also a ‘strict Muslim’ and only wants to be treated by Muslim doctors. In those cases, religion can be seen as a threshold in access to health care. However, the variety in health care providers makes this threshold not that high.

According to respondent Sd3IV, at the health care services “[t]hey do not really see your religion in health care. They do not ask in what you believe in.” So from the perspective of the health care providers, religion does not play a role in access to health care. The only difference a respondent mentioned is the difference in prayer of the doctor, but the approach or treatment from the doctor is not dependent on someone’s religion, according to respondent J3I. Christians go to a Muslim doctor and vice versa, he said. The different religious hospitals are not really a problem. They are part of Indonesia, the country is multi-religious, and so are the hospitals (Respondent C5III).

In general, religion does not matter in access to health care, according to the respondents. If the service is okay and the patient are respected, than it is good for them:

My child get an operation at Bethesda, there the most doctors are Christian. It is okay for me. Me and my family pray for ourselves, and also the doctors do. Besides, even at Bethesda there is a musholla – an Islamic prayer room – inside the building. At that hospital they also respect other religions. (Respondent J4I)

However, it seems there are some exceptions while discussing this characteristic. For example, the Christian respondent C5II said another (non-)religious hospital or doctor does not matter for him. But discussing the Islamic hospital of Muhammadiyah, he said: “Well, that is specific Islamic…” (Respondent C5III), suggesting that he does not like that hospital because of the Islamic atmosphere over there: “We are feeling ourselves not comfortable in that place [...]. It is the matters of prayers.” And later on, more generally speaking to make this issue not that big for him: “People prefer to go to their ‘own’
hospital” and “it also depends on the distance”. Some Muslim respondents may also have a slight preference to go a hospital or doctor of their own religion:

*I like it more when I have a doctor who is also Muslim. Then I am more happy with it. But for Panti Rapih and Bethesda it is different. The doctors there are good.* [...]  
*I am comfortable to go there as a Islamic woman.* (Respondent Sr4III)

While the Muslim respondents go to all hospitals, in general, it looks like Christian respondents prefer Christian hospitals, but not really the Islamic ones. A side note is that this also has something to do with the cleaning and the service (Respondents C6I, C5IV).

### 8.3 Income

Income creates more financial capital. As we have already seen in the different groups of Chapter 6, the more financial capital, the more other capital people, in general, have. However, it also depends on your own expenditures to which health care service you go. A woman (Respondent J4II) mentioned:

*My neighbour has a lot of income. She can go directly to the best hospitals. Another neighbour of me is earning less money, but also she goes to good hospitals. So, it also depends on how much money you want to spend on your health care.*

A recurring aspect in the interviews were the classification of low, middle, and higher incomes. A rough classification can be based on the following: lower incomes in Indonesia can rely on (almost) free health care from the public health care provider; higher incomes have enough money for their health care expenditures (at least in the public health care sector). While the middle-income groups are threatened to fall between two stools. One woman (Respondent Sr4III) described it as follows:

*Rich people can go to the health care services. It is hard for the middle class, you need money first and then you can pay for the BPJS. Poor people can go because they have free BPJS. The government in Yogyakarta cares a lot about them […], they only have eye for the poorest.*
Another respondent (Sr3III) mentioned the same issue: “Even people with money have sometimes problems to pay BPJS”. So financial capital does not say everything. For a household, the costs per person can be quite high when it is not covered by BPJS: “The middle class has problems to pay BPJS. There are a lot people in Indonesia who are middle class. For poor people it is free, rich people, they can pay; but for the middle class it can be difficult” (Respondent Sr3III). In other words, it is not as black and white as it looks at first sight. In this grey area, it sometimes seems that low incomes have access to healthcare to a larger extent, compared to middle income groups. Instead of the usual stepwise low-, middle-, higher incomes it sometimes seems like: middle-, low-, higher incomes.

However, the general line is that when people can spend more money on healthcare, they cannot only afford better service, but also quicker receive response with less bureaucracy. In a puskesmas service, it makes no sense who you are and how much money you have. In a hospital, it makes more sense: it depends on your insurance or how much you want to pay for the service in which class you are hospitalized. Only when there is an emergency the hospitals will take care of the victim, regardless of his insurance. Also, with more money you can get other medicines:

*People with more money can more optimize the health care they want. They can afford more expensive medicines. Those are not always better than generic medicines, but there are cases. In the hospital it can be different, for example with different kinds of antibiotics.* (Respondent C5IV)

Other respondents said it is not that complicated: “There are no differences in health care divided by income – as long as you pay!” (Respondent C5III). In case people cannot pay it, there are options for a discount or easier ways to pay, but people have to figure that out by themselves. The health care financial system is not always that clear for people. A woman (Respondent C6I) had BPJS but was not really using it, because of the system: “Normally I will just go to the doctor in the hospital, and not using BPJS. Then I pay with my own money. Because when I have pain I will just go to the hospital. I do not want to wait for the letter.”
8.4 Ethnicity

According to Hasan Basri (UGM; personal communication 16-06-2016), the role of ethnicity in access to health care has two sides: it does matter and at the same time it does not matter at all. In the first place, it does not matter, especially for Yogyakarta which is multi-religious and multi-ethnical:

*In Indonesia is already for centuries a lot of exchange in cultures. That is another trend, that continues till these days with rapid exchange within this country and abroad. Different cultures live next to each other and exchange ideas and habits.*

This is also the general idea among the respondents (Table 9), where the majority said that ethnicity does not matter in access to health care:

*In Yogyakarta it is all the same, no differences in health care. It is all the same, it is multi-ethnic and multi-religious. [...] A lot of people here come from Borneo, Sumatra or are Tionghoa, but for health care that does not matter. (Respondent C5II)*

<table>
<thead>
<tr>
<th>Ethnicity (No. of Respondents)</th>
<th>No role</th>
<th>Yes a little bit</th>
<th>Yes</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Javanese (8)</td>
<td>100% (8)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Chinese (7)</td>
<td>71% (5)</td>
<td>14.5% (1)</td>
<td>-</td>
<td>14.5% (1)</td>
</tr>
<tr>
<td>Others (5)</td>
<td>40% (2)</td>
<td>40% (2)</td>
<td>-</td>
<td>20% (1)</td>
</tr>
<tr>
<td>Total (20)</td>
<td>75% (15)</td>
<td>15% (3)</td>
<td>-</td>
<td>10% (2)</td>
</tr>
</tbody>
</table>

*Table 9. Role of ethnicity*

Most of the respondents said that there are no differences in access to health care based on ethnicity. One respondent said the following about it: “There are a lot of different foreigners here from all over Indonesia. Also the doctors come from other provinces” (Respondent Sd3IV). Another respondent said quite the same: “For me the ethnicity of the doctor does not matter. If he or she is Javanese or Tiong Hoa. Also people around here think the same. Here in Yogyakarta, we are already mixed; so it is all the same” (Respondent C5IV). However, another respondent emphasized that there are a lot of Javanese: “Because in Yogyakarta there are a lot of Javanese, but people not really think
about people’s ethnicity or religion” (Respondent J3I). As long as the doctor can heal them, that is most important. It shows that people are getting used to people of other ethnicities and it is becoming normal for them.

For people of other ethnicities than Javanese, it is not a problem that a doctor is Javanese. And also vice versa: for people with the Javanese ethnicity, it does not matter that the doctor is non-Javanese. “Here, people do not really think about people’s ethnicity or religion. [...] As long as they have the ability to make people better than it is good” (Respondent J3I). “It is the same! All we want is being healthy. It is their profession, so not about ethnicity anymore” (Respondent C5III).

However, there is also the other side of the medal, where ethnicity does matter, as Hasan Basri (UGM; personal communication 16-06-2016) describes: “Ethnicity, and all the associated social and cultural processes, we should not underestimate them. Sometimes, it does not play a role, sometimes it does. It depends on the community.” So, ethnicity in access to health care has two sides. The other side are, according to Hasan Basri (UGM; personal communication 16-06-2016), the social and cultural processes. Those play definitely a role: “Ethnicity matters, it can become a barrier to get health care. Moreover it is also about the cultural expression of for example a disease.”

Hasan Basri (UGM; personal communication 16-06-2016) uses the example of language: the meaning of words in a community can be different, the load of words can be different. People from different ethnicities have their own words. The traditional perspectives in an ethinical group also play a role. This is an issue respondent Sr4III mentioned as well. For her, a health care provider with the same ethnicity can be more comfortable. People with the same ethnic background may understand each other maybe better: “Then I can say more about it”. And: “If I want to ask something, I can ask her directly”. So it is about culture, which also includes language: “Sometimes we [the Sumatran respondent and a Sumatran nurse] use our own language”. Language can be seen as a certain barrier: “When someone has another language, than I am more lazy to ask”. It costs more energy to speak in a language which is not your mother tongue or when it is a language you never use for your feelings or expressions.
Another Sumatran respondent (Sr3III) does not have any problems with a doctor of another ethnicity and has never had them before. But he knows that it can play a role. According to him, it is particularly based on religion in the different hospitals: “Sometimes in the hospitals, they will not give a letter of recommendation to other hospitals because they are based on different religions and ethnicities”. He also mentioned that he knows someone who does not want to be treated at Muhammadiyah hospital, because they might not treat people properly there. One respondent (J4II) explicitly mentioned the Chinese, when it is about ethnicity in health care:

*Like the pharmacy, the owners are Chinese, the doctors mostly too, and the customer also often Chinese. The Chinese are really independent, and also may be proud about their health care. And I think they are more confident with people with the same ethnicity. In the public hospitals there are less doctors who have another ethnicity. That is more in the private health facilities. And also for the patients if they come, they can choose which doctor they want.*

That kind of difference was also felt by respondent C6I. He is from Chinese origin and goes to the puskesmas:

*I feel there is a difference. Maybe the attitude or something like that. But I don’t really care about it. But off course there is, for example I am Chinese. If I go to the puskesmas, sometimes they say: why you came here? Because I am Chinese, and yeah, in general Chinese here have a lot of money, so then they ask that. Hahaha. But yeah I have BPJS. That is why. And then they make not a distinction in it.*

That kind of feeling different can also be a consequence of stereotyping. People can feel that others approach them differently. The doctor and nurses spoken to for this research said that there are no differences in how they approach different ethnicities. However, they know there can be differences. One respondent (J3I) explicitly said something about one ethnicity group, which shows that stereotyping can play a role in access to health care (next page):
In general, they [Papuan people] are angry all the time, so people don’t respect them. They don’t really care about Papua. I experienced it also in the hospital, it happened very often. Mostly it is because of accidents. It happens very often. Also because of alcohol. Yes, it is a problem. [...] Well, in general it is good. For patients and the staff it is for them better to be more calm, so the health care service they can handle it. So people should not be angry for example. In general, that all is good, except for Papua people.

This can take place between patients or within a professional-patient relation. Stereotyping is a phenomenon that should be mentioned here, because people can be treated differently which can have an effect on people’s access to health care. However, people can also be used to a different, causing it does not matter anymore:

*In the puskesmas service there is a nurse who is Batak. She is from Sumatra. They speak more loudly, so that is not the same with people in Yogyakarta, with Javanese people. But now I can understand.* (Respondent Sd3V)

Struggles between people with another ethnical background sometimes occurs. Javanese people are more introvert, while other groups can be more loud. These struggles can sometimes be heard or seen in the hospital, which is also agreed on by the doctor and the nurse. “Sometimes people are angry when they do not understand the other, when they speak too loud. Then there are tensions between different people,” according to nurse Diana who works in a hospital (personal communication, 17-06-2016).

But people also change, maybe even adapt, when they are from another place, as respondent Sd3V mentioned: “People also change here. Their attitude becomes more Javanese”, and respondent J2I: “The doctor from the pharmacy I go to, I think he is Batak, but now the doctor can also speak Javanese. So it is pretty much the same as a Javanese doctor.” These cultural processes can also change over time (Respondent C6l): “Panti Rapih is changing. I think, eighty percent of the people there is Muslim. But it is a catholic hospital. Before it was not that much, now it looks more like a public hospital.” This may indicate that the role of ethnicity as a factor in access to health care may change over time, because people use adaptability to the place where they now live. The role of
ethnicity becomes smaller, because people adapt to a changing environment and/or to people from the ‘main’ ethnicity.

### 8.5 Specific Differences in Access to Health Care

At the end of this chapter, we are able to answer the sub-question:

*What do inhabitants of the Tugu area specifically say about differences in their access to health care?*

In this chapter, four kinds of personal characteristics regarding access to health care in Yogyakarta are discussed. Gender, religion, income, and ethnicity: all four of the characteristics are easy to distinguish in the Tugu area. At the end, we can conclude that all can play a role in having more or less access to health care. Most of these aspects are not visible on the surface, but seem to be present underneath. When discussing these characteristics with the respondents, it initially looked like these do not play a role, but in the end, some issues came forward.

Concerning gender, access can be limited especially for women when they want to be treated by a woman doctor. Female medical workers are in the minority. The choice for a woman doctor can result in limited access to health care. Like gender, also religion can play a role. People with different religious backgrounds are living next to each other in Tugu area. Their religions are visible in different religious hospitals, although most hospitals are tolerant to all religions. A part of the respondents did not want to be hospitalized in a certain religious hospital because they were non-religious or other-religious. This can be an obstacle in having access to the health care they need. Both gender and religion show that money is not always the leading factor. For example, an Islamic woman with a lot of financial and physical assets has many possibilities in having health care in Yogyakarta. However, she can be limited in her access when she only wants to be treated by female medical staff and the hospital ward only has a male doctor. So even with financial space, this woman is limited in her access, because of her own choice.

However, money decides a lot: with more financial capital, people have the opportunity and the ability to choose for a health care provider of a bigger range. This
enlarges the amount of health services available. People with lower financial capital have less to choose from, but can often use free BPJS. People of the middle income group have to pay for it, whereby especially for them, the costs can hinder the way to full access to health care. However, it is also about the willingness of people how much money they want to spend on health care.

Ethnicity of people in having access to health care has two sides. On the one hand, it does not play a role at all: Yogyakarta has been a multi-ethnical city for centuries and Indonesia knows a lot of population groups within her territory. You can say that Indonesia, one of the world’s most ethnically diverse countries, is used to differences. This is also what a lot of the respondents mentioned: ethnicity does not play a role, because Yogyakarta is multi-ethnical, and for that reason it is okay to be from another ethnic group than the Javanese majority group. However, on the other side, ethnicity does play a role. This is evident in ostensibly small things like languages and people’s habits and traditions. Stereotyping can also play a role in this. These elements make ethnicity as a personal characteristic relevant in access to health care in Yogyakarta.
Conclusion and Discussion

In the right to health care, an important element is the actual access to health care. The presence of health care services cannot guarantee good access to health care, just as the mere availability of food cannot prevent famine (Sen, 1981). Access is a broad and complex concept, which can be seen as a collective term with several dimensions to it. Access is equitable when the quality of health care does not alter because of personal characteristics (Millman, 1993; as cited in Szczepura, 2005). This research aimed to acquire further understanding of how inhabitants with several different ethnical backgrounds of Tugu area in the city of Yogyakarta have access to health care. The role of ethnicity has been discussed and light has been shed on specific personal characteristics (Box 11). This research did not only focus on physical access, but also considered various cultural, social, and financial aspects. The heterogeneity of Indonesia in general, but also more specific the urban area of Yogyakarta, made it relevant to focus on ethnicity.

Box 11: Brief research review

The main question formulated for this research was:

What role does ethnicity have in the access to health care in Tugu area, Yogyakarta, and how is this influenced by gender, religion, and socio-economic status?

This question was subdivided into three sub-questions. The first sub-question focused on the use of health care of the inhabitants of the Tugu area in Yogyakarta. This has been answered by sketching portraits of them. The second focused on the experiences of respondents regarding their access to health care. Sub-question three dealt with the personal characteristics gender, religion, income, and ethnicity. In order to answer the
main question in this chapter, the sub-questions will be covered in several sub-sections first. It was considered important to give the floor to the respondents of different ethnicities and discuss the elements regarding access. In doing so, an attempt was made to get a view as clear as possible of the role of ethnicity in the access to health care of the inhabitants of Tugu area in Yogyakarta.

9.1 Trajectories in Health Care

In Yogyakarta, there are various health care services. There are hospitals, puskesmas services, and private clinics. Some are governmental, others are not. Some are based on religious thoughts, others not. Some health care providers offer several levels of service. In all those different options, people have to find their way. Therefore, different trajectories in getting health care are possible. One goes directly to the specialist in the hospital, the other via the health care centre with a referral letter to the hospital. Some are limited in their access, for example because of financial reasons. In other words, different ‘trajectories’ in health care are possible in Yogyakarta.

The livelihood approach, as explained by Chambers and Conway (1991), can be used to split people into different groups based on their capital assets. These include natural, human, financial, physical, and social capital. In this study, this livelihood approach has been used successfully to divide the respondents into six different capital assets groups. These capital assets determine for a great part someone’s access to health care, in the sense that people make choices based on them. It seems that this depends predominantly on people’s financial and physical assets. The financial asset in particular decides how much money people want to spend on their health care – and the underlying question of how much money they can spend. When people have more money to spend on health care, they go less often or not at all to the puskesmas services for primary health care, but straight to a private general practitioner or a doctor in a hospital.

The choice for a health care provider also depends on the environment. What do they know, what kind of advice can they give? This social capital, family or neighbours, can be of great importance in going to a health care centre. Family can be particularly decisive if there is, for example, a family doctor. It seems that people make use of their background, consciously or unconsciously, to make choices regarding health care.
Something that plays a role in this, can be people’s length of stay in urban contexts. Some families live for generations long in Yogyakarta. They built up a large number of social contacts throughout the lives of the family members. The more social capital someone or a family have, the more joint knowledge people have to base a choice for a health care provider on.

9.2 Experiences regarding Access

Access in this research is defined according to Penchansky and Thomas’ (1981) 5A’s. This stands for availability, accessibility, affordability, acceptability, and accommodation. Obrist et al. (2007) replaced accommodation with adequacy, which they found more appropriate when it comes to people’s expectations. In this research, this taxonomy was applied to the health care system in Yogyakarta, Indonesia. Affordability was found to be the most important ‘A’. For example, people make choices based on regulations of the BPJS, if they use that. To meet the requirements, people have to go to one or have to choose within a limited number of health care services. This can be linked to the financial capital assets in the livelihood approach.

The availability, in terms of the quantity, of the health care providers in the city centre of Yogyakarta seems, at first sight, high. But all respondents had experienced or could tell that the waiting line at certain health care providers can be very long. For some people, this is a thing which shows that there are not enough health care facilities. When it is about accessibility, the transportation for the respondents in the city centre of Yogyakarta is not really a problem. People have their own car or motorcycle – or can barrow it or they walk. Transportation, however, can be difficult in health care emergency situations in kampongs which are not designed for large vehicles. Availability and accessibility seem to be not that important in an urban area, but it looks like these are also connected to the affordability part of access to health care. Financial assets determine where you live and therefore have an influence on someone’s accessibility and the availability of health care.
Concerning adequacy, it seems that people had more expectations of the organization of health care when they had more financial capital. The general idea is that the organization of the health care in Yogyakarta is getting better, although people can still name possible improvements. Regarding acceptability, respondents generally felt accepted, because they shared certain social and cultural values. In general, people felt accepted, because of the friendliness of doctors. They felt comfortable because of the time a doctor takes to treat the patient. However, there were some exceptions of people who did not feel totally accepted.

Listening to the stories of the respondents, the most recurring aspect in their comments of how they decide where to go with their complaints, is the financial capital asset. This financial part is important in the sense that when people have money to spend on health care, they can easily have access to the health care provider to their preference. People with low assets predominantly use puskesmas services while people with higher assets use the private doctors more. Money also comes back in availability (more freedom to choose your health care provider/medicines) and accessibility (money for transportation). To a lesser extent, this can also be the case for adequacy (more money to health care, possible higher expectations) and acceptability (possible feeling more accepted because of better service).

Health care is seen as a human right and therefore it also has to do with justice. According to Soja (2010), justice has a geography in which the equitable distribution of resources, services, and access is a basic human right. Related to the topic of health care, social tensions or feelings of inferiority should not hinder people in their access to health care services. John Rawls (1971), in his description of distributive justice, focuses on rights, liberties, opportunities, income, and wealth. In this research, it was found that there is neither spatial nor social injustice in the sense that people are totally excluded from health care. All capital assets groups have access to health care services, regardless of people’s background or belief. However, taking a more critical look, there may be barriers for certain people: women (e.g. more male doctors), non-Islamic people (e.g. more Islamic or general focus services), and poor people (e.g. living in more difficult to reach places). These findings indicate both spatial and social injustice, as these elements are also main issues in health geography as discussed in a reviewing article by Rosenberg (2013).
The entitlement approach can be linked to social (in)justice. In this approach, Sen (1981, 1999) emphasized the importance of capabilities, entitlements, and endowments. One of his key arguments is that poverty, in the broadest sense of the word, is a result of an inadequate, poor set of initial endowments and entitlements combined with a lack of capabilities (Mitlin, 2013; Sen, 1999). This can result in social injustice and is often linked to spatial injustice. Entitlement refers to “[a] set of alternative commodity bundles, over which a person can establish command, given the prevailing legal, political, and economic arrangements” (Sen, 1981, p.156). In this research on access to health care, a great part of the respondents were affiliated to the national health care insurance BPJS, while others have taken out another health insurance or both. All these people were entitled to health care. People with BPJS are entitled to money from the government, whereas people with another health insurance are entitled to money from the insurance company. If people have to pay for their insurance and they do not have enough money for it, it is more difficult to be entitled to health care, as is the case for the middle income group. They are not entitled to free BPJS, but if they want an insurance they have to pay hefty fees based on their income. In this sense, the entitlement is legal (e.g. there is a contract), political (e.g. there is health care policy and BPJS), and economic (people pay for the service).

The other set is the endowment set which consists of knowledge and possession. This also includes capital assets. The ownership of capital assets determines whether people can go through the so-called ‘access barrier’ comprising the 5 A’s of access. However, with low (financial) capital, people can be helped to go through the access barrier with support of institutions, such as the government (e.g. providing BPJS). This is made visible in the model of Ergler, Sakdapolrak, Bohle & Kearns (2011) as shown in Figure 21 (next page).
In the urban Tugu area of Yogyakarta, there are several health care facilities in the direct environment. Although health care facilities are concentrated in cities, the presence of health care services cannot guarantee good access to health care. The geographical availability and physical proximity of facilities do not necessarily imply better access for poorer residents as other factors also play a role (Ergler et al., 2011).

9.3 Gender, Religion, Income, and Ethnicity in Access to Health Care

Although personal characteristics do not seem to be that important in a multi-ethnic and multi-religious city as Yogyakarta, they can limit someone’s access to health care. Those limitations are not always visible and do not always come up during discussions. Initially, it looks like these do not play a role, but in the end some issues come forward.

Concerning gender, access can be limited especially for women when they want to be treated by a woman doctor. Female medical workers are in the minority. The choice for a woman doctor can result in limited access to health care. Religion can also play a role. People with different religious backgrounds are living next to each other in Tugu area.
and their religions are also visible in different religious hospitals. A part of the respondents did not want to be hospitalized in a certain religious hospital because they were non-religious or other-religious. This can be an obstacle in having access to the health care they need, although most hospitals are tolerant towards all religions.

Money decides a lot: with more income, there is, in general, more financial capital. With more financial capital, people have the opportunity and the ability to choose from a larger range of health care providers. This enlarges the amount of health services they can choose from. People with lower financial capital have less to choose from, but can often use free BPJS. People of the middle income group have to pay for it and especially for them, the costs can hinder the way to full access to health care.

It seems that ethnicity plays a ‘silent’ role. A role that you will not see or hear at first sight, but only notice when you zoom in further on this subject. In the urban Tugu area, ethnicity does not seem to have a large influence on availability and accessibility. Basically, to go to a health care provider here does not cost that much money, time, and energy. However, ethnicity and access in the urban area definitely makes sense when you focus on where people live. In general, the Chinese respondents live in better accessible houses, while the Javanese, Sumatran, and Sundanese respondents live, to the utmost extent, in kampongs, which are less accessible. This also seems connected to the affordability part of access to health care. The Chinese seem to be entrepreneurs more often, and to have more financial capital. In that sense, affordability is for them not really or less of an obstacle to get health care.

In this study, ethnicity seems, at first sight, not to play a role in people’s access to a health care provider, as also came forward in the study of Suryadarma, Widyan, Suryahadi, & Sumarto (2006). People are used to the multicultural environment and do not find it problematic. Moreover, different ethnicities have always co-existed in Indonesia. Yogyakarta has been a multi-ethnic city for centuries and Indonesia knows a lot of population groups within her territory. Yogyakarta is an important urban area, with places to live and work for people from all over Indonesia. Besides the Javanese citizens, other cultural groups have been living together in the same city for sometimes many years and many generations. You can say that Indonesia, one of the world's most ethnically diverse countries, is used to differences. This is also what a lot of the respondents
mentioned: ethnicity does not play a role, Yogyakarta is multi-ethnical, and for that reason it is okay to be from another ethnic group than the Javanese majority group.

On the other hand, ethnicity does matter, with regard to social and cultural processes. That is why this research focused on the role of ethnicity in the access to health care. For that reason, respondents were found from four different ethnical backgrounds: the Javanese, Chinese, Sundanese, and Sumatran ethnicity. In the interviews with them, some issues regarding ethnicity in access to health care came forward. Although Yogyakarta is a multi-cultural city, ethnicity can make the difference in having more or less access to health care. For example, each ethnical group has their own traditions. Although some groups have lived in Yogyakarta for many years, they have still maintained their own standards and manners in how they use health care. Stereotyping can also play a role in this. These elements make ethnicity as a personal characteristic relevant in access to health care in Yogyakarta.

These examples of issues related to ethnicity show that personal characteristics matter. This is in line with numerous studies (e.g. Hadi et al., 2008; Nelson, 2002; Brown Ojeda, Wyn & Levan, 2000), which all show that ethnicity can matter in having access to health care. In these studies, for example, the language people speak and stereotyping are elements which play a role. This can even be in ostensibly small things like languages and people’s habits and traditions. These factors also show the core of ethnical theories such as primordialism (see: Yang, 2000), in which biological ties and connections based on religion, culture, and language are always relevant. In general, respondents felt comfortable with their roots by their ties and inherited personality traits. For people of another ethnicity, it is easy to have a prejudice or a stereotype of another ethnicity. Based on this, people use pigeonholing, which means that people classify others (e.g. with another ethnical background) into a certain category. These ethnicity or ethnicity-related issues are meaningful in having access to health care in the urban Tugu area of Yogyakarta.

9.4 Reflection on Research
Although the intention of this research was to go thoroughly and painstakingly through all loops of the ‘analytic circles’ (see: Section 3.3, p.33; Cresswell, 2007), there are some limitations and things that could have been done better. A reflection regarding to the
methods of this research has already been provided in Section 3.4. In this section, a reflection will be given on this research in general. It is instructive to reflect on this research. Reflection is a considerable step in a learning process and it might be useful for future studies.

In the first place, the inhabitants of Tugu area in Yogyakarta were central in this research. For that reason, the external validity is limited. Hence, overall statements about access to health care and ethnicity should be made with the necessary caution. Nevertheless, this research gives insight into the importance of taking ethnicity into account when it is about access to health care in an urban area. This can be insightful for policy makers in order to, for instance, change unhealthy habits or in creating awareness of certain health risks. However, this research is about a specific case in Yogyakarta, whereby it is not recommended to take over the results of Tugu area and apply them to other cases without caution.

The definitions of both access and ethnicity are disputable. Although these two concepts have been sufficiently defined in Chapter 1, the concepts may still have been unclear for the reader and the interviewees during the interviews. Individuals tend to give their own meaning to these words, often based on their knowledge and feelings. The same applies to the 5 A’s of access, where, on top of that, translation difficulties arose as well. The concepts were translated into Indonesian words, but the emphasis or meaning in the Indonesian language is sometimes slightly different than in the English language.

The subject of this research, with the corresponding concepts, might have been too broad. The respondents in this research were, in the first place, divided into four different ethnical groups. Moreover, the study divided the respondents into six capital assets groups. In addition, a focus on personal characteristics was made where the respondents were also partly discussed based on these characteristics. As a result, this research seemed to lack focus during the process. In hindsight, a more focused study might have been better. This could have increased its clarity. However, the obtained data was useful in formulating an answer to the research question as clear as possible, despite all these differences between the respondents.
9.5 Recommendations

This research showed the relevance of ethnicity as an aspect in access to health care. However, there is still a whole field to discover on making health care efficient and customized. More research is needed to unravel the concept of access and learn on this subject. Good access to health care in all its facets is of significant importance and attributes to the third goal of the sustainable development goals from the United Nations (2015): Ensure healthy lives and promote well-being for all at all ages. In this case, research needs to connect with policy. An important question regarding this is: how to ensure healthy lives and promote well-being? Access plays a significant role in answering these kind of questions. First of all, in the physical way, for example, in having the opportunity to go to a health care facility, but also in other ways, such as having access to valuable information about health and getting health care. Policymakers need to bear in mind that access is a broad concept. Just focusing on the accessibility part is not enough, as also the other A’s of access are relevant. Building a brand new hospital only payable for high income groups in a neighbourhood with low and middle income groups, will in general not enlarge access of these two groups. Taking ethnicity into account in policy is relevant in ensuring people’s access. If language is an obstacle, policy can be made to solve language issues. If people’s habits or traditions are not appreciated, policy can be aimed at growing an understanding of each other’s different ethnical backgrounds.

In the sector of health care, the access to it is of significant importance. Studies on this subject contribute to a further understanding of the concept. A follow-up study could deepen the role of ethnicity in access to health care, for example, to follow one specific ethnic group in the city of Yogyakarta. Other follow-up studies might focus more on the role of institutions and vulnerability contexts, and delve deeper into the culture of health as related to urbanity, ethnicity, and wealth. Furthermore, a comparison study should be done that not only focuses on an urban area, but both on an urban and a rural area. In a rural area, accessibility may be low, which makes it necessary for people to go to a certain facility. It may be relevant to see whether people’s ethnic background matters in this case.

Further research could, for example, explore other aspects regarding access to health care, like age. Perhaps there are differences in how young and older people have access to health care. Take for example the influence of social media, where especially
the younger generations are active. How does this effect the access to health care? Are young people going to a health care provider faster because of that, or are they satisfied with some information from the internet? Other research could focus on the certain prestige of medical staff. This might be a threshold in taking steps to go to a health care provider. This relationship between doctor and patient can be more unilateral. The so-called hierarchical distance can create lower access to health care, because people are unfamiliar with medical terms or medical staff. Furthermore, research could be done to determine the role of social control. If people do not feel comfortable because of their problem, they might avoid the health care providers in their own neighbourhood. Moreover, people might avoid their own social environment. These circumstances can cause lower access to health care, and it might be interesting to take this into account for further research. So keep going on with doing research: keep wondering, keep exploring, and be amazed.
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## I. Overview Interviewees

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<th>Number</th>
<th>Gender</th>
<th>Age</th>
<th>Profession/Background</th>
<th>Religion</th>
<th>Dates of Interviews</th>
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<tbody>
<tr>
<td>J1I</td>
<td>Female</td>
<td>51</td>
<td>Housewife</td>
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<tr>
<td>J1II</td>
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<tr>
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<td>J3I</td>
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<tr>
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<td>Islamic</td>
<td>11-05-2016 / 09-06-2016</td>
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<tr>
<td>J4I</td>
<td>Female</td>
<td>50</td>
<td>Herbalist</td>
<td>Islamic</td>
<td>28-04-2016 / 03-06-2016</td>
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<tr>
<td>J4II</td>
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<td>56</td>
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<td></td>
<td></td>
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<tr>
<td>C1I</td>
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<td>54</td>
<td>Businessman</td>
<td>Catholic</td>
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<tr>
<td>C5I</td>
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<td>40</td>
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<tr>
<td>C5II</td>
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<td>32</td>
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<tr>
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<td>77</td>
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<td>C5IV</td>
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<tr>
<td>C6I</td>
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<tr>
<td>Sd3I</td>
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<td>Sr2I</td>
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<td>Widow/House owner</td>
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</tbody>
</table>
**Experts/Informants**

The interviews with the experts and informants have been both formal as informal. They were valuable for conducting this research. Not all of these interviews are recorded.

<table>
<thead>
<tr>
<th>Expert/Informant</th>
<th>Institution</th>
<th>Position</th>
<th>Details</th>
<th>Communication Dates</th>
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<tbody>
<tr>
<td>Dr. Hasan Basri</td>
<td>Fakultas Kedokteran</td>
<td></td>
<td>Universitas Gadjah Mada (UGM), Yogyakarta, Indonesia</td>
<td>16-06-2016</td>
</tr>
<tr>
<td>Dr. Made Kutanegara</td>
<td>Pusat Studi Kependudukan dan Kebijakan</td>
<td></td>
<td>Center for Population and Policy Studies</td>
<td>30-03-2016</td>
</tr>
<tr>
<td>Dr. Sukamdi</td>
<td>Pusat Studi Kependudukan dan Kebijakan</td>
<td></td>
<td>Center for Population and Policy Studies</td>
<td>26-03-2016 / 16-06-2016</td>
</tr>
<tr>
<td>Doctor Tugu</td>
<td>Physician living in Tugu Area; from West Java (Sunda) Islamic</td>
<td></td>
<td>Working for the Health Insurance Financial agent Aksa and doctor at JIH Hospital and in Kulonprogo Hospital</td>
<td>10-06-2016</td>
</tr>
<tr>
<td>Diana; Nurse at JIH</td>
<td></td>
<td></td>
<td>Javanese, 26 years, working at the paediatrics department Islamic</td>
<td>17-06-2016</td>
</tr>
<tr>
<td>Veron; Nurse at Bethesda</td>
<td></td>
<td></td>
<td>From East-Indonesia, 24 years, Work as nurse in training Christian</td>
<td>08-06-2016</td>
</tr>
</tbody>
</table>
II. Respondents Interview Guide 1

Interview Guide
Session 1 – Descriptive Interview

1. Introduction

> Start in Indonesian language

[Translation] I am Jurgen from Holland and I am doing research at the Gadjah Mada University in Yogyakarta. My research topic is about access to health care. For that reason, I would like to have two interview sessions with you. Today the first session, and another time the other one. Because my Indonesian language is not sufficient, Ali is here for the translations. This interview will take approximately 1 hour. Your participation is voluntary. Your name will be fictitious during the data-analysis, so your answers are anonymous and your privacy is protected. The conversation will be recorded for research proposes.

Do you have any questions?
Do you agree to participate in this research?

2. General information

First, I would like to know some general information about you.

Name:
Gender:
Age:
Religion:
Ethnicity*:
Profession:

* If it is not clear: How would you describe your ethnicity?

Address:
Telephone number:

General questions:
- How long do you live here in Yogyakarta?
  - If you lived somewhere else, where? And why did you move to this place?
- How is your household?
  - With how many people do you live in your house?
  - What relation do you have with these people?
3. Interview 5 A’s

Access to health care is more than only the distance to a health care provider. During this interview I would like to ask you several things related to this subject. It is about Availability, Adequacy, Accessibility, Affordability, and Acceptability. Let’s start the interview!

- Remember the last time you made use of health services. Can you describe how it was?

Availability
- How many facilities are there in your environment?
- According to you, are there enough health services in this area? Why?
- Which facilities do you use?
  - Why not the others – conditions and factors that hinder you?
- How do you determine choosing a health care centre?
- How often do you use the health facilities?
- When do you take the decision to make use of health care?
- Where are you going for a small problem, for example when you hurt yourself?
- Where are you going for a bigger problem?
- How would you assess them (the different services you use)?
  - Are you happy with the care you receive from your clinic/doctor?
  - What should you change if there are improvements?
  - Do they have enough time to listen to your problem or question?
- If you would like to see your doctor more often, what sorts of things would help?
- Where do you usually go when you have questions about your health?

Adequacy
- What do you think about your access to information about health and/or diseases?
  - Is it good or bad? Why?
- What do you think of the Indonesian health care system here in Yogyakarta?
- Do you believe that everyone has entrance to that system?

Accessibility
- What is your opinion about the location of the different services?
  - Are the services on the right location?
  - Improvements? Bad accessible?
- How are you going to the services when you need them?
Affordability
- Do you have BPJS?
  - What sort of?
- Do you have a health insurance?
  - What sort of?
  - Why that one?
- (What are the regular prices to go to the general practitioner?)
- Can you afford it?
- What are people’s experiences of user fees?
- How much do you spend on health?

Acceptability
- What do you think of the doctors they treated you?
- Are you comfortable asking your doctor questions?
  - Why?
- What do you think of the staff (reception, nurses, lab, etc.) at your clinic/hospital?
  - Friendly and helpful? Do you feel welcome there?
- Are you feeling yourself fully accepted by the hospital? Why (not)?
  - Do they treat you on the same way, as they do with other people?
  - Having had experience in different treatment in people?

End
Thank you very much. I finished all my questions. Is there something else about the access to health care or your life that you want to share with me?

Thank you!
III. Respondents Interview Guide 2

- Introduction

Thank you to be here again. The previous session we talked about your access. Now we will have the last session. This interview will take approximately ... minutes. The conversation will be recorded for research proposes. Your name will be fictitious during the data-analysis, so your answers are anonymous.

- You say... (possible reaction on first interview). Is that correct?

- Interview questions
  - My research is about access. What is – what you now know – according to you the definition of access to health care?
    - Can you describe it?
    - Important factors?
  
  - What does the term ‘equal access’ mean for you? Can you describe it? Can you describe it in the context of health care?
    - What is equal?
    - What is optimal equality in health care?

I would like to discuss the 5A’s again with you. You may, from your own experience or what you know from your environment, specify if you notice a difference in health care/your access to health care.

<table>
<thead>
<tr>
<th>English</th>
<th>Bahasa Indonesia</th>
<th>Nederlands</th>
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<tbody>
<tr>
<td>Availability</td>
<td>Ketersediaan</td>
<td>Beschikbaarheid</td>
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<tr>
<td>Accessibility</td>
<td>Aksesibilitas</td>
<td>Toegankelijkheid</td>
</tr>
<tr>
<td>Adequacy</td>
<td>Kecukupan</td>
<td>Toereikendheid</td>
</tr>
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<td>Affordability</td>
<td>Keterjangkauan</td>
<td>Betaalbaarheid</td>
</tr>
<tr>
<td>Acceptability</td>
<td>Penerimaan</td>
<td>Acceptatie</td>
</tr>
</tbody>
</table>
Now, I would like to discuss more specific factors.

**Gender**
- What is your opinion about having a doctor of the opposite sex?
- Do you think there is difference in how men and women have access to health care?
  - Examples
- Can gender be an obstacle in access to health care? Why (not)?
  - Examples

**Income**
- What is your opinion about BPJS?
- Can you make a distinction in income group, how does people use health care?
  - Stereotype

**Ethnicity**
- What is your opinion about having a doctor of another ethnicity?
- What do most people round here think of their access to health care? The same as you? (People of your ethnicity)
- Can you see something about differences in access to health care divided by ethnicity?
  - Examples
  - Stereotypes
  - Language / Cultural barriers

**Religion**
- What is your opinion about having a doctor of another religion?
- Does your religion play a role in your access to health care?
  - Examples
- Can you see something about differences in access to health care divided by ethnicity?

**Closing**
- Which other factors could be important determinants in (un-)equal access to health care?
  - Examples
- Is there something else about the access to health care or your life that you want to share with me?

Thank you! Terima Kasih!
Gift for you from Holland
IV. Informants Interview Guide

○ Introduction

I am Jurgen Hartman and I am doing research at the Gadjah Mada University in Yogyakarta. My research topic is access to health care. For that reason, I would like to interview you. This interview will take approximately ... minutes. The conversation will be recorded for research proposes. Your name will be fictitious during the data-analysis, so your answers are anonymous. (Because my Indonesian language is not sufficient, Ali is here for the translations.)

○ General information

Name:
Gender:
Age:
Religion:
Ethnicity*:
  * How would you describe your ethnicity?

○ General questions

- What is your profession and what sort of work you do?
- Where are you working?

Health care in general/ Policy
- Can you explain me the health care system?
- When are people going to the puskesmas/hospital/general practitioner?
- In the hospital/centre you are working, what kind of people are coming here?
- What are the policies to help patients?
- How to handle difficult situations?
- Why is this hospital built here?
- Consequents, what does that mean?
Health care and ethnicity
- What is your experiences of people from different religions?
- Ethnicities?
- Gender?
- Are there any specialized services you offer to people from another culture?
- What challenges if any do you think that ethnic minority groups might experience in accessing primary health care or clinical services in general?
- Any challenge specific to more the Chinese or the Javanese?
- What would you like to see happen to address those challenges or barriers – at you clinic in particular; broader or more general changes – by way of resources, support, etc.? 

Do you know peoples background?
- Did they know your SES, religion, ethnicity? How?

Thank you! Terima Kasih!
Gift for you from Holland