MAKARA, KESEHATAN, VOL. 10, NO. 1, JUNI 2006: 1-6

UNDER-UTILIZATION OF COMMUNITY HEALTH CENTERS IN PURWOREJO REGENCY, CENTRAL JAVA

Atik Triratnawati

Department of Anthropology, Faculty of Cultural Science, Gadjah Mada University, Yogyakarta 55281, Indonesia

Email: atik_triratnawati@yahoo.co.id

Abstract

The basic strategy of the Ministry of Health to achieve Health For All In Indonesia 2010 is through health paradigm, decentralization, professionalism and health service management. Community health centers play an important role to achieve the goal. Unfortunately, underutilization of community health centers is still a problem in Purworejo. The purpose of this study was to know the utilization of community health centers using a sociological health approach. Qualitative research by observation, in-depth interview and focus group discussion were done among different types of group. The study was done in Purworejo District on February and March 2000. The main problems related to under-utilization of community health centers are mostly on administration (less quality services, un-efficient, long hours waiting), strong bureaucratic system (physician has a dominant power, overlapping programs, poor coordination and integration with other divisions) and cultural behavior of the community (labeling/stigma, self-care dominant, lack of community participation). To overcome under-utilization of community health centers the administration and bureaucracy should be changed into more efficient, not bureaucratic management. In addition social changes of the community culture is needed. As a consequence through these changes the staff of the health centers will be more efficient and effective.

Keywords: under-utilization, community health center, bureaucracy, cultural behavior

1. Introduction

The recommendations of The Alma-Ata Conference were seen as a breakthrough in the official policy formulation, for they stemmed from an explicit recognition that the promotion of health depends upon improving socio-economic conditions and the alleviation of poverty. By highlighting the environmental, social and economic determinants of health status, the Alma Ata Declaration recognized that health could not be attained by the health sector alone. The strategy called for an inter-sectoral approach addressing the broader issue of underdevelopment [1].

One of the programs in Indonesia to achieve Indonesia Health Vision by the year 2010 is providing primary health care by the government. The primary health care concept is a shift of emphasis from hospital-doctor oriented care to community-based primary health care [2].

The development of an effective primary care approach must give attention to those who actually seek services and to the larger community as well. This may involve the mobilization not only of physicians, nurses, technicians and physician assistants, but also nurse practitioners, health educators and social workers. To the extent that the population is sufficiently large, it become more economical than smaller practices to provide supporting services to facilitate comprehensive care and care more attuned to patient with less common needs, such as the parents of retarded children, the bereaved or the spouse of chronically ill persons. Primary care, if it is to be effective, must be accessible to the population it serves. Accessibility includes financial access as well as the ability to reach the facility, to schedule a prompt appointment, and to be protected from unnecessary bureaucratic hassles. Services must be accessible not only to the aggressive, motivated and sophisticated patient but also to those who are more timid, frightened and suspicious [3].

The health systems of Kenya, Ghana, Zaire, Pakistan, Indonesia and Bangladesh are the result of strong entrepreneur policies. Although the Ministries of Health of these countries have developed nation wide networks for preventive and curative services, their support structures are weak, and health services are under-utilized. Ambitious health plans have not been implemented and the proportion of the Ministry of Health share in the national government budget has been declining. In five countries above most physicians with government appointments, spent much time in private practices. Most hospitals and medical schools in Indonesia are private [4].

Similar to other developing countries, Indonesia also has a strategy to achieve Indonesia Health Vision by the year 2010: health paradigm, decentralization, professionalism and manage care should be chosen as pillars for the strategy. As a country with a population of more than 215 millions, it is a heavy task for the government to serve the population with health care, since they are living scattered in more than 13.600 islands. Also Indonesia has a variety concerning race, ethnic, religion, social strata, education and language. Therefore it is difficult for the health services to satisfy the whole community at the same time. At present the total health cost in Indonesia is estimated to be approximately Rp. 5.1 billion, with 30% attributed by the government (estimated only around 2.5% of the total annual government budget) and 70% is from private sectors including the community [5]. In the early 1968, the government tried to run health centers in every sub-district with the same design. The primary health care emphasized preventive and curative care. In terms of health services, community health centers function is to deliver the primary health care.

The primary health care (PHC) or *Puskesmas* serve varied societies who predominantly are based on agricultural economy and almost 90 per cent of the people are Moslems. Indonesians GNP per capita in the 2000 was U$ 600-700. Income distribution was extremely uneven. The literacy level, nevertheless, has greatly improved over recent decades and by the 1993 reached 80% among adults [6].

Since the last 30 years, the health status of the Indonesian people increased gradually because health centers were established in Indonesia. But after the economic crisis in 1997, the condition changed. The impact of the crisis has affected all aspects of life in Indonesia. Finally this situation leads to the condition in which many people could not afford to fulfill their basic needs such as health, nutrition and education. Life expectancy was 62.2 years and it is expected to be 65,9 by the year 2000. PHC's had strong contribution in decreasing fertility, mortality and morbidity, but community health centers as a part from PHC's activities still faced many problems influencing the utilization.

It has been widely reported that most Indonesia health care centers are seriously under-utilized. A United Nations agency report in 1979 stated that "It is not uncommon that there is less than 10 visitors a day at some centers. In some rural areas, less than 10 % of the surveyed people have ever been examined by a physician, less than 40 % have ever been to the health center, and only 20 % of mothers have ever attended a Maternal Child Health center. Most people in these areas seek care from more readily accessible and supporting traditional practitioners or from local equivalent of drugstores" [7]. At present, the use of health centers is reported to be somewhat more, but still relatively low, compared to other countries.

Purworejo Regency, Central Java, had also some problems like other PHC's in Indonesia. The utility of PHC's seemed to be decreasing. The district of Purworejo has 25 PHC's, 63 sub-PHC's, 81 physicians, 26 dentists, and 233 paramedics [8]. This district comprised of 16 sub-districts and 494 villages. The land contour of Purworejo varies from 2 meter above sea level to 325 meter above sea level so that some areas are considered mountainous. According to the district health authority, the health condition of population in Purworejo is still dominated by infectious disease, especially among children. In addition the nutritional deficiencies of the women and children are also major problems in Purworejo [9].

Qualitative research in utilization of PHC's will be more suitable than quantitative one. Qualitative research findings can enhance awareness of social dynamics in the clinical setting. This study investigated the utilization of primary health care units through health sociology approach, especially focusing on the bureaucratic, administrative aspect of health care management, also on health seeking behavior, medical pluralism and labeling of community health centers.

2. Methods

Subjects of this study were some *Puskesmas* in Purworejo District, Central Java, as a part of a study project of the Community Health and Nutrition, Research Laboratories, Faculty of Medicine, Gadjah Mada University. The qualitative method using in-depth interview, observation and Focus Groups Discussion (FGD) were adopted to gather the data.

Qualitative research offers insight into social, emotional, and experiential phenomena in health care. Qualitative research questions tent not to ask "whether or how much" but rather to explore questions like "what, how, and why". In addition, qualitative reports do not typically generate answers but rather generate narrative accounts, explanations, typologies of phenomena, conceptual frameworks, and the like [10].

In-depth interview among 3 health personnel and 3 persons from the community were done to understand their belief and perception about *Puskesmas*. Observation is used to give more detailed and context-related information from health personnel, patients and community [11]. FGD is used because it is a relatively fast method to learn about different perspectives on issues. FGD was done among 8 types of groups such as: paramedic, non paramedic (administration staff), laboratory staff, bureaucrats, mothers who have children under five years old, adolescents, adults, and elderly people. Each FGD consisted of 8-10 participants from different villages or different *Puskesmas*. The data collection was done during February-March 2000 (observation, FGD and in-depth interview).

All the interviews and FGD were recorded. After the translation, the data was classified into certain themes, for easier analyzing. The data analysis was descriptive with health sociology perspectives. The health sociology was focused on bureaucracy and/or administration and also on the people beliefs related to *Puskesmas*.

3. Result and Discussion

In Indonesia, although the staffing, quality of care and utilization levels vary widely, each *Puskesmas* has at least one physician and one mid-wife, with a service area covering approximately 30.000 persons, while a sub-center usually serves a total of 11.000/12.000 persons [12]. Under-utilization of PHC's in Purworejo happened because some PHC's received only 75 patients a day, a number which is moderate for Central Java. Some PCH's in Purworejo had 200 patients on special days related to the Javanese calendar. The location of the PHC's who has many patients usually was in the city (central), and near the market. FGD's health personnel asserted that:

"Every *pon* and *kliwon,* days on the Javanese calendar, PHC's in X and Y sub-districts were full with patients. Most of them came from remote areas. Usually, they came to the city besides to go to the market also to visit PHC's to seek medication".

Some PHC's in remote areas, especially mountainous areas, had only a few patients. The transportation was still a major problem for the patient in reaching the nearest PHC's. Another reason was that the physician was not available if they needed help. Most of the PHC's in remote areas had very limited facilities, including medical equipment. The health personnel sometimes were not available during working hours. These reasons may influence the patient in deciding to visit the PHC.

One of the possible reasons for under-utilization of community health centers in areas of Purworejo was because of different characteristics of the population to be served. It seemed that the government plan in building the health centers was purely to reach their planning target, but did not concern the basic need of the societies. There were many problems related to the management of the community health center such as:

3.1. Bureaucratic System

The Purworejo district is divided into 16 sub- districts. Each sub-district is served by at least one health center which provides primary health care. Most of the units had a full time physician and the total staff usually consisted of about 10 or more health workers, including a nurse, a midwife, a village midwife, a sanitary inspector, laboratory, communicable disease workers, clerk and others. In conducting the daily activities often the health personnel found difficulties to serve the patients because of so many regulations and a strong bureaucratic system. Sometimes, the health personnel faced a dilemma. On the other hand, they must treat the patient quickly especially for emergency cases, but they had also to consider the hierarchy of authority. Many times, the health personnel faced medical and/or administrative problems; they never took decisions by themselves, because the physician as the manager of the community health center controls all decisions. There were some barriers such as: culture/behavior of the staff, hierarchy, etc., if the health personnel need consultation of the physician. Besides physicians were not available during working hours in some districts or the regency, because the physician were committed with many activities. Therefore this problem was difficult to overcome. The strong bureaucratic system is sometimes not suitable for many areas of Purworejo. Since every area has a specific geographical, economic, social strata, culture, etc. management cannot be generalized. For many PHC's, the decentralization system of health care is may be more suitable in strengthening the health care needs for the people. In

the future after the autonomy system will be applied in all areas, the condition of the health care system hopefully will be improved.

Bureaucracies exhibit a hierarchical structure of authority, a chain of command not unlike that of a modern military organization. The bureaucratic hierarchy is controlled by an elite group of top managers who make decisions with the technical advice, but without the consent, of those below them in the hierarchy[12]. The hierarchy of the *Puskesmas* staff itself may influence the power of bureaucratic leaders. They are not open to discussion.

The paternalistic system also influenced the bureaucratic system. In the community, the older person and a person who has a high position have stronger power. The paternalistic culture also exists in the health personnel community. All of the problems in the community health center were always discussed with the physician, which took more time. If the problem needs a solution as quick as possible such as in emergency cases, discussion with the physician is a time related constraint.

3.2. The Physician is Not Available During Working Hours

Sometimes the patients who want to visit the physician were very upset because the physician was not present in the health center. Most of the patients came from remote areas. They spent much time and money for transportation in order to see the physician. However, it was difficult to meet the physician for consultation. Most of the physicians usually had many activities: it may be related to their duties as a private physician but also as a manager of the health center. The physician had to attend ceremonies, meetings, training courses, seminars, conducted by the government or private sectors. Usually the meetings, coordinating, training, etc. were held during working hours. Consequently, the health personnel (midwife or nurse) replace the duty of the physician. Usually if the patient really needed the physician they tended to choose the early morning or evening time to visit the private practice of the physician which was open for the public before and after the working hours of the *puskesmas*. Although patients spent more money when visiting the private practice they were convinced that drugs and services were better than at the *puskesmas* so that the recovery was quicker.

The physician as a manager of the *puskesmas* had many duties, not only related with the managerial or curative role but also duties related to the government bureaucratic system such as: attend meetings at district or sub-district level, meetings with the local government, give speeches/lectures [13]. The physician sometimes also had private activities such as taking courses, or continued their education to obtain a master degree. Consequently, the physician was only available in *puskesmas* 1-2 times a week.

3.3 Poor Coordinating and Integrating Aspect

Community health centers have the responsibility to deliver health care to the community. But to achieve the goal, it is difficult to work alone, so that collaboration with other divisions is needed. Collaboration between the Ministry of Health, the Board of Family Planning Ministry, the Ministry of Empowerment of Women Role, the Ministry of National Education, the Ministry of Social Affairs, etc., was established for a long time. Many programs of the community health center, which is initiated other than the Department of Health, are supervised or conducted by the health center. The community health centers are responsible in conducting many health programs, since the Ministry of Health always coordinate and integrate with other ministries. However, many health programs did not have good coordination and integration because of overlapping programs. Many programs of other ministries related to communities are also connected with the health centers. The physician reports the progress report of the program to the Ministry of Health and other collaborating ministries. The result is an overloading work of the health personnel staff, and "unfortunately" the collaborating ministry has less work. This problem influences the efficiency and productivity in providing adequate health services to the patients. Another consequence is that the community health center tends to have a low performance because lack of persons with specific skills.

In other word, in this study it was found that the bureaucratic system in PHC's was still traditional, because the personnel had the perception that who has free time should help other members of the PHC's staff. The nurse will help the pharmacist; the driver will help the administration staff if needed etc. The whole PHC's staff always considered PHC's as a system, so that every section will help another section. This happened in some PHC's with very limited staff.

3.4. Less Quality Services

Most of community health centers in Purworejo did not work during a full day. The time bureaucracy of the government possibly is the cause that patients (consumers) were not satisfied with the services. In rural areas, usually community health centers opened at 08.00 a.m. and closed at 11.00 a.m., others closed later. The health personnel staff did not work

based on the time bureaucracy, because the regulation on working hours was as follows: start at 07.00 a.m. to 02.00 p.m. According to the health personnel staff, the last patients are visiting the center at 10.30 a.m., mainly for the benefit of the administrative staff who after the last visitors were doing administrative work.

Sometimes, the patients spend much time to wait before the physician or paramedics were attending them. The long waiting time before being examined by the physician may cause the patients to look for private physicians with better services. It was also admitted that for patients with severe health condition, the medical equipment was not available, so that the patient had to be referred to the hospital. The perception among patients was "that if the physicians are referring patients to the hospital, it means that the patients are in bad (severe) condition and also that the physician is not able to cure the disease, therefore patients tend to go directly to the hospital then to community health centers".

3.5. PHC's Labeling

The perception among the community was "that PHC's are only suitable to cure diseases such as: common cold, cough, fever, or diseases for children under five". Most of the patients are women and children. The women visited the PHC's for ante natal care or for the delivery of their babies. They were also accompanying their children to seek medication. Only a few patients were adult males or teenagers. FGD teenagers and male adults asserted:

"Most of the PHC's patients from our village are women and children. The children have diseases like common cold, cough and fever or need immunization. The women are attending the centers for tetanus toxoid (TT) immunization, for ante natal care (ANC) or for delivering their babies. Elder women seek medication for fatigue, and achy joints. Teenagers and male adults are very rare as visitors of the centers"

In addition, some FGD informants such as teenagers and adult males also reported that PHC's are only suitable in curing acute diseases, not chronic diseases. If someone has a severe disease they tend to visit a private clinic or hospital. Some FGD participants and informants said that drugs from the PHC's were very limited, therefore cannot cure their diseases. Most people believed that the drugs from the private physician or hospital are of better quality than from the PHC's. These facts may influence the community willingness to utilize the PHCs.

3.6. Traditional Medical System Still Dominant

Although the Ministry of Health has a program for village midwives to help deliveries and management of sick children in rural areas, traditional birth attendants are still popular. Most women gave birth at home; several of them were attended by traditional birth attendants.

The pattern of health-seeking behavior of Purworejo community was self medication (self-care) with purchased drugs, traditional healers, and private physicians. Self-care is not limited to the individual but also includes members of one's own household. In many cases, the family operates as a therapeutic group: it is a network for sharing knowledge and experience, making therapeutic decisions and sharing prescriptions as well as medicines[13, 14]. The lower income families were more dependent on self-care. In contrast, higher income families obviously made the most use of physicians, who were nearly always from private sectors.

In societies like Central Java, a multiplicity of health systems, a situation which we may term as medical pluralism, is usually related with the presence of different cultural or ethnic groups within one society, each adhering to its own medical tradition[15]. But medical pluralism can also be the result of the introduction and acceptance of a foreign tradition in a culture. The presence of the biomedical tradition or western world is another reason. Medical pluralism is still relevant to the Purworejo setting, since public transportation and low income generating jobs were still a problem among the poor. Medical pluralism may increase the choice of health service alternatives for rural people[16].

3.7. Lack of Community Participation

The main idea of primary health care is community participation approach. Primary health care and community development are twin concepts [17]. The community participation is the heart of the health and development process, but practically the government has a strong role. In many cases, the society is not a part of the system because the program came from the government (top down program). Although the society is participating, there is always a strong intervention from the government. On the other hand, the health centers program represents a return to technologically and cost oriented approach. The local government has a target for its income derived from the health center services. This leads towards the inability of patients getting appropriate attention since the physician in charge has to fulfill the target income.

4. Conclusion

Although many public health efforts have been implemented in Purworejo, the Purworejo public health status is still unsatisfactory. The majority of the PHC's patients were only women and children under five. The women visited the PHC's because of problems such as perinatal, pregnancy related disorders[18]. Another reason why the women visited PHC's frequently than men is although women tend to live longer than men, they seemed to experience a higher level of ill health [19]. So, compared to other groups of people such as teenagers and male adults, women faced more problems related to illness, so that they need more help from medical personnel than others.

One factor of the condition is caused by under-utilization of community health centers. Health service utilization is, however, not a single behavior but represents a chain of behavioral events. The health care system in developing countries such as Purworejo is markedly pluralistic in the sense that there exist competing medical systems such as traditional and cosmopolitan medicine. These medical systems and multiple alternative sources of care which the patients could choose influence under-utilization of health centers.

To improve the utilization of community health centers the bureaucratic system should be changed to an un-bureaucratic system. If the community health centers practice an un-bureaucratic system and less paternalistic system, the health personnel would be capable to make their own decision, especially to solve emergency problems. In the same time, the administration of community health center should be changed in order to be more effective and efficient. The health personnel staff should give first priority for health services, and not administrative reporting. In the future, continuing education programs should be provided to increase their efficiency and effectiveness.

The physician as a manager of the health center has too many duties, not only related to skill, management and profession but also related to socio-cultural and administrative aspects. To reduce the duties, the physician should have the special/prerogative right to choose another PHC's staff to attend a ceremony, seminar or coordinating meeting. The physician should be focused on their work i.e. treating patients. The availability of the physician during working hours will motivate patients to visit the health center.

Integration and coordination between divisions or departments of the government and non-government institutions should be improved in order to reduce the task of health care staff especially the physician. More over it is imperative that the government should consider the improvement of community participation through e.g. bottom-up programs as a part of the government policy.

References

1. Ashtana E. Implication of Alma-Ata Conference. In: Philips DR, Verhasselt Y. editors, *Health and Development*. London: Routledge, 1994: 37-42.
2. Price P. Maternal and Child Health Care Strategies. In: Philips DR, Verhasselt Y. editors, *Health and Development*. London: Routledge, 1994: 32-34.
3. Mechanic D. *Medical Sociology*. New York: The Free Press, 1978: 90.
4. Kloss H. The Poor Third World: Health and Health Care in Areas That Have Yet to Experience Substantial Development. In: Philips DR, Verhasselt Y. editors, *Health and Development*. London: Routledge, 1994: 112.
5. Azwar A, *Menuju Pelayanan Kesehatan yang Lebih Bermutu*. Jakarta: Yayasan Penerbitan IDI, 1996: 5.
6. ESCAP, *Quality of Life in The ESCAP Region*. United Nations, 1995: 1-23
7. Roemer MI. *National Health Systems of The World Volume One: The Countries*. London: Oxford University Press, 1991: 45-49
8. Badan Pusat Statistik Kabupaten Purworejo. *Purworejo Regency in Figures 2003*. Purworejo: BPS Kabupaten Purworejo dan Bapeda, 2004: 80-81.
9. Wilopo SA. Community Health and Nutrition Research Laboratory: Key Issue on the Research Design, Data Collection and Management. *Kumpulan Paper-paper LPKGM* 1997; 13.
10. Giacomini MK, Cook DJ. Users'Guides to the Medical Literature, *JAMA* 2000; 284: 357-482.
11. Krueger RA, *Focus Groups A Practical Guide for Applied Research*. Newbury Park: Sage Publications, 1988 :7.
12. Cholil A, Iskandar MB, Sciortino R. *The Life Saver: The Mother Friendly Movement in Indonesia.* Jakarta: The State Ministry for the Role of Women and Ford Foundation, 1998: 67-70.

13. Sciortino R. *Menuju kesehatan madani*. Yogyakarta: Pustaka Pelajar, 1999: 45-70.
14. Foster GM, Anderson BG, *Medical Anthropology*, New York: John Wiley and Sons Inc, 1978: 99.
15. Hardon A, Boonmongkon P, Streefland P, et. al. *Applied Health Research Manual, Anthropology of Health and Health Care*. Den Haag: Koninklijke Bibliotheek, 1995: 21-28.
16. Kanungsukkasem U. Determinants of Health Service Utilization in Rural Thailand. In: Yoddumnern-Attig B, Attig GA, Boonchalaksi W, et al. editors, *Qualitative Methods for Population and Health Research*. Salaya: Institute for Population and Social Research Mahidol University, 1993: 287.
17. Yusof K, Batumalai S, Lin WY, et al. *The ABC's of Community Participation in Primary Health Care.* Kuala Lumpur: Social Obstetric and Gynaecology Faculty of Medicine University of Malaya, 1989: 5-7
18. Kosen S, Gunawan S. Health Services in Indonesia. *Medicine in Asia* 1996; 165: 641-644.
19. Daykin N. Sociology. In: Naidoo J, Wills J. editors, *Health Studies*. New York: Palgrave, 2001: 101-124.