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POOR HOUSEHOLDS EXPENDITURE FOR PREVENTIVE AND CURATIVE HEALTH NEEDS

WYDATKI BIEDNEGO GOSPODARSTWA DOMOWEGO NA POTRZEBY LECZENIA I PROFILAKTYKI ZDROWIA

Abstract

The purpose of this research is to analyze: 1) patterns and allocation of household expenditure in poor urban and rural areas for preventive and curative health needs in Jambi Province; 2) socio-economic factors that affect their expenditure. Data is gathered thorough poor households at the locus of chosen village. To analyze the patterns and allocation of household expenditures, descriptive statistical measures as well as single and cross frequency tables is used. Furthermore, to analyze the factors influencing, multiple regression model is used. The results found that: 1) the average health expenditure per capita per year of was IDR 67,391. It is 1.37 percent of the total annual expenditure per capita, or only 3.56 percent of the total per capita annual expenditure for non-food needs. Furthermore, detailed health expenditures for curative and preventive, it was found that 73.36 percent of health expenditures for poor households were for curative needs and only 26.64 percent were allocated for preventive health needs; 2) socioeconomic factors that significantly influence health expenditure are: family head age, head of the family education, field and business status, per capita expenditure, and structure of household members according to age, education and main activities. Therefore to improve health poor household service requires a massive campaign to encourage them to go to service center. This service is granted by local governments, though it still have difficulties to be implemented on health insurance scheme in Indonesia (BPJS).

Keywords: preventive, curative and poor family

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Streszczenie

Celem tego badania jest: 1) analiza wzorców i dystrybucji wydatków domowych na biednych obszarach wiejskich i miejskich na potrzeby leczenia i profilaktyki zdrowia w prowincji Jambi w Indonezji; 2) czynniki społeczno-ekonomiczne, które wpływają na te wydatki. Dane zostały zebrane w biednych gospodarstwach domowych w wybranych miejscowościach. W celu analizy wzorców i dystrybucji wydatków domowych zostały wykorzystane miary statystyki opisowej, a także tabele częstości pojedynczej i krzyżowej. Ponadto został wykorzystany model analizy regresji wielokrotnej. Wyniki wskazują że: 1) średnie wydatki na zdrowie na osobę rocznie to 67 391 indonezyjskich rupii. To tylko 1,37 procent całkowitych rocznych wydatków na osobę lub tylko 3,56 procent całkowitych rocznych wydatków na potrzeby nieżywnościowe. Ponadto, szczegółowe wydatki na leczenie i profilaktykę zdrowia wskazują na to, że 73,36 procent wydatków na zdrowie dotyczyło leczenia, i tylko 26,64 profilaktyki; 2) czynniki społeczno-ekonomiczne, które znacząco wpływają na wydatki na zdrowie to wieki głowy rodziny, wykształcenie głowy rodziny, obszar i status działalności gospodarczej, wydatki na osobę oraz wiekowa, edukacyjna i zawodowa struktura gospodarstwa domowego. W celu poprawienia ochrony zdrowia biednych gospodarstw domowych potrzebna jest masowa kampania, zachęcająca je do odwiedzania ośrodków zdrowia. Usługi w takich ośrodkach są zapewniane przez lokalne władze, chociaż wciąż są pewne trudności z ich realizacją w ramach systemu ubezpieczenia zdrowotnego w Indonezji (BPJS).

Słowa kluczowe: Profilaktyka, leczenie, biedna rodzina

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Statement of the problem in general outlook and its connection with important scientific and practical tasks.

National health performance has an important role in creating quality human resources. So in order to achieve sustainable economic development, it must be preceded by improving the quality of human resources, especially in the health sector.

According to the World Bank (1993) health contributes to economic growth through four paths, namely 1) reduction in production losses caused by sick workers; 2) reduce access to natural resources because of illness; 3) reduce alternative use of resources used to cure diseases; and 4) reducing the attendance rate of school children and increasing the ability to receive lessons.

Health problem should be nationally managed where the solution depend on government and society. Based on society consideration, efforts and behavior of preventive, curative and rehabilitative communities is the important determinants to determine public health degree. According to Kirscht in Smet (1990) preventive behavior is individual or social behavior that related to the medical service includes a variety of behaviors, such as check-ups for prevention or initial examination and immunization.

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Furthermore, according to Effendy, Ferry and Makhfudi (2009) curative is an activity and / or a series of medical activities that aimed at curing disease, reducing suffering due to disease, disease control, or controlling disability so that the quality of patients can be kept as optimal as possible. Furthermore rehabilitative efforts are activities and / or a series of activities to restore health so that individuals can return to normal activities.

Regarding national health issues in Indonesia, Jambi Province requires human resources good health conditions to achieve goal development.

However, especially in terms of health consideration, human resources performance shows unsatisfactory conditions. According to National census 2015, it is almost a quarter (24.45 percent) of the total population in Jambi is reported had health problems (heat, cough, runny nose, diarrhea, dizziness, chronic diseases and others) in the last 1 month of the survey. Health problems have caused disruption to various activities of the population, both work activities, schools and daily activities.

Based on the same data shows that more than half (55.39 percent) of the population stated that their activities were disturbed due to health complaints experienced. Based on the above explanation, this research two aims: 1) analyze the pattern and allocation of expenditure of poor households for preventive and curative health needs and; 2) Analyzing socioeconomic factors which affect the expenditure of poor households for fulfill preventive and curative health needs.

Analysis of latest research where the solution of the problem was initiated.

Health behavior

According to Notoatmodjo (2003) health behavior is a person's response to stimuli related to illness and disease, health care systems, food and the environment. Health behavior consists of: 1) behavior towards sickness and disease, responds to pain and disease internally or externally; 2) behavior towards the health care system, response to modern and traditional health care systems; 3) behavior towards food, related to knowledge, perceptions, attitudes and practices of food as well as the elements contained in it and 4) behavior towards the health environment, response to the environment as determinant of human health. Furthermore, according to Green (1980) health conditions are influenced by two main factors, behavioral factors and non behavior.

Furthermore, it is explained that behavior is formed by 3 factors, namely: 1) predisposing factors that manifest in knowledge, attitudes, beliefs, values and so on; 2) supporting factors, manifest in the physical environment, available or unavailability of health facilities or facilities, and 3) driving factors that are manifested in the attitudes and behavior of health workers or others.

In other words, health behavior is determined by the knowledge, attitudes, beliefs, traditions and so on of the person or community concerned. In addition, the availability of facilities, attitudes and behavior of health workers on health will also support and strengthen the formation of behavior.

Factors Affecting Consumption / Expenditure

The allocation of individual or community health expenditure could be explained based on the basic theory of consumer behavior. Samuelson (1999) mentioned that one of economic goal is to explain the basics of consumer behavior.

Consumers will encourage choosing high-value goods and services on the one hand, but on the other hand are limited by their own income. Demand behavior postulated that the more products consumed the higher welfare established (Nurhadi, 2000). So, the quality and quantity of goods consumed reflects the level of prosperity of consumers. Furthermore, Salvatore (1994) argues that individual demand is determined by the satisfaction received. Demand behavior hence, believes that the more goods and services consumed, the higher the level of a person's welfare.

Regarding buying behavior, it is taught as prices increase where nominal income is fixed, real income will decrease. This makes consumers to reduce purchasing for all types of goods and services. Besides price, Spencer (1977); Penny (1994) explained factors influencing are: disposable income, number of family members, age of family members, previous income and expectations of future income.

To those factors, Samuelson (1999) added that the main factors that influence and determine the amount of expenditure for consumption are disposable income, permanent income and income according to the life cycle, wealth and other determinants such as social factors and consumer expectations.

While Dornbusch (1994) noted life cycle hypothesis developed by Modigliani to propose planning public consumption and saving behavior for the long term determinant which provide the best way possible during their lives. Sukirno (2000) classify the factor to as follow: 1) future expectations, 2) population, and 3) price level. Parkin (1993) argues that household consumption expenditure primarily determined by disposable income and income expectations. Kadariah (1996) added that to general low income groups spend a large part of their income for absolute necessities such as; food, housing and clothing. Contrastly, the higher a person's income, the smaller the expenditure allocated to basic needs.

In relation to poor households, Pitomo (1992) argued they prepare more income for basic needs, both for individual needs and consumption (food, clothing, housing) and certain social service needs (drinking water, sanitation, transportation, health and education).

Related Research

The survey on household expenditure in the United States in 1993 report that expenditures on health care and entertainment were categorized as superior goods and rental housing as inferior goods. Demand for superior goods increases as income increases otherwise for inferior goods.

It was also noted that the average proportion of expenditure on health was 5.2 percent. This figure is far greater than for Indonesia, which is only 1.3 percent (Pindyck & Rubinfeld, 1998; Hartoyo, 1998b).

The difference in expenditure allocation occurs because of differences in income levels, education and economic conditions of a community/region. Hartoyo (1998a) suggested that parents' income levels positively related to allocations for education and health.

The number of family members is negatively related to allocations for education and health. Family support for investing their children can be reflected in the allocation of income. Parents, who care about the quality of their children, are likely to spend more money on activities or needs that can improve children's quality.

In line with that, Anwar (2007) and Munparidi (2011) found that the proportion of expenditure allocation for food consumption is inversely proportional to the amount of income, the greater income, the smaller the proportion of allocation for food consumption. On the contrary, the proportion of expenditure allocation for non-food consumption is directly proportional to the amount of income, -proportion of allocation for non-food consumption increases as family income increase.

In addition to income factors, Adiana (2012) found that education and family numbers had a positive and significant influence on consumption. Number of children who still financed and elderly family members will have an impact on the expenditure level.

Furthermore, Wahyuni (2011) states the role of socioeconomic status that influence the expenditures, they are education level, income level, type of work, position, parents, special facilities and valuable household items at home.

Work is a result of education and is one of the determining factors. Furthermore, Ginting (2013) found a significant relationship between workload with the nutritional status of workers, include in food consumption. Workers who use working time more than 8 hours a day tend to have poor nutritional status and conversely workers who use less than 8 hours a day tend to have good nutritional status.

Accordingly, if excessive working time or lengthening work time will increase workload and heavy workloads must be balanced with calorie intake.

Munandar (2008) states that excessive workloads have a bad influence on workers, therefore the need for nutrients for a workforce must be in accordance with the light weight of the workload that they receive, such as excessive workload, will require more energy sources.

Aims of paper. Methods

Data, population and sample

The main data comes from surveys of poor households in Jambi Province.

Sampling is conducted with through two stages process. First, select villages from the determined districts. Of the 11 districts it is determined one region that categorized to highest health status, one region with an average, and the last with the lowest one. The region category based on life expectancy indicators.

Based on this, Jambi City was chosen as the region with the highest life expectancy (72.32 years), Muaro Jambi Regency as an area with life expectancy approaching the provincial average (70.84 years) and Tanjung Jabung Timur Regency as an area with the lowest life expectancy (65.56). In Muaro Jambi and Tanjung Jabung Timur Regencies, one sub district and two villages (represent uraban areas) are assigned. In the city of Jambi there is no village area, so three sub-districts were designated as research locations.

Villages are chosen based on the consideration of the village with the highest number of poor households.

The second stage is to select a sample of 25 poor households in each chosen village / village. The number of selected villages is 9 villages so that the number of samples is 225 poor households. Sampling from selected villages is done by random sampling.

Data gathering

Instruments for collecting data used structured questionnaire. In addition to data gathering, it is also used "in-depth interview" technique.

Data analysis

Data were analyzed descriptively with single and cross frequency tables. Furthermore, to analyze factors that influence expenditure, multiple regression models is used. The model is showed as follow.

$$Y = \beta_0 + \beta_1 X_1 + \beta_{2.D1} X_{2.D1} + \beta_{2.D2} X_{2.D2} + \beta_{3.D1} X_{3.D1} + \beta_{3.D2} X_{3.D2} + \beta_4 X_4 \\ + \beta_5 X_5 + \beta_6 X_6 + \beta_7 X_7 + \beta_8 X_8 + \beta_9 X_9 + \beta_{10} X_{10} + \beta_{11} X_{11} + \beta_{12} X_{12} \\ + \beta_{13.D1} X_{13.D1} + \beta_{13.D2} X_{13.D2} + \beta_{14} X_{14} + ei$$

where:

Y= percentage of expenditure on health needs

X1 = Age of family head (year)

X2 = formal education level of the head of the family (dummy variable), primary school is the basis,

X2.D1 1 = Junior High School; 0 = others

X2.D2 1 = Senior High School; 0= others

X3 = Head of family education (dummy variable), Agricultural is the basis

X3.D1 1 = Industry; 0 = others

X3.D2 1 = Service; 0 = others

X4 = Job status of the family head (dummy variable: 1 = informal; 0 = formal)

X5 = percapita expenditure (, 000 IDR)

X6 = the amount of family member

X7 = the amount of toddler family member (under 5 year) (%)

X8 = percentage of productive family member (15 – 64 year) (%)

X9 = percentage of elderly family member (over of 65 years)

X10 = percentage of family member graduated over Senior High (%)

X11 = percentage of family member at ongoing school (%)

X12 = percentage of work family member (%)

X13 = Region residence (dummy, Jambi city as basis)

X13.D1 1= Tanjung Jabung Timur; 0 = others

X13.D2 1= Muaro Jambi; 0 = others

X14 = rural at city region (variabel dummy: 1 = urban, 0 = rural)

Exposition of main material of research with complete substantiation of obtained scientific results. Discussion


Result and discussion

Individual Characteristic

The age of the respondent, family head is relatively varied, the avarage is 44.67 years. Overall, education level is relatively low, most (52.00 percent) only have elementary school education and below. Furthermore, the type of work, the largest occupation was in the industry (27.11 percent), followed by other services (24.44 percent) and agriculture 19.56 percent. Finally, based on employment status, generally the employment of the heads of poor households is in the informal sector. It is only 12.98 percent worked in the formal sector and the other largest part (87.11 percent) worked in the formal sector.

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Family Characteristic

The average number of respondents is 4.76 people. Based on gender, female household members were 51.08 percent and male were 48.92 percent. Based on the age structure, 13.78 percent of household members are under-five (between 0 - 4 years), 13.33 percent are 5 - 9 years old, 11.11 percent are 10-14 years old, 56.44 percent are of productive age (15 - 64 years) and 5.33 percent belong to elderly (65 years and above). Furthermore, household activities (35.01) percent (including family heads) were of employment status, 32.68 percent still go to school status, and 25.68 percent with primary household care activities and 6.63 percent with job seeker.

House Expenditure Patterns for Health Needs

The average annual per capita expenditure yearly for urban poor households is Rp. 4,905,433. In general, public expenditure can be divided into two groups, on food and non-food. The level of need for the two groups is basically different. The pattern of spending on food and non-food consumption of the poor is presented in the following Table 1.

Table 1. Per capita average expenditure for food and non food, 2018.

Description	Amount (Rp)	%
Food	3.013.407	61.43
Non Food	1.892.026	38.57
Total	4.905.433	100.00

Source: Primary data, 2018

Furthermore, household expenditure for health needs is included in the non-food expenditure group. Thus, it is reported that the average health expenditure per capita per year of poor households is IDR 67,391. It is only 1.37 percent of the total per capita annual expenditure of poor households which amounts to Rp 4,905,433, or only occupies 3.56 percent of the total per capita annual expenditure for non-food needs amounting to Rp 1,892,026. However, health expenditures could be detailed for curative and preventive. It was found that 73.36 percent of health were for curative and only 26.64 percent for preventative.

In detail, the allocation of expenditures for health services based on curative and preventive expenditures is presented in Table 2 below.

Table 2. Average Per capita Expenditures yearly for Health Needs in 2018.

Description	Amount (Rp)	%
Curative	49.438	73.36
Preventive	17.953	26.64
Total	67.391	100.00

Source: Primary data, 2018

The Effect of socioeconomic variables on health expenditure

The estimation health expenditure of poor households is presented in Table 3. Hence, it is known that simultaneously independent variables have a significant effect on the expenditure of poor households for preventive health needs. This model can explain variations of 62.70 percent while the rest (37.30 percent) is explained by variables outside this model.

Tabel 3. Estimated model of total health expenditure for poor households in Jambi Province in 2018.

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
1 (Constant)	16.213	3.393		4.779	.000
X1	.038	.022	.085	1.697	.091
X2D1	.417	.788	.031	.529	.597
X2D2	2.063	.693	.179	2.978	.003
X3D1	2.691	.663	.219	4.060	.000
X3D2	2.277	.783	.167	2.907	.004
X4	2.655	.729	.206	3.642	.000
X5	.001	.000	.186	3.656	.000
X6	.547	.184	.150	2.968	.003
X7	.230	.091	.125	2.520	.012
X8	.067	.022	.161	2.997	.003
X9	.175	.207	.042	.842	.401
X10	.069	.038	.094	1.837	.068
X11	.032	.035	.047	.933	.352
X12	.125	.044	.146	2.840	.005
X13D1	-2.481	.700	-.205	-3.543	.000
X13D2	-2.084	.754	-.166	-2.764	.006
X14	.917	.618	.076	1.483	.139
F hitung = 16,695***					
Adjusted R square = 0,6920					

Source: Primary data process result, 2018

Furthermore, based on the partial test model, it is known that the age family head has a significant positive effect on the proportion of preventive expenditure.

The older the age of the head of the family, the greater the percentage of expenditure for health needs.

In terms of education, there is no difference in the proportion of health expenditures between junior high school-educated households and those with lower elementary education. It is proofed by insignificant regression coefficient X2D1.

However, the proportion of household heads of senior high school education and above is significantly greater than 2.063 percent compared to the heads of households with elementary education and below (as a basic category), it is supported by significant coefficient of X2D2.

In terms of employment, it is seen that family heads working in the industrial sector and the service sector have a greater proportion on health expenditure than the heads of households who work in the agricultural sector (as a basic category).

This can be seen from the significant coefficients of X3D1 and X3D2. Otherwise, there is a significant influence on the X4 variable which indicates a difference in health expenditure for poor households with family heads working in the informal sector with the formal sector. Furthermore, per capita expenditure (X5) shows a significant positive effect.

The structure of household family showed significant effect, except the percentage of elderly household members (X9) and the percentage of household members on school (X11). Based on the direction of influence, it shows that the more children under five, the more productive members of the household age, the more household members with senior secondary education and above, and the increasing number of household members who work will increase the proportion of poor household health expenditure.

In terms of the research locus, it appears that poor households in Tanjung Jabung Timur and Muaro Jambi regencies have a smaller proportion of health expenditure than poor households in Jambi City. However, when compared to city-villages, there is no difference figure in the proportion of health expenditure for poor households in urban areas with rural poor households (not significant X14).

In a broader perspective the problems of poor household health are faced with the problem of population administration. In Indonesia, for example, even though a health insurance scheme (BPJS) has been obtained, residents may not easily get access to be served, because those who deserve to be called poor are difficult to find due to population administration problems (Bunker, J.P, 2001, Xu, K., et al.).

This was added because the ability of poor households to get health services unless they were sick.

Local government programs as reported by Aji, B., (2013) are determined by the amount of costs that must be incurred by poor households. Although this should be noted that for poor households in accordance with the BPJS program, the financing has been borne, the problem is the administration to increase their participation in the intended health program.

Samb, B., et al. (2010) related to the poor households, arguing that patients who suffer from chronic diseases do not necessarily get services in the scheme of public health insurance. Furthermore, Nandi A, Ashok A, Laxminarayan R (2013) explain in India, even

the political affiliation of community groups and the conditions of the residential districts also determine the participation of health services in poor households.

Balarajan Y. et al. (2011). Adding to this, the socioeconomic differences of poor household also affect the amount paid for health insurance.

Conclusions

1. The average age of head family of poor households relatively young with low formal education and generally works in the informal sector. Meanwhile, the average number of poor household family is 4.76 people (including head family). Meanwhile, the structure of household members is characterized by the proportion of men and women who are relatively balanced, more than half are in the productive age category and more than one third are in the working status.
2. The average health expenditure per capita per year for poor households is IDR 67,391, it is 1.37 percent of total expenditure, or it is only 3.56 percent of the total per capita annual expenditure for non-food needs. Furthermore, detailed on health expenditures for curative and preventive health needs, it is found that 73.36 percent of health expenditure for poor households is for curative needs and only 26.64 percent is allocated for preventive health needs.
3. Socio-economic factors that have a significant effect on poor household health expenditure are education of the head of household, field and business status, per capita expenditure, and structure of household members according to age, education and main activities

Suggestion

To improve the health status of the community, especially the poor, the government should be able to increase socialization efforts regarding preventive action.

It is important due to low attention for preventive action. This must be integrated with National Health Insurance (BPJS) which provides health insurance for poor households.

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