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Health Disparity Reduction Policy through Community Health Centers in Remote Areas

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ABSTRACT

The gap in access and quality of health services in Indonesia, especially in remote areas, is a structural problem that continues to hamper the development of the health sector. The unequal distribution of health workers, limited infrastructure, and low investment in basic service facilities cause people in 3T (Disadvantaged, Frontier, and Outermost) areas to experience delays in medical treatment and high maternal and infant mortality rates. Community health centers as primary health care institutions play a strategic role in overcoming this problem. However, the effectiveness of the role of Community Health Centers is often hampered by the imbalance between central policy design and local conditions, as well as a lack of resources and infrastructure. This study uses a qualitative approach with a case study in one of the 3T areas to explore the challenges and strategies for reducing health disparities through Community Health Centers. The results show that the health policies implemented are often not contextual to local needs, such as limited medical personnel and infrastructure. Therefore, an approach based on local data and involving the community in policy formulation is needed to create more adaptive solutions. Decentralization of policies and the use of technology such as telemedicine are key to increasing the effectiveness of health services in remote areas.

Keywords: Health Disparities; Health Centers; Decentralization of Health Services

INTRODUCTION

The gap in access and quality of health services in Indonesia is a structural problem that continues to overshadow the development of the health sector, especially in remote areas. Based on Rafli's report (2024), there is still a striking disparity in the distribution of health workers between urban and rural areas, with a much lower ratio of doctors and medical personnel in disadvantaged, outermost, and remote areas (3T). This problem is exacerbated by the lack of transportation facilities, limited health infrastructure, and low investment in basic service facilities. As a result, people in remote areas often experience delays in medical treatment, low immunization coverage, and high maternal and infant mortality rates. This shows that the right to equal health services, as guaranteed

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in the 1945 Constitution and Law No. 36 of 2009 concerning Health, has not been fully fulfilled for groups in marginalized areas.

Furthermore, this inequality reflects the existence of a development bias that is still centered on urban areas, so that the national health policy approach is often not contextual to the geographical and social realities of remote areas. A study by Maharani and Sarjito (2024) shows that disparities in health status and access to health services in Indonesia are greatly influenced by social determinants, such as education level, poverty, and geographic location. In this context, a technocratic approach alone is not enough—a reconstruction of health policies is needed that supports spatial and social justice. Without more progressive interventions based on local needs, Community Health Centers in remote areas will continue to face serious challenges in fulfilling their strategic role as the frontline of public health services.

To address the challenges of health disparities in remote areas, Community Health Centers have a strategic role as primary health care institutions that are not only oriented towards curative, but also promotive and preventive. Within the framework of the decentralization of the Indonesian health system, Community Health Centers are actually designed as the vanguard in a tiered service system, with the task of serving all levels of society without geographical or social discrimination. However, the effectiveness of this role is often hampered by unequal budget distribution and weak managerial capacity at the local level. According to research by Juliswara & Nugraheni (2024), most Community Health Centers in remote areas still experience a shortage of essential medical equipment, limited drug logistics, and lack of training for health workers in community-based services. When infrastructure and resources are inadequate, Community Health Centers lose their function as agents of public health transformation.

In addition to resource issues, a top-down policy approach is also an obstacle in optimizing the role of Puskesmas. Health programs that are implemented are often not based on the contextual needs of local communities, but rather come from uniform central instructions. A study by Nadia et al (2023) shows that community participation and area-based policy adaptation are key factors in the success of Puskesmas in carrying out promotive and preventive functions effectively. Therefore, a bottom-up policy transformation is needed, which encourages local data-based planning and community involvement in the decision-making process. Only by strengthening local autonomy and designing policies that are responsive to the real needs of remote communities can Puskesmas truly function as the main instrument in overcoming chronic health disparities in Indonesia.

The Indonesian government's commitment to reducing health disparities has been realized through various national policies, including the integration of health services in the National Medium-Term Development Plan (RPJMN) and strengthening the National Health Insurance (JKN) program. However, in practice, this commitment has not fully reached people in remote areas. Although JKN is claimed to have increased access to health services, a study by Iamtrakul

et al (2024) shows that disparities still occur, especially because health facilities participating in this program are more concentrated in urban areas. On the other hand, remote areas are still constrained by geographical aspects, limited infrastructure, and dependence on Community Health Centers as the only service providers, not all of which are facilitated to support optimal implementation of JKN.

Furthermore, although the Sustainable Development Goals (SDGs) explicitly place health issues in Goal 3, the government's approach to achieving them is still normative and less based on spatial inequality indicators. Consequently, although national indicators such as the reduction in maternal and infant mortality rates have improved, these indicators do not sufficiently reflect the reality of remote and underdeveloped areas. A study by the United Nations Development Programme (UNDP, 2021) underlines that the achievement of SDGs in Indonesia shows a large gap between developed provinces and underdeveloped areas, especially in the fields of health and welfare. Therefore, a paradigm shift is needed from mere administrative commitments to affirmative policies that focus on resource redistribution and strengthening health systems based on underdeveloped areas, by making Puskesmas a center for inclusive and contextual service innovation.

The challenges of implementing policies in remote areas lie not only in technical aspects such as infrastructure or the number of medical personnel, but also in the weak coordination across sectors that should be the backbone in supporting the sustainability of Puskesmas services. In practice, the health sector often works separately from other sectors such as education, transportation, and social, even though synergy between sectors is very important for building a holistic health ecosystem. For example, access to health services will not be optimal if it is not supported by adequate road infrastructure or an integrated health information system. According to WHO (2022), the Health in All Policies approach is one of the key strategies for creating effective health governance, especially in areas with geographic and social complexity such as remote areas. Without collaboration between sectors, existing policies tend to be symbolic and unable to touch the root of the problem in the field.

In addition, monitoring and evaluation of the implementation of health policies at the local level are often not carried out systematically and based on data. Many health programs run without strict monitoring mechanisms, so there is not enough feedback to correct weaknesses in implementation. A study by Bayat et al (2023) shows that the lack of capacity of local governments to conduct policy evaluations has resulted in many health initiatives being unsustainable, and even tending to fail to achieve their targets. This is exacerbated by the minimal involvement of the community in the evaluation process, even though the community is an important actor who has local knowledge and direct experience of the quality of services received. Therefore, strengthening the evaluation system based on participation and transparency is an urgent step to ensure the effectiveness of the implementation of health disparity reduction policies through health centers in remote areas..

RESEARCH METHODS

This study uses a qualitative approach with a case study strategy to explore in depth the implementation of health disparity reduction policies through Community Health Centers in remote areas. This approach was chosen because it is able to capture the dynamics of policies in the local context and understand the challenges, strategies, and perceptions of related actors in the field. The research location was chosen purposively in one of the 3T (Disadvantaged, Frontier, and Outermost) areas that have a high dependence on Community Health Center services. Key informants include the head and health workers of Community Health Centers, health service officials, community leaders, and users of health services.

Data collection was conducted through in-depth interviews, participant observation, and study of policy documents and operational reports of the Health Center. Data were analyzed thematically through a process of reduction, categorization, and systematic drawing of conclusions. To maintain the validity of the data, this study applied triangulation of sources and methods, and confirmed the findings through member checking with key informants. This approach is expected to provide a comprehensive picture of the effectiveness of the policy and the challenges of its implementation in remote areas.

RESULTS AND DISCUSSION

Effectiveness of Implementation of Health Disparity Reduction Policy in Remote Area Health Centers

1. Imbalance Between Central Policy Design and Real Conditions of Health Centers in Remote Areas

Basically, the imbalance between the design of central policies and the real conditions of health centers in remote areas can be understood through the perspective of policy theory that emphasizes the importance of fit between formulated policies and local contexts. The one-size-fits-all policy model often applied by the central government tends to ignore variations in regional capabilities to implement these policies (Putri & Ilyas, 2024). In this case, the central government, although it has set policies with the aim of reducing health disparities, has not sufficiently explored the social, economic, and geographical contexts that exist in each region. As a result, these policies cannot be implemented effectively in areas with greater structural challenges, such as lack of basic infrastructure, limited medical personnel, and significant transportation barriers. Research conducted by Lim et al (2023) shows that the gap in access to health in remote areas is more due to the inability of the central government to adapt policies to diverse local conditions, which ultimately affects the achievement of the goals of the JKN program and other health services.

Furthermore, in public policy analysis, there is an argument that effective health policies require contextual data collection and evidence-based analysis to assess conditions on the ground. A more data-driven approach and involving local actors in policy formulation will result in policies that are more responsive and adaptive to specific regional needs. According to Musfiroh & Yogopriyanto

(2024), policies formulated at the central level often conflict with the realities faced by officers in the field, in this case medical personnel at the Community Health Center. Resource constraints, operational standards that are not in accordance with local capacity, and administrative pressures faced by Community Health Centers in remote areas, make them trapped in a dilemma between meeting formal targets set by the central government or providing services that are more in line with the needs of the local community. The success or failure of a policy is greatly influenced by the capacity of field officers to interpret and implement the policy in the existing context.

On the other hand, the theory of policy decentralization states that to achieve social justice and equal distribution of health services, it is necessary to have a greater division of authority to local governments and health centers to adjust policies to local conditions. In the context of Indonesia, where there is a large disparity between urban and remote areas, this decentralized approach will be more effective in reducing disparities. For example, research conducted by Sentanu et al (2024) shows that regions that have more autonomy in managing health programs tend to be better able to adjust health services to local needs, optimize existing resources, and overcome geographical constraints in more creative ways. Decentralization also opens up opportunities for local stakeholders to participate in the policy process, which can produce more innovative and community-based solutions. Reducing inequality in health services will only be achieved if health policies can synergize with local needs and capacities, paying attention to contextual elements that influence the effectiveness of implementation.

2. Limited Resources as a Key Barrier to the Implementation of Primary Health Care Services

Scientifically, a more critical approach to resource limitations in the health sector leads to the importance of understanding social determinants of health (SDH), which play a role in exacerbating health service disparities. A study by Siregar et al (2025) explains that inequality in access to health services, which is influenced by factors such as income, education, and geographic conditions, plays a direct role in worsening public health. In the context of Community Health Centers in the 3T region, this SDH is a major barrier to ensuring equal health services. In addition, this inequality is increasingly apparent when health infrastructure in remote areas is inadequate to support effective services. This is in accordance with the systems theory in health management science, which states that every part of the health system, be it human resources, infrastructure, or budget, is interconnected and must function harmoniously to achieve a common goal, namely optimal public health.

Further evidence of the need for needs-based budget allocation can be found in a study by Hanson et al (2022) which emphasizes the importance of a more flexible and responsive fund allocation policy to local characteristics, rather than using a uniform approach that does not consider regional diversity. In practice, the 3T region faces acute problems in resource distribution due to a lack of

evidence-based data and planning. Without a careful planning system, health funds often do not reach the right point, namely the primary health facilities that need it most. Therefore, a needs-based allocation approach based on measuring local health needs (such as disease prevalence, population, and infrastructure conditions) is very relevant. By using this approach, Health Centers in the 3T region can obtain fund allocations that are more in line with real challenges and needs in the field, and ensure that primary health services run more effectively (Aspawati et al., 2022).

The absence of ongoing training and supervision also contributes to significant disparities in service quality between regions. Research by Effendy et al (2024) revealed that ongoing training for medical personnel, especially in remote areas, is an important factor in maintaining the quality of health services. Without access to adequate training, medical personnel cannot keep up with the latest scientific developments that can improve service effectiveness. Further studies have shown that structured and scheduled supervision can reduce medical errors and improve compliance with clinical standards. In the context of Puskesmas, minimal supervision means low quality and accuracy of diagnosis, as well as suboptimal patient management. Therefore, telemedicine and online training can be effective technological solutions to bridge the knowledge gap, given the difficult geographical conditions. Telemedicine integration can increase access to remote medical consultations and accelerate the transfer of knowledge and skills to health workers in remote areas.

The Role of Local Actors and Social Dynamics in Supporting Primary Health Care

1. Adaptive Strategies of Local Actors in Responding to Structural Limitations

The adaptive approach taken by local actors in the health sector, especially the heads of health centers and medical personnel, is in line with the concept of adaptive governance. They argue that success in managing socio-ecological systems, including the health sector, is highly dependent on the ability of local actors to adapt to changes and dynamics that occur in the field. Adaptive governance emphasizes the importance of flexibility, collective learning, and the capacity of local actors to respond to challenges that cannot always be predicted by central policies. In this context, the strategies implemented by local actors demonstrate creativity in managing limitations, which can be seen as a form of fulfilling community needs that are often ignored by national health policies that are rigid and inflexible to local conditions (Maniagasi, 2021)

The emphasis on the importance of social capital is also supported by Alderwick et al. (2021) who identified that social relationships built among community members play an important role in facilitating cooperation and participation in various programs, including health services. Social capital that exists between health workers and community leaders, such as village heads or religious leaders, not only increases the effectiveness of services but also makes it easier to convey important health information to communities who may have

misperceptions or beliefs about health issues. With strong social capital, local actors are able to overcome cultural and social barriers that may hinder the success of health programs coming from the center.

However, limitations in the national health policy structure indicate an imbalance in centralized governance which, according to Sulaiman (2021), has the potential to reduce the capacity for innovation at the local level. Policies that are too centralized tend not to accommodate the diversity of needs and challenges faced by regions with very different geographic, social, and economic conditions. In this case, greater decentralization in the health system in Indonesia can provide local actors with more autonomy to adapt policies to local needs. Ostrom (1990) in his theory of governance polycentricity suggests that the success of resource management, including in the health sector, will be more achieved if there is a more flexible system, where decision-making is carried out at various levels of government, allowing each actor to adjust policies to specific local conditions. Therefore, recognizing the role of local actors innovating and adapting to their own conditions can be key to increasing the effectiveness of health policies in Indonesia.

2. Social and Cultural Dynamics as Determinants of the Effectiveness of Health Services

The social and cultural dynamics that influence the effectiveness of health services can be better understood through the theory of social determinants of health (Pomeo & Winarti, 2024). According to this theory, social factors such as socio-economic status, education, social networks, and cultural norms play a major role in determining access to and the quality of health services received by the community. In this context, the social relationships that exist between health workers and the community are important factors in creating trust in the formal health system. Research by Januraga & Ked (2024) shows that communities that have strong social networks and positive interactions with health service providers tend to have better health levels. Open, empathetic communication based on an understanding of the community's socio-cultural background will reduce barriers to health services, especially in areas with high cultural diversity.

Furthermore, the role of local figures in strengthening community acceptance of health services has also been discussed in a study by Riyanto & Kovalenko (2023). They stated that community figures, be they traditional, religious, or other local leaders, function as catalysts for change in the acceptance of health programs. When these figures support a health policy, they not only function as mediators of information, but also as symbols of trust that can move the community to be more open to modern medical approaches. Moreover, the active participation of these figures in the planning and implementation of health programs provides a deep sense of ownership to the community, which in turn increases the success rate of the program. Without the support of local figures, health programs will have difficulty gaining trust, especially in communities that highly value their norms and traditions.

In a study on cultural integration in health services, Aprilia et al (2024) in their book stated that a deep understanding of the cultural values of the community is very important for health workers. Without adjustments to local values, many people feel that medical services are not relevant to their lives, and even feel ignored in the treatment process. This leads to a rejection of formal health services, and prefers to rely on traditional or spiritual medicine which is considered more in accordance with their understanding. In a study conducted by Marlina et al (2020), it was stated that ignoring local wisdom in health policies can lead to decreased participation, especially in areas that have strong traditions and beliefs in alternative medicine. Therefore, it is important for medical personnel to develop cultural competencies that enable them to respond to the health needs of the community in a way that is in accordance with the norms and values that apply in the community.

CONCLUSION

In conclusion, the effectiveness of implementing health disparity reduction policies in remote health centers faces significant challenges due to the imbalance between central policy design and real conditions in the field. Policies implemented are often not adapted to local conditions, such as limited infrastructure, shortage of medical personnel, and geographical constraints. A more data-based approach and involving local actors in policy formulation can produce solutions that are more adaptive and responsive to local needs. Limited resources, both in terms of budget, infrastructure, and training of medical personnel, further exacerbate the disparity in health services, especially in the 3T areas. Therefore, a fund allocation approach based on local needs and the use of technology such as telemedicine are key to increasing service effectiveness. In addition, the role of local actors and socio-cultural dynamics are very important in supporting the success of health policies. The social capital that is established between health workers and the community, as well as support from local figures, strengthens acceptance of health services. Cultural integration in health services also plays a major role in overcoming cultural barriers and increasing community participation. Thus, decentralization of health policies and a more inclusive and adaptive approach to the local context can be effective solutions to reduce health disparities in remote areas.

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