

## Social Inequality and Access to Health Services in Indonesia: A Conflict Theory Analysis of the Social Production of Public Health Risks

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**Abstract:** This article examines social inequality and access to health services in Indonesia through the perspective of conflict theory. Public health is understood not only as a medical issue, but also as a social issue influenced by the distribution of resources, socio-economic position, education, occupation, place of residence, and power relations. This study employs a qualitative approach using a library research method. The data were obtained from books on sociological theory, journal articles, reports from international institutions, government data, and relevant previous studies. The analysis was conducted using qualitative content analysis, with conflict theory as the main analytical framework, supported by the concept of the social determinants of health.

The findings indicate that the expansion of the National Health Insurance program, known as Jaminan Kesehatan Nasional (JKN), has improved public health protection, but has not fully eliminated inequalities in access to health services. Poor communities, informal workers, rural populations, and residents of remote areas still face barriers such as limited health facilities, unequal distribution of health workers, indirect costs, low health literacy, and differences in service quality. This article concludes that public health risks are socially produced through structural inequality; therefore, health equity requires policies that are more responsive to and supportive of vulnerable groups.

**Keywords:** Social inequality; health services; conflict theory; health risk; social determinants of health.

## 1. Introduction

Public health is one of the important indicators in assessing the quality of a country's social development. From a sociological perspective, health is understood not only as an individual biological condition, but also as the outcome of social processes influenced by economic, political, and cultural structures, as well as the distribution of resources within society. The World Health Organization (WHO) emphasizes that an individual's health condition is strongly influenced by the social determinants of health, namely social, economic, and environmental factors that shape people's life opportunities and well-being<sup>1</sup>. Thus, public health issues cannot be separated from the context of social inequality, which affects access to education, employment, a healthy environment, and health services.

In Indonesia, health development has made significant progress through the implementation of the National Health Insurance program, known as Jaminan Kesehatan Nasional (JKN). According to the World Health Organization (WHO), JKN coverage had reached more than 95% of Indonesia's population, or approximately 260 million people, by the end of 2023<sup>2</sup>. Nevertheless, the expansion of membership coverage has not fully eliminated inequalities in access to health services across social groups and regions. Data from Statistics Indonesia (Badan Pusat Statistik or BPS) show that health insurance ownership still varies across provinces and community groups, indicating differences in people's ability to access health services<sup>3</sup>. People with higher socio-economic status generally have greater capacity to obtain quality health services through private hospitals, additional insurance, and better access to health information. In contrast, poor communities, informal workers, rural populations, and people living in remote areas still face various barriers in obtaining adequate health services.

Inequality in access to health services can be observed through various forms of barriers, such as financial constraints, geographical distance to health facilities, the unequal distribution of health workers, differences in the quality of health facilities, low health literacy, and the complexity of administrative procedures. Research<sup>4</sup> shows that urban communities in Indonesia have greater opportunities to utilize hospital outpatient services compared to rural communities, reflecting disparities in access based on place of residence. These findings indicate that access to health care is not determined solely by the availability of medical facilities, but also by an individual's social position within the structure of society. Individuals or groups with stronger economic resources, educational backgrounds, and social networks tend to have greater opportunities to obtain health services in a timely, appropriate, and high-quality manner.

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<sup>1</sup> WHO, "Social Determinants of Health" (Geneva: World Health Organization, 2024), [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1).

<sup>2</sup> WHO, "Indonesia's Success in Achieving 90 Percent Coverage and Minimizing Out-of-Pocket Expenses Through National Health Insurance Expansion" (Geneva: World Health Organization, 2023), <https://www.who.int/about/accountability/results/who-results-report-2020-mtr/country-story/2023/indonesia-s-success-in-achieving-90-percent-coverage-and-minimizing-out-of-pocket-expenses-through-national-health-insurance-expansion>.

<sup>3</sup> BPS, "Persentase Penduduk Yang Memiliki Jaminan Kesehatan Menurut Provinsi Dan Jenis Jaminan" (Jakarta: Badan Pusat Statistik, 2025), <https://www.bps.go.id/statistics-table/3/VVVST00zbE11R3N4WjBjelQyeEZIRUpzSzBWV1p6MDkMw%3D%3D/persentase-penduduk-yang-memiliki-jaminan-kesehatan-menurut-provinsi-dan-jenis-jaminan--2021.html>.

<sup>4</sup> Agung Dwi Laksono et al., "Urban and Rural Disparities in Hospital Utilization among Indonesian Adults," *Iranian Journal of Public Health* 48, no. 2 (2019): 247–55, <https://pmc.ncbi.nlm.nih.gov/articles/PMC6556184/>.

In this context, public health risks cannot be understood as merely natural phenomena. Health risks are also socially produced through structural inequalities that limit the ability of certain groups to protect themselves from disease, obtain treatment, and maintain their quality of life. The World Health Organization (WHO) emphasizes that poverty, low levels of education, unsafe working conditions, and limited access to public services are social determinants that contribute to health inequities in various countries.<sup>5</sup> Therefore, diseases and public health problems need to be understood as consequences of the unequal distribution of resources within society. Conflict theory provides a relevant analytical framework for understanding this issue. From the perspective of conflict theory, which is rooted in the thought of Karl Marx, society is composed of social groups with unequal interests and unequal access to resources. Inequality in the control of economic and political resources affects the ability of social groups to obtain basic services, including health services<sup>6</sup>. In this context, health services can be understood as a social resource whose distribution is influenced by power relations. Groups with greater economic and social capital tend to have easier access to quality health care, while marginalized groups often remain in a disadvantaged position. Through the perspective of conflict theory, inequality in access to health services in Indonesia can be analyzed as a form of structural injustice. This inequality is not merely a technical issue of medical service delivery, but is also related to how the state, the market, and social institutions distribute health resources to society. When health services are more easily accessible to certain groups while other groups face social and economic barriers, the health system has the potential to reproduce pre-existing social inequalities. This condition is consistent with the view that health inequities reflect broader social and economic inequalities in society<sup>7</sup> which states that health inequities are a reflection of broader social and economic inequalities within society.

This study is important because public health discourse often places excessive emphasis on individual behavioral factors, such as diet, lifestyle habits, or adherence to treatment. Although behavioral factors play an important role, this approach is not sufficient to explain why certain social groups are more vulnerable to health problems than others<sup>8</sup> emphasizes that individual health behavior is strongly influenced by the surrounding social and economic conditions. In other words, people's health choices are not always entirely free, but are constrained by existing social, economic, and political structures.

This study aims to analyze the relationship between social inequality and access to health services in Indonesia using the perspective of conflict theory. The main focus of this article is to explain how social inequality affects people's access to health services and how such inequality contributes to the social production of public health risks. Therefore, this article is expected to contribute to the development of health sociology studies, particularly in understanding public health as a socio-structural issue rather than merely an individual medical problem.

## **2. Method**

This study employs a qualitative approach using a library research method. This approach was selected because the study aims to sociologically analyze the relationship between social inequality and access to health services in Indonesia, particularly in explaining how such inequality contributes to the social production of public health risks.

The data used in this study were derived from relevant scientific literature and secondary data. The data sources included books on sociological theory, journal articles, reports from the World Health Organization (WHO), data from Statistics Indonesia (Badan Pusat Statistik or BPS), World Bank data, and previous studies discussing inequalities in access to health services, social determinants of health, and disparities in health care services in Indonesia<sup>9, 10, 11</sup>.

Data were collected through documentation, namely by tracing, selecting, and reviewing various written sources relevant to the focus of the study. The selection of sources was based on thematic relevance, source credibility, data currency, and their contribution to strengthening the theoretical analysis.

The data were analyzed using qualitative content analysis. The analysis was carried out by identifying major themes, such as social inequality, access to health services, social class, regional disparities, power relations, and public health risks. These themes were then interpreted using conflict theory as the main analytical framework, supported by the concept of the social determinants of health. Conflict theory is used to understand health services as a social resource whose distribution is not neutral, but is influenced by economic, social, and political inequalities<sup>12</sup>. Meanwhile, the concept of the social determinants of health is used to explain that public health risks are influenced by social factors such as income, education, occupation, place of residence, environment, and access to public services<sup>13</sup>.

Data validity was maintained through source triangulation, namely by comparing information from theoretical books, journal articles, reports from international institutions, and official government data. Through this method, the study is expected to provide a sociological explanation of inequality in access to health services in Indonesia as part of the reproduction of social inequality within society.

### 3. Social Inequality from a Sociological Perspective

Social inequality refers to a condition in which resources, opportunities, and access to basic needs are not distributed equally within society. In sociological studies, social inequality is understood not only as differences in income, but also as differences in access to education, employment, decent housing, a healthy environment, social protection, and health services. Such inequality shapes the social position of individuals

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<sup>5</sup> WHO, "Social Determinants of Health."

<sup>6</sup> George Ritzer and Jeffrey Stepnisky, *Sociological Theory*, 11th ed. (Thousand Oaks, CA: SAGE Publications, 2021), <https://us.sagepub.com/en-us/nam/sociological-theory/book268230>.

<sup>7</sup> Vicente Navarro, "What We Mean by Social Determinants of Health," *International Journal of Health Services* 39, no. 3 (2009): 423–41, <https://doi.org/10.2190/HS.39.3.a>.

<sup>8</sup> WHO, "Social Determinants of Health."

<sup>9</sup> WHO, "Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health" (Geneva: World Health Organization, 2008), <https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1>.

<sup>10</sup> Badan Pusat Statistik, *Statistik Indonesia 2023* (Jakarta: Badan Pusat Statistik, 2023), <https://www.bps.go.id/publication.html>.

<sup>11</sup> World Bank, "World Development Indicators" (Washington, DC: World Bank, 2023), <https://databank.worldbank.org/source/world-development-indicators>.

<sup>12</sup> Ritzer and Stepnisky, *Sociological Theory*.

<sup>13</sup> WHO, "Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health."

and groups within the structure of society, thereby affecting their life chances and their ability to meet basic needs. According to<sup>14</sup>, sociological theory views inequality as part of the social structure that can reproduce differences in power and opportunities among groups. Groups with greater economic, social, and political capital tend to gain better access to strategic resources. Conversely, marginalized groups tend to face limitations in accessing public services, including health services. Thus, social inequality is an important concept for understanding why certain groups are more vulnerable to health problems than others. Social inequality also includes differences in income, education, gender, region, and insurance ownership, which structurally influence access to and utilization of health services. Various theoretical and empirical frameworks show that poverty, economic inequality, as well as geographical and demographic factors increase barriers to accessing quality health services in Indonesia. The principles of social justice and the right to health have been enshrined in national regulations and the country's legal framework.<sup>15, 16</sup> The universalism of the National Health Insurance program, known as Jaminan Kesehatan Nasional (JKN), aims to improve access and equity. However, empirical evidence shows that inequities persist in the utilization of health services between rich and poor groups, as well as across different regions<sup>17, 18</sup>. In addition, differences in access to education and socio-economic factors also shape individuals' capacity to utilize health services, including through health literacy, digital access, and social security<sup>19, 20</sup>.

### 3.1. Social Inequality as the Basis of Inequality in Access to Health Care

The literature review shows that access to health services in Indonesia cannot be separated from the structure of social inequality embedded in society. Inequalities in income, education, employment, place of residence, and health insurance ownership shape differences in people's ability to obtain adequate health services. Although Indonesia's health system has expanded through the National Health Insurance program, known as Jaminan Kesehatan Nasional (JKN), access to health services remains not fully equal for all groups in society. The expansion of JKN represents an important achievement in health development in Indonesia. WHO reported that by the end of 2023, JKN had covered more than 260 million people, or over 95% of Indonesia's population. This program has played a role in reducing financial barriers to health services and

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<sup>14</sup> Ritzer and Stepnisky, *Sociological Theory*.

<sup>15</sup> Harlin S Rasya and Irwan Triadi, "Akses Keadilan Dan Kesenjangan Sosial: Transformasi Melalui Peran Hukum Tata Negara," *Indonesian Journal of Law and Justice* 1, no. 4 (2024): 12, <https://doi.org/10.47134/ijlj.v1i4.2330>.

<sup>16</sup> Devi S Ariani and Pujiyanto Pujiyanto, "Ekuitas Layanan Rawat Inap Rumah Sakit Di Indonesia," *Jurnal Ekonomi Kesehatan Indonesia* 4, no. 1 (2019), <https://doi.org/10.7454/eki.v4i1.2371>.

<sup>17</sup> Ariani and Pujiyanto.

<sup>18</sup> Achmad Djunawan, Alif I Lillah, and Ratna S Dewi, "Pemanfaatan Fasilitas Pelayanan Kesehatan Primer Di Area Perkotaan Berdasarkan Status Ekonomi Dan Kepemilikan Jaminan Kesehatan (Analisis Data IFLS 5)," *Media Kesehatan Masyarakat Indonesia* 21, no. 4 (2022): 224–37, <https://doi.org/10.14710/mkmi.21.4.224-237>.

<sup>19</sup> Ika Ayuningtyas, "Ketimpangan Akses Pendidikan Di Kalimantan Timur," *Jurnal Pendidikan Dan Kebudayaan* 6, no. 2 (2021): 117–29, <https://doi.org/10.24832/jpnk.v6i2.2128>.

<sup>20</sup> Eviana B Sutanto et al., "Erosi Ketimpangan Kesehatan Digital," *Praxis Jurnal Sains Teknologi Masyarakat Dan Jejaring* 5, no. 2 (2024): 175–87, <https://doi.org/10.24167/praxis.v5i3.11114>.

lowering out-of-pocket expenditure to approximately 27.5% of total health expenditure. However, broad membership coverage has not automatically eliminated inequalities in access, as social, economic, geographical, and administrative barriers continue to affect people's ability to utilize health services effectively<sup>21</sup>. BPS data also show that health insurance ownership still varies across provinces and types of health insurance. This variation indicates that access to health protection has not been fully distributed equally across all regions of Indonesia. These differences are important in sociological analysis because they demonstrate that national health policies still operate within unequal social and geographical structures<sup>22</sup>.

From the perspective of conflict theory, inequality in access to health services indicates that health care is a social resource whose distribution is influenced by people's social position. Groups with stronger economic capital, educational backgrounds, and social networks have greater opportunities to obtain quality health services. Conversely, poor communities, informal workers, rural populations, and people living in remote areas are more vulnerable to access barriers. Thus, access to health care is determined not only by medical needs, but also by the socio-economic power possessed by individuals or groups.

### **3.2. Regional Inequality and Disparities in Health Care Services**

One of the most prominent forms of inequality in access to health care in Indonesia is regional inequality. Urban communities generally have better access to hospitals, specialist physicians, diagnostic facilities, transportation, and health information. In contrast, rural communities and remote areas often face limited health facilities, long distances, high transportation costs, and shortages of health workers.

Laksono et al. (2019)<sup>23</sup> showed the existence of urban-rural disparities in the utilization of hospital outpatient services in Indonesia. Regional inequality is also linked to socio-economic dynamics across regions, which can affect the availability and utilization of health facilities and infrastructure. This is relevant for understanding how decentralization policies need to be designed so that eastern regions do not continue to lag behind in access to health services<sup>24</sup>. Urban communities have greater opportunities to use hospital services compared to rural communities. This finding indicates that place of residence is not merely a geographical factor, but also a social factor that influences people's opportunities to obtain health services.

These regional disparities show that the existence of JKN has not fully resolved the issue of access if it is not accompanied by the equitable distribution of health facilities and health workers. People may already have health insurance, but they still face difficulties when health facilities are far from their place of residence, services are limited, or referrals require substantial costs and time. In other words, health insurance provides financial protection, but does not always guarantee actual access to quality services.

From the perspective of conflict theory, regional inequality can be understood as a form of structural inequality in the distribution of public resources. Economic and political

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<sup>21</sup> WHO, "Indonesia's Success in Achieving 90 Percent Coverage and Minimizing Out-of-Pocket Expenses Through National Health Insurance Expansion."

<sup>22</sup> BPS, "Persentase Penduduk Yang Memiliki Jaminan Kesehatan Menurut Provinsi Dan Jenis Jaminan."

<sup>23</sup> Laksono et al., "Urban and Rural Disparities in Hospital Utilization among Indonesian Adults."

<sup>24</sup> Raden I A Hafis, "Pembangunan Daerah Perbatasan Yang Terabaikan: Kajian Perbatasan Kecamatan Rupa Utara Kabupaten Bengkalis – Selat Malaka," *Gema Publica* 3, no. 2 (2018): 111, <https://doi.org/10.14710/gp.3.2.2018.111-119>.

centers tend to have more complete health facilities, while peripheral or remote areas often experience limited services. This condition shows that the health system does not operate in a vacuum, but functions within an unequal development structure between the center and the regions, urban and rural areas, and dominant and marginalized groups.

### **3.3. The Economic Burden of Health Care and the Vulnerability of Poor Groups**

Another important finding is that the economic burden of health care remains a factor influencing people's access to health services. Although JKN has reduced financial barriers, people may still bear indirect costs, such as transportation, accommodation, loss of income due to absence from work, costs for patient companions, and the purchase of medicines or services that are not fully covered. The World Bank notes that out-of-pocket expenditure remains an important indicator in assessing the economic burden of health care in Indonesia.<sup>25</sup>

For poor communities and informal workers, these indirect costs can become serious barriers. These groups generally have unstable incomes, limited savings, and weak social protection. When they become ill, they face not only medical risks, but also economic risks due to loss of income and increased household expenses. In many cases, this condition may lead poor households to delay treatment, rely on self-medication, or seek health services only when their illness has worsened.

Studies show that health budget redistribution policies and social solidarity programs need to be designed to reduce disparities between regions, while maintaining the quality of health services so that they remain affordable and easily accessible, particularly for poor communities and remote areas<sup>26,27</sup>.

Conflict theory helps explain that the economic burden of health care is not experienced equally by all social groups. Middle- and upper-class groups have more options, such as access to private hospitals, additional insurance, specialist medical services, and preventive examinations. In contrast, poor communities are more dependent on public health services, which often have limited capacity. This difference shows that the health system can reproduce social stratification: groups that already have greater resources obtain better services, while economically disadvantaged groups are more vulnerable to health risks.

### **3.4 Social Determinants and the Production of Health Risks**

The review also shows that public health risks are produced by unequal social determinants. The World Health Organization (WHO) explains that a person's health

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<sup>25</sup> World Bank, "Out-of-Pocket Expenditure (% of Current Health Expenditure) - Indonesia," *World Development Indicators* (Washington, DC: World Bank, 2024), <https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=ID>.

<sup>26</sup> Sri I S Dai, Syarwani Canon, and Devi O Bauty, "Analisis Pengaruh Rls, Pengeluaran Perkapita, Uhh, Dan Tingkat Kemiskinan Terhadap Ketimpangan Distribusi Pendapatan Di Kbi Dan Kti," *Jesya (Jurnal Ekonomi & Ekonomi Syariah)* 6, no. 1 (2023): 535–44, <https://doi.org/10.36778/jesya.v6i1.950>.

<sup>27</sup> Uswatun Hasanah, "Pengaruh Ketimpangan Pendapatan, Pendapatan Per Kapita, Dan Pengeluaran Pemerintah Di Bidang Kesehatan Terhadap Sektor Kesehatan Di Indonesia," *Jurnal Ilmu Ekonomi Terapan* 2, no. 1 (2017), <https://doi.org/10.20473/jiet.v2i1.5504>.

condition is influenced by the social conditions in which they are born, grow, live, work, and age. Factors such as income, education, occupation, residential environment, sanitation, food, and access to public services contribute to health inequalities<sup>28,29</sup>.

In the Indonesian context, communities living in poverty, working in the informal sector, residing in densely populated or unhealthy environments, and having low levels of education tend to face higher health risks. They are more likely to experience limited access to health information, difficulties in obtaining nutritious food, limited access to sanitation, and delays in receiving medical services. Health risks, therefore, do not arise randomly, but are closely related to a person's social position within the structure of society.

Navarro (2009)<sup>30</sup> emphasizes that health inequities are a reflection of broader social and economic inequalities. This view is important because it shifts the understanding of public health from an individualistic approach toward a structural approach. Health problems cannot be adequately explained solely through individual behaviors, such as diet, exercise habits, or adherence to treatment. These behaviors are shaped by social conditions that either constrain or enable a person to live a healthy life.

From the perspective of conflict theory, the production of health risks occurs because social groups do not have equal access to the resources that enable them to live healthy lives. Dominant groups have greater capacity to protect themselves from risks through education, better environments, safe employment, and quality health services. In contrast, marginalized groups are in a more vulnerable situation because their access to these resources is limited. Thus, public health risks are the result of power relations and inequalities in the distribution of resources.

### 3.5 Access to Health Care as an Arena of Power Relations

This discussion emphasizes that access to health services is an arena of power relations. Who receives prompt services, who has to wait, who has choices in health care, and who is forced to accept limited services are strongly influenced by socio-economic position. Groups with economic capital can choose health facilities with better quality, whereas poor communities often have to depend on available services, even when their quality and accessibility are limited.

Ritzer and Stepnisky (2021)<sup>31</sup> explain that conflict theory views social institutions as arenas of competing interests and resource distribution. In the context of health, hospitals, insurance, financing policies, and referral systems can be understood as parts of the social structure that influence people's life chances. When these structures are unable to ensure fair access, health services can become a mechanism for reproducing inequality.

Thus, inequality in access to health services does not merely reflect problems in service management, but also indicates social injustice in the distribution of health resources. Groups with stronger social positions tend to benefit from the existing system, while

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<sup>28</sup> WHO, "Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health."

<sup>29</sup> WHO, "Social Determinants of Health."

<sup>30</sup> Navarro, "What We Mean by Social Determinants of Health."

<sup>31</sup> Ritzer and Stepnisky, *Sociological Theory*.

vulnerable groups more often bear the burden of risk. This is consistent with the framework of conflict theory, which emphasizes that social inequality is maintained through institutions that appear neutral, but in practice may benefit certain groups.

#### 4. Conclusion

Social inequality significantly affects access to health services in Indonesia. Access to health care is determined not only by the availability of medical facilities or health insurance ownership, but also by socio-economic position, education, occupation, place of residence, economic capacity, and social networks within society.

The expansion of the National Health Insurance program, known as Jaminan Kesehatan Nasional (JKN), represents an important step in improving public health protection. However, broad membership coverage has not fully eliminated inequalities in access. Poor communities, informal workers, rural populations, and residents of remote areas still face barriers such as limited facilities, the unequal distribution of health workers, indirect costs, low health literacy, and differences in service quality.

From the perspective of conflict theory, health services are a social resource whose distribution is influenced by power relations and structural inequalities. Groups with greater economic, social, and political capital tend to have easier access to timely and quality health services. Conversely, marginalized groups are more vulnerable to delayed treatment, the economic burden of health care, and higher health risks.

Thus, public health risks do not arise merely as natural phenomena, but are socially produced through inequalities in income, education, occupation, residential environment, and access to public services. Therefore, public health issues need to be understood as socio-structural problems, not merely as medical issues or matters of individual behavior.

This study emphasizes that health equity in Indonesia cannot be achieved solely through the expansion of health insurance coverage. It also requires the equitable distribution of facilities, improvement in service quality, strengthening of primary health care, reduction of indirect cost barriers, and policies that are oriented toward vulnerable groups.

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