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Sociological Perspective in Handling Conflicts in Public Health Issues

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Abstract

This study aims to identify the social factors that cause inequality in access to health services in the community and analyze the dynamics of interaction between medical personnel and patients that contribute to conflicts in the health sector. This study uses a qualitative approach with a case study method, involving in-depth interviews with five informants consisting of patients, medical personnel, and health facility managers. The results showed that socioeconomic inequality, educational level, geographical conditions, and uneven health policies are the main factors causing inequality in access to health services. In addition, ineffective communication dynamics, different expectations, and power imbalances between medical personnel and patients contribute significantly to conflicts in medical interactions. This study suggests the need for improvements in the distribution of health resources, increased public health literacy, and communication training for medical personnel to reduce inequality and prevent conflict. These findings are expected to provide insights for the development of more inclusive health policies and improve the relationship between medical personnel and patients.

Keywords: Inequality of Access to Health Services, Dynamics of Medical Interactions, Communication

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1. Introduction

The health system is one of the fundamental elements in the life of modern society. Around the world, this sector plays an important role in ensuring that every individual receives proper care and maintains their quality of life. However, behind the importance of this sector, there are various challenges involving social, economic, and cultural conflicts, which ultimately affect the ability of the health system to function optimally. In the sociological context, conflicts in the health sector are not only seen as technical or administrative issues. This conflict is often the result of societal inequality, the economic gap, cultural differences, as well as the differences in values between various groups in society. Dissatisfaction, distrust, and social tension often arise when health services are not evenly distributed or when access to quality health care is limited to certain groups. Not only does this impact the quality of care, but it also affects the social relationships between stakeholders in the health sector.

One of the root causes of conflict in the health sector is unequal access to health services. In many countries, communities in low socioeconomic positions often face greater obstacles in obtaining necessary care. They may live in areas far from health facilities, lack health insurance, or face excessive medical costs. This inequality creates a sense of injustice, especially when more financially capable groups can easily access modern health facilities and get better care. In a sociological perspective, this kind of inequality can be understood as a manifestation of unequal power structures, where economically and politically stronger groups have greater control over resources, including health services. In addition, the interaction between medical personnel and patients is also often a source of conflict. Differences in expectations, lack of effective communication, and high work pressure on medical personnel often lead to tension. Patients may feel that they are not being treated with respect, are not being given enough information, or are not getting the attention they need. On the other hand, medical personnel may feel that they are working under severe pressure, with limited resources, and facing unrealistic demands from patients or management. The imbalance creates an uneasy relationship, ultimately impacting the quality of care and the patient experience.

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Health policies implemented by the government are also often a source of conflict. When the policies implemented do not involve community participation or do not consider the needs of vulnerable groups, resistance and tension arise. For example, policies that restrict access to certain drugs or that require people to pay high insurance premiums can lead to protests and feelings of injustice. In a sociological perspective, these types of conflicts reflect the incompatibility between the policy structure and community needs, and demonstrate a lack of communication and engagement in the decision-making process.

Conflict in the health sector also reflects greater tensions in society. Economic inequality, social injustice, and cultural differences are often reflected in the way health services are provided and received. In highly socially fragmented societies, conflict in the health sector is one arena where these tensions manifest themselves. For example, in multicultural societies, differences in values and beliefs about medicine, illness, and health can cause tension between patients and medical personnel from different cultural backgrounds. A qualitative approach allows us to see these conflicts not only as problems to be solved, but also as symptoms of broader social injustices. The problem formulation in this study is: What are the social factors that cause inequality in access to health services in the community? Also, how do the dynamics of interaction between medical personnel and patients contribute to conflicts in the health sector? Therefore, a better understanding of these conflicts can help us formulate more effective solutions that not only address the symptoms but also the root causes.

Theoretical Foundation

Sociology, as a science that studies social relations and the structure of society, provides a valuable approach to understanding conflict in the health sector. Conflict theory, developed by Karl Marx and Max Weber, explains that social inequality and power differences are often a source of conflict. In the context of health, unequal access to health services, differences in social status between patients and medical personnel, and the uneven distribution of resources often trigger tensions in the health system.

The other relevant theory is the structural functionalism theory, proposed by Emile Durkheim, who states that conflict is part of the social dynamics necessary to keep the

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balance in society. Conflict in the health sector often serves to spotlight imbalances in the delivery of health services and to encourage change in a more just direction.

2. Methodology

1) This research uses a qualitative approach with a case study design, where the focus of the research is to explore the experiences, perceptions, and views of five relevant frequenters. Each informant was selected because they have a direct or significant relationship with the phenomenon under study, such as:
   - Allowing space for participants to express their experiences and perspectives without the limitations of survey or quantification formats.
   - Explore emerging themes in depth, emphasizing the meaning behind the data obtained.
   - Holistically examine events or situations.
   - Using multiple data sources, such as in-depth interviews, observations, documents.
2) Selection of Informants

   Informants were selected by purposive sampling based on their relevance. And the profiles of the informants are as follows:
   a) Two patients: from different socio-economic backgrounds, to provide perspectives on inequalities in access to health services.
   b) Two medical personnel: such as doctors or nurses who have direct experience in interacting with patients from various backgrounds.
   c) A local health policy maker or health facility manager: to provide insight into how health policies or systems can create or exacerbate inequalities and conflicts.

3. Results and Discussion

A. Results

The results of this study present the main findings related to two problem formulations, namely the social factors that cause inequality in access to health services in the community, and the dynamics of interaction between medical personnel and patients that contribute to conflict in the health sector:

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1. **Social Factors Causing Inequality of Access to Health Services**

Based on data collected through in-depth interviews and document analysis, this study found a number of social factors that are the main causes of unequal access to health services in the community. These factors include:

a. **Socio-Economic Inequality**

One of the main findings is that economic status has a significant influence on an individual's ability to access health services. Informants from low socioeconomic groups often face financial obstacles in paying for medical expenses, buying medicine, or even paying for transportation to the nearest health facility. In contrast, informants with higher incomes generally do not face these obstacles, although they may still complain about the quality of services. These differences in socioeconomic status mean that most people with low incomes are either forced to delay seeking treatment or use cheaper but often less effective alternative methods.

b. **Level of Education and Health Literacy**

The data shows that education also plays an important role in determining access to health services. Low-educated informants often do not understand the importance of preventive health care, such as immunization, routine check-ups, or a healthy lifestyle. In addition, these people are often unaware of their rights as patients and are reluctant to ask questions or seek further assistance. Consequently, these individuals are more vulnerable to health complications that should be preventable if given adequate knowledge.

c. **Geographic Conditions and Infrastructure**

Geographic location is also an important factor in access inequality. Residents living in rural or remote areas often have to travel long distances to reach health service centers, with limited transportation infrastructure. Bad road conditions and lack of public transportation cause additional costs that are difficult for the poor to afford. As a result, they often depend on local health

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facilities that might not have adequate resources, like specialist doctors or modern medical equipment.

d. Cultural and Social Perceptions of Health

Cultural and social factors also influence access to health services. Some informants noted that in their communities, there is a traditional belief that modern health services are not needed except in emergencies. Moreover, stigma towards certain diseases or certain medical procedures can prevent someone from seeking medical help. For example, in certain communities, mental illness or infectious diseases are often seen as a disgrace, so sufferers and their families are reluctant to come to health facilities. These cultures not only hinder access, but also aggravate overall health conditions.

e. Gaps in Public Policy and Services

Informants from low-income groups often feel that government programs to improve access to health services are uneven or non-transparent. They complain that health insurance or subsidy assistance does not always reach those in need, or that the administrative process is too complicated. This uneven distribution of resources exacerbates existing inequalities, making it more difficult for certain groups to obtain quality services.

2. Dynamics of Interaction between Medical Personnel and Patients that Contribute to Conflict

In addition to inequalities in access to services, this study also explores how the dynamics of interaction between medical personnel and patients can trigger conflict. Some aspects that were found include:

a. The Difference Between Expectations and Reality of Service

Patients often come with high expectations of health services, especially in terms of the speed and quality of treatment. However, in practice, medical personnel may be burdened by an excessive number of patients, limited equipment, or protocols that must be followed. As a result, patients feel disappointed and dissatisfied. Frustration can increase on both sides when

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expectations are not met, often leading to verbal conflicts or even formal complaints.

b. Lack of Effective Communication

A significant finding is that communication between medical personnel and patients often does not go well. Healthcare workers, who may be under time pressure or have a high workload, sometimes do not provide sufficient explanation of diagnoses, procedures, or treatments. As a result, patients feel confused or even suspicious of medical decisions. On the other hand, some patients are also unwilling to ask questions or express their discomfort, creating even deeper communication gaps.

c. Inequality of Power in Relationships

The relationship between medical personnel and patients is often hierarchical, with medical personnel seen as having full authority. Informants from the patient group mentioned that they felt they had no say in the medical decisions made for them. This inequality exacerbates conflict when patients feel that they are treated like a "case" instead of as individuals in need of personal attention. Whenever patients feel neglected or unappreciated, distrust of medical personnel increases, often becoming sources of tension.

d. Stigma against Certain Groups

Several medical personnel admit that they have prejudices against certain groups of patients, for example, patients who are considered less compliant with treatment or who come from a low socioeconomic group. Even though these prejudices are not always realized, patients can feel the resulting behavior, for example, a less friendly tone of voice or an attitude that seems dismissive. On the other hand, stigmatized patients become uncooperative, eventually triggering protracted conflicts.

e. Working Conditions of Medical Personnel

The high workload, limited support staff, and pressure to meet service targets often leave medical personnel feeling exhausted and unmotivated to

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provide the best service. Medical personnel informants mention that they often do not have enough time to interact personally with patients. These situations create an atmosphere where conflict is more likely to occur, as both medical personnel and patients are not in the optimal mental and physical condition to communicate effectively.

B. Discussion

1. Socio-Economic Inequality as the Dominant Factor

Socio-economic inequality is clearly the underlying cause of the gap in access to health services. This study shows that individuals from low socio-economic groups not only experience financial constraints, but are also trapped in a cycle of being unable to prioritize their health. For example, informants from the lower economic class claimed to prefer to allocate money for urgent needs such as food and shelter, rather than paying for preventive health checks. This situation is in line with Max Weber's theory of social stratification, which explains that economic class affects life chances and access to resources, including health. On the policy side, although programs such as national health insurance are designed to reduce cost barriers, implementation is often uneven. Complicated administrative processes and lack of information prevent many vulnerable groups from taking full advantage of the program. This inequality creates a widening gap between people who have the resources to obtain quality care and people who do not.

a. Health Literacy and Access to Information

Research findings also show that health education and literacy play a major role in determining access. Less educated people tend to be less aware of available facilities and services. For example, some informants mentioned that they were not aware of the existence of community health centers or mobile health services, which are actually more affordable. The inability to understand medical information also exacerbates this inequality. Informants are often confused by medical terms or administrative procedures, making them reluctant to proactively seek health services. The sociocultural approach also plays a role

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here. Some communities have norms that consider certain diseases shameful or taboo to discuss. Consequently, individuals from these groups prefer not to seek treatment, even when they experience symptoms that require medical attention. Therefore, education and cultural factors together create additional barriers to accessing health services.

b. **Geographical Influence and Infrastructure**

Geographical factors and infrastructure also play an important role in creating inequality. People living in rural or remote areas face great difficulties in accessing health services. Informants from these areas report that trips to the nearest health facility often take hours and require significant transportation costs. Furthermore, the availability of health services in these areas is often limited. Small facilities may only have one or two medical personnel without adequate equipment. These geographical inequalities highlight the need for policies that focus on improving accessibility in rural areas.

c. **Cultural and Social Perceptions of Health**

Cultural and social factors also influence access to health services. Several informants noted that in their communities, there is a traditional belief that modern health services are not needed except in emergencies. In fact, stigma towards certain diseases or certain medical procedures can prevent someone from seeking medical help. For example, in certain communities, mental illness or contagious infections are often seen as a disgrace, so sufferers and their families are reluctant to come to health facilities. Not only does this culture hinder access, but it also worsens overall health conditions.

d. **Gaps in Public Policy and Services**

Informants from low-income groups often feel that government programs to improve access to health services are uneven or non-transparent. They complain that health insurance or subsidy assistance does not always reach those in need, or that the administrative process is too complicated. This uneven

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distribution of resources exacerbates existing inequalities, making it more difficult for certain groups to obtain quality services.

2. **The Dynamics of Interaction Between Medical Personnel and Patients that Trigger Conflict**

a. **Mismatched Expectations Between Patients and Medical Personnel**

Patients often come with high expectations of health services, such as fast treatment and instant healing. However, the reality on the ground shows that medical personnel have to deal with heavy workloads, strict protocols, and limited equipment. This creates a gap between expectation and reality. When patients feel that their needs are not being met, they tend to become frustrated and blame the medical staff. On the other hand, medical staff who are already under pressure are often unable to show enough empathy, which makes the situation even worse.

b. **Ineffective Communication**

Poor communication between medical personnel and patients is a major factor in the emergence of conflict. Medical personnel often use technical terms that patients find difficult to understand, or do not provide adequate explanations of the procedures to be performed. Informants from the patient group reported that they felt they were being treated like "objects" rather than partners who had a say in medical decision-making. The concept of "authoritative relationship" in medical sociology, where medical personnel are seen as figures of authority who cannot be challenged, is in line with this. These inequalities can be overcome through communication training and the development of more equal relationships between medical personnel and patients.

c. **Workload and Fatigue of Medical Personnel**

High workloads, especially in understaffed health facilities, also contribute to conflict. Health workers report that they often feel exhausted and do not have time to interact personally with each patient. This makes the service

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less personal and makes patients feel neglected. Consequently, tensions increase, and conflicts easily occur. Better managerial approaches, such as fair work scheduling and increased staffing levels, can help alleviate this pressure.

d. **Prejudice and Stigma in Interaction**

Stigma perceived by patients, particularly from certain social groups, is a significant source of conflict. For example, patients from low socioeconomic backgrounds feel that they are often considered “lack of discipline” by medical personnel. Meanwhile, medical personnel may have certain prejudices against this group, such as the assumption that they will not comply with medical instructions. This type of stigma creates an uneasy relationship, which can eventually lead to open conflict.

e. **Sociological and Theoretical Implications**

Theoretically, these findings reflect the dynamics of power and social norms that influence medical interactions. Inequality in the relationship between medical personnel and patients shows that this interaction is not just a professional relationship, but also reflects the broader social structure. The theory of symbolic interactionism can be used to understand how the meaning attached to the roles of medical personnel and patients affects their relationship. In other words, conflicts do not only arise from technical factors, but also from the way both parties interpret and respond to each other's roles.

4. Conclusion

This study identifies and explores two main aspects of the focus: first, the social factors that cause inequality in access to health services in the community, and second, the dynamics of interaction between medical personnel and patients that trigger conflict in the health sector. Inequality of access is mainly due to differences in socioeconomic status, level of education, and geographical conditions and infrastructure. Individuals with low socioeconomic backgrounds and limited education often lack access to quality health services. In addition, geographical obstacles, such as remote locations and poor infrastructure, further exacerbate this disparity. Although government health programs have

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been introduced, their implementation is often uneven, leaving certain groups without adequate protection or assistance. On the other hand, conflicts between medical personnel and patients are largely influenced by ineffective communication, differing expectations, and power imbalances in their relationships. When medical personnel are faced with heavy workloads and time pressures, communication with patients is often interrupted or limited. This creates a perception gap and dissatisfaction, which ultimately triggers tension and conflict. Overall, this study shows that the issue of inequality and conflict in health services is not merely a technical issue, but also has deep social roots. Consequently, efforts to improve access and reduce conflict must include strategies that improve communication, expand health literacy, and ensure a fairer distribution of ressources across all levels of society.

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