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SOCIOECONOMIC BASED INEQUALITY IN HEALTHCARE ACCESS: A CONCEPTUAL ANALYSIS

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Abstract - *Socioeconomic status comprising income, education, and occupation systematically influences healthcare access and quality received by different population groups. This study constructs a conceptual framework explaining mechanisms through which each component affects access dimensions. A systematic literature review method was applied following established qualitative research procedures. Income determines ability to pay treatment costs directly and purchase private health insurance with broader coverage. Education influences health literacy required to navigate complex healthcare systems and communicate effectively with medical providers. Occupation determines type of insurance coverage and time flexibility to seek care when needed. Healthcare access is multidimensional including availability, affordability, accessibility, acceptability, and accommodation. All five dimensions can fail independently creating various patterns of inequality across socioeconomic groups. Service quality varies systematically through financial, cognitive, and structural mechanisms. Cumulative disadvantage explains how access inequality worsens across individual life courses and transmits across generations. Universal health coverage reduces financial barriers but non financial barriers persist and remain unevenly distributed. Geographic maldistribution of facilities reinforces inequality as poor regions receive last priority for development. Health literacy as an education product remains undervalued in access policy despite its critical role.*

Keywords: socioeconomic status, healthcare access, health inequality, cumulative disadvantage, health literacy.

INTRODUCTION

A person's socioeconomic status shapes many aspects of life, including the quality of health care that can be accessed and enjoyed. A high income allows someone to choose the best health facilities regardless of cost, while those with low income are forced to rely on public services that are frequently overcrowded and under-resourced. This disparity in access occurs not only between countries but also within the same country, between wealthy and poor groups. Families with large incomes can obtain treatment for serious illness immediately without waiting months in line, while patients from the lower economic class often find that their condition has already become severe by the time they finally get their turn for treatment. National health development itself still faces considerable challenges in equalizing service access and managing infectious disease across regions with differing economic capacities (Harianto et al., 2024). This condition reinforces the cycle of poverty, since illness that is not properly treated reduces work productivity. Workers who are continuously ill lose income and find it increasingly difficult to escape the trap of poverty. Health inequality rooted in differences in socioeconomic status is one of the greatest challenges facing modern health systems (Inas et al., 2024). Ignoring this fact means allowing structural injustice to continue without meaningful efforts at improvement.

Education as a component of socioeconomic status affects access to health services through two main channels: knowledge and employment. A person with higher education is better able to understand complex health information and to distinguish reliable sources. They read medication labels, understand doctors' instructions, and seek a second opinion when they doubt a diagnosis. This knowledge allows them to use the health system more effectively than those who are health illiterate (Telfair & Shelton, 2012). Individuals with lower education, by contrast, often fail to recognize the early symptoms of serious illness until their condition is severe, and are more easily misled by advertisements for counterfeit medication or alternative treatments lacking adequate scientific evidence. This vulnerability is compounded by the circulation of falsified health certificates, a practice that violates both criminal law and professional ethics and further erodes the reliability of information available to less educated patients (Hartika et al., 2023). Education also determines the type of work a person obtains, which in turn affects access to health insurance provided by employers. Multinational companies operating health-related services are in fact bound by local legal obligations regarding the coverage they must provide their workers, although enforcement of these obligations often remains uneven in practice (Waluyo et al., 2024). High-salaried office workers generally receive comprehensive insurance coverage for themselves and their families. Informal workers or freelance laborers often have no protection at all, so every treatment cost must be covered on their own, and this gap in insurance protection widens the divide in access between highly educated and less educated groups significantly.

The type of employment not only determines income and insurance coverage but also regulates the time available to access health services. Office workers with fixed working hours and annual leave entitlements can easily take leave to seek treatment (Pei et al., 2017), and can schedule appointments with specialists during working hours without worrying about losing wages. Daily wage laborers paid by the hour, in contrast, must choose between seeking treatment or losing income; if they decide not to work for a day, their entire income for that day disappears without any guarantee. The economic consequence of seeking treatment becomes so heavy that many choose to delay care until it becomes a genuine emergency. Workplace conditions shaped by technology and management practice can either ease or worsen an employee's ability to take time off for medical needs, and such conditions tend to affect groups of workers unevenly (Darmawan, 2024). Strong organisational collaboration and social capital within a workplace can also determine how flexibly management accommodates an employee's need for medical leave, since firms with weak internal coordination tend to apply leave policies rigidly regardless of individual circumstances (Putra, Mardikaningsih & Darmawan, 2021). Night-shift workers or those working in remote locations also face particular difficulties in accessing health facilities, since the operating hours of community health centers or clinics often do not match the free time available to them after work. As a result, routine checkups and preventive care are neglected because they are considered inconvenient or impossible to arrange, and by the time they finally reach a health facility, the illness has already reached an advanced stage that is more difficult to treat. This pattern repeats continuously and reinforces the relationship between type of employment and overall health status.

The quality of health care a person receives is largely determined by their ability to pay beyond what public insurance covers (Baird, 2016). Patients from a high socioeconomic background can choose the most experienced doctors and hospitals with the most advanced technology, obtaining private recovery rooms for quiet healing as well as food suited to special dietary needs. This difference in quality is even visible in the length of consultation time given by the same medical personnel. Legal protection for nurses carrying out medical practice in hospitals is also uneven, and this in turn affects the attentiveness and thoroughness that patients from different economic backgrounds ultimately receive (Yulius et al., 2023). Weak legal protection of patient rights under prevailing medical ethics standards similarly leaves poorer patients with little recourse when they receive substandard treatment, since formal complaint mechanisms are rarely accessible to those without legal knowledge or resources (Herisasono et al., 2023). A wealthy patient who is a regular customer at a private clinic may receive a full thirty-minute consultation, while a poor patient at a community health center with a long queue receives only three to five minutes from an exhausted doctor. An assessment of BPJS patients' satisfaction with service quality at community health centers in Surabaya found that shorter consultation time and heavier caseloads directly reduce patients' perceived quality of care (Darmawan et al., 2022). Within such a short period, it is impossible for the doctor to conduct an adequate history-taking or explain the treatment plan in detail, so patients return home with minimal understanding of their illness and lack easy access to ask further questions when instructions are unclear. This difference in time per patient produces a significant difference in diagnostic quality and treatment adherence, so that health outcomes between rich and poor patients differ greatly even when they suffer from the same illness.

Geographic ease of access to health services is also closely tied to a community's socioeconomic status (McGrail et al., 2023). Wealthy people can choose to live in areas with complete health facilities within a short walking distance and own private vehicles that allow them to reach a distant hospital quickly in an emergency. Poor families are often forced to live in peripheral or rural areas with limited transportation access, where the distance to the nearest health facility can be dozens of kilometers, with damaged roads and scarce public transportation. Even basic necessities that underpin health, such as water meeting safe drinking parameters, are often harder to obtain in these underserved areas (Issalillah, Khayru & Aisyah, 2022). The cost of transportation alone to seek treatment is already burdensome, not to mention the cost of the treatment itself, and in an emergency such as a complicated delivery, delays in reaching the hospital can be fatal. Mothers and infants can lose their lives simply because a distance cannot be covered quickly with simple transportation. Adequate social support during pregnancy has been shown to ease the anxiety mothers feel while anticipating childbirth, yet women in remote areas rarely receive this support because the health workers who could provide it are themselves difficult to reach (Issalillah & Khayru, 2022). The uneven distribution of health facilities reinforces inequality in access, since poor areas are always the last priority for development. Telemedicine has been proposed as a way to distribute access to health services more evenly, though its application still faces considerable technical and infrastructural challenges in underserved regions (Khayru & Issalillah, 2022). Luxury private hospitals only open branches in city centers or elite areas that promise financial returns, and areas with poor populations are unattractive to private investors, so public services become the only recourse; the burden on community health centers and regional hospitals becomes very heavy because they serve large populations with limited resources.

Universal health coverage programs implemented in various countries aim to reduce inequality in access based on economic status (Barron et al., 2023). However, their implementation on the ground often fails to reach the poorest groups because of various administrative obstacles. Complicated registration requirements demanding certain documents become a barrier for those who are illiterate, and the time and cost needed to secure enrollment are not insignificant. The shift toward digital culture and social media has changed how people interact with public services, and lower-income

groups without adequate digital literacy or access are often left behind in online-based registration systems (da Cruz, Issalillah & Fariz, 2024). Even after being registered, they still face limitations in the choice of referral health facilities, since hospitals that accept payment from public insurance programs often differ from the hospitals they would prefer, forcing patients to accept treatment at facilities with long queues and limited amenities because that is their only option. A juridical review of the rights of indigent patients found that legal protection on paper is often not matched by practice in the field, leaving poor patients with no effective way to demand the referral facility or standard of service they are legally entitled to (Noor et al., 2023). Assessments of service quality and patient satisfaction in public health care consistently show that patients placed in the lowest class of care report lower satisfaction than those able to pay for an upgrade (Khayru & Issalillah, 2022). The class of care covered is typically the third class, with many patients sharing one room and minimal privacy, while patients with greater ability to pay can choose to upgrade at considerable additional cost. As a result, universal coverage programs do not fully eliminate inequality but merely reduce its severity, and the poorest groups still receive lower-quality service than those who can afford to pay a supplement.

The main problem is the absence of a system capable of detecting inequality in health service access based on economic status at an early stage. Routine data collected by health facilities rarely includes detailed information on patients' income or education, and without adequate data, policymakers do not know which population groups are the least reached by services. The interventions designed become blind and poorly targeted because they rely on mistaken assumptions about community needs. An empowering leadership style that grants greater autonomy to frontline health workers could improve their capacity to identify local needs and design more responsive interventions, yet such an approach is still rarely applied in the public health sector (Darmawan, 2024). As a result, programs to address inequality use a one-size-fits-all approach that is bound to fail; areas struggling with transportation access receive the same solution as areas whose main problem is treatment cost, while the groups most in need remain unreached because interventions are not designed around their specific profile. Organizational innovation strategies that strengthen resilience and competitiveness, as commonly applied in the business sector, have rarely been adopted by public health institutions seeking to improve their responsiveness to inequality (Mardikaningsih et al., 2024). Comprehensive regulation paired with consistent law enforcement is essential for protecting rights within the health sector, yet such enforcement in practice frequently remains weak and inconsistent across regions, leaving accountability gaps unresolved (Mubasyiroh & Issalillah, 2023; Rezza et al., 2024). The absence of an effective feedback mechanism also means that program failures are not quickly identified or corrected, so the health system continues to operate inefficiently, with no one accountable for measuring whether the inequality gap is narrowing or widening. Funding for inequality-reduction programs is often cut because there is no evidence that the programs have succeeded, and this paradox turns unequal access to health services into a perpetual issue that is never fully resolved.

The next issue concerns the cross-generational influence of health access inequality experienced by parents on their children. Parents who do not receive adequate health care during their reproductive years give birth to children with poorer initial health conditions, and infants born to mothers with poor nutrition and minimal prenatal care face a higher risk of developmental disorders. These children begin life with lower physical and cognitive capital compared with peers from well-off families. Throughout their growth, access to preventive health services such as immunization and routine checkups is also limited, so they fall ill more often and are absent from school, causing their academic performance to lag behind. This early disadvantage also carries psychological weight, since children who grow up with poor health and limited social interaction tend to develop lower well-being that follows them into adulthood (Oluwatosin & Darmawan, 2024). Social stigma attached to poor health or family background can further shape how these children are perceived and treated by their peers, adding another layer of psychological burden beyond the physical disadvantage they already carry (Khayru & Gardi, 2024). This educational setback ultimately limits the type of work they can obtain as adults, leaving low-wage jobs without decent health insurance as the only option available. When they have children of their own, the cycle of health access inequality repeats again across generations. Breaking this chain requires intervention not only in health services but also in the broader social determinants at play; addressing health access inequality means addressing poverty, education, and structural injustice at the same time. Failure to understand this cross-generational dimension keeps health policy reactive rather than preventive.

The need to understand the mechanism of health service access inequality has become urgent because of its wide-ranging and lasting impact. A country that fails to address this problem will continue to lose its human resource potential needlessly. Children from poor families who could have become scientists or leaders fail to reach their potential because of health problems, and national productivity as a whole declines because part of the workforce lives with chronic illness. The cost of treating advanced disease that could actually have been prevented burdens an already limited public financial system, while wealthy groups remain healthy and productive, so economic inequality keeps widening over time. A society unequal in health is also unequal socially, because inability creates shame and isolation, and an unjust health system reflects the failure of the social contract between the state and its citizens. Research on the relationship between socioeconomic status and access to health services is needed to design fairer policy; a solid theoretical understanding will guide practical intervention on the ground so that it is not misdirected. Normative research of this kind becomes the foundation for fundamental systemic change, not merely a patchwork improvement.

This study aims to systematically describe the relationship between the components of socioeconomic status and the dimensions of healthcare access. The resulting theoretical framework includes the identification of the pathways of influence of income, education, and occupation on the affordability, quality, and type of services. The theoretical contribution of this study is integrating the theory of social determinants of health with the concept of healthcare access into a complete causal model. Its practical contribution is providing a diagnostic tool for policymakers to identify the most marginalized population groups. The government can use this framework to evaluate whether universal health coverage programs truly reach those who need them most. Hospitals and community health centers can conduct self-assessments regarding access disparities in their respective working areas.

RESEARCH METHODS

A systematic literature review approach is used in this study, as outlined by Templier and Paré (2015), who distinguish between systematic, semi-systematic, and integrative reviews. The systematic approach was chosen because the research question requires the identification and synthesis of all theoretical evidence regarding the relationship between socioeconomic status and healthcare access. Inclusion criteria were applied to articles discussing the relationship between at least one component of socioeconomic status and one dimension of service access. Articles discussing social determinants of health only in general terms without specifying mechanisms were excluded from the analysis. Every inclusion or exclusion decision was documented with clear reasoning to fulfill audit requirements. The collected data were then analyzed thematically to identify patterns of relationships between variables (Folayan, 2019).

The systematic and accountable analysis process is ensured through the guidelines on qualitative research formulated by Denzin and Lincoln (2018). The analysis began with open coding to identify concepts emerging repeatedly in the collected literature. Concepts such as financial barrier, geographical accessibility, health literacy, waiting time, and quality differential were identified as initial themes. The second step, axial coding, was conducted to group related codes into higher and more abstract categories. The categories formed include: financial barriers, geographical barriers, cognitive barriers, and structural barriers. The third step, selective coding, was performed to identify the core category explaining the central mechanism of the overall model. The core category in this study was identified as cumulative disadvantage, which is the accumulation of disadvantages from various reinforcing barriers. The validity of the findings was maintained through source triangulation and cross-checking among propositions from different authors. The analysis process was iterative, with researchers moving back and forth between the data and the constructed conceptual framework. A conceptual model on the influence of socioeconomic status on healthcare access and quality was produced as the final finding.

RESULTS AND DISCUSSIONS

Socioeconomic status is defined as a person's or a family's relative position in the hierarchy of access to valuable resources in society. The main components of socioeconomic status include income, education, and employment, each of which affects health through a different pathway. Evidence shows that socioeconomic inequality in health is not limited to working-age adults but persists into old age (Corna, 2013). Income determines the ability to pay for treatment costs, insurance premiums, and transportation to health facilities (Kwabi-Addo, 2017). Education affects health literacy, namely the ability to understand medical information and navigate a complex service system. Employment determines the type of health insurance a person holds as well as the flexibility of time to access services when needed. These three components are interrelated and often highly correlated, yet each has an independent effect on access to services. A person with high income but low education may still struggle to understand complicated treatment instructions. Conversely, a person with high education but low income may be unable to pay for medication prescribed by a doctor. Public service systems that rely on frontline health workers to bridge these gaps often place heavy strain on the workforce itself, and prolonged exposure to high-need patients can erode staff capacity to respond adequately (Khayru & Darmawan, 2023). Therefore, interventions targeting only one component without considering the others will produce suboptimal results. Understanding the specific effect of each component is necessary to design policy that is properly targeted and effective.

In medicine and medical devices, the issue becomes more complex because the object being promoted is directly related to the body, health, and often patient safety (Sahidu et al., 2023). Access to health services is a multidimensional concept that cannot be reduced simply to distance from the nearest health facility. The first dimension of access is availability, namely whether the type of service needed actually exists in the patient's area of residence. The second dimension is affordability, namely whether the cost required to obtain the service does not burden the patient. The third dimension is accessibility, namely whether the patient can reach the service without significant transportation or time barriers. Digital tools such as artificial intelligence are increasingly offered as a way to close this accessibility gap, though their benefit still depends heavily on whether patients in underserved areas can actually use them (Khayru, 2022). The fourth dimension is acceptability, namely whether the service provided matches the patient's cultural values and preferences. Cases of malpractice involving midwives illustrate how a failure in this dimension can directly threaten

patient safety, particularly for mothers who have limited alternative facilities to turn to (Vitrianingsih et al., 2023). The fifth dimension is accommodation, namely whether the service system can adjust to the patient's needs and limitations. Legal protection for patients at community health centers remains a persistent concern under this dimension, since the accommodation offered to low-income patients often falls short compared with private facilities (Tampil et al., 2023). These five dimensions of access can be fulfilled or unfulfilled independently of one another in practice. A health facility may be easy to reach geographically but so expensive that it becomes financially inaccessible. Another facility may be cheap and nearby but does not provide the specialist service the patient needs. Access inequality occurs when low socioeconomic status groups experience failure across more dimensions at once (Ibrahim et al., 2024).

Income as a determinant of access to health services works mainly through two mechanisms: direct payment ability and insurance ownership. Socioeconomically disadvantaged households are more likely to delay seeking health care compared with more advantaged households (Gordon et al., 2020). High-income families can pay for treatment at private hospitals themselves without needing to rely on insurance, and can also afford private health insurance premiums that provide access to the best facilities and doctors. Legal protection for patients' rights within the insurance system itself remains uneven, so even those who are formally covered do not always receive the benefits they are entitled to (Tamaka et al., 2023). Poor families, in contrast, must depend on public insurance programs that often have limited coverage and facility choices. Even with public insurance, poor patients still face additional costs that are not covered, such as transportation and certain medications. The concept of catastrophic health expenditure occurs when the costs a family must bear exceed forty percent of disposable income. Facilities responsible for palliative care of terminal patients illustrate this burden clearly, since prolonged chronic treatment can accumulate costs that push a family well past this threshold (Wahyusetiawan et al., 2024). For poor families, treatment costs for chronic illnesses such as cancer or kidney failure can reach that proportion. Such spending pressure frequently forces trade-offs with other basic needs, including food consumption, so that a family's food security deteriorates as health costs rise (Aisyah & Issalillah, 2021). As a result, many choose not to seek treatment or to stop treatment midway once funds run out. This tragic decision often ends in premature death that could actually have been prevented with proper care. Staged payment systems or fee waivers for those unable to pay have not yet fully resolved this problem.

Education affects access to health services by improving health literacy, which allows for more effective navigation of the system. Health literacy includes the ability to read and understand health information, including medication labels and medical consent forms. This is where pharmacists carry a direct legal responsibility to protect patients, since inaccurate or incomplete explanation of medication can put low-literacy patients at particular risk (Setiawan et al., 2023). This ability is essential for following complicated treatment plans involving multiple medications with different schedules. Patients with low health literacy often take medication incorrectly, forget follow-up schedules, or fail to understand side effects that need to be monitored (Afni, 2021). They are also less able to communicate symptoms accurately to doctors, so the diagnosis given may be inaccurate. This communication gap is one reason misdiagnosis remains a recurring legal concern for doctors, particularly when patients are unable to describe their condition clearly (Setiyadi et al., 2023). In addition, they tend to be passive in their relationship with health workers and do not dare to ask questions when instructions are unclear. A related problem arises around consent for medical treatment, since patients with limited literacy often sign consent forms without fully understanding what they are agreeing to, undermining their autonomy as patients (Issalillah et al., 2023). Harris et al. (2011) found that the most common reason for delaying care was that respondents considered themselves not sick enough to seek treatment, illustrated here in the pro-rich inequality in subjectively perceived need for health care. Patients with higher education are better able to search for information from various sources, including the internet, before deciding on a treatment option. They are also more critical of medical advice and willing to ask for a second opinion if they doubt the initial diagnosis. Individuals with higher education are more aware of the options available. Professionals have easier access to public health facilities because they are able to bear additional costs and seek care when they need it (Sindhukumari & Thomas, 2023). This capacity for self-advocacy produces a significant difference in quality of care between highly educated and less educated patients. Doctors tend to give more explanation and more treatment options to patients who appear to understand medical terminology.

Type of employment affects access to health services through three pathways: insurance ownership, time flexibility, and exposure to occupational risk. Formal sector workers with permanent contracts almost always have company health insurance that covers employees and their families (Hegland & Berdahl, 2022). Informal workers such as construction laborers, street vendors, or fishermen have no protection whatsoever from their employer. They must rely on public insurance programs whose registration is often hampered by bureaucracy and lack of information. Time flexibility also differs greatly between office workers and daily wage laborers paid by the hour. A daily laborer must choose between losing wages or seeking treatment when sick, since there is no paid leave. Workers who live far from urban centers face a compounding disadvantage here, as patterns of urban sprawl push low-income households toward the fringes where transportation to health facilities is scarce and daily commuting already consumes much of their time (Wisnujati & Mardikaningsih, 2021). Night-shift workers or workers located far from health facilities also face particular difficulties in accessing services. In addition, certain types of work also create specific health risks that require access to specialized services. This is especially clear for workers exposed to hazardous environments, where

health burdens tend to concentrate among low-income groups living or working near sources of pollution such as waste sites (Issalillah & Mardikaningsih, 2022). Mine workers require routine examinations for lung disease caused by coal dust that are not available at all facilities. Chemical factory workers require rapid access to toxicology services in the event of exposure to hazardous substances. The unavailability of these specific services worsens access inequality for workers in high-risk sectors.

The quality of health care patients receive varies systematically by socioeconomic status through several mechanisms at once (Stepanikova et al., 2017). Wealthy patients tend to choose doctors they know personally and trust to be competent. This long-term relationship allows doctors to understand a patient's health history more thoroughly. Poor patients often switch between doctors at public facilities because the referral system leaves them with no choice. Doctors unfamiliar with a patient's history must start from scratch each time within a limited consultation period. This condition opens the door to medical negligence, since clinical decisions are made without adequate history information (Lethy et al., 2023). Telemedicine schemes could actually ease this problem by extending consultation access to patients who struggle to see a regular doctor (Khayru & Issalillah, 2022). Private hospitals where wealthy patients seek treatment have better nurse-to-patient ratios, allowing more intensive care. Public facilities where poor patients seek treatment are understaffed, forcing nurses to serve too many patients at once. This quality gap is also visible in medication availability at hospital pharmacies. Wealthy patients receive medication available at the hospital's internal pharmacy without needing to search elsewhere. Poor patients are often given prescriptions that must be filled at outside pharmacies that may be out of stock or too far away. When prescribed medication is hard to obtain, some patients turn to herbal remedies without adequate supervision from health workers, increasing the risk of misuse (Mansyur et al., 2024). The accumulation of small differences in every aspect of care produces large differences in overall health outcomes.

The mechanism of cumulative disadvantage explains how inequality in health care access worsens over a person's life course (Leopold, 2016). A child from a poor family may miss basic immunizations because the mother does not know the schedule or cannot afford transport to the clinic. As a result, the child becomes more vulnerable to infectious diseases that vaccination could otherwise prevent. The illness causes frequent school absences, leaving the child behind peers academically. This educational setback limits future job options, confining the person to the informal sector without insurance. Social stigma and stereotypes tied to economic background further narrow the job opportunities available to them (Sajjapong et al., 2022). As an adult informal worker, they lack access to routine health checks that could detect disease early. By the time a chronic illness is finally diagnosed, it has already reached an advanced, hard-to-treat stage. The cost of treating advanced-stage disease is so high that it drains savings and pushes the family further into poverty. The children of this newly impoverished family will repeat the same cycle, starting from a worse position than their parents did. Breaking this cycle requires intervention at many points simultaneously, not just one aspect. Policies that prioritize both health and equitable distribution are an essential condition for breaking this chain (Issalillah, 2021). Programs that focus only on the child without helping the parents will not break the intergenerational chain.

Universal health coverage policies implemented across various countries show mixed results in reducing access inequality based on economic status (Johar et al., 2018). Countries with single-payer public insurance systems, such as the UK or Canada, have significantly eliminated financial barriers. However, non-financial barriers such as distance, waiting times, and health literacy remain and are unevenly distributed. Telemedicine regulation that takes patient safety into account could be one way to cut down these distance and waiting-time barriers (Sasmita et al., 2023). Poor patients still face longer waiting times for elective procedures due to an opaque priority system. Countries with multi-payer systems, such as the United States, still leave millions of citizens uninsured despite reforms. This uninsured group is dominated by informal workers and the unemployed, who need protection the most. Developing countries implementing universal coverage programs often face inadequate facility capacity. The number of hospital beds and health workers is not proportional to the population that must be served. As a result, care quality declines for everyone, but the poor bear the worst of it. Those who can afford to do so avoid long queues by going to private facilities outside the system. These private facilities often market their services aggressively, making medical advertising regulation necessary to protect patients from misleading claims (Sahidu et al., 2023). Universal coverage without increased facility capacity simply shifts the queue from one place to another. The poor remain stuck in the longest queues, facing the most serious health consequences.

Geographic disparities in the distribution of health facilities systematically reinforce access inequality based on socioeconomic status. Private investors build luxury hospitals in areas with a concentration of residents able to pay for premium services (Dai et al., 2022). Poor areas on the outskirts of cities or in rural regions are unattractive to investors due to their low profit potential. Building community health centers and regional hospitals as a solution for poor areas is often delayed by limited government budgets. When facilities are finally built, their quality is often inferior to private facilities in major cities in terms of equipment and expertise. Specialist doctors are reluctant to be placed in remote areas due to a lack of supporting facilities and career development opportunities. As a result, patients from poor areas who need specialist care must travel long distances to major cities. McLaren et al. (2014) also found that both monetary and travel costs restrict individuals' health care-seeking behavior. Transportation and accommodation costs during treatment in major cities become an additional, heavy burden. Given that financially better-off households are more likely to live

within a 10 km radius of a facility, availability may be an important supply-side constraint linked to more frequent delays in care and unmet needs among the poor (Cabieses & Bird, 2014). Family members accompanying the patient also lose income from missing days of work. This situation shows how a burden that should be shared collectively ends up being carried alone by the patient and their family (Saputra & Darmawan, 2021). Many patients decide not to undergo specialist treatment because they cannot afford these indirect costs. They instead turn to traditional healers or alternative treatments that are cheaper but scientifically unproven. Such traditional medicine practices often operate without an adequate regulatory framework, leaving legal protection for patients weak (Romlah et al., 2024). Untreated or poorly managed conditions worsen over time, eventually leading to disability or premature death.

Health literacy, as a product of education, has an influence that is often underestimated in health access policy. Patients with high health literacy are able to find information about their rights as patients within the care system. They know the complaint procedures available if they receive poor service and are willing to use them as a negotiating tool. This willingness is closely tied to how a person's social identity is shaped through education and social status (Hariani, 2023). Once a person recognizes they have a health need, understands that need, and seeks and reaches health services, utilization occurs (Levesque et al., 2013). Patients with low literacy do not even know they have the right to receive information about diagnosis and treatment options. This lack of awareness makes the legal protection that should be attached to patients, as seen in dental care cases, difficult to enforce effectively (Indaryanti et al., 2023). They simply accept whatever treatment is given without ever questioning whether it is the best option for their condition. A similar pattern appears in the stigma surrounding mental illness, which makes patients reluctant to seek or question the treatment they receive (Aisyah & Issalillah, 2022). Health workers tend to give less information to patients who appear unlikely to understand complex explanations. This assumption becomes a self-fulfilling prophecy, since patients never learn because they are never told (Finn, 2018). Efforts to improve health literacy through education in elementary and secondary schools have proven more effective than interventions aimed at adults. Children who learn about health from an early age carry those habits throughout their lives. Adaptive learning processes introduced from an early age have proven more effective at forming habits that persist into adulthood (Kurniawan & Darmawan, 2021). However, investment in school-based health education is often neglected because its benefits only become visible decades later. Yet a health-literate generation would significantly reduce the long-term burden on the health system. Health policies that focus solely on service provision without building the population's health literacy remain an incomplete approach.

All socioeconomic status indicators are measured in the same way across cultures. The definitions of income, education, and occupation hold different meanings in agrarian societies compared to modern industrial societies. Cash income is not the sole economic source for farmers who also consume their own harvested crops. Formal education does not necessarily reflect health knowledge because valuable traditional knowledge exists. The same occupation can hold different social statuses depending on the local cultural context. Cross-cultural research is needed to test whether the mechanisms found in this study are universal. Cultural factors also influence the types of access barriers that are most dominant in a particular society. In societies with strong kinship ties, gotong royong-based contribution payment systems may be more effective (Abdullah et al., 2023). In individualistic societies, a self-insurance-based approach may be more compatible with prevailing norms. This framework needs to be adapted carefully when applied in contexts different from its underlying assumptions. Nonetheless, the principle that socioeconomic status systematically affects healthcare access is universal across cultural boundaries.

CONCLUSIONS

Socioeconomic status, consisting of income, education, and occupation, influences healthcare access through various mutually reinforcing pathways. Income determines the ability to pay for direct medical costs and quality private health insurance premiums. Education affects the health literacy required to navigate the service system and communicate effectively with medical personnel. Occupation determines the type of insurance held as well as the schedule flexibility to access services when needed. Healthcare access is a multidimensional concept encompassing availability, affordability, accessibility, acceptability, and accommodation. These five dimensions of access can fail to be independently fulfilled, thereby creating various patterns of inequality. The quality of services received by patients varies systematically based on socioeconomic status through dual mechanisms. The cumulative disadvantage mechanism explains how access inequalities worsen throughout a person's life course across generations. Universal health coverage policies succeed in reducing financial barriers but do not thoroughly eliminate non-financial barriers. Geographical differences in facility distribution exacerbate inequalities because poor regions are always the lowest priority in development. Health literacy as a product of education has an influence that is often underestimated in healthcare access policies.

The implications for health policymakers include the need for a multidimensional approach that does not focus solely on service financing. Eliminating financial barriers through universal coverage is a first step but is not enough to eliminate inequality. The government needs to invest in health literacy improvement programs in schools and the wider community. The distribution of health facilities must prioritize regions with low socioeconomic status even if they are economically disadvantageous. Referral systems need to be redesigned to reduce waiting times for poor patients on non-

emergency elective procedures. Future research can empirically test the relative proportion of each socioeconomic status component's contribution to access inequality. Longitudinal studies are needed to track how cumulative disadvantage effects develop from childhood to adulthood. Field experiments can test the effectiveness of various interventions in reducing specific access dimensions. Cross-country comparisons will show what systemic factors make some countries more successful in overcoming inequality. The government is advised to integrate socioeconomic status data into routine health information systems for monitoring. Finally, political commitment to reducing inequality must be reflected in budget allocations that favor the most marginalized groups.

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