



## **UNDERSTANDING THE CONSUMER EMPOWERMENT IN HEALTH SERVICE**

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### **ABSTRACT**

Health services are one of the most necessary services of the community, and these fields need to be addressed to provide the best health services for the community. This research aimed to analyze the influence of social, demographic, and economic characteristics toward empowered consumers on health services. This research used a cross-sectional design through a survey of 100 people and direct interviews. The data were analyzed using descriptive and inferential analysis. The result showed that 46-67 years old male respondents, who were highly educated (>12 years), and have a job with >360 815 IDR incomes per month were the most empowered group of respondents than others. Regression analyses revealed that a high length of education and high income would increase the value of the consumers' empowerment index.

**Keywords:** Consumers empowerment; online purchases; socio-demographic characteristics.



## 1. INTRODUCTION

Services in the health field are one of the services required by people (Kristiadi, 1994). Thus, the health field needs to be improved so people could get the best health services. Adequate health services mean fast, excellent hospitality, and not expensive services (Wijono, 2010). Although, recently, management or service problems arise and create concern people.

The people that use health service facility often has difficulty fulfilling the requirement to get the service that they need. Thus, it means that improvement toward health service quality, from administrative services to medical assistance, is required (Jolly & Gerbaud, 1992). Moreover, for the hospital, the patient can exit the consumption loop, so it is also essential for the hospital to get feedback from the consumer that can identify their problem with the services to keep them within the circle (Owusu-Frimpong, 2010).

Not all consumers realize the quality of services given to them or even cross-checking if it already follows government law within the health services. Many consumers are having a loss because the services are not what they expected. This proves that consumer protection in Indonesia still needs more attention, especially from the government. That is why to overcome that; consumer empowerment improvement is necessary.

Consumer empowerment is a favorable subjective situation from control enhancement (Wathieu et al., 2002). The consumer who was empowered can be seen from their consumer skills, such as knowledge regarding consumer law or consumer protection institutions, finding information, and complaint behavior (Simanjuntak & Yuliati, 2015). In health service itself, empowered patients play an active part in the decision making process about their health and quality of life (Castro et al., 2016; Schulz & Nakamoto, 2013). The study of Hoch et al. (2011) on empowerment in Dermatology services found that the increasing empowerment led to consumers' activity, such as more advocacy on dermatology disease and effort to improve the dermatologist-patient relationship by the consumer itself.

Research about consumer empowerment, especially in the health services field, is still limited in Indonesia. Previous research about consumer empowerment was done by Simanjuntak et al. (2014a) about consumer empowerment on food packaging. Consumer empowerment in health services was not developed yet. Brunero et al. (2009) found that in mental health services, the number of people having explained and knowing their rights and responsibilities is still low. Therefore, this becomes a field that is very interesting to study further regarding the influences of social characteristics, demographics, and economy on consumers' empowerment in health services. Based on the previous explanation, this study



aimed to 1) identify the social, demographic, and economic characteristics of the consumers in health services; 2) analyze the influence of social, demographic, and economic characteristics of the consumers on consumers' empowerment in the health service field. Overall, the present article was divided into several parts, namely, introduction, literature review, results, discussion, conclusions, and suggestions.

## **2. LITERATURE REVIEW**

### **2.1. Consumer empowerment**

Consumer empowerment is a positive subjective state caused by increased control (Wathieu et al., 2002). In this study, the patient is considered as a consumer of the hospital. Anderson and Funnell (2010) stated that patient empowerment was a process designed to help change the behavior toward self regarding their medical decision. Consumers can be empowered through different sources, both through government regulation and consumer education (Hunter & Garnefeld, 2008).

Empowerment is a critical concept concerning consumer education (Brennan & Coppack, 2008). With consumer education, there is an increasing opportunity to develop an awareness of consumer rights and responsibilities that will influence consumer decisions and the broader implications of those decisions (Knights, 2000). In 2011, Brussels Commission Staff Working Paper stated that consumer empowerment is a function of the knowledge, skills, and firmness of consumers, protection, rules, and institutions designed to support when consumers play a role.

### **2.2. Relationship of social characteristics and consumer empowerment**

According to Nardo et al. (2011), non-active consumers worked less powerfully than those who do. Job-status was significantly different between the two groups on consumer skills (Simanjuntak et al., 2014b). Damayanti (2017) stated that work affected the empowerment of consumers. If the respondent did not have a job, the index of consumer empowerment would be higher.

According to Simanjuntak and Yuliati's (2015) research, the higher income and education levels would increase consumer' skills and knowledge of consumer protection laws and consumer protection education institutions. Also, they were more likely to seek information before making purchases actively and generally more empowered. Raquib et al. (2009) revealed that highly educated people had more knowledge and skills. Based on the analysis of previous research, hypotheses can be formulated as follows:



- H1a: Educational level has a significant effect on consumer empowerment.
- H1b: Job-status has a significant effect on consumer empowerment.

### **2.3. Relationship of demographic characteristics and consumer empowerment**

Gender influences complaint behavior on consumers (Heung & Lam, 2003). Asmarany (2013) suggested that women were more likely to make complaints and complain to third parties. Ruslan (2013) showed a relationship between demographic factors on customer complaint behavior and revealing that women are more likely to complain than men. Age was proved to have a significant relationship with consumer complaint behavior. Simanjuntak (2020) mentioned that gender negatively influenced consumer empowerment. The higher the age of the consumer, the lower the empowerment of the consumer. Based on these discussions, the following hypotheses can be formulated:

- H2a: Gender has a significant effect on empowerment consumers.
- H2b: Age has a significant effect on consumer empowerment.
- H2c: Large families have a significant effect on empowerment consumers.

### **2.4. Relationship of economic characteristics and consumer empowerment**

Consumer empowerment was influenced by income (Simanjuntak et al., 2014a). In this research, Simanjuntak et al. (2014a) found that the higher the income of consumers in the city, the higher the empowerment of the consumers. Yuliati and Azola (2009) stated that income was significantly related to consumer empowerment. Consumers with higher incomes tended to complain more, compared to consumers with lower incomes. Kennedy et al. (2005) and Grunert et al. (2010) concluded that consumer knowledge, as part of the aspect of empowerment, is different based on economic status. The following hypothesis was formulated based on these findings:

- H3: Income has a significant effect on consumer empowerment.

Based on the above discussions, a research framework related to the influence of social, demographic, and economic characteristics on the empowerment of the consumers in health services was developed (Figure 1).

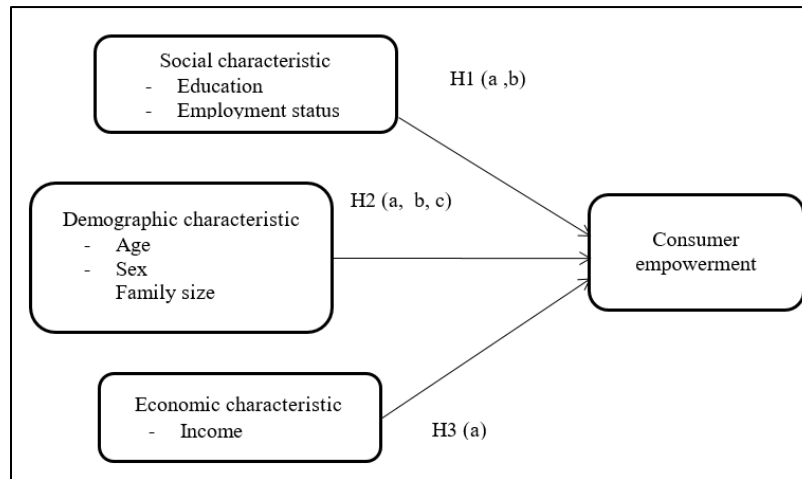


Figure 1 Framework for this study

### 3. RESEARCH METHODOLOGY

This research used a cross-sectional study. Data were collected through a survey using a questionnaire as tools. The research was conducted in November 2017 – January 2018, including preparing the research proposal, data retrieval, data processing, data analysis, and research report. The research population was male or female consumers aged 30 or above who used health services and made an individual decision with a medical history in public or private hospitals a minimum of twice in the last two years. The sampling technique used was purposive sampling, which resulted in 100 respondents.

Primary data were obtained from the interviews using a questionnaire. The questionnaire included questions on social characteristics (length of education, employment status), demographic characteristics (age, gender, family size), economic characteristics (income), and consumer empowerment with a focus on health services. Consumer empowerment was measured using an instrument adapted from Simanjuntak et al. (2014a) and modified following the health service setting ( $\alpha = 0.879$ ).

The instrument consists of three parts: Consumer Skill (nine items), Consumer Awareness (five items), and Consumer Assertiveness (11 items). On the Consumer Skill and Consumer Assertiveness questionnaires, a four-point Likert scale was used and responses were rated as never (1), sometimes (2), often (3), and always (4). Conversely, the Consumer Awareness questionnaire used a single response with responses rated as do not know (0) and know (1). The obtained data were later processed through editing, coding, data input, and analysis using Microsoft Excel and Statistical Package for Social Sciences (SPSS) 23.0 for Windows.

### 4. RESULT AND DISCUSSION



#### 4.1. Respondent Characteristics

Overall, the number of respondents was 100 people consisting of 28 men, and the rest were women. Based on Papalia and Old (2009), age was categorized into two groups: early adults (30-45 years) and middle-aged adults (46-67 years). The results showed that the majority were in the young adult age group, and only 3 out of 20 respondents were middle adults with an average age of 37.9 years.

The family size is grouped into three categories based on BKKBN (2005): small families ( $\leq 4$  people), medium families (5-6 people), and large families ( $\geq 7$  people). The results showed that 64% of respondents came from small families; only 1 in 10 had a large family. The length of education in this study was divided into eight categories, referring to the Ministry of Education and Culture (2015), where the average length of education in Indonesia is 12 years. It was found that the number of respondents with elementary and undergraduate education levels was almost the same, namely 27 and 28 people, respectively. The average length of education was 12.9 years or equivalent to the level of high school education.

Based on the Bogor City BPS (2016), per capita income per month in Bogor City of a family less than 360,518 IDR is considered poor. Per capita income refers to family income for one month divided by the number of family members. Table 1 shows that the average family income per month is 3,005,695 IDR. Twenty-eight families had per capita income per month below the poverty line. As many as 72 families had per capita income per month above the poverty line. Based on the type of work, three out of 10 respondents worked as traders, 24% were housewives/unemployed, and only 1% of the respondents worked as farmers.

Table 1: Summary of the respondent characteristics

Variables	Percentage (%)
Age category	
30-45 years old	85.0
46-67 years old	15.0
Family size category	
Small family ( $\leq 4$ people)	64.0
Medium family (5-6 people)	26.0
A large family ( $\geq 7$ people)	10.0
Education	
Incomplete elementary school	7.0
Elementary school	27.0
Middle school	15.0
High school	14.0
Diploma	2.0
Bachelor	28.0

Variables	Percentage (%)
Postgraduate	7.0
<b>Income</b>	
≤ 360.518 IDR per capita/month (Rp)	28.0
>360.518 IDR per capita/month (Rp)	72.0
<b>Employment</b>	
Housewives/not working	24.0
Merchant	30.0
Private employee	21.0
Civil servant	5.0
Laborer	19.0
Farmer	1.0

Table 2 shows the respondents' disease history in the last two years. As many as 20% of respondents had ulcer disease, 9% of respondents had typhus, and 8% of respondents had a cough and cold, asthma, and heart disease in the previous two years.

**Table 2: Summary of the type of diseases suffered by the respondents in the last two years**

No	Diseases	Percentage (%)
1	Stomachache	20.0
2	Typhus	9.0
3	Asthma	8.0
4	Heart disease	8.0
5	Cough and colds	8.0
6	High blood pressure	7.0
7	Fever	7.0
8	Cholesterol	6.0
9	Diabetes	4.0
10	Diarrhea	4.0
11	Stomach disease	4.0
12	Skin allergy	3.0
13	Uric acid	3.0
14	Hemorrhoids	2.0
15	Toothache	1.0
16	Anemia	1.0
17	Tonsillitis	1.0

Table 3 shows that 30% of respondents were exposed to the disease in the last two months, and 21% were affected by the disease within the previous month. A respondent that had diseases in the period of less than one last month was 16%, and only a few respondents (1%) were affected by the disease in the previous ten months.

**Table 3: Summary of respondents' period of sickness**





Last sickness	Percentage (%)
Less than one month	16.0
Last 1 month	21.0
Last 2 month	30.0
Last 3 month	11.0
Last 4 month	13.0
Last 5 month	4.0
Last 6 month	2.0
Last 7 month	2.0
Last 10 month	1.0

The results of the study presented in Table 4 show that many respondents came to the hospital to receive treatment (41%). Some respondents received treatments in the health center (35%). The clinic became the last choice for respondents for treatments (24%).

Table 4: Summary of the place of received treatment

Place of treatment	Percentage (%)
Health center	35.0
Clinic	24.0
Hospital	41.0

## 4.2. Consumer empowerment

### 4.2.1. Consumer skill

Consumer skills refer to consumers’ skills and knowledge related to services in the health sector. Based on the results of the study, the respondents’ average consumer skill index was 48.85, which is categorized as low. This is because more than half of respondents (58%) felt that the drugs offered by the doctor sometimes did not affect the healing process. Also, 1 in 2 respondents stated that they never asked for details of costs for a treatment at a hospital/clinic/health center. There are no respondents in the good category.

Table 5: Distribution of respondent based on consumer skill

Category consumer skill	Percentage (%)
Low (index <60)	82.0
Moderate (index 60-79)	18.0
Good (index ≥80)	0.00
Min-Max	0.0-77.78
Average±SD	48.85±13.15

### 4.2.2. Consumer Awareness

Consumer awareness is the awareness of respondents about their rights as consumers. The results showed that the majority of consumers in this study showed a low level (78%),





indicating that more than half of respondents were lacking in consumer awareness when obtaining health services. This result is caused by the majority of respondents not knowing about consumer protection laws (75%), consumer legal protection rights (73%), Consumer Dispute Resolution Bodies (BPSK) (93%), and other consumer protection agencies (75%). Only 12% of respondents were included in the good category, and 10% in the medium category because they knew the rights and obligations of each consumer about health services (43%).

**Table 6: Distribution of respondent based on consumer awareness category**

Consumer awareness category	Percentage (%)
Low (index <60)	78.0
Moderate (index 60-79)	10.0
Good (index >80)	12.0
Min-Max	0.0-100.0
Average±SD	25.4±28.96

#### **4.2.3. Consumer assertiveness**

Consumer assertiveness is the tendency of respondents to convey satisfaction/dissatisfaction and file complaints related to services in the health sector. The results of the study showed that the majority of consumer assertiveness was in a low category (97.0%). Only 3% of respondents belong to the medium category, and no respondents were in the high category. This is because 6 out of 10 respondents stated that they sometimes complained about the performance of medicines given by doctors, and most respondents (81%) never complained about hospital services. More than half of the respondents had experienced disappointment with the facilities in hospitals, clinics, and health centers.

**Table 7: Distribution of respondent based on consumer assertiveness category**

Consumer assertiveness category	Percentage (%)
Low (index <60)	97.0
Moderate (index 60-79)	3.0
Good (index >80)	0.0
Min-Max	0.0-69.7
Average±SD	35.52±14.53

#### **4.2.4. Consumer empowerment index**

Research results in Figure 2 show that the consumer empowerment index in the health services field was 36.6. This finding was lower than other researchers, such as the consumer empowerment in generation Y reached 53.84 (Simanjuntak, 2015), formal education 54.34 (Simanjuntak & Umiyati, 2021), telecommunications 51.6 (Simanjuntak & Putri, 2020), the



food sector 38.63 (Simanjuntak, 2018), electronic products 41.78 (Simanjuntak & Putri, 2018), and online shopping 49.7 (Simanjuntak, 2020).

Based on dimensions, consumer skills had the highest index (49.34) compared to other dimensions. In contrast, the dimension with the lowest index was consumer awareness (27.36). That indicates that respondents still lacked knowledge about consumer laws and consumer protection institutions. Consumer awareness was also categorized low, with an average value of 36.78. This finding quite different from earlier studies that concluded consumer complaint behavior was still low (Simanjuntak, 2019; Wandani & Simanjuntak, 2019) that needed more attention (Simanjuntak & Hamimi, 2019).

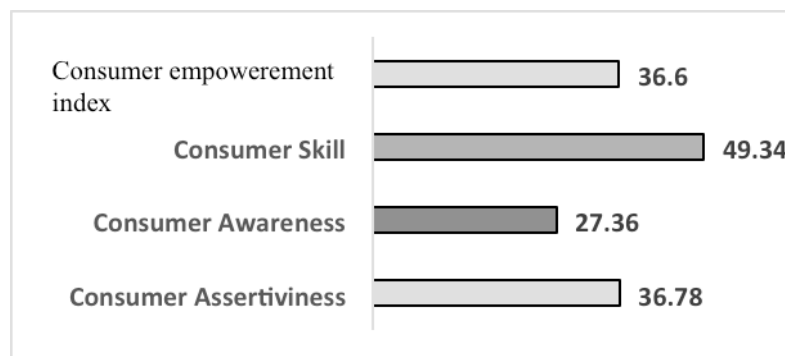


Figure 2: Average index of consumer empowerment based on consumer empowerment dimension in health services

Figure 3 shows an average consumer empowerment index on health service fields. The consumer empowerment index of the male respondents is higher than that of female respondents. This result follows the findings by Simanjuntak and Yuliati (2016) in which male and female consumers showed similar levels of consumer empowerment. The average value of the consumer empowerment index among respondents aged 30-45 years old was lower than respondents from the older age group (46-67 years old). The consumer empowerment index for those with higher education of more than 12 years was higher than those with lower education levels (<12 years).



Figure 3: Average consumer empowerment index based on respondents' social characteristics.

According to Simanjuntak and Yuliati (2016), consumer empowerment index consists of five categories: (1) aware (score 0.0 - 20.0); (2) understand (score 20.1 - 40.0); (3) capable (score 40.1 - 60.0); (4) critical (score 60.1 - 80.0); and (5) empowered (score 80.1 - 100.0). Based on the test result (Figure 4), more than half of respondents (51%) were in the capable category. This finding shows that sometimes respondents only search for information regarding health service (50%). Even though not always, they did ask about the use of medicine (22%).

Also, the respondent knew about their rights and responsibilities regarding health services (43%). However, there were also respondents categorized in understand category; patients only know without doing anything. For example, 5 out of 10 respondents never filed any complaints regarding the facility in the hospital/clinic/health center. Three out of 10 reported that their complaint would not be necessary, even though they know about their rights. Those results indicate the low levels of consumer empowerment in health services. This study also revealed that 1 out of 10 respondents were in the critical category. This means that they always read about medicine instructions and had knowledge about consumer protection law in Indonesia, health institutions, and find it essential to complain when they were disappointed with the health services.

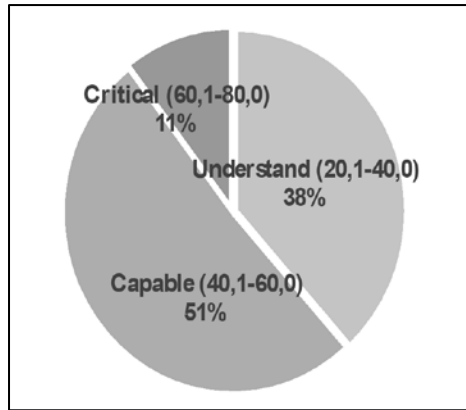


Figure 4: Index category of consumer empowerment on health services

#### 4.2.5. *The relationship between consumer skill, consumer awareness, and consumer assertiveness with consumer empowerment index*

Pearson correlation test is employed to examine the relationship between consumer skill, consumer awareness, and consumer assertiveness with the consumer empowerment index. Based on the result (Table 8), the coefficient correlation values between these variables were significant. Consumer skill was positively correlated with consumer awareness ( $p < 0.05$ ). This indicates that the higher the consumer skill, the higher the consumer awareness. Consumer skill was also positively associated with consumer assertiveness ( $p < 0.01$ ). Consumer awareness showed a significant positive relation with consumer assertiveness ( $p < 0.01$ ). Consumer skill, consumer awareness, dan consumer assertiveness had a significant positive connection with the consumer empowerment index ( $p < 0.01$ ).

Table 8: Coefficient correlation

	Consumer Skill	Consumer Awareness	Consumer Assertiveness	Consumer Empowerment Index
Consumer Skill	1.000	0.220*	0.316**	0.551**
Consumer Awareness		1.000	0.498**	0.889**
Consumer Assertiveness			1.000	0.752**
Consumer Empowerment Index				1.000

Note. \*) significant with  $p < 0.05$  \*\*) significant with  $p < 0.01$

#### 4.2.6. *Factors Influencing Consumer Empowerment Index toward Health Services*

A multi-linear regression analysis was employed to test the influence of social, demographic, and economic characteristics (age, sex, family size, employment status, length of education, family income and last treatment) on consumer empowerment. Table 9 shows

that the length of education and family income has a significant positive relationship on consumer empowerment. The higher the education and family income, the higher the consumer empowerment. A score of adjusted R square shows that the variables in the model only explained 28.7% of its influence on consumer empowerment, whereas 71.3% was influenced by other variables excluded from this study, such as attitude and respondent perception.

**Table 9: Results of regression analysis of the influence of social, demographic, and economic characteristics on consumer empowerment**

Independent Variables	Unstandardized coefficient	Standardized coefficient	p
Constant	22.249		0.064
Age (year)	0.105	0.052	0.569
Sex (1= male; 2= female)	0.344	0.011	0.924
Employment status (0= not working; 1= working)	-3.530	-0.103	0.267
Length of education (year)	1.395	0.467	0.000**
Family income (Rupiah/month)	0.000	0.245	0.039*
Family size (people)	-0.343	-0.035	0.697
Last treatment (month)	-1.411	-0.175	0.069
F		6.697	
Adjusted r square		0.287	
Sig.		0.000 **	

Note. \*) significant with  $p < 0.05$  \*\*) significant with  $p < 0.01$

## 5. DISCUSSION

### 5.1. Consumer empowerment on service health

According to Hunter and Garnefield (2008), consumer empowerment is a positive subjective condition that is resulted from a comparison between consumer abilities and consumer existing or previous abilities. Consumer empowerment is an effort to inform about purchasing behavior of goods and services to consumers (Shibly, 2009). The index of consumer empowerment in health services in this study is in the able group (51%). That is, respondents are only able to use the rights and obligations of consumers to make the best choices, including choosing health services that are right for themselves, not up to the stage of fighting for their rights.

Compared with previous consumer empowerment research conducted by Simanjuntak and Yuliati (2014), the index of consumer empowerment in the food was in the understanding category (26.57). In contrast to the research conducted by Simanjuntak (2020), the index of consumer empowerment in online purchases was in the capable category (49.7), while the study undertaken by Saniya (2017) showed that the index of consumer empowerment in the field of



public transportation was in the capable category (44.56). This means that the index of consumer empowerment in those sectors is lower than the index of consumer empowerment in health services. However, according to Nardo et al. (2011), essential elements of empowerment, namely consumers, must be aware of their decisions when buying, must be able to get information about their rights and must have access to advocacy and compensation. Based on these results, the average respondent is only in the capable category and is considered helpless.

Based on the dimensions of consumer empowerment, consumer skills have the highest index compared to other dimensions. This shows that 60% of respondents have actively sought information related to the rules of drug use properly. The empowerment of consumers in consumer awareness is demonstrated by the high percentage of consumer knowledge of their rights and obligations about health and knowledge of advocacy rights (legal protection) as consumers. However, low levels of consumer awareness cause the index of empowerment of consumers to be categorized low. This was because most respondents did not know the consumer protection law at a health institution in Indonesia and did not know about the Consumer Dispute Settlement Agency (BPSK).

## **5.2. Influences of social characteristics on consumer empowerment**

The results of the study show that the level of education has a significant effect on the empowerment of consumers on acceptable social characteristics variables (Hypothesis 1a accepted). This is following the results of research by Simanjuntak et al. (2013) and Simanjuntak and Yuliaty (2015) stating that higher education levels would make consumers more skilled, have information about the laws of consumer protection and consumer protection education institutions, actively seek information before making a purchase, and generally more empowered. This is following the results of the study in which the average education level of the respondents is equivalent to high school.

In this study, the average index of consumer empowerment among higher-educated respondents is higher than that of lower-educated respondents. Thus, consumers with more than 12 years of education are more empowered than consumers with less than 12 years of education. Ekanem et al. (2006) stated that the level of education influences a person's behavior in seeking information through media, such as television, the internet, and word of mouth. According to Raquib et al. (2009), highly educated people had more knowledge and were mature. Also, they had skills and a better understanding and are critical to be more empowered (Raquib et al., 2009).



The results of the study do not support Hypothesis 1b; the status of employment does not have a significant effect on consumer empowerment. This finding is in line with the research by Simanjuntak and Putri (2018), which found that employment did not affect consumer empowerment. The largest percentage of respondents in this study was traders. Based on the results of the study, the average index of consumer empowerment whose work is higher than those who do not work. According to Nardo et al. (2011), non-active consumers worked less powerfully than those who work.

### **5.3. Influences of demographic characteristics on consumer empowerment**

The results of the study indicate that the hypothesis is not supported as a whole on the demographic characteristic variables. According to Lyon et al. (2002) and Ruslan (2013), age was proved to have a significant relationship with consumer complaints behavior. Older age may limit consumers' access to information. Thus, the older the consumers, the more they need to be empowered. According to Hurriyati (2010), four factors influenced consumer behavior, one of which is personal factors that include age, lifestyle, personality, and self-concept.

The results of the study do not support Hypothesis 2a, where age does not have a significant effect on consumer empowerment. This finding is not in line with previous research stating that empowerment was influenced by age (Nardo et al., 2011; Lyon et al., 2002). The results showed that respondents aged 30-45 years old are more empowered compared to other age groups. This is not in line with previous studies conducted by Nardo et al. (2011), who found that age played an inverse role in empowerment; the younger generation was more skilled, aware, and involved than the older generation. This is arguably due to the experience of the consumer in using more comprehensive health services. According to Handoyo and Setiawan (2015), age influenced consumer complaining behavior, which is included in one dimension of consumer empowerment.

The results of the study do not support Hypothesis 2b. The influence of gender on consumer empowerment is not evident in this study. This result does not support prior studies by Heung and Lam (2003) and Simanjuntak and Yuliati (2016). These studies suggested that gender had a significant effect on consumer empowerment. Despite the insignificant finding, this study indicates that men respondents reported a higher consumer empowerment index than women respondents. This research finding supports previous research conducted by Midha (2012), which stated that men were more empowered than women. However, the study is not in line with previous research where women were more likely to complain and file a complaint to third parties than men (Asmarany, 2013; Handoyo & Setiawan, 2015).



#### **5.4. Influences of economic characteristics toward consumer empowerment**

Economic factors are factors that play an essential role in increasing empowerment (Thapa & Gurung, 2010). The results of the study show that the hypothesis is supported as a whole on the economic characteristics variable support Hypothesis 3. Thus, income is proved to have a significant effect on consumer empowerment in the health service sector. The average income per capita of the respondents in this study is Rp3,005,695. Respondents whose incomes higher than Rp360,518 are found to be more empowered than lower incomes. The regression test results also show that income has a significant positive effect on consumer empowerment in health services. This indicates that the higher the income of a person, the higher his level of consumer empowerment.

This result is in line with prior studies (Simanjuntak et al., 2013; Simanjuntak et al., 2014a). In these studies, it was found that the higher incomes of consumers in the city will increase the empowerment of consumers. Yuliati and Azola (2009), Gholipour (2010), Nardo et al. (2011), and Simanjuntak and Yuliati (2015) also suggested that income was significantly related to consumer empowerment. Consumers who have higher incomes are more likely to file a complaint than consumers who have lower incomes. Research conducted by Phau and Sari (2004) also suggested that income had a positive and significant relationship with consumer complaining behavior. Similarly, Thapa and Gurung (2010) explained that economics is a factor that plays an essential role in increasing empowerment.

#### **5.5. Limitation**

There are several limitations in this study that can be addressed in future studies. First, the research is only carried out in several areas in Bogor City, so it cannot be representative of the entire Bogor City. Therefore, careful attention should be given in interpreting the findings. Second, the instruments used in this study are closed questions. Therefore, to obtain more in-depth results and analysis, future research is suggested to incorporate open-ended questions.

### **6. CONCLUSION AND RECOMMENDATION**

#### **6.1. Conclusion**

The number of respondents in this study is 100 people consisting of 28 men and 72 women. The average age of the respondent is 37.9 years. The majority of respondents have small-sized families. The average education level of respondents is 12.9 years or equivalent to high school education. On average, per capita family income per month of respondents is Rp3,005,695. The average empowerment index of health services is 36.6, with the highest



category in the understand category. Simultaneously, all independent variables influence the empowerment of consumers. Partially the length of education and income has a positive effect on the empowerment of consumers in this study. This shows that respondents with higher education levels are more likely to have a higher consumer empowerment index. Similarly, respondents who have high incomes are more likely to have a higher consumer empowerment index.

## 6.2. Recommendation

This study shows that consumer empowerment in health services is still considered low. Respondents cannot express their complaints well regarding the health service that they receive. This indicates that there is still a lack of consumer awareness to file a complaint when they are disappointed with the service. Based on the findings in this study, several recommendations are proposed. The government is expected to provide information to the citizens, directly and indirectly through social media, to promote consumer awareness and encourage Indonesian people to be more empowered. Consumers should attempt to improve their knowledge about consumers' rights and consumer protection institutions in Indonesia, especially the available consumer protection institutions in their region. This is expected to improve the service quality from the service providers, including those in the health sector. Finally, further research is necessary to improve the research instrument by conducting studies on different populations and incorporating various variables to increase validity. Future research is expected to conduct interviews with the addition of open-ended questions.

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