

## THE ILLNESS EXPERIENCE IN HYPERTENSION PATIENTS WITH LOW SOCIOECONOMIC STATUS

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### Abstract

Hypertension is one type of disease that is usually experienced by adults, where arteries have excessive pressure, which is above 140 mm Hg for systolic and diastolic 90 mm Hg. Hypertension is not only a physical experience, but also needs to be understood as a psychological and social experience. Health is a social problem because it is related to how a person finances his health and access appropriate health facilities. The purpose of this study was to obtain psychosocial dynamics in the experience of hypertension in patients with low socioeconomic status. This study used a qualitative method with an Interpretative Phenomenological Analysis (IPA) approach through semi-structured interviews. Three participants involved were female, aged 30 to 45 years, and had more than one year suffered from hypertension. This study found six superordinate themes that focused on perceptions of causes, perceptions of hypertension, unpleasant feeling, social resources, improvement efforts, and health development.

**Keywords:** hypertension; illness; low socioeconomic status

### Abstrak

Hipertensi merupakan salah satu jenis penyakit yang biasanya dialami oleh orang dewasa, di mana arteri memiliki tekanan berlebih, yaitu di atas 140 mm Hg untuk sistolik dan diastolik 90 mm Hg. Hipertensi tidak hanya pengalaman sakit yang terkait fisik, tetapi juga perlu dipahami sebagai pengalaman psikologis dan sosial. Kesehatan menjadi masalah sosial karena terkait dengan bagaimana seseorang membiayai kesehatannya dan mendapatkan fasilitas kesehatan yang layak. Tujuan dari penelitian ini adalah mendapatkan dinamika psikososial dalam pengalaman sakit pada penderita hipertensi yang berstatus sosial ekonomi rendah. Penelitian ini menggunakan metode kualitatif dengan pendekatan *Interpretative Phenomenological Analysis* (IPA) melalui wawancara semi-struktur. Tiga partisipan yang terlibat berjenis kelamin perempuan, berusia 30 hingga 45 tahun, dan sudah lebih dari satu tahun menderita hipertensi. Penelitian ini menemukan enam tema superordinat yang berfokus pada persepsi terhadap penyebab, persepsi terhadap hipertensi, perasaan yang tidak menyenangkan, sumber daya sosial, upaya perbaikan, dan perkembangan kesehatan.

**Kata kunci:** hipertensi; sakit; status sosial ekonomi rendah

### INTRODUCTION

Hypertension has become one of the global issues in the preventive and control projects carried out by the World Health Organization (WHO) from 2013 to 2020 because it is an invincible killer causing the emergence of other deadly cardiovascular diseases, such as heart attacks and strokes (World Health Organization [WHO], 2013). The data of WHO, as stated in A Global Brief on Hypertension, around 9.4 million people die

each year due to complications caused by hypertension and this number was estimated to increase in the range between 2015 and 2030; it was approaching to 18% in 2008, then it was also estimated to reach 20% in 2015 and will be close to 24% by 2030.

In Indonesia, through Basic Health Research (*Riset Kesehatan Dasar - Riskesdas*) conducted by the Health Ministry of the Republic of Indonesia through the Health Research and Development Agency (Badan

Penelitian dan Pengembangan Kesehatan [Balitbangkes], 2013), it showed that the increase in hypertension patients from 2007 amounted to 7.6% and it increased to 9.5% in 2013 in which the number of hypertension sufferers were women which reached 12.3% much more compared to men which consisted of 6.6%. The increase in hypertension patients can be detrimental to state finances up to IDR 300 trillion, where the growth of most hypertension sufferers was in rural areas (Widiyana, 2014). Rodwin, Spruill, and Ladapo (2013) observed that there were psychosocial effects (such as depression) associated with economic status in people with cardiovascular disease.

Socioeconomic status (SES) is also often used as one of the factors affecting the emergence of hypertension, because it is related to risky behavior that can directly (for example stress occurrences due to unemployment) or indirectly (such as lifestyle changes due to urbanization) which triggered hypertension (WHO, 2013). SES according to the American Psychological Association (APA, 2010), is not only related to income but also educational attainment, financial security, and subjective perceptions of social status and class. SES is often used to determine individual or community health (Adler & Newman, 2002). The lack of hypertension knowledge, for example, became an obstacle to awareness of hypertension, in addition to stress, anxiety, and depression that hinders a healthy lifestyle to prevent hypertension (Khatib et al., 2014).

Pain is not only a physical experience, but also a psychological and social to economic experience. Stroebe (2011) stated that material is one of the external resources that a person uses for coping, in addition to social support. This of course will be related to one's access to appropriate health services. The problem is that individuals with low SES certainly have limitations on this access.

A meta-analysis study conducted by Leng, Jin, Li, Chen, and Jin (2015) showed that low

socioeconomic status could increase the risk of hypertension in all SES indicators; it included education, income, or employment. In contrast, the findings of Glover, et al., (2020) on African American adults suggested a low risk of hypertension at high socioeconomic status including during childhood. This can be a macro threat to countries living below the poverty line where the risk of hypertension was much higher (Fan, Strasser, Zhang, Fang, & Crawford, 2015).

The government through the Ministry of Health is trying to solve this problem by issuing policies on health financing programs, such as the National Health Insurance - Healthy Indonesian Card (*Jaminan Kesehatan Nasional - Kartu Indonesia Sehat - JKN-KIS*) which was organized by the Social Security Administering Body (BPJS) which was a transformation of PT Askes (Persero) (Badan Penjamin Jaminan Sosial Kesehatan [BPJS-Kesehatan], 2018). However, there were still many obstacles in its implementation, for example the inefficient service of JKN-KIS users (Amelia, Purbolaksono, & Nur, 2014).

Socioeconomic factors, such as health financing, are important because they are related to patient behavior in getting health assistance such as health services or health seeking behavior (HSB) such as a qualitative study conducted by Musinguzi et al., (2018) in Uganda. In Indonesian context, Rahmawati and Bajorek (2018a) conducted a qualitative study related to drug consumption in patients with hypertension in rural areas of Yogyakarta, Indonesia, where participants referred to alternative medicine, due to limited access to care services, in addition to the need for anti-hypertensive drugs and support for the patient as well as the expectations of the patient.

The aforementioned problems raise further questions regarding social efforts such as what hypertension patients with low socioeconomic status do. Therefore, the objective of this study was to obtain

psychosocial dynamics in the experience of hypertension in patients with low socioeconomic status.

**METHOD**

This research used a qualitative approach. Participants involved in this study were three women who live in the province of Special Region of Yogyakarta. The initial plan of the researcher was to conduct a screening through a socioeconomic status questionnaire at one of the health centers in Yogyakarta. The questionnaire used refers to the socioeconomic status questionnaire which refers to the 14 criteria for poverty according to BPS (Central Statistics Agency), for example, the floor area of the residence is not more than 8m<sup>2</sup> per-person, the floor of the residence is made of soil, bamboo, or cheap wood, the house lighting does not use

electricity, and so on. However, the results of the initial screening of the researchers from the eight visitors of Puskesmas (*Pusat Kesehatan Masyarakat* - Public Health Care Center) were patients with middle to upper socioeconomic status.

The researcher changed the search for participants by conducting a screening through the same questionnaire in two villages in the Kalasan area of Yogyakarta. The results obtained three participants who fit the criteria of the researcher, namely low socioeconomic status and had high blood pressure for about one year. The researchers adhere to the criteria for hypertension stated by WHO (2013) in which hypertension is an arterial pressure that exceeds 140 mm Hg for systolic and 90 mm Hg diastolic in adults. Information about participants can be presented as follows:

**Table 1.**

General Information on the Participants

	Participant A	Participant B	Participant C
Age	43 years old	45 years old	34 years old
First diagnosis	April 2015	2005	2010
Education	Elementary School	Elementary School	Junior high school
Occupation	Housewife	Farmer	Maid
Highest blood pressure	95 mmHg (diastolic)	185/95 mmHg	140 mmHg (systolic)
Income	± IDR 400.000	< IDR 600.000	± IDR 500.000

Data were collected through semi-structured interviews. The interview used bilingual, namely Indonesian and Javanese. Data analysis used the Interpretative Phenomenological Analysis (IPA) method, which is a phenomenological qualitative approach that focuses on revealing individual experiences in expressions (Smith, Flowers, & Larkin, 2013). Furthermore, Smith et al., Also stated that science is an approach to qualitative, experiential, and psychological research which is informed through the concept and discussion of three key areas of the philosophy of science, namely phenomenology, hermeneutics, and ideography.

The data analysis process included reading and rereading interview transcripts, initial

noting, developing emerging themes, searching for *connections* across emergent themes, moving on to the next case and looking for patterns of whole cases (Smith et al., 2013).

**RESULTS AND DISCUSSION**

This research was conducted in Yogyakarta area, especially in the rural area of Kalasan, Sleman Regency. Most of the inhabitants are farmers. Their daily language is Javanese. This study also used a bilingual interview technique, namely Indonesian and Javanese. The researcher himself has the capacity to speak these two languages. Although there are terms in Javanese in the Yogyakarta region that researchers only know about, so researchers need to confirm their meaning to

the participating residents themselves, the local occupation, or even their own fellow researchers. The researcher translated the Javanese quotations conveyed by the participants during the data collection interviews into Indonesian.

After the researcher transcribed the interview with the participants, the researcher carried out the analysis process, until he found the super-ordinate finding. Researchers compiled the super-ordinate findings of each participant in the following main themes:

**Table 2.**  
The Main Theme

Participant A	Participant B	Participant C
Perceptions of Causes		
Consumption of food	Hasty person ( <i>Kemrungsung</i> )	Household problem
Perceptions of Hypertension		
<i>Cengeng-cengeng</i> or Sore neck that inhibits activity	Pain like being deprived of his/her soul.	The burden of thoughts triggers pain
Unpleasant Feelings		
“ <i>nyemlangi</i> ” (worrying)	Troublesome	Anxious
Improvement Efforts		
Reducing Anxiety	Medical and traditional healing	Being more calm-down
Social Resources		
Advice from Doctors and Other Patient	Doctor and Neighbors’ Help	Concern of Others
Health Development		
Keep doing activities	Becoming a “slow” person	Having relaxed thoughts

### Perceptions of Causes

A number of causes that allow the occurrence of hypertension according to the participants were caused by several factors. Participant A perceived that the pain they suffer was due to food consumption. Participant B thought that the salty food triggered hypertension. This was because participant A had to adjust to her husband who came from outside the city with the cuisine characteristics that tends to salty taste. This was influenced by lack of information about the causes of hypertension.

Participant B who claimed to have anxiety or felt unsettled in doing something (in Javanese terms, namely *kemrungsung*). In addition, participant B also said he was angry. This was often related to unfinished work matters.

“*Saderengipun ya istilahe mau nggak mau ya harus kerja tho mas? Iya misalnya ini belum selesai, kan mikir, mikir kemrungsung kan?*”

[Like it or not, I have to work, right? If my job is not finished yet, I will overthink about it, right?] (B, 325 – 326).

The participant C, her blood pressure increase was triggered by pregnancy and domestic conflicts they experienced. This created psychological pressure on participant C which then encouraged her to spend more time working with the aim of diverting her mind.

The researcher concluded that the participants perceived the pain they suffer according to their personal assumptions. The psychological element in the form of stress, for example, directly or indirectly affected

the formation of behavior that leads to the triggering of hypertension.

### **Perceptions of Hypertension**

Participants have their own experience of typical hypertension. Participant A, for example, expressed a feeling of *cengeng-cengeng* (stiff-neck) when the symptoms of hypertension appeared. These pains appear because of tiredness from activities so that they were considered to hinder their work activities. Participants admitted that there was a decrease in physical activity since they got sick. Participant A consumed *obat warung* (drugs sold in stalls) because they thought it was a kind of normal headache.

*“Alasannya ya itu tadi, saya orang bodoh, ada yang bilang ya saya ikuti, barangkali nanti dapat mengurangi gitu lho.”*

[The reason is that I am uneducated. Some recommend me to buy the drugs, so I do. Maybe later it can heal it] (A, 267-268).

In the case of participant B, the pain due to the appearance of hypertension symptoms was felt "tightening" in the area around the nape of the neck. The pain is sometimes followed by other consequences such as nausea or dizziness such as spinning. Participant B said it felt like his life was being taken. Just like participant A, participant B also consumed *obat warung* (drugs sold in stalls) to relieve the symptoms of the illness.

Participant C often felt the symptoms of hypertension because she often thinks about household problems. It is not uncommon for the symptoms to appear when the participant is working at a neighbor's house. This also often makes it difficult for the participant to sleep. Participant C felt "*cekut-cekut*" (throbbing pain in head) to describe the pain she felt.

The authors concluded that when symptoms such as pain due to hypertension appeared,

there was a response to immediate relief. The participants think that the pain hinders daily activities. Limited information due to low socioeconomic status makes participants respond to pain the same as pain caused by other illnesses.

### **Unpleasant Feeling**

The description of hypertension gave rise to an unpleasant feeling. He/she was worried that his /her illness would be fatal just like other sufferers. Participant A saw other hypertensive patients who fell and caused a stroke.

*“Ada kan, itu darah tinggi terus jatuh, terus menyebabkan stroke, seperti itu lho. Malah membuat saya khawatir”*

[You know those with high blood pressure then fall down. It caused strokes, like that. In fact, it worries me] (A, 104 – 105).

Participant B considered that pain was bothersome both while on the move and while resting. For example, when Participant B felt the need to rest, but his/her neck would hurt when he touched the pillow.

Participant C believed that high blood pressure was the result of an uneasy mental condition (mind and heart). Her domestic problems triggered this mental state. Participant C felt restless, causing physical problems.

The authors concluded that the unpleasant feeling caused by hypertension raises a number of problems. This encourages participants to make corrective efforts to reduce it.

### **Improvement Efforts**

The three participants indicated that there were efforts to deal with the pain they suffered. Participant A visited the public health care center to have a checkup. Participant A felt that his/her concern due to hypertension was reduced after receiving

action from health workers. In addition, participant A also diverted his/her mind about pain by working; participant A has its term as “*keslamur*” (to forget the pain by working).

*“Keslamur itu ya tertutup pekerjaan gitu lho, jadi tidak terasa.”*

[Keslamur is to forget the pain intentionally by working, so I won't feel it] (A, 298).

Similar to participant A, participant B also felt anxious feelings due to decreased hypertension after seeing her regular doctor. In addition, participant B also made traditional efforts by eating *pace* (Noni) fruit.

Participant C stated that she/he did not feel the pain when talking to other people, because his focus was diverted to other things.

*“Kulo saniki teng laundry, terus jadi apa itu, laundry situ, tapi dari tetangga terus ke laundry, sebelum ke tetangga itu jadi tukang kebun TK Jogja, di tiga tempat. Kita berusaha me itu, dengan aktivitas.”*

[Now, I work in a laundry. Previously, I worked as a maid in my neighbor. Before it, I worked as a gardener in a kindergarten in Jogja. I worked in three places previously. I tried to forget the pain by working] (C, 484-486).

Participant C also carried out preventive behaviors, namely the changes of behaviors that appeared in individuals as a form of prevention against the recurrence of the pain they suffered. For example, reducing consumption of risky foods, resting. This includes psychological efforts by not thinking about things that are considered heavy or more calming.

The efforts related to physicals will have an indirect impact on the participants' emotional condition, and vice versa. Visits to medical

personnel or consumption of certain fruits that are perceived to lower blood pressure, at least reduce the participants' anxiety due to illness. On the other hand, efforts that are not related to physical or medical efforts, such as working or talking with other people can reduce the pain they feel.

### Social Resources

Efforts to improve were obtained by the participants through social resources in the form of a number of parties who were perceived to be able to help the pain suffered by them. Participant A believes that every health worker can give positive results on his/her health. The participant used the health insurance provided by the government to access affordable health services. On the other hand, neighbors also provide information that was considered useful for improving their health, especially advice given by other sufferers with similar illnesses.

Similar to participant A, participant B also positioned the family as a companion or first aid when pain due to hypertension appeared. Participant B also received help from his/her neighbors in the form of fruit which was believed to relieve high blood pressure, such as *pace/noni* fruit. In addition, participant B also received material assistance from neighbors and relatives, even in the form of debt for medical treatment.

*“Pinjam, kalau lagi punya beras ya jual beras. Kalau nggak punya ya itu.”*

[If I have enough rice, I will sell it. If I don't have one, I'll borrow money] (B, 300-305).

Participant B preferred to go to a doctor he/she trusts compared to using government facilities in the form of health insurance, which participant B thought to have limited choices of health workers. He/she also thought that seeing a doctor he/she trusted could relieve the pain.

Participant C also had more confidence in going to his/her regular doctor. Participant C preferred to spend his/her personal money rather than using existing health insurance. Participant C was also greatly helped by the concern of his/her neighbors about the household problems he/she was facing and providing jobs to meet the economic needs.

The author concludes that social resources included health workers, neighbors, and families. Everything depends on the results he/she expects in a positive way. Health workers were believed to be able to provide assistance to physical problems. When it was related to emotional and information about illness, the three participants trusted their neighbors more, while the family acted as a companion when there were problems related to illness, for example helping when they feel fainted.

### **Health Development**

Health development is an indicator that shows the success of the improvement efforts that have been done. For participant A, pain was not an obstacle to do activities. Participants choose to stay active in order to be able to divert their attention to the pain they are suffering from, in addition to being able to meet their daily needs. However, participant A also reduced his/her work activities like never before.

Participant B who changed from a hasty person, for example, was rushing to do his/her job to being a "slow" person, namely becoming a calmer person in doing the job. Participant B hopes to work again, although not as much as before.

*“Kalau sekarang, saya suda dipikir slow saja, rengganglah istilahnya, pikirannya tidak perlu terlalu tegang gitu.”*

[Now I will think it slowly, just relaxed. My mind doesn't need to be that stressed] (B, 348-349).

Participant C tried to be more relaxed by not thinking too heavily about their household problems. Participant C can return to activities to get income to meet the economic needs of her family after the husband left her.

Health development is shown through social development in the form of activities that can be carried out again by the participants. The word “work” occurred in all three participants when discussing illness or health. They stated that disease inhibits activities, especially for work. Activity is a means to divert participants' attention to illness and problems. Apart from of course physical development, namely by reducing the pain they feel. Psychological development is indicated by changes in personality and emotional condition. The researcher describes the overall dynamics of the participant's pain experience in picture 1.

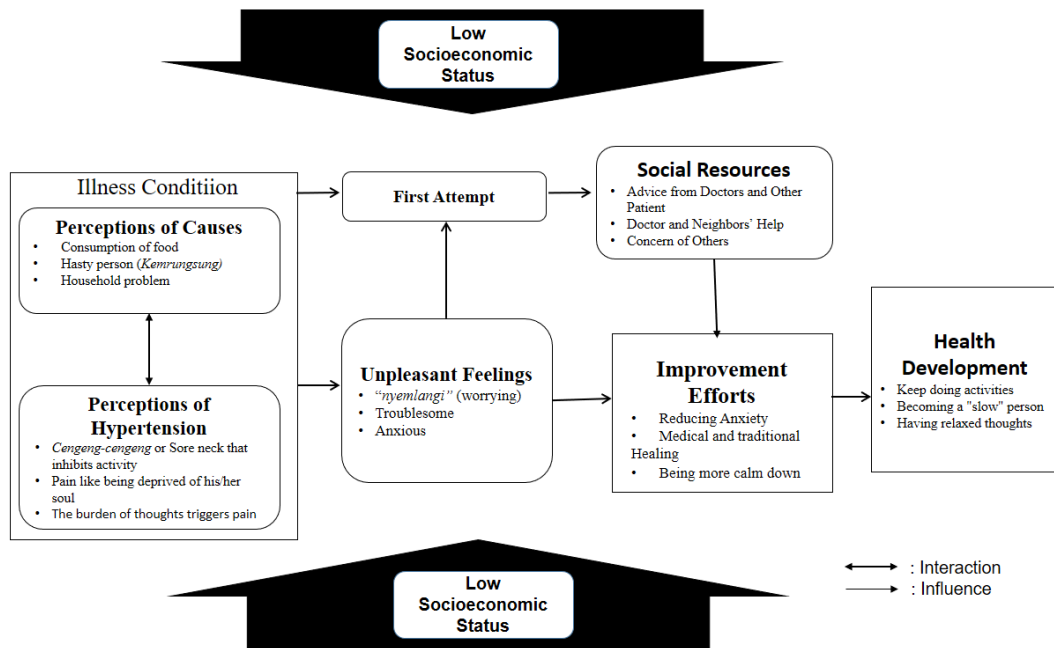
The psychosocial dynamics of the hypertension illness experience in picture 1 shows that the socioeconomic Status affected the limitations of participants in accessing health facilities and health-related information. Low education tends to lead to dependence of participants on other people who are considered to be able to provide solutions to their health problems. In addition to the experience of having encountered almost similar symptoms in the previous time. This forms a participant's description of hypertension and its causes.

These risks and the eating behavior of participants who prefer foods caused a risk for high blood pressure. Ignorance of information about the diseases suffered by the participants causes individuals to tend to eat these foods. The ignorance of the information regarding the disease also caused an inaccurate interpretation of the disease which leads to inappropriate treatment efforts, for example the subject's initial perception that the symptoms that appear are

common headaches, so that it is sufficient to be treated with market drugs.

The information obtained by participants from other people, both neighbors and health workers, has provided a different perspective of illness. Then it emerged emotional

consequences that were different from before. Worries, feelings of distress, and anxiety are emotional consequences experienced by all participants. However, on the other hand, it is the emotional consequence that drives efforts to make improvements.



**Figure 1.** Psychosocial Dynamics of Hypertension Illness Experience

Improvement efforts made by participants were an interaction between physical and emotional improvement efforts. The efforts to improve their health can be caused by personal and situational influences. These efforts were also influenced by the existence of social support that was obtained by individuals' socio-emotional and instrumental as well as material that provides support for individuals. Material support will direct individuals to choose health care facilities that are considered appropriate by participants.

Health development is an indicator and evaluation obtained by participants to show the results of all their pain experiences. This development can be in the form of physical improvement (pain reduction) or psychological change (becoming a different person), both of which will be useful for getting social improvement through work.

For the participants, work is a responsibility and pain become its obstacle.

Quon and McGrath (2015) found that subjectivity to low socioeconomic status is associated with adverse health effects. Wang and Geng (2019) found that lifestyle is a mediator between socioeconomic status and health. This can be caused by the way people with low socioeconomic status think (Manstead, 2018). Mani, Mullainathan, Shafir, and Zhao (2013), based on experimental results, stated that poverty can hinder cognitive performance. The impact of low socioeconomic status can be in the form of low levels of education. This will affect a person's belief in the cause of the disease (Pickett, Allen, Franklin, & Peters, 2014).

Han's research (2014) shows that the level of education is related to access to information



that a person gets to new drugs or health technology, even though education itself does not significantly affect mental health in Chinese society, but life experiences, values, and a distant view of life more influential than education itself. The need for this information is also seen in post-ICU patients to follow up on the care that must be done (Vlake et al., 2020). However, limited education due to conditions of low socioeconomic status causes cognitive limitations to access the information needed regarding their health. This causes a person's representation of his illness to be limited to information that is known from his experience and environment.

A mental representation of illness someone suffering from evokes an emotional response. Research by Foxwell, Morley, and Frizelle (2013) states that the perception of pain can predict quality of life and mood in people with coronary heart disease. In addition, conditions of low socioeconomic status can also trigger stressful experiences that will have an impact on the negative or positive emotions and cognition of individuals (Matthews, Gallo, & Taylor, 2010) and can be a moderator of stress (Stroebe, 2011). Ningsih, Yuniastuti, and Handayani (2018) in their research in the Boyolali area, found that stress affects hypertension status in addition to genetic factors. Irrational beliefs and external locus of control can also increase the risk of blood pressure (Afsahi & Kachooei, 2020).

Research by Nair, et al. (2020) shows how patients with chronic kidney disease with low socioeconomic status, are less able to control disease progression and experience a number of psychological problems. In addition, research by Adrianson, Ancok, Ramdhani, and Archer (2013) on Indonesian and Swedish people shows that positive affect can be predicted through optimism and health. It can be said that in this study, individuals who experience pain tend to have negative rather than positive feelings.

This study shows that coping with pain appears to be a treatment that has both emotional and physical effects, so it can be said that Javanese seek treatment that can have both physical and emotional effects. This is almost in line with the research of Karademas, Tsalikou, and Tallarou (2010) which states that emotional regulation and coping strategies that focus on pain will be related to physical health and psychological well-being, where coping strategies that focus on pain will be related to emotional relationships and physical, whereas emotional regulation will be related to psychological well-being.

On the other hand, Casagrande et al., (2019) found that people with hypertension and heart disease were less able to use task-focused coping, participants focused more on emotional coping. Research by Sanz et al., (2010) found that there are psychological factors, such as stress and certain personality types, on poor control over hypertension. The abilities and characteristics of a person in terms of emotional intelligence are thought to reduce acute stress (Lea, Davis, Mahoney, and Qualter, 2019).

Issues of socioeconomic status and health can interact with each other, which according to Matthews and Gallo (2011) can be related to positive intrapersonal and interpersonal resources. Research by Cornwell and Waite (2012) shows that social networks owned by people with hypertension can help manage the disease. Heard, Whitfield, Edwards, Bruce, and Beech (2011) also suggested that stress is not directly related to hypertension in African Americans, but it is mediated by the role of social support. Perhaps this is what Helgeson, Jakubiak, Van Vleet, and Zajdel (2019) call communal coping, which is an optimal picture of an effort to match patients between partners in which one person has chronic disease.

Emotional support provided by others has an impact on the coping performed by a hypertensive patient. Baker and Berenbaum

(2011) suggested that attention to emotions given by others will give success to given coping interventions, in other words, emotional coping can have an influence on the success of coping with problems. The emotional dimension in chronic disease patients also needs to be a concern for health workers who are considered lacking (Turner & Kelly, 2000). Support from health professionals can be in the form of improving self-regulation skills so that patients can increase healthy habits, although self-regulation can also be raised by patients (Weidner, Sieverding, & Chesney, 2016). However, health workers also need to understand beliefs related to hypertension to be able to take action and prevention, such as in the research of Akinlua, Meakin, Bashir, and Freemantle. (2018) on health workers at the primary level.

Individuals who have limited access to health services to professionals will turn to their social networks, such as neighbors and family (Legido-Quigley et al., 2015). This explains that the limited economic and information resources possessed by individuals will divert them to their social network resources to get social support which is expected to alleviate their illness. On the other hand, social support can also be a material resource needed by a sick person, for example, to get into debt. Although on the other hand, going into debt, according to Keese and Schmitz (2011), can have an impact on poor physical health. Sweet, Nandi, Adam, and McDade (2013) also show, in a longitudinal study, that the relatively high impact of household debt can have an impact on deteriorating mental and physical health. In addition, a meta-ethnographic study conducted by Smith and Anderson (2018) shows that people with low socioeconomic status in the UK do not recognize health inequality as a form of resistance to stigma and shame.

Often the costs incurred for hypertension treatment are higher than the monthly

household income, thus threatening the family economy, as studied in Ethiopia (Zawudie, Lemma, & Daka, 2020). Rice (2013) also states that health administration is often an obstacle in obtaining health insurance provided by the government. Stigma against poverty can also have an impact on health and health inequality among the poor in Scotland (Inglis, McHardy, Sosu, McAteer, & Biggs, 2019). Therefore, appropriate health policies are needed so that people can access health services properly. Here, it is necessary to involve the study of behavioral science and also social determination in health policy studies (MacKay & Quigley, 2018). In addition, it also takes advantage of the application of behavioral economics to improve public health policies at a lower cost (Matjasko, Cawley, Baker-Goering, & Yokum, 2016).

Low socioeconomic status can be a cause of stress for the participants themselves. Research by Hu et al., (2015) in China found that psychological stress can increase the risk of developing hypertension in participants aged 40-60 years, especially in female workers. In a neuroscience study, hypertension can interfere with brain function which has an impact on cognitive performance (Ladecola et al., 2016). Illness is also not an obstacle to working to meet the needs of life as usual, for a hypertensive sufferer with low socioeconomic status. Work can be a means of coping with the sick condition as found in this study. This is an indicator of the progress of the process of improvement efforts made by the patient.

The meaning of pain cannot be separated from cultural influences, Tirodkar et al. (2011) found that South Asian immigrants have their own meaning for health and disease where the concept is related to spiritual, physical, and psychosocial factors. This meaning will certainly have an impact on the patient to choose the treatment that is carried out. In this study, for example, participants used natural medicines such as pace to lower blood pressure. A similar thing

was found by Shamsi, Nayeri, and Esmaeli (2017) through a qualitative study in Iran of hypertensive patients using non-pharmacological methods or what is called herbal medicine.

In the context of Indonesia, especially for Javanese people, hypertension in people with low socioeconomic status in rural areas needs to be studied further. Rahmawati and Bajorek (2018b) conducted a cross-sectional study of hypertension sufferers in rural Yogyakarta, which showed that non-compliance with drug consumption was identified with a low level of education, besides that the Yogyakarta rural community believed that drugs needed to be taken when symptoms appeared in addition to limited services. Health and preferences for using traditional medicine. These results are similar to the findings in this study where hypertensive patients also chose to use alternative medicines besides medical drugs.

The development of pain is an individual evaluation of the illness. How does the individual judge that his illness has improved himself, his physical, and even his social life? In this study, it was found that the indicator for the health of Javanese women is that they can return to work. The same thing is in line with research conducted by Hidajat (2005). Future research still needs to dig deeper into the relationship between health and work in Javanese. Mogler, et al. (2013) stated that external motivation such as money is less able to change healthy behavior than intrinsic motivation such as, for example, being healthy so that you can play with your grandchildren again.

Almost in line with the research of Lindsay, MacGregor, and Fry (2014) on hemodialysis patients who found that they try to gain control in their life such as their work relationships. In this study, work is one that affects individual health, for example job satisfaction which becomes a mediator in mental and physical health (Charkhabi, Alimohammadi, & Charkhabi, 2014; Russo,

Guo, & Baruch, 2014). However, as stated by Rovesti, et al. (2018), health is related to the environment and adaptability and its integration into the context of individual life.

## CONCLUSION

Low socioeconomic status has impacts; one of them is on one's efforts to access health facilities and health-related information. Instead, individuals access it from their experience and social environment, thus forming a separate perception of the causes and hypertension itself. Perception of the cause or disease itself then creates an unpleasant feeling that encourages improvement or coping. One form of coping resources is external resources, namely social and material support. The role of social support is important in efforts to achieve improvement, whether it is done instrumentally, mentoring, and emotionally. Material resources also affect coping choices, for example accessing health services. The aim of the efforts made by the individual is an improvement in his/her condition, because the hypertension is hindering the individual's activities or work. Further research is needed to further explore the factors that affect the experience of pain in hypertensive patients, for example cultural factors and economic behavior in term of health care financing experienced by hypertensive patients.

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