Journal of Information Systems Engineering and Management
2025, 10(35s)
e-ISSN: 2468-4376
https://www.jisem-journal.com/

Research Article

Health Insurance and Access Policy for the Lower-Class Community in Obtaining Healthcare Services in Bandar Lampung City, Indonesia

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ARTICLE INFO

Received: 29 Dec 2024
Revised: 15 Feb 2025
Accepted: 24 Feb 2025

ABSTRACT

National Health Insurance (JKN) is tasked with the responsibility of providing access to healthcare services for all citizens through Badan Penyelenggara Jaminan Sosial (BPJS/Social Security Agency) policy in Indonesia. Therefore, this research aimed to analyze the impact of BPJS Kesehatan policy on the access of the lower-class community to healthcare services. A survey method was used in the lower-class community and analyzed quantitatively and qualitatively. The results showed that (a) BPJS policy facilitated ease of access to healthcare services but the process was not free for the community, (b) access was provided to basic and referral healthcare services without achieving equitable and high-quality standards for citizens, (c) the existence of differentiated services based on VIP, as well as Classes 1, 2, and 3 indicated the effects of some healthcare policies on financial capability, and (d) Services in Community Health Center (Puskesmas) and hospitals were affordable for low-income population in terms of cost, social support, and physical accessibility.

Keywords: Health Policy, Access, Healthcare Services, Quality Equalization, Lower-Class Community

INTRODUCTION

National Health Insurance (Jaminan Kesehatan Nasional/JKN) is a policy required to create an affordable, and efficient healthcare system. The implementation of the concept can be facilitated through Social Security Agency, known as Badan Penyelenggara Jaminan Sosial (BPJS), particularly through BPJS Kesehatan (health insurance). BPJS Kesehatan has been operational for 13 years, obtaining a positive response from the community. This includes enhanced accessibility to healthcare services and the alleviation of medication costs (Bhirawa, 2014; Suryani, 2016). Additionally, BPJS users can obtain referrals when treatment is required, and individuals are directly referred to hospitals and specialist doctors (Yusriadi, 2009). Before the implementation, Makhya (1997), Mubasyiroh, Nurhotimah & Laksono (2016), Laksono & Hidayati (2008), Zahtamal et al. (2011), Laksono & Pranata (2013), Astuti & Laksono (2014), and Suraya et al. (2016) showed that community access to healthcare services was categorized as low, specifcally among the lower-income population. Hidayat et al. (2004) on the impact of mandatory health insurance on equal access to outpatient care also found significant positive impacts. The Askes program, which required compulsory health insurance for civil servants, had a significant positive impact on access to public healthcare facilities. Similarly, Jamsostek program had a positive impact on access to outpatient care in public and private facilities. Expanding insurance coverage to the entire population is expected to significantly improve access to care. However, both Askes and Jamsostek respondents did not have a positive impact on equal access.

The research by Harimurti et al. (2013) with UNICO focused on community health insurance (Jamkesmas) coverage for the poor and near-poor. The scope, depth, and extent of Jamkesmas coverage as well as interaction with the Indonesian healthcare system were investigated. The ability of Jamkesmas to address funding constraints and improve healthcare facilities for the poor and near-poor was also analyzed. The performance was below the potential, even though 40% of poor and near-poor households were covered. There was an increase in use among cardholders, and the number of private providers also increased. Local governments initiated 300 complementary Jamkesmas

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initiatives. Over the past five years, increased attention has been directed toward the lower-income demographic, the value system inherent in BPJS policy, and the advancement of healthcare services. Research on BPJS policy and community access to healthcare services is relevant and important to explain the implementation, specifically concerning access to healthcare for the lower-income population. The significance of this research is shown by three important factors. First, the principle that the desire of sick people to recover is a fundamental human right. Therefore, demands for health justice or the absence of discrimination should be implemented. Since the implementation of BPJS policy, community access has become important. Second, public perception, specifically among the lower-income population, has not been widely known. After the implementation of BPJS policy, healthcare services experienced an enhancement in accessibility and quality. Third, the relevance of the concept of healthcare service access is questioned in terms of quality. The research questions are as follows: 1) How does the implementation of BPJS policy affect access to healthcare for the lower-income population? 2) What values show the implementation of BPJS policy?

OBJECTIVES

The objectives of this research are to:

1. The research aims to analyze how the implementation of BPJS (National Health Insurance) policy has affected the accessibility of healthcare services for the lower-income population. Specifically, it will explore if BPJS has improved the ability of these populations to access medical care, treatment, and healthcare facilities.

2. The research seeks to understand public perception, particularly among lower-income communities, about the effectiveness of BPJS in improving healthcare services. This includes assessing how the community views the policy's success in enhancing healthcare accessibility and the quality of services received after the policy's implementation.

3. Another objective is to explore what values or principles are reflected through the implementation of BPJS, such as equity, justice, and non-discrimination in healthcare. The study aims to identify how these values are demonstrated in the policy and its impact on society, especially the marginalized or lower-income groups.

LITERATURE REVIEW

Health Policy

According to World Health Organization (WHO), health policy is defined as "the decisions, plans, and actions conducted to achieve specific care objectives in a society." There are several categories, comprising public, mental, and health care insurance.

Health policy is a component of health system (Bornemisza & Sondorp, 2002), including resources, organizational structure, management, support services, and health services (Cassels, 1995). This policy aims to design programs at the central and local levels to bring about changes in health determinants (Davies 2001; Milio 2001). Furthermore, it is a series of decisions, plans, and actions taken to achieve specific health objectives in the community. Other experts described the variable as policies intended to have a positive impact on population health (de Leeuw:1989).

Based on the opinions, health policy refers to the steps and strategies taken by governments, health organizations, or related institutions to promote, protect, and improve public health. This policy includes various aspects, such as disease prevention, access to health services, epidemic control, community empowerment, improving the quality of health services, and health-related regulations.

Concept of Healthcare Access

Accessibility has various synonymous terms such as availability and access (Frenk, 1992:842) and these two concepts cannot be distinguished. According to Donabedian (1973), accessibility transcends the presence or availability of resources at a specific time and location. This includes the features of the resource facilitating or decreasing the utilization by potential clients. Access to healthcare is an essential aspect, defined by the availability of medical services to the population. WHO has defined healthcare availability as the proportion of the population that has access to medical services. Therefore, a significant number of people must be able to receive necessary healthcare

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services. Optimal access to healthcare implies that providers, including authorized medical and paramedical staff, are ready to provide timely care and interventions. This includes situations where professionals need to visit patients at homes or other locations.

At the European Union (EU) level, there are two approaches to achieving universal access to healthcare, namely addressing "basic needs" and "equality." The first approach focuses on ensuring that basic healthcare needs are met for all individuals, regardless of socio-economic status or other factors. The second approach achieves equality, meaning that citizens should have equal opportunities to access high-quality services.

Equal access has been recognized as important for individual and public health. This recognition shows the importance of ensuring that every individual has equal access to healthcare services, regardless of background or circumstances. By promoting equal access to high-quality healthcare services, society can work to improve health outcomes and reduce disparities. According to Mubasyiroh et al., (2016) and Laksono, (2016), access to healthcare can be viewed from four dimensions, namely 1) Availability of services, including facilities, human resources, and service hours, 2) Physical access to reach facilities for receiving services, including road infrastructure and transportation availability, 3) Economic access, such as medical expenses, transportation costs, and insurance ownership, and 4) Social access, comprising information completeness, friendliness of workers, satisfaction with services, and community trust in workers.

The Lower-Class

Sociologically, society is structured into diverse strata, a concept referred to as social stratification. This phenomenon is characterized by the hierarchical ranking of individuals in a particular social system treated as relatively superior or inferior. The analysis of social stratification can be conducted through a classification scheme that includes various factors such as (1) membership in a kinship unit, (2) personal qualities, (3) achievements, (4) possessions, (5) authority, and (6) power (Parsons, 1940).

Pitirim A. Sorokin (in Soekanto, 1990) defined social stratification as the differentiation of the population or society into hierarchical classes, with the highest and lowest classes being the manifestations. According to Kerbo (2017), the existence of the system implies some form of legitimization of people and the unequal distribution of valued goods, services, and prestige. A stratification system would remain stable over time without belief systems justifying inequality and unequal ranking. In this context, social stratification arises due to the unequal distribution of goods, services, and prestige.

Carles Muntaner (1996) conducted most research of inequalities and access to healthcare using income as the sole indicator of social stratification. Despite the significance of social theory in health insurance research, no empirical research compared the ability of different models to predict coverage. Common measures used to categorize members of society into strata include wealth, power, honor, and knowledge. Wealth is measured by factors such as the type of housing, vehicles, clothing, and shopping habits for expensive items. According to Gans (1992), the "underclass" society is categorized as including groups isolated from broader social and economic opportunities. This society possesses very low income levels, and limited skills, as well as faces challenges such as unemployment, crime, and family instability.

The measure of power is seen in members of society with power or the greatest authority being categorized as occupying the upper class. Meanwhile, the measure of honor is determined by wealth and power. Individuals who are most respected and honored hold the highest position and the measures are prevalent in traditional societies, often represented by the elderly.

METHOD

The descriptive survey method is used to describe and analyze the phenomenon of policies and access to health services for low-income communities. Primary data collection includes the distribution of questionnaires and interviews, while secondary data is obtained from health policy products, particularly BPJS. Therefore, a mixed-method approach is adopted in this research. The sample characteristics include BPJS users who belong to the low-

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income group, namely those who have a card, have received medical treatment, pay BPJS Class 3 contributions, do not have a permanent income, and have completed elementary or secondary education.

The respondents are BPJS cardholders in the low-income community of Bandar Lampung City, particularly those who pay for Class 3 with a monthly premium obligation of Rp35,000 per person. The methodology includes purposive sampling, where sample selection is guided by an assessment to determine which samples are most appropriate, valuable, and representative of the population under consideration.

The total number of BPJS Class 3 respondents is 158,034 people, or about 13.06% of the total population of Bandar Lampung City. Meanwhile, recipients of the Contribution Assistance (PBI) from the State Budget (APBN) or the National Health Insurance (Kartu Indonesia Sehat/KIS) total 380,875 people, or 31.47%, and 64,935 people are part of the Regional Health Insurance (Jamkesda).

Based on the number of low-income communities and the homogeneous characteristics of the sample, each district has one Puskesmas (Community Health Center) and one referral hospital in the 20 districts of Bandar Lampung. In each district, six BPJS Class 3 respondents are selected, so the total sample consists of 120 respondents. This number is chosen to represent the low-income community group at the district level.

Odds and Odds Ration

The data analysis method includes statistical analysis of odds and odds ratios. The odds ratio is a statistical measure used to compare the relationship between two groups or conditions in terms of the occurrence or probability of an event (Harrell, 2019). Specifically, this measure describes the comparison between events that occur in exposed and non-exposed groups (Simpson et al., 2002; Azen & Walker, 2011).

The odds ratio is a key statistical measure that can be computed for any 2 × 2 contingency table (or a 2 × 2 subset of a larger contingency table). To define the odds ratio, we first define the concept of odds. The odds of an event occurring (sometimes referred to as a “success”) are the probability that the event occurs relative to the probability that it does not occur.

For example, if the odds that a student in Indonesia will graduate from high school are 3.0, it means that the probability of graduating is three times higher than the probability of not graduating. If the probability of the event occurring in the population is π, then the odds of the event occurring are given by

$$\text{Odds} = \frac{\text{Probability "success"}}{\text{Probability "fail"}} = \frac{\pi}{1-\pi},$$

Where π= probability “success”, and 1- π = probability “ fail”.

The odds ratio is simply defined as the ratio of two odds. Although the definition seems simple enough, interpreting the odds ratio can be tricky (and easily confused with the interpretation of the odds). The Odds Ratio is defined as follows:

$$\text{Odds Ratio} = \theta = \frac{\text{Odds group 1}}{\text{Odds group 2}}$$

It is important to note that the interpretation of the odds ratio requires two components: (1) the category or event of interest (i.e., “success”) in the computation of the odds, and (2) the groups defined as “group 1” and “group 2” in the computation of the odds ratio (Azen and Walker, 2011).

RESULTS

Based on field research, the implementation of the BPJS policy has not yet reached full coverage, particularly among low-income or poor communities. Only 83.43% of BPJS class 3 respondents are registered, bearing the financial burden without government assistance. Jamkesda in Bandar Lampung has been implemented since 2013, and the

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e-ISSN: 2468-4376
https://www.jisem-journal.com/

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policy is part of the Jamkesmas program initiated by the Mayor of Bandar Lampung, Herman HN, which was set to take effect starting January 1, 2015. All hospitals, including community health centers (Puskesmas), sub-district health centers (Puskesmas Pembantu), village health posts (Poskeskel), and inpatient facilities, are part of this program. It includes class III inpatient care for five days, and this program is accessible to both the financially capable and incapable. Unlike the Jamkesda program, which is only for the poor, hospital costs are reimbursed by the local government when patients use the free healthcare service card. Additionally, this card ensures that the less fortunate can receive adequate healthcare services. According to the data, the Bandar Lampung City Government's policy regarding access to healthcare services for BPJS respondents is viewed from a financial aspect. The government does not fully cover healthcare costs because this policy is not entirely free but provides financial access assistance.

The assistance provided through the KIS program covers less than 30%, with the remaining support coming from the Bandar Lampung City Government. Therefore, the provision of healthcare services tends to align with privatization, leading to a lack of fulfillment of responsibility towards low-income communities. In line with BPJS recipients, there are also KIS policy beneficiaries funded by the state budget (APBN). KIS recipients are exempt from any payments, as the related costs are fully covered by the state or subsidized by the government. According to Table 1, the majority of respondents are recipients of health assistance programs, mostly consisting of PBI JK (APBN) and KIS (Contribution Assistance Recipients). The number of recipients is 380,875 individuals, or about 31.47% of the total. This shows that the majority of program respondents are poor people who receive assistance from the state budget (APBN) and KIS.

Table 1. Achievement of JKN-KIS Program Membership Coverage as of May 2023

No	Coverage	Number of Respondents	Total Percentage	Description
1	PBI JK (APBN) represents "Non-Tax State Revenue (APBN) Beneficiaries," KIS (beneficiaries of contribution assistance) means "Recipients of Premium Assistance	380.875 (3151940)	380.875/1 209 937= **31.47%**	"Poor community from APBN, KIS."
2	PBPU Pemda (PBI APBD), Jamkesda	64.935	64.935/1209937= **5,37 %**	Poor community from APBD
3	PPU (Wage-Earning Employee)	367.801	367.801/1 209 937= **30.39%**	PNS, TNI POLRI dan BUMN
4	PBPU/Independent	158.034	158.034/1 209 937= **13.06 %**	Independent/ class 3
5	Not an employee (BP)	38.027	38.027/1 209 937= **3.14%**	Veteran, Retiree, Investor
	Total	1.009.672	1.009.672/1 209 937= **83,44 %**	

Source: BPJS Bandar Lampung City, 2023

Access to Healthcare Services

1. Accessibility of Healthcare Services

Table 2 shows that 75% of respondents stated that healthcare facilities are available; 85% of respondents stated that care facilities are available; 51% of respondents stated that service hours are available; 72% of respondents stated that access to services is good and available; and 63% of respondents stated that access to general practitioners and dentists is available. The lowest accessibility indicator is service hours, with only about 51% when analyzing healthcare services at community health centers (Puskesmas) and hospitals, measured by the availability of

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2025, 10(35s)
e-ISSN: 2468-4376
https://www.jisem-journal.com/

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laboratories, general practitioners, dentists, inpatient and outpatient services, emergency departments (IGD), and service hours.

Therefore, access follows regular office hours, and healthcare services at Puskesmas are only available until 2:00 PM. Other indicators, such as access to general practitioners and dentists, also show relatively low figures, with less than 63%. This indicates that general practitioners and dentists are not available every day, and working hours end before noon, as shown in Table 2.

From Table 2, the category of low-income or financially incapable populations, with the presence of the BPJS and KIS policies, shows relatively equal access to the availability of healthcare services. However, when evaluating the population, the number of individuals covered by BPJS and KIS is less than 100%, around less than 15%, as shown in Table 2. In terms of service quality over the last five years, Puskesmas still lacks specialist doctors, laboratory facilities are limited, and some sub-districts have Puskesmas with inpatient facilities. As a result, low-income people's access to healthcare is limited to basic health services. The category of low-income or financially incapable populations, with the presence of the BPJS and KIS policies, shows relatively equal access to the availability of healthcare services. However, when evaluating the population, the number of individuals covered by BPJS and KIS is less than 100%, around less than 15%, as shown in Table 2. In terms of service quality over the last five years, Puskesmas still lacks specialist doctors, laboratory facilities are limited, and some sub-districts have Puskesmas with inpatient facilities. As a result, low-income people's access to healthcare is limited to basic health services.

Table 2: From the odds analysis of 3.00 for the availability of healthcare facilities, the odds of a respondent stating that healthcare facilities are available is 3 times greater than the odds of a respondent stating that facilities are lacking; Odds of 5.76 for care facilities, meaning the chances that a respondent states care facilities are available is 5.76 times greater than the chances that a respondent states care facilities are lacking; Odds of 1.04 for service hours, meaning the chances that a respondent states service hours are available is 1.04 times greater than the chances that a respondent states service hours are lacking; Odds of 2.52 for access to service, meaning the chances that a respondent states access to service is available is 2.52 times greater than the chances that a respondent states access to service is lacking; Odds of 1.69 for the availability of General Practitioners and Dentists, meaning the chances that a respondent states the availability of General Practitioners and Dentists is available is 1.69 times greater than the chances that a respondent states the availability of General Practitioners and Dentists is lacking.

Table 2. Healthcare Service Availability Access dan service hours sebagai references untuk odds ratio.

No	Healthcare Service Availability (Healthcare Facilities, Resources, Service Hours)	**π**	**Odds.**	**Odds Ratio**
1	Service Hours	0.51	1.04	-
2	Access to Services	0.72	2.52	2.42
3	Availability of General Practitioners and Dentists	0.63	1.69	2.32
4	Healthcare Facilities	0.75	3.00	2.88
5	Care Facilities (Inpatient, Outpatient, Emergency Room)	0.85	5.76	5.54

Source: Data from the 2023 Research Results

From Table 2, the odds ratio results with service hours as the reference show the following results:

- Odds ratio = odds (healthcare facilities) / odds (service hours) = 2.88. This means that the odds of respondents being satisfied with healthcare facilities are 2.88 times greater than the odds of respondents being satisfied with service hours.

- Odds ratio = odds (care facilities) / odds (service hours) = 5.54. This means that the odds of respondents being satisfied with care facilities are 5.54 times greater than the odds of respondents being satisfied with service hours.

Journal of Information Systems Engineering and Management
2025, 10(35s)
e-ISSN: 2468-4376
https://www.jisem-journal.com/

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- Odds ratio = odds (access to service) / odds (service hours) = 2.42. This means that the odds of respondents being satisfied with access to service are 2.42 times greater than the odds of respondents being satisfied with service hours.

- Odds ratio = odds (availability of General Practitioners and Dentists) / odds (service hours) = 2.32. This means that the odds of respondents being satisfied with the availability of General Practitioners and Dentists are 2.32 times greater than the odds of respondents being satisfied with service hours.

2.Physical Access to Healthcare Facilities

The results show that low-income or financially incapable communities have access to healthcare services of more than 90%. Therefore, accessibility in terms of infrastructure (roads) and transportation facilities does not appear to be an issue, as seen in Table 3.

Table 3. Physical Access to Healthcare Facilities and Transportation facilities are available to access healthcare facilities as reference for odds ratio

No	Physical access to reach healthcare facilities to obtain healthcare services (pre-road infrastructure conditions and availability of transportation means)	π	Odds.	Odds Ratio
1	Transportation facilities are available to access healthcare facilities	0.93	13.29	-
2	The road conditions to healthcare facilities are good	0.95	17.80	1.34

Source: Data from the 2023 Research Results

Based on Table 3, from the odds analysis results of 13.29 for the availability of transportation facilities to access healthcare facilities, the odds of a respondent stating that transportation facilities are available to access healthcare facilities is 13.29 times greater than the odds of a respondent stating that transportation facilities are lacking. For the odds of 17.80 regarding the condition of the roads to healthcare facilities being good, the odds of a respondent stating that the road conditions to healthcare facilities are good is 17.80 times greater than the odds of a respondent stating that the road conditions to healthcare facilities are not good.

From Table 3, the odds ratio results with the availability of transportation facilities to access healthcare facilities as the reference show the following:Odds ratio = odds (The road conditions to healthcare facilities are good) / odds (Transportation facilities are available to access healthcare facilities) = 1.34. This means that the odds of respondents being satisfied with the road conditions to healthcare facilities being good are 1.34 times greater than the odds of respondents being satisfied with the availability of transportation facilities to access healthcare facilities.

3. Economic Access

Table 4. Economic Access in Healthcare Services and Charged for the purchase of medicines, lab tests, doctor procedures not provided by BPJS as a references for odds ratio.

No	Economic access (medical expenses, transportation costs to healthcare services, and health insurance ownership)	π	Odds.	Odds Ratio
1	Charged for the purchase of medicines, lab tests, doctor procedures not provided by BPJS.	0.45	0.83	-
2	BPJS class 3 premiums are expensive	0.36	0.56	0.67
3	Transportation costs to Puskesmas and	0.64	1.81	2.18

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2025, 10(35s)
e-ISSN: 2468-4376
https://www.jisem-journal.com/

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	Hospitals			
4	The burden of BPJS contributions for the family is burdensome on financing	0.64	1.81	2.18
5	Receiving medical treatment using BPJS is beneficial for the community	0.99	101.00	121.68

Source: Data from the 2023 Research Results

Based on Table 4, 33 respondents stated that the cost of purchasing medication, laboratory tests, and doctor procedures are factors affecting economic access. A ratio (π) of 0.45 indicates that the majority of respondents agree with this statement. 36% of respondents stated that BPJS class 3 premiums are expensive; 64% of respondents stated that transportation costs to Puskesmas and hospitals are expensive; 64% of respondents stated that the burden of BPJS contributions for the family is burdensome on financing; and 99% of respondents stated that receiving medical treatment using BPJS is beneficial for the community.

From Table 4, the odds analysis results are as follows:

- Odds of 0.83 for "charged for the purchase of medicines, lab tests, and doctor procedures not provided by BPJS," meaning the odds of respondents agreeing that these costs are charged is 0.83 times greater than the odds of respondents disagreeing.
- Odds of 0.56 for "BPJS class 3 premiums are expensive," meaning the odds of respondents agreeing that BPJS class 3 premiums are expensive is 0.56 times greater than the odds of respondents disagreeing.
- Odds of 1.81 for "transportation costs to Puskesmas and hospitals," meaning the odds of respondents agreeing that transportation costs are expensive is 1.81 times greater than the odds of respondents disagreeing.
- Odds of 1.81 for "the burden of BPJS contributions for the family is burdensome on financing," meaning the odds of respondents agreeing that the burden of BPJS contributions is a financial burden is 1.81 times greater than the odds of respondents disagreeing.
- Odds of 121.68 for "receiving medical treatment using BPJS is beneficial for the community," meaning the odds of respondents agreeing that BPJS is beneficial is 121.68 times greater than the odds of respondents disagreeing.

From Table 4, the odds ratio with "charged for the purchase of medicines, lab tests, and doctor procedures not provided by BPJS" as the reference shows the following results:

- Odds ratio = odds (BPJS class 3 premiums are expensive) / odds (charged for the purchase of medicines, lab tests, and doctor procedures not provided by BPJS) = 0.67, meaning the odds of respondents agreeing that BPJS class 3 premiums are expensive is 0.67 times greater than the odds of respondents agreeing that the purchase of medicines, lab tests, and doctor procedures not provided by BPJS are charged.
- Odds ratio = odds (transportation costs to Puskesmas and hospitals) / odds (charged for the purchase of medicines, lab tests, and doctor procedures not provided by BPJS) = 2.18, meaning the odds of respondents agreeing that transportation costs to Puskesmas and hospitals are expensive is 2.18 times greater than the odds of respondents agreeing that the purchase of medicines, lab tests, and doctor procedures not provided by BPJS are charged.
- Odds ratio = odds (receiving medical treatment using BPJS is beneficial for the community) / odds (charged for the purchase of medicines, lab tests, and doctor procedures not provided by BPJS) = 121.68, meaning the odds of respondents agreeing that receiving medical treatment using BPJS is beneficial for the community is 121.68 times greater than the odds of respondents agreeing that the purchase of medicines, lab tests, and doctor procedures not provided by BPJS are charged.
- Odds ratio = odds (the burden of BPJS contributions for the family is burdensome on financing) / odds (charged for the purchase of medicines, lab tests, and doctor procedures not provided by BPJS) = 2.18, meaning the odds of respondents agreeing that the burden of BPJS contributions for the family is burdensome on financing is 2.18

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times greater than the odds of respondents agreeing that the purchase of medicines, lab tests, and doctor procedures not provided by BPJS are charged.

Meanwhile, the burden of BPJS contributions for families, including transportation costs to Puskesmas or hospitals, is also a factor that affects economic access. Respondents stated that having BPJS or KIS (Health Insurance) facilities greatly helps in accessing healthcare services.

Economic access impacts respondents' behavior in using healthcare services. Of the 33 respondents, 25 respondents have a high tendency to not access healthcare services (STS - Stop The Search). A total of 99 individuals fall into the "Disagree" category, and 85 individuals failed to access healthcare services with odds of 0.45.Among the respondents, 30 stated that BPJS class 3 premiums are expensive. The majority, 23 individuals, disagreed with this statement, while only 6 agreed. The probability of agreeing with the perception about premium costs is about 0.36, indicating that the likelihood of agreeing is higher than disagreeing.

Similarly, 30 respondents consider transportation costs to Puskesmas and hospitals to be expensive. The majority, 23 individuals, disagreed with this statement, while only 6 agreed. The probability is about 0.64, showing that the likelihood of respondents disagreeing with transportation costs is higher than agreeing.

Among the respondents, 43 respondents consider the BPJS family contribution burden a financial issue, 80 disagreed, and only 62 agreed. The odds value, around 0.64, indicates that the likelihood of respondents disagreeing with the statement is higher than agreeing.

The use of BPJS for medical treatment is seen as helpful by the respondents. Among this group, the majority, 66 individuals, strongly agreed with the statement, while only 8 individuals agreed. The probability, reaching 101, indicates that the likelihood of strongly agreeing with the statement is much higher than agreeing.

In conclusion, additional healthcare costs outside of BPJS tend to make respondents reluctant to access healthcare services. Meanwhile, the benefits and support from BPJS encourage the use of healthcare services. The conclusion is based on limited data from one respondent for the final statement, so caution is needed when making broader generalizations.

4. Social Access

Based on Table 5, the respondents gave positive feedback on the behavior and service of healthcare providers. This is because healthcare providers are friendly and provide a sense of safety. The high π (proportion) value indicates that the majority of respondents agree or strongly agree with the statement.

Table 5. Social Access in Healthcare Services and Healthcare workers are friendly in providing healthcare services to independent BPJS respondents as reference for odds ratio.

No	Social access (completeness of information from healthcare workers, friendliness of healthcare workers, satisfaction with services, and public trust in healthcare workers)	**π**	**Odds.**	**Odds Ratio**
1	Healthcare workers are friendly in providing healthcare services to independent BPJS respondents	0.88	7.29	-
2	Services provided by healthcare workers provide a sense of safety and trust	0.97	27.67	3.29

Source: Research results 2023

There is dissatisfaction among BPJS respondents regarding the quality of service and uncovered costs. In this context, costs that are not covered by BPJS must be paid out-of-pocket. Furthermore, service hours are limited to office hours, from 08:00 to 14:00. This indicates that the poor feedback may be due to a lack of clarity, speed, or politeness in

providing information. Meanwhile, BPJS respondents are concerned about uncovered service costs. These costs create a significant financial burden, which can be a problem for individuals who rely on healthcare services.

Based on Table 5, the odds analysis shows an odds of 7.29 for healthcare workers being friendly in providing healthcare services to independent BPJS respondents. This means that the likelihood of respondents agreeing that healthcare workers are friendly in providing services is 7.29 times greater than the likelihood of agreeing that services provided by healthcare workers provide a sense of safety and trust. The odds of 27.67 for services provided by healthcare workers giving a sense of safety and trust indicate that the likelihood of respondents agreeing with this is 27.67 times greater than the likelihood of respondents stating that services provided by healthcare workers do not provide a sense of safety and trust.

From Table 5, the odds ratio analysis with healthcare workers being friendly in providing healthcare services to independent BPJS respondents shows the following: Odds ratio = odds (services provided by healthcare workers provide a sense of safety and trust) / odds (transportation facilities are available to access healthcare facilities) = 1.34. This means that the odds of respondents being satisfied with services provided by healthcare workers giving a sense of safety and trust are 3.29 times greater than the odds of respondents agreeing that healthcare workers are friendly in providing healthcare services to independent BPJS respondents.

DISCUSSION

This study aims to analyze the BPJS policy on access to healthcare services for low-income communities. The implementation of BPJS Health has increased the tendency to use public facilities, such as community health centers (Puskesmas) and hospitals, to access healthcare services. This is evidenced by the accessibility of healthcare services for low-income people, particularly in terms of financing, which is very affordable for the third-class standard. The healthcare services used by low-income people are essentially basic services.

Access to services is obtained through BPJS class three facilities, where individuals are required to pay a monthly fee of IDR 45,000. There are 158,034 respondents paying for class three BPJS, or 13.06%, while 71.7% and 31.47% receive Jamkesda and National Health Insurance (KIS). This data shows that the Bandar Lampung City Government does not fully cover the cost of healthcare services for low-income communities, including the majority of third-class respondents who pay BPJS, who are considered financially unable.

From a policy intervention perspective, the government's role is limited to facilitating the provision of basic and limited advanced services, particularly regarding the quality of healthcare services. This limitation is evident in the availability of healthcare services, including laboratory equipment, doctors, staff, and medicines.

For BPJS, KIS, and Jamkesda respondents who require high-quality services, such as specialist doctor consultations, laboratory tests, and treatment for specific diseases, alternatives must be available, including additional treatment costs. The healthcare system still applies discriminatory policies based on the ability to pay for services, including VIP and Classes 1, 2, and 3. This differentiation indicates the existence of discriminatory policies in service provision, where the level of service is determined by the individual's financial ability. For the middle and upper-income communities, access to healthcare services does not solely depend on the healthcare services provided by the government due to their economic ability to seek various alternatives. However, for low-income people with financial limitations, their options highly depend on government policy interventions, particularly in the form of free or affordable services. According to Makhya (1997), when financial conditions are unaffordable, individuals will opt for alternative healthcare services or simply wait for recovery without medical intervention.

Iwan Gardono Sujatmiko (2010) defines healthcare service capitalism as granting permission and encouraging the inclusion of the private sector to generate profit. Since 60%-70% of the population (“Lower Indonesia”) is still in the low-income category and the economy is weak, private hospitals are reluctant to reach out to the public. In an economic context, investors are uninterested because the perspective is unprofitable. Therefore, policy intervention to eliminate service differentiation and ensure healthcare quality remains the best option to assist low-income communities. BPJS, KIS, or Jamkesda policies should focus on providing access and eliminating healthcare service differentiation based on population dimensions. The elimination aims to ensure equal access and high-quality healthcare services, regardless of economic, social, or geographic background.

Research Article

CONCLUSION

In conclusion, the role of the government through the BPJS policy is a form of facilitative intervention and regulation. This policy provides access, especially for low-income communities, to obtain healthcare services. It includes access to the availability of healthcare services, costs, as well as social and physical factors. In terms of meeting quality requirements for low-income communities, satisfaction has not been achieved. Furthermore, humanitarian values are applied because the Bandar Lampung City Government's policy in providing free healthcare services has not yet achieved 100% coverage. The differentiation based on VIP, as well as Classes 1, 2, and 3, from a public policy perspective, shows that the quality of services can vary for different population groups, depending on financial access. Privatization, efficiency principles, availability of doctors and medicines, laboratory tests, and facility provision also impact low-income communities.

The development of inclusive policies includes creating and implementing clear and firm policies regarding healthcare service inclusion. This can include equal access, improved service quality, and continuous evaluation of existing policies. Ensuring the quality of specialist doctors, medicines, and comprehensive laboratory facilities ensures that healthcare services at community health centers meet the same quality standards as other facilities. Therefore, the concept of a free health insurance scheme should be applied for low-income communities to eliminate financial barriers and guarantee access to healthcare services.

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