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SOCIOECONOMIC INFLUENCES AND LIMITED CHOICE OF HEALTH CARE SERVICES: A STUDY OF THE BPJS SYSTEM IN INDONESIA

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Abstract. Socioeconomic inequality in Indonesia is still a major factor affecting people's access to health services, including in the BPJS Kesehatan system. Although BPJS aims to provide universal health insurance, limited collaborating health facilities, different service quality compared to the private sector, and administrative and regulatory constraints often hinder participants from getting optimal care. The impact of these limitations can be seen in the quality of services received by BPJS patients, such as long queues, delays in medical treatment, and limited medicines covered. To overcome this problem, comprehensive policy reform is needed, including increasing the number of health facilities that accept BPJS, simplifying the referral system, and increasing budget allocation to improve service quality. With these strategic steps, BPJS is expected to become a more inclusive, efficient health insurance system that can provide equitable health services for all Indonesian people.

.Keywords: BPJS Kesehatan, Socioeconomic Inequality, Access to Health Services

I. INTRODUCTION

Socioeconomic inequality in Indonesia remains a significant problem, impacting various aspects of people's lives, including health. The striking difference in income between the upper and lower economic groups reflects the uneven welfare distribution [1]. Data from the Central Statistics Agency (BPS) shows that the Gini ratio, which measures income inequality, has remained at around 0.38–0.40 in recent years, indicating a fairly high gap [2]. In addition, differences in access to education and employment are also factors that exacerbate this inequality. People with low levels of education tend to have limited employment opportunities, especially in the informal sector with unstable incomes and inadequate social security protection[3]. This condition reinforces the cycle of poverty, where groups with weak economies find it increasingly difficult to improve their standard of living.

In addition, socio-economic inequality is also reflected in the geographical gap between urban and rural areas. Urban areas, especially in Java, have better access to health facilities, quality education, and job opportunities compared to rural areas and underdeveloped regions such as Papua or East Nusa Tenggara. Communities in remote areas often face limitations in basic infrastructure, such as impassable roads and a lack of adequate health services. This inequality is further exacerbated by differences in access to technology and information, where people with higher economies have more opportunities to obtain information and services that can improve their welfare [4].

Socioeconomic inequality has a direct impact on access to and quality of health services received by the community. Upper-middle economic groups generally have better access to quality health facilities, either through private health insurance or direct payments. They can easily get health services at well-known hospitals, consult with specialist doctors, and obtain more complete medicines [5]. In contrast, lower economic groups often rely on government-provided health services, such as community health centers and regional hospitals, which often experience limitations in medical personnel, facilities, and equipment. In addition, those who work in the informal sector or have low incomes may have difficulty paying BPJS premiums regularly which affects their active participation in the national health insurance program [6].

In addition to financial constraints, geographic factors also play a significant role in the inequality of access to health services. In rural and remote areas, health facilities are often far away and difficult to reach, while the number of medical personnel available is also limited. Many people in remote areas have to travel for hours, even days, just to get basic health services. This situation causes delays in disease treatment and increases the risk of more serious complications [7]. In comparison, people in urban areas have many choices of hospitals and clinics with more complete facilities and shorter waiting times. This inequality reflects how socioeconomic factors determine a person's level of health and their chances of getting proper medical care.

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Various studies and statistical data show that economic status has a strong correlation with the level of public health. For example, a report from the Indonesian Ministry of Health shows that maternal and infant mortality rates are higher in areas with high poverty rates compared to more prosperous areas. Data from BPS also notes that poor communities have a higher prevalence of infectious diseases, such as tuberculosis and acute respiratory infections (ARI), compared to upper economic groups. This is due to unhealthy environmental conditions, poor nutrition, and limited access to quality health services [8].

In addition, a World Bank study shows that low-income communities tend to be more susceptible to chronic diseases such as hypertension and diabetes, but have lower access to adequate treatment. In many cases, they cannot afford the necessary medicines or even avoid regular health check-ups for fear of the costs involved. In contrast, upper-income groups have better financial ability to live a healthy lifestyle, including accessing nutritious food, exercising regularly, and undergoing preventive health check-ups. The inequality indicates that economic factors can affect access to health services and determine a person's quality of life and life expectancy in Indonesia [9].

BPJS Kesehatan was established as part of the implementation of the National Health Insurance (JKN) system which seeks to provide health protection for all Indonesian people. The establishment of BPJS Kesehatan is mandated in Law Number 40 of 2004 concerning the National Social Security System (SJSN), which states that every citizen has the right to receive social security which includes health insurance, employment, and other social protection. Article 19 Paragraph (1) of the SJSN Law states: "Health insurance is organized nationally based on the principles of social insurance and equity principles to ensure that participants receive health care benefits and protection in meeting basic health needs [10]."

As a follow-up to the SJSN Law, the government then issued Law Number 24 of 2011 concerning the Social Security Administering Body (BPJS), which regulates the establishment of BPJS as an institution responsible for organizing health and employment insurance. Article 5 Paragraph (1) of the BPJS Law states: "The Social Security Administering Body consists of BPJS Health and BPJS Employment." BPJS Health began operating on January 1, 2014, as an institution that replaced Askes (Health Insurance) which previously only served civil servants (PNS) and certain participants. With this change, the scope of health insurance was expanded to cover the entire population of Indonesia, both those working in the formal and informal sectors, as well as the poor whose contributions are borne by the government [11].

BPJS Kesehatan is based on the principles of social insurance and equity principles, as stated in Article 4 of the SJSN Law, namely:

1. The principle of cooperation, where participants who can pay higher contributions will help less able participants.
2. The principle of non-profit means that funds collected from participants are used entirely for the benefit of health services.
3. The principle of portability ensures that participants continue to receive health insurance benefits even if they change jobs or locations.
4. The principle of mandatory participation where every citizen must be registered as a BPJS Kesehatan participant.
5. The principle of accountability and transparency ensures that fund management is carried out responsibly [12].

One of the main objectives of the BPJS system is to ensure that every citizen, regardless of social and economic status, has equal access to quality health services. This is in line with the mandate of Article 34 Paragraph (2) of the 1945 Constitution, which states that the state is responsible for providing adequate healthcare facilities and public facilities. With this system, people do not need to be concerned about high costs when getting health services because everything is covered by the social security mechanism. Since its implementation in 2014, BPJS Kesehatan has provided great benefits to the community, especially for the lower middle economic groups who previously had difficulty accessing health services. Based on a report from BPJS Kesehatan, by 2023, more than 250 million Indonesians have registered as participants, making it one of the largest health insurance systems in the world. This program has also helped reduce the death rate from diseases that can be prevented with early treatment, as well as expanding the scope of vaccinations and maternal and child health services [13].

However, in its implementation, BPJS Kesehatan also faces various challenges. One of the main problems is the financial deficit that often occurs due to the imbalance between contribution revenues and claim cost expenditures. Many participants only pay contributions when they need medical services, thus burdening the system that should run on the principle of mutual cooperation. To overcome this problem, the government has increased BPJS contribution rates on several occasions, as stipulated in Presidential Regulation Number 64 of 2020 concerning the Second Amendment to Presidential Regulation Number 82 of 2018 concerning Health Insurance, which regulates new rates for independent participants. In addition, there are still many complaints from participants regarding the quality of services provided by health facilities that collaborate with BPJS. Some of the problems that often occur include long queues at hospitals, limited drugs covered, and discrimination in services between BPJS patients and general patients. Another obstacle is the limited number of specialist doctors and health facilities that accept BPJS patients, especially in remote areas.

One of the main issues in the BPJS Kesehatan system is the limited number of health facilities and medical personnel who accept BPJS patients. Although BPJS has collaborated with many hospitals and health centers throughout Indonesia, not all health facilities are willing to accept BPJS patients due to the low claim rates paid by BPJS to hospitals. Many private hospitals choose to limit the number of BPJS patients or even not accept them at all because they consider the rates set insufficient to cover operational costs. As a result, BPJS participants often have to queue for a long time at hospitals or health centers that accept BPJS, especially in big cities with a very high number of patients. In addition, the number of

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medical personnel serving BPJS participants is also limited, so patient consultation times with doctors are often shorter than for general patients.

In terms of service quality, BPJS participants often face different treatment compared to patients who use private health services or pay independently. In many hospitals, BPJS patients must follow a tiered referral system, which requires them to first get an examination at a first-level health facility (health center or clinic) before they can get treatment at the hospital. It often slows down the handling of diseases, especially for patients with serious medical conditions that require immediate action. In addition, some hospitals differentiate facilities for BPJS patients and general patients, such as in terms of the availability of inpatient rooms. BPJS patients are generally placed in class 3 wards with more patients in one room, while general patients can get rooms with more comfortable facilities and faster service.

The impact of limited health service options is most felt by groups of people with low economic status. Those who rely on BPJS as the only access to health services often have to accept less than optimal services compared to those who can pay for health services independently. This condition exacerbates the inequality in access to health, where upper economic groups can easily get the best care, while lower economic groups have to face various obstacles, ranging from long queues to lower quality of service. In addition, some BPJS participants also have difficulty obtaining the necessary medicines, because not all medicines are covered by BPJS and often the stock of medicines in health facilities that accept BPJS is limited.

Various studies and data show that obstacles in the BPJS system are still a significant problem. For example, a report from the Ombudsman of the Republic of Indonesia in 2022 noted that the most complaints from BPJS participants were long queues, difficulty in getting inpatient rooms, and a referral system that was considered too bureaucratic. A study by the SMERU Research Institute also revealed that BPJS patients in remote areas face greater challenges because the number of health facilities that collaborate with BPJS is limited, so they have to travel far to get medical services. This issue shows that although BPJS has helped improve access to health for the wider community, there are still many aspects that need to be improved so that the health services provided are truly equitable and of high quality for all participants.

II. RESEARCH METHOD

The research methodology carried out is a normative or doctrinal legal research method. This normative or doctrinal legal research methodology is normative juridical law research or normative law research which is basically an activity that will examine the internal aspects of positive law. This is done as a consequence of the view that law is an autonomous institution that has no relationship with other social institutions. So that to solve the existing problems, what is seen as a problem in research with this approach is only limited to the problems that exist in the legal system itself, not to human behavior that applies legal rules. Normative legal research focuses more on the scope of legal conception, legal principles, and legal principles. It can be concluded based on existing doctrine, that normative legal research is a type of legal research methodology that bases its analysis on applicable laws and regulations and is relevant to the legal issues that are the focus of the research.

III. RESULTS AND DISCUSSIONS

Socioeconomic disparity is a condition in which there are significant differences in the distribution of income, wealth, and opportunities between groups in society. From a legal perspective, this gap is closely related to human rights, as regulated in Article 28H paragraph (1) of the 1945 Constitution, which states that every citizen has the right to receive adequate health services. In addition, Law Number 36 of 2009 concerning Health, especially Article 4, emphasizes that everyone has the right to health without discrimination [14]. However, in practice, economic factors are often the main barrier for low-income communities to access quality health services. From an economic perspective, social disparities in health can be explained through the theory of "Inverse Care Law" which states that the groups of people who need health services the most often get the most limited access due to financial constraints and uneven health service infrastructure [15].

Socioeconomic inequality has a direct impact on the access to health services received by the community. Individuals from upper economic groups have the financial ability to obtain better health services, such as access to private hospitals, consultations with specialist doctors, and the use of additional health insurance that provides more choices in medical care. In contrast, low-income groups rely heavily on public health systems such as BPJS, which despite providing universal health insurance, still face various obstacles such as limited facilities, long queues, and a tiered referral system. This condition causes a gap in the quality of services received by the community based on their economic status. As a result, the poor are more vulnerable to delays in treatment, higher mortality rates from preventable diseases, and lower levels of health compared to more prosperous groups [16].

Health insurance is a system designed to ensure that all citizens have access to adequate health care without being burdened by excessive costs. Countries implement different health insurance models according to their social, economic, and political conditions. The Beveridge model, used in countries such as the United Kingdom and Spain, implements a health system entirely funded by taxes and controlled by the government. In this system, hospitals and medical personnel are generally civil servants, and health care is provided free of charge to the public. Meanwhile, the Bismarck model, applied in Germany, France, and Japan, uses a social insurance scheme where contributions are paid by workers and employers through independent insurance agencies. This system relies on mandatory contributions from the working community and provides broader health coverage and flexibility in choosing health care providers [17].

Countries like the United States use a hybrid model, where the health system is dominated by the private sector, but

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there are still public health insurance programs such as Medicare and Medicaid for vulnerable groups such as the elderly and low-income people. Meanwhile, developing countries like Thailand and Brazil implement a universal health insurance system funded by the government to ensure that residents have access to basic health services. The main differences between these models lie in the source of funding, the mechanism for distributing services, and the role of the government in organizing the health system. In Indonesia, the national health insurance system implemented through BPJS Kesehatan adopts the principles of social insurance and cooperation, where all citizens are required to become participants and pay contributions according to their income level [18].

BPJS Kesehatan is a public legal entity established based on Law Number 24 of 2011 concerning the Social Security Administering Body (BPJS). Article 5 Paragraph (1) of the BPJS Law states that the Social Security Administering Body consists of BPJS Kesehatan and BPJS Ketenagakerjaan. BPJS Kesehatan is tasked with organizing the National Health Insurance (JKN) program for all Indonesian citizens, including formal and informal workers and the miserable, whose contributions are borne by the government. The system is based on the principles of social insurance and equity, as regulated in Article 19 paragraph (1) of Law Number 40 of 2004 concerning the National Social Security System (SJSN) that "Health insurance is organized nationally based on the principles of social insurance and equity principles to ensure that participants receive health care benefits and protection in meeting basic health needs [19]."

In its implementation, every citizen is required to become a BPJS Kesehatan participant, as stipulated in Article 14 of the BPJS Law, which states that "Everyone, including foreigners who work for at least six months in Indonesia, is required to become a participant in the social security program." With this system, each participant pays a monthly contribution, the amount of which is determined based on the participant category, either as a wage-earning worker (PPU), a non-wage-earning worker (PBPU), or a recipient of contribution assistance (PBI) whose contributions are paid by the government for the impoverished and disadvantaged [20].

Since it began operating on January 1, 2014, BPJS Kesehatan has succeeded in increasing the coverage of health services in Indonesia with the number of participants reaching more than 250 million people by 2023. This program has helped the community gain access to more equitable health services, including outpatient services, inpatient care, medical procedures, and medicines covered under applicable provisions. However, the implementation of BPJS Kesehatan also faces various challenges, such as a financial deficit due to an imbalance between contribution receipts and treatment claims, limited health facilities that collaborate with BPJS, and complaints regarding the quality of services received by participants.

One of the biggest challenges is the delay in payment of claims to hospitals and medical personnel due to the BPJS budget deficit. This has caused several hospitals to be reluctant to accept BPJS patients or limit the number of patients who use this service. In addition, the tiered referral system is often considered to make it difficult for participants, especially for those who need specialist services immediately. The government continues to carry out various reforms to improve the efficiency and sustainability of this program, including through a policy of increasing contributions as stipulated in Presidential Regulation Number 64 of 2020, which adjusts the contribution rates for independent participants to reduce the BPJS financial deficit. Although still facing various challenges, BPJS Kesehatan remains one of the main pillars in realizing a universal health insurance system in Indonesia.

One of the main factors that causes limited health service options for BPJS participants is the limited health facilities and medical personnel who work with BPJS.

Many private hospitals are reluctant to accept BPJS patients because of the low claim rates paid by BPJS compared to the actual cost of treatment. In addition, the BPJS budget deficit often causes delays in the payment of claims to hospitals, so some health facilities limit the number of BPJS patients they serve. The tiered referral system implemented by BPJS is also an obstacle for participants because they must go through several stages of examination at first-level health facilities before they can receive treatment at referral hospitals. It often slows down patient access to specialist services and more complex medical procedures.

These service limitations have a direct impact on the quality of care received by BPJS patients. Long queues at health facilities that accept BPJS cause patients to wait longer to receive medical examinations or treatments, which in some cases can worsen their health conditions. In addition, the difference in facilities between BPJS patients and general patients is still a problem, especially in terms of the availability of inpatient rooms and access to certain medicines that are not always covered by BPJS. As a result, many BPJS participants are forced to seek other alternatives at their own expense or even postpone treatment due to the limited services available. It shows that although BPJS has provided access to health for the entire community, there are still major challenges in ensuring that the services provided are truly quality and equitable for all participants.

One of the biggest challenges in the BPJS Health system is the limited number of hospitals and health facilities that accept BPJS patients. Although BPJS has collaborated with many hospitals and clinics in Indonesia, not all health facilities are willing to serve BPJS participants optimally. Many private hospitals limit the number of BPJS patients they accept or even do not collaborate at all, especially because BPJS claim rates are considered too low compared to the operational costs they incur. In addition, delays in payment of claims from BPJS to hospitals are also a factor that makes some health facilities reluctant to accept BPJS patients. As a result, BPJS participants often have only limited options for obtaining health services, especially in remote areas where the number of hospitals that cooperate with BPJS is little.

In terms of service quality, there is a quite striking difference between BPJS services and private health services. BPJS patients generally have to go through a tiered referral system, which requires them to be examined at a first-level

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health facility (health center or clinic) before they can be referred to a larger hospital. This process often slows down patient access to specialist services, especially for those who need immediate medical treatment. In addition, hospitals that accept BPJS usually have long queues, which causes patients to wait a long time to get treatment. Unlike general patients who can immediately consult with a specialist doctor or get a treatment room with better facilities, BPJS patients often experience limitations in the choice of services and facilities they receive.

Administrative and regulatory constraints are factors that limit BPJS patients' access to health services. A strict referral system often becomes an obstacle for patients to get the health services they need quickly. In addition, regulations governing the scope of services and medicines covered by BPJS sometimes force patients to seek alternatives at their own expense. For example, not all types of medication or certain medical procedures are covered by BPJS, so patients must pay additional costs or even postpone treatment. In addition, differences in service classes based on BPJS membership categories also create disparities in the quality of care received by patients. These constraints show that although BPJS aims to provide universal health insurance, there are still various limitations that affect the effectiveness of this system in providing optimal health services for the entire community.

Public perceptions of BPJS services vary, depending on their personal experiences to access health services through this system. For some people, especially those in the lower economic class, BPJS Kesehatan is considered a savior because it provides access to medical services that were previously difficult to reach due to financial constraints. However, many BPJS participants feel services are still far from optimal. Long queues, complicated referral systems, limited facilities, and differences in treatment compared to general patients are the main complaints that often arise. Some patients feel that BPJS services tend to be slower than private health services, so they have to wait longer to get the medical treatment they need. This perception is exacerbated by the experience of patients who feel that medical personnel at some health facilities prioritize general patients over BPJS patients because of the lower reimbursement rates from BPJS.

Several cases show that the limitations of services in the BPJS system can have a serious impact on patient health. For example, there are reports of patients experiencing delays in treatment due to long referral procedures, so that their condition worsens before receiving appropriate treatment. Cases such as patients with chronic diseases who have to move from one facility to another due to limited drugs covered by BPJS also often occur. In addition, in remote areas, the lack of health facilities that cooperate with BPJS means that patients have to travel long distances to obtain health services, which in some cases causes delays in treatment and worsens their condition. The impact of these limitations not only affects individuals directly but also contributes to high morbidity and mortality rates due to diseases that could be prevented or treated earlier with a more efficient and equitable health service system.

One of the main steps that needs to be taken to improve the effectiveness of the BPJS system is to expand the network of health facilities that cooperate with BPJS. The government needs to provide incentives to private hospitals so that more are willing to accept BPJS patients, for example by adjusting fairer claim rates and speeding up the process of paying claims to hospitals. In addition, it is necessary to build and increase the capacity of hospitals in remote areas so that people who live far from the city center can still access quality health services without having to travel far. With the increasing number of health facilities that accept BPJS, the choice of services for participants will be wider, thereby reducing long queues and improving the quality of care for patients.

Regulatory reform is also needed to expand the choice of health services for BPJS participants. One aspect that needs to be improved is the tiered referral system, which is currently often considered to hinder patient access to specialist services. More flexible regulations, for example by providing exceptions for patients with certain conditions to receive direct treatment at the hospital without having to go through lengthy procedures, can speed up the treatment process and increase BPJS participant satisfaction. In addition, the scope of services and medicines covered by BPJS also needs to be expanded so that patients are not burdened with additional costs that should be covered by the national health insurance system. With more adaptive regulations oriented towards patient interests, BPJS health services can become more effective and inclusive.

Increasing the budget allocation for BPJS health services is also a crucial factor in improving this system. The government needs to ensure that the health budget allocated in the APBN is sufficient to cover the BPJS deficit and improve the quality of services. Currently, BPJS's financial deficit is often the cause of late payment of claims to hospitals, which ultimately has an impact on limited services for participants. With a larger budget, BPJS can increase claim rates for hospitals and medical personnel so that they are more motivated to provide the best service for BPJS participants. In addition, the increased budget also allows BPJS to develop more efficient technology and administrative systems, such as digitalizing health services to speed up the claims and referral process. With more proactive policies and adequate financial support, BPJS Kesehatan can become a more inclusive, efficient, and quality health insurance system for all Indonesian people.

IV. CONCLUSION

Socioeconomic inequality is still a major factor affecting public access to BPJS Kesehatan services. Although BPJS aims to provide universal health insurance, in reality there are still many participants from low economic groups who have difficulty in obtaining optimal health services. The limited number of health facilities that cooperate with BPJS, the tiered referral system, and the limited scope of services and medicines covered are major challenges in realizing a fair and equitable health system. The impact of these limitations can be seen from the quality of care often lower than private health services, long queues that slow down medical treatment, and additional financial burdens for patients who need treatment outside the scope of BPJS. Therefore, comprehensive policy reform is

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needed to address these problems and ensure that every BPJS participant can obtain decent health services without discrimination. To overcome these challenges, strategic steps are required to improve the BPJS system to make it more qualified and inclusive. The government needs to increase the number of health facilities that cooperate with BPJS, accelerate the claim payment process, and simplify referral regulations so that patients can access health services more quickly. In addition, policies that are more adaptive to the needs of the poor and vulnerable must be implemented, such as expanding the scope of services and ensuring that vulnerable groups receive services without administrative barriers. Further research is also needed to evaluate the effectiveness of the reforms that have been implemented, to ensure that policy changes truly have a positive impact on society. With comprehensive system improvements, BPJS Kesehatan can become a more inclusive health insurance solution and deliver better health protection for all Indonesian people.

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