MPPKI (June, 2024) Vol. 7 No. 6

ISSN 2597– 6052

DOI: https://doi.org/10.56338/mppki.v7i6.5221

MPPKI

Media Publikasi Promosi Kesehatan Indonesia

The Indonesian Journal of Health Promotion

Research Articles *Open Access*

Analysis of Factors Influencing BPJS Membership Status in the Independent (PBPU) and Non-Worker Segments

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ABSTRACT

Introduction: Universal Health Coverage (UHC) is a significant agenda outlined in the SDG 2030. In order to achieve UHC, Indonesia established the Social Security Management Agency (BPJS) in 2014. Nearly a decade after its establishment, BPJS experienced a financial deficit in its first six years, followed by a surplus during the COVID-19 pandemic. This has impacted the sustainability of BPJS Health. One of the factors contributing to the financial deficit is the non-compliance of participants in paying BPJS contributions, particularly in the Non-Wage Earner/Self-Employed/Independent (PBPU) and Non-Worker segments who are required to pay contributions individually. When participants fail to pay contributions for six consecutive months, their membership status is converted to inactive. From the 2022 BPJS Sample Data, it was found that 799,384 out of 2,305,435 (34.67%) participants had inactive membership status.

Objective: This study aims to analyze the factors influencing BPJS membership status in the Independent and Non-Worker segments.

Method: The method that used in this study is quantitative analysis of secondary data from the 2022 BPJS Sampel Data with the Linear Probability Model (LPM), Logit and Probit Models. The analysis is conducted using STATA to obtain univariate, bivariate and multivariate analyses.

Result: From a sample of 545,507 participants, if was found that 54.20% had inactive membership status. Factors such as age, gender, marital status, treatment class, healthcare facility type, and participant segmentation affect membership status. The LPM regression results indicate that the factors leading to inactive membership status are being of productive age, male, belonging to class 1 and 2, utilizing primary healthcare facilities, and being in the Independent segment.

Conclusion: Therefore, stateholders such as the central government and BPJS need to collaborate in efforts to reduce the number of inactive membership statuses.

Keywords: BPJS Membership Status; Sustainability of BPJS; Compliance of Paying Contribution

INTRODUCTION

Health is a fundamental need and a right for every human being, and it is the responsibility of every country to ensure it. In order to guarantee optimal health for everyone, a country must provide accessible healthcare services to anyone, anytime, and anywhere. One of the efforts made by countries to ensure that every society has access to healthcare services is the implementation of Universal Health Coverage (UHC). Universal Health Coverage is a concept advocated by the World Health Organization (WHO) since the 1950s (1). In the United Nations conference in 2015, UHC was included as an indicator of the Sustainable Development Goals (SDGs) that each country should achieve by 2030 (2).

A country is said to have achieved UHC based on the population coverage, although there are three dimensions that serve as important indicators to measure whether a country has achieved UHC, which are: coverage of services, coverage of population, and coverage of costs (3). The main principle of UHC is that everyone has the right to access essential healthcare services without financial barriers, and every service should be affordable and available whenever and wherever needed. Globally, around 2 billion people faced difficulties in accessing healthcare services due to financial constraints in 2019 (4). Therefore, the goal of UHC is crucial, particularly in ensuring that no one falls into poverty due to healthcare costs (1,2).

Several developed countries such as Japan, South Korea, Thailand, Canada, the United Kingdom, and Taiwan have successfully implemented UHC. Each country has its own patterns and approaches to achieving UHC, depending on policies, resources, and systems. It is important to note that there is no one-size-fits-all system that can be applied in every country. However, long-term investments in UHC made by developed countries are estimated to improve the economy by reducing out-of-pocket expenses, improving public health, and enhancing productivity. Unfortunately, developing countries still face significant challenges in achieving UHC due to limited resources (5).

Indonesia, as a developing country, has a great ambition to achieve UHC. Therefore, since 2014, Indonesia has implemented the National Health Insurance (JKN) through the Social Security Organizing Agency (BPJS) for Health. In terms of population coverage, based on the 2022 data from BPJS, the number of participants enrolled in JKN has reached around 90-91%. However, the government's commitment to achieve 100% population coverage by 2019 has not been fully realized due to various inhibiting factors. It took more than 100 years for Germany to achieve UHC, and Thailand also needed several decades, from 1963 to 2002, to reach UHC. This comparison indicates that Indonesia has achieved significant progress, especially as the world's largest single payer.

Looking at the financial coverage aspect, out-of-pocket expenses (OOP) have decreased from 60% in 2014 to 34.76% in 2019 (6). However, the results still fall short of the WHO target of below 20%. Furthermore, according to the Global Monitoring Report in 2023, the incidence of catastrophic health expenditure through OOP for households spending 10% of their total income is 2%, while those spending up to 25% of their total income is 0.4% (4). Therefore, the government needs to work hard to reduce OOP costs and the incidence of catastrophic health expenses.

Moving on to the service coverage aspect, the benefit package of JKN is comprehensive, including promotion, prevention, curative, and rehabilitative services (7). Wide and comprehensive service coverage requires significant medical costs. The increasing medical cost inflation, coupled with inactive BPJS membership, will impact the sustainability of BPJS. Based on the financial reports of the Social Security Fund (DJS) from 2014 to 2019, BPJS has consistently experienced deficits, with a temporary surplus during the COVID-19 pandemic. After the pandemic, BPJS experienced a deficit again in 2023 (8–10).

JKN participants can be broadly divided into two main segments: the Beneficiary of Premium Assistance (PBI) and non-PBI segments. The PBI segment receives government subsidies through the State and Regional Budgets (ABPN and APBD). The non-PBI segment consists of Wage Recipients (PPU), Non-Wage Workers (PBPU) or self-employed individuals, and Non-Worker (BP). The PBI segment plays a vital role in achieving UHC because they are the vulnerable population who cannot afford to pay for health insurance. On the other hand, the non-PBI segment contributes to the sustainability of JKN through their premium payments. Based on the BPJS report data for the year 2022, the PBI segment contributes more than half of the BPJS premium revenue, accounting for 44.6% from the State Budget (ABPN) and 16.4% from the Regional Budget (APBD). The contributions from the PPU segment amount to 24.9%, PBPU segment 12.4%, and BP segment 1.7% (11).

According to the BPJS financial report for 2022, the average premium received by BPJS in 2022 was Rp. 47,998.28 per person per month, while the average premium received in 2021 was Rp. 49,335.79 per person per month. These figures show a decrease despite an increase of 13,051,821 individuals (5.54%) in JKN participants from 2021. This can be attributed to several factors, one of which is non-compliance in paying premiums regularly. Based on the BPJS 2022 Sample Data, it was found that 799,384 out of 2,305,435 participants (34.67%) had inactive membership status, meaning they did not pay premiums for a period of six months or more, consecutively. Assuming that 35% of the total 2022 BPJS participants, which is 248,771,083 individuals, irregularly pay premiums for six months with an average premium of Rp. 47,998.28 per person per month, BPJS will experience a shortfall in revenue

of approximately 25 trillion Indonesian Rupiah. This is a significant amount, especially considering the increasing elderly population and medical costs, which greatly affect the financial sustainability of BPJS.

Furthermore, particularly in the PBPU and BP segments, participants are required to independently pay their BPJS premiums, unlike the PBI and PPU segments where the premiums are covered by the central and regional governments and employers. These segments consist of individuals with irregular incomes, which greatly influence their Ability to Pay (ATP) and Willingness to Pay (WTP). To date, there have been only a few studies examining the factors that affect compliance in paying premiums at the local level, with none specifically focusing on the entire country of Indonesia. Therefore, the membership status or active participation of BPJS participants in paying premiums regularly in the PBPU and BP segments in Indonesia needs to be closely monitored and further investigated. Thus, the researcher aims to analyze the relationship between membership status and (a) age group, (b) gender, (c) marital status, (d) treatment class, (e) type of healthcare facility, and (f) participant segmentation (particularly PBPU and BP) in relation to BPJS membership status.

METHOD

This research utilizes secondary data from the BPJS Sample Data 2022. The BPJS Health sample data consists of a subset of the entire membership and healthcare service data that has been extracted to maintain data quality. The data includes participants from 2016 to 2021. The inclusion criteria for this study are participants of BPJS from the PBPU and Non-Worker segments. Excluded from the sample are participants who have been reported as deceased, cases with missing data, as well as segments from the PBI and PPU categories.

The BPJS Sample Data 2022 will be analyzed using the Linear Probability Model (LPM). However, due to limitations in using the LPM, the researcher will also analyze the data using the logit and probit models to ensure that the regression results yield values between $0 < y < 1$. The data analysis will be conducted using STATA SE version 16.1. The regression model employed in this study to determine the probability of active BPJS membership status for patients is as follows:

$$P(y = 1|x|) = \beta_0 + \beta_{1-3}X_{Age} + \beta_4 X_{Gender} + \beta_{5-6}X_{Marital\ Status} + \beta_{7-8}X_{Class} + \beta_{9-10}X_{PHC} + \beta_{11}X_{Segments} + \varepsilon$$

The dependent variable in this study is membership status (the probability of having an active membership) on a binary scale, with a value of 1 indicating an active status and 0 indicating an inactive status. Age is calculated as the difference between the data sample year (2022) and the year of birth, and then grouped into four age categories (consisting of the 18-44 age group as the baseline, ≤17 years, 45-64 years, and ≥65 years). Gender is divided into two groups based on dummy variables (with a value of 1 representing females) compared to the reference baseline of males. Marital status is categorized into three groups: married (as the baseline), unmarried, and divorced. Treatment class refers to the type of hospital room chosen by participants and is differentiated into three classes: Class 1, 2, and 3, with Class 3 serving as the reference; Healthcare facility type (PHC) indicates the first-level healthcare facility chosen by participants and can be categorized into three types: general practitioners (as the reference), clinics, and community health centers. Participant segmentation used in this study consists of two groups only: PBPU and Non-Workers (as the reference). $\beta_{1\text{-}3}$ reflect the parameters for each age group, β_4 reflects the parameter for female, $\beta_{5\text{-}6}$ for marital status, $\beta_{7\text{-}8}$ for treatment classes 1 and 2, $\beta_{9\text{-}10}$ for participants using clinic and community health center facilities, respectively, and β_{11} reflect the parameters for Independent (PBPU) segmentation group.

RESULT AND DISCUSSION

In this study, the number of samples that met the inclusion and exclusion criteria was 545,507. The average age of the sample was 39 years, with the majority being female (50.68%), married (53.91%), classified under treatment class 3 (64.29%), having a primary healthcare facility at a community health center (44.46%), and belonging to the PBPU/self-pay segment (85.85%). The researcher found that age group, gender, marital status, treatment class, healthcare facility type, and participant segmentation were significantly associated with membership status (p-value <0.0001). The independent variables examined accounted for 6.17% of the impact on membership status (R-squared 0.0617). Through univariate analysis (see **Table 1**), it was found that 54.20% of participants had an inactive membership status, meaning they did not pay their BPJS premiums regularly for six consecutive months since the data sample was taken. Among the participants with inactive premium payment, 87.49% came from the PBPU (Independent) segment, while the remaining 12.51% came from the Non-Worker segment. Based on a research study conducted by (12), it was found that 28% of PBPU participants did not pay premiums regularly due to factors such as the number of household dependents, financial difficulties, membership in other social protection programs, and utilization of healthcare services.

Table 1. Frequency Distribution of Variables in BPJS Participants

Variables	Mean (SD)	Frequency (n)	Percentage (%)
Age	39.17 (±22.52)		
- 18 – 44 years		218,479	40.05%
- ≤ 17 years		110,760	20.30%
- 45 – 64 years		132,473	24.28%
- ≥ 65 years		83,795	15.36%
Gender			
- Male		269,033	49.32%
- Female		276,474	50.68%
Marital Status			
- Married		294,089	53.91%
- Unmarried		226,840	41.58%
- Divorced		24,578	4.51%
Class			
- Class 3		350,689	64.29%
- Class 2		102,777	18.84%
- Class 1		92,041	16.87%
Healthcare Facility Types			
- General Practitioner		128,107	23.48%
- Clinic		174,891	32.06%
- Community Health Center		242,509	44.46%
Participant Segmentation			
- Non-Worker		77,176	14.15%
- Independent (PBPU)		468,331	85.85%
Membership Status			
- Inactive		295,674	54.20%
- Active		249,833	45.80%
Total		545,507	100%

Age

Age is an important factor in health as individuals tend to experience more illnesses and diseases as they age, especially in the elderly population. The cost of healthcare services for the elderly always increases. The largest age group in this study was the 18-44 age group (40.05%), followed by the 45-64 age group, ≤17 years, and the elderly ≥65 years. Based on bivariate analysis (see **Table 2**), it appears that age is significantly associated with membership status. Specifically, the 45-64 age group is approximately twice as likely to be active in membership status (OR = 2.02, p-value < 0.0001), and the elderly ≥65 years are also nearly twice as likely to be active (OR = 1.83, p-value < 0.0001) compared to the productive group, which is the 18-44 age group. It is evident that only 38.85% of the active members who regularly pay premiums belong to the 18-44 age group, as they are considered to have a much lower risk of contracting diseases compared to the elderly age group.

Looking at the regression analysis using the Linear Probability Model (LPM) in this study, after adjusting for other variables, the difference between the ≤17 years age group and the 18-45 years age group did not show significant changes. As mentioned above, the 45-64 age group and the ≥65 years age group are more likely to pay premiums regularly compared to the 18-44 age group. After adjustment for other variables, each additional participant in the 45-64 age group and the ≥65 years age group increases the probability of being active by 17.07% and 16.24%, respectively. Similar findings were reported in studies by Intiasari et al. and Tsuroyya et al., indicating that individuals below 35 years of age tend to be less punctual in premium payments, and this non-compliance decreases with increasing age (13,14).

Based on the analysis results, it is evident that the younger or productive age group tends to be less involved in the principle of mutual cooperation of the Indonesian National Health Insurance (BPJS), which significantly affects the financial aspect of BPJS sustainability. Furthermore, this situation leads to adverse selection, where the risk pooling between healthy and sick participants becomes imbalanced. In order for BPJS to sustainably provide health and financial protection to the Indonesian population, it is crucial to provide socialization efforts to ensure that the productive age group has better literacy and understanding of health insurance, more accurate actuarial calculations, tariff adjustments, and policy adaptations in risk group distribution.

Table 2. Bivariate Analysis of the Relationship Between Independent nad Dependent Variables

Variable	Membership Status				OR	CI 95%	*p-value*
	Inactive		Active				
	n	%	n	%			
Age							
- 18 – 44 years	133,566	61.13%	84,913	38.87%	-	-	-
- ≤ 17 years	65,266	58.93%	45,494	41.07%	1.10	1.08 – 1.11	<0.0001
- 45 – 64 years	58,059	43.83%	74,414	56.17%	2.02	1.99 – 2.04	<0.0001
- ≥ 65 years	38,783	46.28%	45,012	53.72%	1.83	1.80 – 1.86	<0.0001
Gender							
- Male	149,330	55.51%	119,703	44.49%	-	-	-
- Female	146,344	52.93%	130,130	47.07%	1.11	1.09 – 1.12	<0.0001
Marital Status							
- Married	152,680	51.92%	141,409	48.08%	-	-	-
- Unmarried	132,438	58.38%	94,402	41.62%	0.77	0.76 – 0.78	<0.0001
- Divorced	10,556	42.95%	14,022	57.05%	1.43	1.40 – 1.47	<0.0001
Class							
- Class 3	182,788	49.66%	167,901	47.88%	-	-	-
- Class 2	61,075	46.06%	41,702	40.58%	0.74	0.73 – 0.75	<0.0001
- Class 1	51,811	62.47%	40,230	43.71%	0.85	0.83 – 0.86	<0.0001
Healthcare Facility Types							
- General Practitioner	63,619	49.66%	64,488	50.34%	-	-	-
- Clinic	80,548	46.06%	94,343	53.94%	1.16	1.14 – 1.17	<0.0001
- Community Health Center	151,507	62.47%	91,002	37.53%	0.59	0.58 – 0.60	<0.0001
Participant Segmentation							
- Non-Worker	36,955	47.88%	40,221	52.12%	-	-	-
- Independent (PBPU)	258,719	55.24%	209,612	44.76%	0.74	0.73 – 0.76	<0.0001
Total	295,674	54.20	249,833	45.80			

Gender

Gender also has a significant relationship with the membership status of BPJS Kesehatan (National Health Insurance). In the female group, there is a higher tendency to regularly pay BPJS premiums for six consecutive months or have an active status, 1.1 times higher than males (OR = 1.11; p-value < 0.0001). After conducting multivariate analysis, it is also evident that with each additional female participant, the probability of being active increases by 2.23%, or females are 1.1 times more likely to have an active status compared to males.

According to a study conducted by Intiasari et al., on factors influencing delayed premium payments in informal sector participants in Banyumas, and a study by Adani et al., on self-employed participants in Depok, it was found that gender is not associated with compliance in premium payments and that females tend to be more likely to not pay or delay their BPJS Kesehatan premiums (13,15). Both studies actually show different results compared to the findings obtained in this study. However, according to a recent study conducted in Hong Kong in 2023 by Chen (16), it was found that women tend to have more positive financial behaviors and attitudes, leading to higher levels of health and life satisfaction compared to men. In this study, with a larger sample size, it is observed that females tend to be active in membership status (regularly paying BPJS premiums).

Marital Status

Marital status has a significant relationship with the membership status of BPJS. Based on bivariate analysis, participants who are unmarried tend to have an inactive membership status (OR = 0.77, p-value < 0.0001) compared to those who are married. Conversely, participants who are divorced have an active status 1.43 times higher than those who are married. After adjustment and multivariate analysis, it was found that both the unmarried and divorced groups tend to have an active membership status in BPJS compared to those who are married. This is consistent with the findings of the research conducted by Intiasari, which indicate that married participants tend to be late in paying their premiums. One of the factors influencing this is the increase in dependents among married participants (13).

Table 3. Multivariate Analysis with LPM, Logit and Probit Model

Variables	(1) LPM	(2) Logit		(3) Probit
	Coef (SE)	Coef (SE)	OR	Coef (SE)
Constant	0.5965* (0.0033)	0.4227* (0.1394)	1.39*	0.3299* (0.0088)
Age				
- 18 – 44 years	-	-	-	-
- ≤ 17 years	0.0029 (0.0021)	-0.0132 (0.0088)	1.01	-0.0072 (0.0054)
- 45 – 64 years	0.1707* (0.0019)	0.7218* (0.0080)	2.06*	0.4403* (0.0071)
- ≥ 65 years	0.1624* (0.0024)	0.6891* (0.0102)	1.99*	0.4209* (0.0082)
Gender				
- Male	-	-	-	-
- Female	0.0223* (0.0013)	0.0961* (0.0057)	1.10*	0.0593* (0.0049)
Marital Status				
- Married	-	-	-	-
- Unmarried	0.0232* (0.0019)	0.1020* (0.0081)	1.11*	0.0643* (0.0049)
- Divorced	0.0427* (0.0033)	0.1815* (0.0142)	1.20*	0.0479* (0.0057)
Class				
- Class 3	-	-	-	-
- Class 2	-0.1492* (0.0018)	-0.6488* (0.0081)	0.52*	-0.3993* (0.0049)
- Class 1	-0.1492* (0.0021)	-0.6459* (0.0092)	0.52*	-0.3988* (0.0057)
Healthcare Facility Types				
- General Practitioner	-	-	-	-
- Clinic	0.0418* (0.0018)	0.1761* (0.0075)	1.19*	0.1093* (0.0047)
- Community Health Center	-0.1332* (0.0017)	-0.5658* (0.0072)	0.57*	-0.3497* (0.0044)
Participant Segmentation				
- Non-Worker	-	-	-	-
- Independent (PBPU)	-0.1246* (0.0024)	-0.5395* (0.0105)	0.58*	-0.3320* (0.0065)
Observation	545,507			
R-Squared	0.0617			
F-Statistic	3258.75			
F p-value	0.0000			
Pseudo R-Squared		0.0459		0.0459
Correctly classified		60.45%		60.36%
Hosmer-Lemeshow chi-sq		426.02		443.60
p-value chi-sq		0.0000		0.0000
Log-likelihood		-358912.06		-358914.52
LR Statistic		34552.42		34547.50
LR p-value		0.0000		0.0000

Notes: **p-value <0.0001*

Treatment Class

The most commonly chosen or held treatment class by BPJS participants is class 3 (64.29%). Referring to Presidential Regulation No. 64 of 2020, the premium amount for class 3 that must be paid by PBPU and BP segment participants is Rp 35,000.00, while the premium amounts for class 1 and 2 are Rp 150,000.00 and Rp 100,000.00, respectively. As the cost increases, demand and compliance in paying premiums decrease. Therefore, the analysis results, both bivariate and multivariate, indicate that participants in class 1 and 2 tend to have an inactive status compared to class 3 participants (multivariate OR 0.52, p-value < 0.0001). This non-compliance is significantly influenced by internal and external factors of participants, as well as by Ability To Pay and Willingness To Pay. Thus, it is crucial to reanalyze the tariff rates set by BPJS in order to improve the active membership status. An active status will have positive impacts on BPJS's financial situation and on individuals themselves.

Healthcare Facility Type

The Primary Health Care Facilities (FKTP) are the types of healthcare facilities registered by each participant when joining BPJS. According to the analysis results, 44.46% of participants are registered at Puskesmas (Community Health Centers). According to research conducted by Noor Latifah, satisfaction with healthcare services impacts compliance in paying BPJS premiums (17). If participants receive healthcare services that exceed their expectations and have previously accessed healthcare services, it positively influences compliance in premium payments. This study also indicates that the type of healthcare facility has a significant relationship in influencing membership status. However, in the multivariate analysis results, it was found that participants who have Puskesmas as their healthcare facility tend to have an inactive status compared to those who visit General Practitioner Practices and Primary Clinics.

The probability of having an active status decreases by 13.32% in the group of participants who have Puskesmas as their healthcare facility compared to those who visit general practitioner practices. The OR values in both bivariate and multivariate analyses are nearly the same, at 0.57 and 0.59 respectively, for having an active status. On the other hand, participants who have Primary Clinics as their healthcare facility tend to have an active status 1.19 times higher than those who visit general practitioner practices. This finding is important to be further analyzed since Puskesmas serves as a primary care facility that prioritizes promotive and preventive efforts, playing a significant role in reducing medical/treatment costs. Moreover, Puskesmas is the most frequently partnered FKTP with BPJS, based on BPJS's 2022 report data.

Participant Segmentation

Participant segmentation involves grouping BPJS participants based on how they pay their BPJS premiums. The PBPU and BP segments are independent segments, where premium payments are mandatory every month without assistance from the government or employers. The PBPU segment consists of participants whose work is primarily in the informal sector. PBPU participants tend to have irregular income each month, making it challenging for them to comply with BPJS premium payments. The same applies to the Non-Worker (BP) segment. Logically, PBPU participants with jobs should be more likely to be able to pay premiums compared to Non-Workers. However, this research shows results that contradict this general logic.

The PBPU segment in this study accounts for 85.85% of participants. The results of both bivariate and multivariate analyses indicate that PBPU segment participants tend to have an inactive status compared to BP participants. The multivariate analysis results show that the PBPU segment has an active status with an OR of 0.58 (p-value < 0.0001) compared to Non-Workers. One contributing factor is the age group, where 43.51% of PBPU participants fall into the 18-44 age group. Therefore, with a lower risk of illness and unstable income, the tendency to have an active membership status decreases.

Table 4. Analysis of the Relationship between Age Group and Participant Segmentation

Variable	Participant Segmentation				*p-value*
	Non-Worker		Self-Employed		
	n	%	n	%	
Age					
- 18 – 44 years	14,690	19.03%	203,789	43.51%	
- ≤ 17 years	1,776	2.30%	108,984	23.27%	< 0.0001
- 45 – 64 years	17,190	22.27%	115,283	24.62%	
- ≥ 65 years	43,520	56.39%	40,275	8.60%	

CONCLUSION

In summary, achieving Universal Health Coverage (UHC) is a complex and ongoing process that requires the collaboration of governments, policymakers, healthcare providers, and society as a whole. It involves ensuring population coverage, financial risk protection, and access to quality healthcare services. While many developed countries have made significant progress in implementing UHC, developing countries face challenges in terms of limited resources and financial sustainability. Indonesia, as a developing country, has made strides in implementing UHC through its National Health Insurance (JKN) program, but there are still areas that need improvement, such as reducing out-of-pocket expenses and achieving financial sustainability. The journey towards UHC requires continuous efforts, monitoring, and adaptation to the specific context of each country.

By analyzing the factors influencing BPJS membership status, this study provides valuable insights for policymakers and healthcare administrators to develop targeted interventions and strategies. These measures can focus on improving compliance with BPJS contributions, particularly among the Non-Wage Earner/Self-

Employed/Independent (PBPU) and Non-Worker segments. Enhancing financial literacy, implementing effective outreach campaigns, and providing supportive policies can contribute to reducing the incidence of inactive membership statuses and promoting the overall success of BPJS in achieving UHC goals.

Further research and monitoring are recommended to assess the long-term impact of implemented interventions and to identify additional factors that may influence BPJS membership status. By continuously evaluating and refining strategies, Indonesia can strive towards achieving optimal population coverage and financial sustainability in its journey towards Universal Health Coverage.

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