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Analysis of Health Service Payment Utilization in National Health Insurance (*JKN*) by Premium-Aid-Recipient (*PBI*) Insurers

Rian A. Gustaman[1] ✉, Kamiel R. Bachtiar[2]

[12]Universitas Siliwangi, Tasikmalaya, Indonesia.

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Abstract

One of the findings in the evaluation of the National Health Insurance Program (*JKN*) implementation in the first 2 years was the high ratio of claims on advanced outpatient services at Advanced Healthcare Facilities (*FKTL*). The cost of health care services per person on non-*PBI-Mandiri* insurers was Rp. 282,139 which is larger than the average of per person per month of Rp. 27,062. Claim rate on the non-*PBI-Mandiri* pool is 1,380%. This is inversely proportional to the *PBI* insurers whose health service utilization is still far below what should be with a very low claim ratio. The specific objective of this research was to analyze the utilization pattern of health insurance funding of *JKN* era in *PBI* insurers to know the description of the determinant that influenced it and resulted in recommendation to the improvement of public health policy of informal non-poor and poverty sector which is expected to support the effort of expansion of membership to public health universe. It was conducted in Kersamenak Village, Kawalu Subdistrict, Tasikmalaya Regency, Indonesia. This research used qualitative approach research.Based on the results of survei that the knowledge about the perception of society about *JKN* program is influenced by the level of insurers' education, the insurer's participation in the organization, and the counselling of *JKN* program.

Abstrak

Salah satu temuan dalam evaluasi pelaksanaan Jaminan Kesehatan Nasional (JKN) pada 2 tahun pertama adalah tingginya rasio klaim pada pelayanan rawat jalan tingkat lanjutan pada Fasilitas Kesehatan Tingkat Lanjutan (FKTL). Biaya pelayanan kesehatan rill per jiwa pada peserta Non PBI Mandiri adalah sebesar Rp.282.139,00 jauh lebih besar dari rata - rata besaran per orang per bulan sebesar Rp27.062,00. Rasio klaim pada pool Non PBI Mandiri adalah sebesar 1.380%. Ini berbanding terbalik dengan peserta PBI yang pemanfaatan yankes masih jauh di bawah yang seharusnya dengan rasio klaim yang sangat rendah. Tujuan khusus dari penelitian ini adalah menganalisis pola pemanfaatan jaminan pembiayaan kesehatan era JKN pada peserta PBI untuk mengetahui gambaran determinan yang mempengaruhinya dan menghasilkan rekomendasi terhadap perbaikan kebijakan pembiayaan kesehatan masyarakat sektor informal non miskin dan miskin yang diharapkan dapat mendukung upaya perluasan kepesertaan menuju kesehatan masyarakat semesta. Penelitian ini dilaksanakan di Kelurahan Kersamenak Kecamatan Kawalu Tasikmalaya Penelitian ini menggunakan penelitian pendekatan kualitatif. Hasil penelitian menunjukkan bahwa pengetahuan mengenai gambaran peresepsi masyarakat tentang program JKN dipengaruhi oleh tingkat pendidikan partisipan, keaktifan partisipan dalam mengikuti organisasi, serta adanya tindakan penyuluhan mengenai program JKN

✉ Corespondence Address:
Jalan Siliwangi 24, Tasikmalaya, 46115
E-mail: rianarie@unsil.ac.id

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INTRODUCTION

National Health Insurance Program (*Program Jaminan Kesehatan Nasional or JKN*) is a form of health reform that aims to overcome the problem of fragmentation and distribution of health insurance. This problem occurs in the Public Health Insurance Program (*Jaminan Kesehatan Masyarakat or JAMKESMAS*) scheme and the Regional Health Insurance Program (*Jaminan Kesehatan Daerah or JAMKESDA*) which result in uncontrolled health care costs and service quality. The National Health Insurance Program (*JKN*) is a part of the National Social Insurance System (*Sistem Jaminan Sosial Nasional or SJSN*) which is implemented through mandatory social health insurance mechanisms.

As of December 2015, the coverage of *JKN* program participation was 156,790,287 insurers. When compared to 2014, the number of insurers *BPJS* for Health (*Badan Penyelenggara Jaminan Sosial untuk Kesehatan* or Social Security Administrator for Health) increased by 17.51% from 133,423,653 in 2014 to 156,790,287 in 2015. Insurers of *BPJS* for Health in 2015 consisted of *PBI* insurers (*Penerima Bantuan Iuran or Premium-Aid-Recipient*) with 98,999,228 insurers and non-PBI insurers with 57,791,059 insurers. *PBI* insurers consisted of insurers with contributions from the National Budget (*APBN* or *Anggaran Pendapatan dan Belanja Negara*) as many as 87,828,613 insurers and from the Regional Budget (*APBD* or *Anggaran Pendapatan dan Belanja Daerah*) amounted to 11,170,615 insurers. While non-*PBI* insurers consisted of wage workers of 37,862,522 insurers, non-wage workers of 14,961,768 insurers, and non-workers of 4.966.769 insurers. According to the proportion, the highest number of *BPJS* for Health insurers in 2015 was the segment insurers of *PBI APBN* which amounted to 56.02%, followed by 24.15% insurers of Wage Workers (*Peserta Penerima Upah* or *PPU*), and segment insurers of Non-Wage Workers (*Peserta Bukan Penerima Upah* or *PBPU*) of 9.54%. The lowest proportion of the BPJS for Health insurers was from the Non-Worker (Bukan Pekerja or BP) insurer segment of 3.17% faster.

Data of beneficiaries of the Indonesian Health Card Program (*Program Kartu Indonesia Sehat* (*KIS*)) was from Integrated Database (*Basis Data Terpadu* or *BDT*) which was resulted from data collection of Social Protection Program (*Program Perlindungan Sosial* or *PLS*) 2011 that conducted by the Central Bureau of Statistics (*Badan Pusat Statistik* or *BPS*) and processed by National Team for Acceleration Poverty Reduction (*Tim Nasional Percepatan Penanggulangan Kemiskinan* or *TNP2K*). From these data, *TNP2K* made a family order that according to welfare rank and socio-economic status. Gradually, the government will distribute the *KIS* to 15.5 million poor families which are 25 percent of the population with the lowest socio-economic status, obtained from the Integrated Database. In the initial stages, the *KIS* will be distributed to 1 million of the 15.5 million families which live in 19 regencies/cities in 10 provinces throughout Indonesia.

One of the findings in the evaluation of the National Health Insurance Program (*JKN*) implementation in the first 2 years was the high ratio of claims on advanced care services at Advanced Healthcare Facilities (*Fasilitas Kesehatan Tingkat Lanjut* or *FKTL*). Data in November 2014 showed the number of registered non-*PBI-Mandiri* (independent) insurers of 7,036,200. Non-*PBI-Mandiri* insurers who utilized health services were amounted to 1.6 million (23%). The cost of health services absorbed was 7.9 trillion rupiahs. The data indicated that the cost of health care services per person on non-*PBI-Mandiri* insurers was Rp. 282,139 which is much larger than the average of per person per month of Rp. 27,062. Claim rate on the non-*PBI-Mandiri* pool was 1,380%. This is inversely proportional to the PBI insurers whose health service utilization was still far below what should be with a very low claim ratio.

METHODS

This study was conducted in Kersamenak Village, Kawalu Subdistrict, Tasikmalaya Regency, Indonesia. Participants in this study were 6 Kersamenak villagers.

This research used qualitative approach research. It is a process of research and understanding based on a methodology that investigates a social phenomenon and human problems. In this study, researchers created a complex picture, examined the words, detailed reports from the views of respondents, and conducted studies on natural situations. Qualitative methodology is a research procedure that produces descriptive data in the form of written or oral words of people and behavior, such as interview transcripts, field notes, drawings, recordings etc.

In qualitative research method, data is collected with several techniques, one of which is in-depth interview method, that is the process of obtaining information for the purpose of research by question and answer while face to face between the interviewer with the informant or the person interviewed, with or without interview guides, where interviewers and informants engage in relatively longer social lives. Interview material is the theme that is asked to informants, whether it is problem or

research objective.

Informant in this research was using sampling technique with certain consideration: purposive sample with special characteristic that is emergent sampling design/temporary, serial selection of sample units/rolling like snowball, continuous adjustment or focusing of the sample/tailored to the needs, selection to the point of dancy/selected until saturated.

The data collection for this study was conducted through an in-depth interview between researchers and participants, as the main data source in the study came from deep conversations between researchers and participants. Prior to the interview, researchers need to know the actual field conditions of research to assist in planning the data retrieval. Things that need to be known to support the implementation of data retrieval are data location, the time and duration of the interview, as well as the costs required.

Data processing was performed by documenting data of interview result and field note. Documentation was performed by playing the recording, then wrote as it is and combined with field notes and then printed in transcript form. The accuracy of transcript was tested by listening to interviews while reading transcripts over and over again. The data was then stored as well as in backups on the computer, in flash discs and in digital discs (CDs) to avoid data loss.

The data that has been collected and then coded to facilitate the analysis of data, because of this code was a differentiator between one participant with other participants. Coding was performed by underlining members on transcripts on keywords then gave member number 1, 2, 3 and so on under the underlined keywords. The code for participants was used P1 for participant 1 and so on.

Data analysis used in this research was qualitative research that is research which data is expressed in verbal form and is analyzed without statistical technique.

The collected data were analyzed. Things to note were the interview transcripts, field notes from the researchers' observation and the researchers' diary of important events from the field and the recording. The analysis of qualitative data is typically an interactive and active process. After the interview, interview results and field notes were immediately transcribed. The writing of the results of data collection through interviews and field notes was performed as soon as possible after the interview. The writing was performed by making transcripts based on interview results and making field notes. The analysis of new data would begin after the researchers fully understand the transcript and field notes.

This study used the method of analysis according to Collaizi. The method was selected because the data analysis steps according to Collaizi are simple enough, clear and detailed to use in this study.

Steps of analysis which was planned to be performed in this study: (1) read the participant's narrative repeatedly, (2) choose words and phrases related to the purpose of the study, the key words are collected according to the specific objectives to be achieved, (3) formulate the meaning for each significant statement by choosing keywords, organized into several category according to participants' statements, (4) group the meanings into theme groups by arranging the theme grid tables which contain categories into sub themes and themes, (5) repeat this procedure for each description of each participant and arrange the formulas into the theme groups, (6) validate the picture back to the participants, give time to participants to read and comment on the identified initial themes and confirm the themes related to the personal experience. The purpose of this meeting is to verify the description of the participants' experience in documenting the care, (7) merge data that emerged during validation into a final description.

RESULTS AND DISCUSSION

Characteristics of Participants

Participants in this study were Kersamenak villagers. From the six participants interviewed, most of the last education was the primary school. Participant 1 was 69 years old, participant 2 was 54 years old, participant 3 was 42 years old, participant 4 was 43 years old, participant 5 was 67 years old, and participant 6 was 66 years old.

From the six participants, four participants were housewives, and the rest worked in the informal sector. *JKN* card ownership type of the participants namely, *KIS Mandiri*, *Jamkesda*, and *KIS PBI*, but there were also participants who did not have *JKN* card. Most of the participants' family members have been registered in either *KIS Mandiri* or *KIS PBI*. In general, participants have used the function of *KIS* for curative treatment.

Knowledge

Based on survey results and knowledge analysis from participants, it is known that there were still participants who did not know about *JKN*, this was proven by:

> *" Teu, teurang, mamah mah teu teurang nanaon " (P2)*

The purpose of the above transcript, the participant was not aware of *JKN* either the definition or the

Table 1. Characteristics of Participants.

Participant	Sex	Age	Type of *KIS*	Occupation	Education
P1	M	69	*Jamkesda*	Farmer	Primary School
P2	F	54	No	Housewife	Primary School
P3	F	42	*KIS mandiri*	Housewife	Junior High School
P4	F	43	No	Housewife	Primary School
P5	F	67	*KIS PBI*	Housewife	Primary School
P6	M	66	*KIS PBI*	Laborer	Primary School

JKN program. The second participant was primary school educated, 54 years old and did not have *KIS*.

The participant's ignorance about the *JKN* was due to several things, namely, low educated participant, lack of enthusiasm, and lack of socialization from health workers on the *JKN* program. Because based on research of Analisa (2015), Rahman (2015) and Ningrum (2014), that education affects the perception on Health Insurance.

From some participants, there were other participants who knew about *JKN* but the participants were indifferent to the *JKN*, as evidenced by:

"tah kitu hehehehe, hoyong mah gratis, hehehehe" (P4)

From the above transcript, it can be interpreted that the respondents did not really know about how the procedure should be in the *JKN* program. The presumption of this participant is that all *KIS* types are free.

The 4th participant (P4) was 43 years old, did not have a *KIS*, a housewife and primary school educated.

Based on the quote, the participant knew what *JKN* is and how the program is, but the participant wanted *KIS* is financed by the government, so did not want to pay the cost in payment of *KIS* contribution.

Participant who had good knowledge already had *KIS* and registered as a *KIS Mandiri* insurer had been long enough, because knew the *JKN* program, as evidenced by:

"gratis... hehehhee.. tos lami da tibarang aya ibu mah ngadamel sadayana teh .. tingawitan taun sabaraha mah... taun 2014 kitu" (P3)

It is clear from the above statement that the respondent had sufficient knowledge because the respondent replied with the knowledge about the *JKN* program. Participant three was graduated from junior high school, 42 years old because respondent had a sufficient education about *JKN*, respondent registered as an insurer of *JKN* program that is *KIS Mandiri.*

The above quote shows the enthusiasm of particThe above quote shows the enthusiasm of participant on *KIS* ownership which was very high because participant already knew what is *JKN* and how the *JKN* program works.

From some participants with the status of ordinary citizens have different knowledge, this is due to several things, including education. According to Rumengan et al (2015) and Khariza (2015) that the education of a person influences on a person's understanding or perception of a thing, the level of education makes a person more able to form a positive perception so as to generate a better understanding of a program.

From some community leaders (*RT* and *RW*) who became insurers on *JKN* the knowledge was considered good enough:

"tapi etamah nanging atos daramel janten lebetna teh ti perusahaan, ngagadughanana teh ti perusahaan da janten kuli, da ti perusahaan masihanana teh, mung ibu BPJS ibumah abah mah ieu BPJS di pasihanana ieumah dibagian ti pemerentah. Fungsi na pami, kan fungsi na mah terutami kanggo berobat we panginten kitu nya eeu.. ieu na mah anu, anu terutami na mah.. uhun panginten kitu, eta eun nana mah"(P1, P6)

Based on the citations of the community figures shows that the knowledge was considered enough about *JKN* but the participants were still a little confused to distinguish *KIS* with *BPJS*, whereas in fact, both are the same, the dues of *KIS* that differentiate, there is out of pocket and there is a *PBI* (Purwandari, 2015). Participants one and two were registered as members of the *JKN* program, graduated of primary school, 69 years old and 66 years old.

After interviewing participants about what is JKNAfter interviewing participants about what is *JKN* and how the programs, it was found that the

knowledge of respondents on *JKN* varied. Some people think it is very useful and there are also assumed indifferent by not using it. Some of these assumptions are proved by:

> *"nya disebabkeun ringan, memang ada keringanan, emang aya keringanan biaya teh saatos gaduh etamah janten teu saratus persen tina uang nyalira tapi dibantos we ku BPJS itu ibu ari apa mah Alhamdulillah sehat, memang sae manfaatna kantenan anu ieu anu euu.. muhun anu di uruskeuna teuaya masalah, Alhamdulillah teuaya masalah, namun anu kajanten kamari ku apa masih keneh ngaluarkeun artos pribadi duka kumaha tah, kantos ngaluarkeun biaya pribadi BPJS sebagian teuacan saratus persen...(P1)*

The participant above was men, 69 years old, had primary education and work as farmers, the participant was *JAMKESDA* insurer. One of six respondents thought that *JKN* was beneficial by relieving medical expenses and paying only half of it.

> *"kantos bapak kan waktos-waktos kamari, dugi keun kan berobat sababaraha sasih eta.. hampir 6 sasih, enya kantos we diajukeun ka Sukaratu.. Alhamdulillah henteu aya ieu, teu aya nganggo uang kitu lah"(P6)*

The above participant was male, 66 years old, *KIS PBI* users, working as laborers and graduated from primary school. One of six respondents thought that *JKN* was beneficial by not using the money to pay for it.

Some participants with sufficient knowledge also revealed that by being a member of *KIS* health insurance, which they spend a little because it is so helpful that they are not too thinking about the cost to be paid to a doctor if sick befall them.

> *"manfaatnanya alhamdulilah upami... (ngeang).. ka dokter gratis kitu. muhun, paling bayar saalit upami nyuhunkeun vitamin mah kan vitamin-vitamin mah hente dikaper"(P3)*

The above participant was female, 42 years old, *KIS Mandiri* user, work as housewife and graduated from junior high school. One of six respondents thought that *JKN* is beneficial if she goes to the doctor does not pay and pay little but if she buys the vitamin must pay because it does not belong to *JKN*.

Based on interviews with some participants, it can be seen that a person's education level affects to the level of knowledge and perceptions of a person, and also the activity of a person in a region where live in an institution also influence to the level of knowledge and perception of a person to an existing problem.

Based on the results of interviews which conducted to two representatives of community leaders in Sukagalih Hamlet with primary school as last education, participant one was 69 years old and participant two was 66 years old, *KIS* ownership of both participants namely the participant one was Jamkesda, the participant was six *KIS PBI* who stated that the program *JKN* especially the *KIS PBI* program has been well targeted yet, there were still some villagers that have not received such assistance. This is evidenced in the transcript of the conversation as follows:

> *"...nyakitulah..tapida kanggo RT ieu mah upamina RT bapak nu nampi sadayana aya... sasaran teh emang tepat mah tepat mung tacan sadayana teu acan merata.."(P1, P6)*

Four of six participants stated that the recipients of *KIS PBI* were on target but, the recipients were still the same. It can be proved in the transcript of the conversation as follows:

> *".... Anu nampi teh eta deui eta deui pami aya bantuan nanaon teh... tipayun dugikeun ka sajalmi teh tiasa tilu nampi kadinya deui kadinya.."(P1, P4)*

The above statement stated by the participant one as a figure that was male, 69 years old, primary school as last education, and *KIS* ownership type was Jamkesda. Participant four was a housewife, aged 43 years old, elementary school as last education, and did not yet have a *KIS*. From these statements it can be concluded that the target of the recipient of *KIS PBI* in the Sukagalih hamlet has been well targeted yet, but it is not spread evenly yet because it is still concentrated on the same target.

In *TNP2K* (National Team on Poverty Reduction Acceleration), the target of *KIS PBI* beneficiary is regulated in Government Regulation No. 101 of 2012 on Beneficiaries of Health Insurance Contributions. It is mentioned that:

1. The criteria of the poor and the needy are stipulated by the Minister of Social Affairs after coordinating with the Minister and/or the head of the relevant institution.
2. The results of the data collection of the poor and the needy conducted by the institutions which hold the government affairs in the field of statistics (Central Bureau of Statistics or *Badan Pusat Statistik* / *BPS*) are verified and validated by the Minister of Social Affairs to be used as an integrated data.
3. The integrated data set by the Ministry of Social Affairs is detailed by province and regency/city and provides the basis for determining the national number of *PBI* Health Insurance.

4. The Minister of Health registers the national number of PBI Health Insurance as an insurer of the Health Insurance program to *BPJS* for Health.

The limitation of the definition of the poor and the needy is the people who have no source of livelihood and/or have the source of livelihood but do not have the ability to meet the basic needs that are appropriate for the life of themselves and/or their family. What are meant by poor people are people who have a source of income, salary, or wages that are only able to meet basic needs but cannot afford to pay contributions for themselves and their families (Riska, 2016). The *KIS PBI* membership data is dynamic so that it will involve the movement of the welfare level of the insurers as well as the ownership replacement. For that need to hold more accurate data collection so that the acceptance of *KIS PBI* in this Sukagalih Hamlet can be achieved according to the target and more comprehensive.

Attitude

According to Wawan and Dewi (2011), attitudes are general evaluations made by humans against themselves, others, objects, or issues.

According to Rosenberg's theory, if a person has a positive attitude toward the attitude object, then this means that there is also a relationship with other positive values associated with the object of the attitude, as well as a negative attitude. Rosenberg created a scale of attitudes and argued that there is a consistent relationship between the affective component and the cognitive component. This means that if a person has a positive attitude towards something, then the cognitive index is also high, and vice versa.

Based on the above theory, it shows that if insurers have a positive attitude toward *JKN*, then the knowledge and feelings about the *JKN* is positive. This is evidenced by the participant's transcript which shows some positive attitude toward *JKN*.

> *"sae mah sae, disebatkeun aya keringanan.... kanggo berobat ka Puskesmas sareng ka Rumah Sakit, dugi ka aya anu gratis teungaluarkeun artos..."(P1, P3, P4, P5, P6).*

The above statement was stated by the five participants with the participants of 1,4,5 and 6 were graduated from primary school, and the participant three with junior high school as last education. Participant 1 used Jamkesda, Participant 3 used *KIS Mandiri*, participant 4 did not have and participant 5 and 6 used *KIS PBI*. Five of the six participants were of the opinion that in the presence of *KIS* participants, they got relief in terms of health finance.

According to Wawan and Dewi (2011), attitudes can also be positive and can also be negative, that was:

1. A positive attitude, the tendency of action is to approach, cherish, and expect a particular object.
2. Negative attitude is the tendency to stay away, avoid, hate, and dislike certain objects.

A positive attitude that expects a particular object is evidenced by the following transcript:

> *"... mudah-mudahan JKN teh ulah bayar.. hoyong kawas batur atuh, aya bantuan kitutah.. janteun kapayuna the tiasa KIS the tiasa diangge ka Dokter teu ka Puskemas hungkul.."(P2, P3, P4,P5)*

This statement was stated by Participants 2, 4 and 5 with the primary school as last education, and 3 participants with junior high school as last education. From the above transcript, four of six participants expected *KIS* assistance from the government for the whole community, especially those who still not registered in *JKN*. Participants hoped that both PBI and *KIS Mandiri* can be free, and expected first-rate health facilities to move to closer health facilities to make them more accessible to the public.

In addition to a positive attitude, there is also a negative attitude shown by the participants. This is evidenced by the following transcripts:

> *".. kitunya teu aya namung nya kitu welah masyarakat hiji dua biasa, abi teu acan kabagean, abi teu acan nampi, mung sakitu..di Dokter mah teu nampi nganggo KIS ka Dokter mah kitu... Anu nampi teh eta deui eta deui pami aya bantuan nanaon teh..nya kerugianna mah pami lamun teu di anggo nya rugelnya.. da tiap bulan bayar.."(P1,P3, P4, P5, P6)*

The above statement was stated by the five participants of participants 1, 4, 5, and 6 with primary school as last education, and participant 3 with the junior high school as last education. Participant 1 used Jamkesda, Participant 3 used *KIS Mandiri,* Participant 4 did not have, and participant 5 and 6 used *KIS PBI*. Based on the transcript, participants' negative attitudes on the description of the use of *JKN* cards in the Sukagalih Hamlet community, there was still an overlap of aid targets because the data used were not updated regularly so that only those who received the assistance. Participant who used *KIS Mandiri*, also revealed that the perceived loss because even if the participant did not get sick

she still has to pay the dues.

Practice

(1) The practice of participant who know about the existence of *JKN* but is reluctant to follow the membership

Behavior is an individual response to a stimulus or an action that can be observed and has a specific frequency, duration, and purpose whether consciously or not. Behavior is a collection of various factors that are so complex that sometimes we do not have time to think about the cause of someone implement certain behaviors. Therefore, it is important to examine the reasons behind individual behavior, before it is able to change that behavior.

Health behavior is basically a person's response (organism) to the stimulus associated with illness and disease, health care system, food and environment. This limit has two main elements, namely response and stimulus or stimulation. Response and human reaction, both arepassive (knowledge, perception and attitude) (Qimamayah, 2012). While in the discussion of this attitude, the researchers will explain how the correlation between knowledge with practice. In accordance with the results of the survey and analysis to the place directly showed that most residents in Sukagalih hamlet did not do things to be performed in response to the existence of *JKN*, two of the six participants who knew *JKN* but are reluctant to follow the participation to become a member of *JKN*. The above statement can be proved by participant's conversation as follows:

"Teu acan, teu acan nanaon jadi da teteurang"(P2)

The answers from the participant with primary school as last education, which was female, 54 years old, able to confirm that the person knew that *JKN* existed, but the participants had no desire to participate. After the researchers performed analysis of the absence of strengthening from the cadre or health institutions.

(2) Practice of participants who know *JKN* and use the function of the card.

Health insurance reduces the public risk to guarantee healthcare costs from their own pockets, in unpredictable amounts and sometimes cost enormously. For that, it is needed a guarantee in health insurance because the insurers pay a premium with a fixed amount. Thus, the health finance is shared jointly by mutual assistance by the insurer's urban village, so that the entire insurers, so it is not burdensome per person (Listiyana, 2017).

National Health Insurance Program is one of the government programs that can help the community in the form of health insurance that many types and usability and can be used by various circles. Many views that the *JKN* program is able to provide all finance from the government or in terms of paid for free, in fact, this is one of the community polemics that should be noticed by the cadres, to give the sense that the financing is not paid as a whole by the government. The results of the survey directly to the place proved there is still such a view, this is evidenced by the discussion as follows:

"nya disebabkeun ringan, memang ada keringanan, emang aya keringanan biaya teh sa atos gaduh eta mah janten teu saratus persen tina uang nyalira tapi dibantoswe ku BPJS itu ibu ariapamah Alhamdulillah sehat, memang sae manfaatna kantenana nuieu anu euu.. muhun anu diurus keuna teu aya masalah, Alhamdulillah teu aya masalah, namun anu kajanten kamari ku apa masih keneh ngaluarkeun artos pribadi duka kumaha tah, kantos ngaluarkeun biaya pribadi BPJS sebagian teu acan saratus persen".

The above statement was stated by one of the community leaders who became participants, the last education was primary school with *JAMKESDA* ownership, could be interpreted as lack of conformity of knowledge with practice, whereas the participants knew everything about *JKN*, but in practice he wanted the payment to be paid in whole.

CONCLUSION

Based on the results of survey analysis conducted to 6 participants, the knowledge about the perception of society about *JKN* program is influenced by the level of participants' education, the participant's participation in the organization, and the counseling of *JKN* program.

Attitudes of the community contained in the survey location, namely the balance between positive and negative attitude. In place there were some people who only knew without direct action to address the program *JKN*, there were also people who have known and able to use the usefulness of the *JKN* program.

For the state of society related to the practice of using the *JKN* program, it is clear that there is a card empowerment by the community. However, there were still some people who have not used the function of the *JKN* program. This can be caused by the inappropriateness between knowledge with attitude and lack of special monitoring from health personnel so that the assumption was formed that did not understand it so that formed a less good practice. Whereas the usefulness of the *JKN* program is very useful for the surrounding community.

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