THE INFLUENCE OF FAMILY SOCIAL ECONOMIC STATUS ON THE SELECTION OF PATTERNS AND METHODS OF HEALTH FINANCING AND ABILITY TO PURCHASE HEALTH SERVICES IN JAMBI PROVINCE

Dwi Noerjoedianto[1], Syamsurijal Tan[2], Zamzami[3], Junaidi[4]

[1)] Student of Doctoral Program in Economics, Faculty of Economics and Business, Unja
[2,3,4)] Lecturer at Doctoral Program in Economics, Faculty of Economics and Business, Unja

Email : dwi_noerjoedianto@unja.ac.id, syamsurijaltan@gmail.com zamzami@unja.ac.id, junaidi@unja.ac.id,

ABSTRACT

Background, Health financing plays an important role in improving the quality of health services, so that the role of all parties is needed. WHO (2010) recommends 6 patterns and 7 methods of health financing to measure the ability to purchase health services. This study aims to examine the effect of family socioeconomic status on the patterns and methods of health financing on the ability to purchase health services in Jambi Province.

Methodology, quantitative design with a survey approach design, exogenous variables (family socioeconomic status) and endogenous variables (financing patterns, financing methods and the ability to purchase health services), a sample size of 770 households. Technique accidental random sampling in western and eastern regions, using questionnaire sheet instruments, analysis of second order SEM PLS data.

Results and Discussion, The characteristics of respondents of productive age 94.8%, male gender 62.7%, high school education level 44.2%, while self-employed / entrepreneur 31.7% with a total of 4 - 6 family members 63.8%.

The condition of family socioeconomic status is measured by low income 36.1%, moderate 33.90%, high 21.04%, and very high 8.96%. Average income of Rp. 3,144,155 per month, its position is above the average income of the Jambi Province minimum wage of Rp. 2,630,162, including the medium category (BPS Propinsi Jambi, 2020).

The results of the PLS SEM analysis obtained the t-statistics value of 25.023, and P-value of 0.004, which means that the direct effect of family socio-economic status on the ability to purchase health services is accepted. The facts show that the socioeconomic status of the family is very much influenced by the level of income, so that the respondents try to set aside some of their income, including the factor of the size of the family members. The second hypothesis, the t-statistics value is 687,514 and the P-value is 0,000, which means that the direct effect of health financing patterns on the ability to buy health services is accepted. The pattern of direct health financing is the government's obligation through direct financing, but

the collaboration of various health financing patterns will result in even stronger access to health services, Hypothesis 3, shown the t-statistic value of 34,772 and P-value of 0,000, meaning direct influence health financing methods on the ability to buy health services are accepted. The pre-service health financing method is in the form of capitation, cooperation with the government based on the number of patients who remain in one particular group area, so that service certainty will be more guaranteed, both in terms of officers and patients, while after services are dominated by direct payments for services, including the payment system in face when it comes to health care facilities. The fourth hypothesis, the t-statistics value is 21.301 and the p-value is 0.017 which means that the three variables are significant and indicate that the pattern of health financing is able to mediate the relationship between family socio-economic status and the ability to purchase health services as an intervening variable. Through the pattern of direct health financing by the government, as well as financial support from the community that is self-managed / independent, including government assistance from abroad and assistance from the private sector. In principle, each family sets aside income, either in the form of savings or in other forms including health insurance programs. families with the ability to purchase health services as an intervening variable. Through the capitation system method, and setting aside a portion of the income including by making financing payments before service and using direct payments, and the system of payment in advance when it comes to health care facilities.

Conclusion, There is a direct effect of family socioeconomic status, patterns and methods on the ability to purchase health services, there is an indirect effect of family socioeconomic status on the ability to purchase health services through health financing patterns and there is an indirect effect of family socioeconomic status on the ability to purchase health services through the method. health financing.

Keywords : The influence of socioeconomic status, collaborative financing, financing from the society

Background, health financing plays an important role in improving the quality of health services, so that the role of all parties is needed. WHO (2010) in Supriyanto, et al, (2018) recommends 6 patterns and 7 methods of health financing that will measure the ability to buy health services. This study aims to examine the effect of family socioeconomic status on the patterns and methods of health financing on the ability to purchase health services in Jambi Province.

Literature Review

The size of the socioeconomic status grouping can be seen from the measure of wealth, including power (Soekanto, 2007), jobs, education, income Sumardi, (2004), number of dependents and asset ownership. Rahman (2002), adding aspects of the condition of the size and location / position of the house, the area of residence, and including the elite or slum areas. Warner classifies the categories of upper, upper, lower, upper middle, lower middle, lower upper and lower class (Sunarto, 2004).

The pattern of health financing, there are 6 categories of health financing patterns that are currently developing, including (1) direct government financing which is the responsibility of the government to its citizens, (2) health insurance, which is a financing system prepared by families when they are healthy, (3) financing from the community, which is managed and agreed upon by deliberation in a particular community, (4) financing from the patient's pocket after using health care facilities, (5) funding from government organizations and external cooperation which is assistance from donor agencies or WHO, specifically certain diseases and (6) financing from the private sector and asset ownership

Health financing methods, there are 7 health financing methods in health care facilities, namely: (1) payment based on disease diagnosis, common in referral service facilities, (2) payment based on daily rates, (3) advance payment based on a definite number of people being served, (4) Payments based on the total budget (Trisnantoro, 2016), (5) Payment based on monthly salary (Supriyanto et al, 2018) and (6) direct payment of fees after service, and (7) reimbursement of prepayments.

The ability to pay is a way for a family head to access health services by optimizing his socioeconomic status through income. The factors that influence according to Steven Russel are (1) the nature of the disease, the frequency, the length of illness and the amount of costs required, (2) the various resources available in the household, including assets, cash, education, investment, the ability to organize resources. effectively, and accounts receivable and (3) family response, namely the decision to organize resources effectively and efficiently.

Hypothesis, as follows: (1) the socioeconomic status of the family has a direct effect on the ability to purchase health services in Jambi Province, (2) the pattern of health financing has a direct effect on the ability to purchase health services in Jambi Province, (3) the method of health financing has a direct effect on the ability to purchase services health in Jambi Province, (4) the socioeconomic status of the family has an indirect effect on the ability to purchase health services through the pattern of health financing in Jambi Province and (5) the socioeconomic status of the family has an indirect effect on the ability to purchase health services through the health financing method in Jambi Province.

Research methodology, quantitative research design with a survey approach design, research locations in the western region of Jambi (Bungo, Sungai Penuh City and Merangin) and Jambi in the eastern region (Jambi City, Batang Hari and Tanjab Barat), the research time was 7 months. The population number of family visits to health facilities is 1,115,465, the number of samples is 770 people. The sampling technique was accidental random sampling. Data sources, derived from primary data (questionnaires) and secondary data (annual reports / official profile documents of government agencies). Instrument of questionnaire data collection, processing and analysis of SEM-PLS second order analysis data.

Result and Discussion

Analysis of the characteristics of the respondents.

The results of the respondents' research are based on the characteristics asin the following Table:

Table 1. Distribution of respondents based on age, gender in 2020

Characteristics	Category/Group	Total	Precentage
Age (Year)	19 – 64	730	94,8
	65 <	40	5,2
Gender	Male	483	62,7
	Female	287	37,3
Last education	Elementary School	98	12.7
	Junior High School	110	14.3
	Senior High School	340	44.2
	Diploma / Bachelor Degree	222	28,8
Profession	PNS/TNI/POLRI	126	16,4
	Honorary Staff, Retired	86	11,1
	Traders, farmers, fishermen	165	21,4
	Self-employed / entrepreneurial	244	31,7
	Freelance	149	19,3
	Total	770	100,0

Source: Processed field data (2020)

The results showed that respondents aged 19 - 64 years old still dominated in this study around 94.8%, with the education level of the majority of high schools equal (44.2%), with employment, as self-employed / entrepreneurial 31.7%. The socioeconomic status of the family is measured by indicators including the income level of the head of the family, the level of population density and the number of family members. The results of the study related to the income of the head of the family were categorized into 4 categories, dominated by low and moderate income. Of the overall income level, the average is Rp. 3,144,155 per month, greater than the average income (UMP) of Jambi Province of Rp. 2,630,162. (BPS Provinsi Jambi, 2020).

Other factors related to the strength of the family in the fulfillment of his life needs are reviewed from the number of family members. Facts show respondents who have a total of 4 - 6 people 63.8%, meaning almost half more have the number of children 3-4 people including father and mother. In detail presentedin this following Table:

Table 2. Distribution of respondents by income and number of family members in 2020

Income (Rp)	**Total**	**Percentage**
< 2.000.000	278	36,10
2.000.000 - 3.999.999	261	33,90
4.000.000 sd. 5.999.999	162	21.04
> 6.000.000	69	8,96
Number of family members		
1 – 3	232	30,0
4 - 6	492	63,8
> 6	48	6,2
Total	**770**	**100,0**

Source: Processed field data (2020)

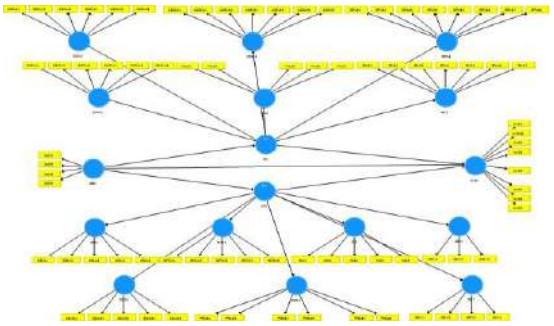
In detail the average distribution of the results of this study shows as follows:

Table 3. Distribution of the average respondent's answers in 2020

	Variable/Indicator	< average	≥ average
SSEK	The income of the head of the family	44,34	55,66
PPK	Direct government financing	44,70	55,30
	Financing with health insurance	47,79	52,21
	Community financing	37,03	62,97
	Financing from the patient's pocket	56,00	44,00
	Financing from government organizations and external cooperation	50,80	49,20
	Private sector financing	55,15	44,85
MPK	Payment based on disease diagnosis	47,14	52,86
	Payments based on daily rates	50,00	50,00
	Advance payment according to the number of people served	47,38	52,62
	Payments based on the total budget	52,21	47,79
	Payment based on monthly salary	49,48	50,52
	Direct financing after service	56,08	43,92
	Prepayment reimbursement	53,45	46,55
KMPK	Ability to purchase health services	37,45	62,55

Source: Processed field data (2020)

Measuring the outer model (Model measurement), a validity test is carried out, with the condition that the indicator is said to be valid if the loading factor value is above 0.70. (Sarwono, 2014), The results showed that there were 7 indicators that were invalid and were excluded from the model, resulting in a structural equation model with 84 valid indicators as follows :



Reliability test, the instrument is said to be reliable if the Cronbach's alpha value is> 0.6 and the composite reliability value is > 0.8, including the AVE value > 0.5, as presented in the following Table:

Table 4. Reliability of research indicators (*Cronbach's Alpha*, *Composite Reliability* and *Average Variance Extracted/ AVE)*

Constructs / dimensions	*Cronbach's Alpha*	*Composite Reliability*	*Average Variance Extracted* (AVE)
Family socioeconomic status (SSEK)	0,986	0,990	0,961
Income	0,986	0,990	0,961
Health financing patterns (PPK)	0,996	0,997	0,884
Direct government financing	0,952	0,961	0,805
Health insurance financing (HI)	0,995	0,996	0,981
Community financing (CF)	0,988	0,990	0,932
Financing from the patient's pocket (OOP)_	0,986	0,988	0,935
Financing from government organization sand external cooperation (GOE)	0,988	0,990	0,930
Private sector financing (PSF)	0,988	0,990	0,923
Payment based on disease diagnosis (DRG's)	0,982	0,985	0,931
Payments based on daily rates (PDT)	0,937	0,952	0,799
Prepayment based on the number of people served (K)	0,953	0,964	0,843
Payment based on total budget (GB)	0,906	0,941	0,842
Payment based on monthly salary (GBL)	0,950	0,962	0,834
Payment of fees directly after service (FFS)	0,956	0,964	0,818
Prepayment reimbursement (PR)	0,924	0,946	0,814
Health financing methods (MPK)	0,991	0,991	0,774

Ability to purchase health services (KMPK)	0,953	0,961	0,754
Ability to purchase healthservices (KMPK)	0,953	0,961	0,754

Source: Processed field data (2020

With the test of validity and reliability of the instrument, the instumen is declared valid and reliable, then the inner model measurement is carried out by conducting a hypothesis test. Hypothesis testing is based on t-statistics > 1.96 or p-value < 0.05, as presented in the following table:

Table 5 Results of boostraping direct influence and indirect influence

Direct Influence	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values
SSEK ➔ KMPK	0,726	0,725	0,029	25.023	0,004
PPK ➔ KMPK	0,993	0,993	0,040	687,514	0,000
MPK ➔ KMPK	1,020	1,020	0,029	34.772	0,000
Indirect Influence	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values
SSEK ➔ PPK ➔ KMPK	0,712	0,713	0,033	21.301	0,017
SSEK ➔ MPK ➔ KMPK	0,741	0,71	0,029	24.919	0,000

Based on the results of the estimation test in this way, it can be interpreted , namely hypothesis 1 obtained a t-statistical value of 25.023 and a P-value of 0.004, which means that the direct effect of family socio-economic status on the ability to purchase health services in Jambi Province is **accepted**. While hypothesis 2 is obtained that the t-statistical value is 687,514 and a P-value of 0,000 means that the direct effect of health financing patterns on the ability to purchase health services in Jambi Province is **accepted**. Furthermore, hypothesis 3 is obtained that the t-statistics value is 34.772 and a P-value of 0,000 means that the direct effect of the health financing method on the ability to purchase health services in Jambi Province is **accepted**. Hypothesis 4 obtained t-statistical value 21.301 and P-value 0.017, meaning that the socio-economic status of the family has an indirect effect on the ability to buy health services through the pattern of health financing as an intervening variable'', **accepted**, and hypothesis 5 obtained a t-statistical value of 24.919 and a P-value of 0.000, meaning that the socio-economic status of the family has an indirect effect on the ability to purchase health services in Jambi Province through the health financing method as an intervening variable'', **accepted.**

Discussion

The influence of family socio-economic status on the ability to purchase health services. If reviewed from the aspect of family socioeconomic status, Jambi Province with an average income of Rp. 3,144,155 per month turned out to be more than the revenue (UMP) in 2020 amounting to Rp 2,630,162 so that there is the ability to buy health services as evidenced by 62,55% of respondents

can afford health costs. However, there are jobs that need attention (19.3%) with freelance day labor jobs, including jobs in the informal sector with an average income of Rp. 1,729,194.

The ability to buy health services is evidenced by the indicator statement (KMPK1) which states that the income as the head of the family is able to pay for health services for all my family members, regardless of the type of health service facilities, both public and private (KMPK2). This is reinforced by government policies that seek to provide health services regardless of the status of health service facilities (Kementerian Kesehatan RI, 2013; Peraturan Presiden, 2018). Supportedby statements related to income, that on average each family has an additional income within 1 month of half of basic income (PDPT2), although there are also claims that there is an additional amount of income with an uncertain amount (PDPT4). The ability of the head of the family to pay the cost of health services has been programmed by the government through Universal Health Coverage (UHC) with a target of 95% by 2020, it turns out that in Jambi Province it has only reached 86.32%, provided that people can directly pay independently according to the criteria. which is desired but the government cannot afford to provide subsidized assistance to the recipient of contribution assistance to pay for health services (Kementerian Kesehatan RI, 2017).

Related to this, the education factor, most of whom have senior high school education (73%), is a strong support for the ability to purchase health services. Supported by the readiness of the number and types of health professionals in all lines of districts / cities in Jambi Province with the ratioof health workers, especially doctors, at position 1: 31 (National Standard 1: 43), and nurses 1: 193 (National Standard 1: 185) Including support for health service facilities, both first-level health facilities (*puskesmas*), as many as 217 units located in remote areas of the region and 37 units at the referral level (hospitals) in the district or provincial capitals (Dinas Kesehatan Provinsi Jambi, 2020).

Research with the same theme as Nguyen Thi conducted in Vietnam in 2013 stated that households with better economic growth will be more optimized in the utilization of health services. (Thoa *et al.*, 2013)**.**

The effect of health financing patterns on the ability to purchase health services. The pattern of health financing occupies the highest average distribution (62.97%), on community sourced financing. This indicates that the community still wants to manage funding from and by and for the community with the principle of mutual cooperation. However, this is only the fulfillment of financing that is of a supportive nature or a non-chronic disease, considering the nature of public financing is limited to service units in a small scope or limited services (Dewi et al, 2018). This is evidenced by the statement of the respondent who stated their willingness to have deliberation in financing the family by forming an *arisan* (regular social gathering for purposes of conducting a lottery) for health costs in the neighborhood (CF1), supported by a statement to provide input to a place or health service unit, when members experience or are in a sick condition (CF5).

Meanwhile, the pattern which is more preferred by respondents after public financing is direct government financing with an above average distribution of 55.30%. This shows that the government has carried out its obligations related to guaranteeing the rights of every citizen in health services. Various sustainable program efforts that are oriented towards health financing are targeted at vulnerable, poor, informal groups and people who need social assistance. One of the efforts with the National Health Insurance for Indonesia Healthy Card (JKN - KIS) program, is to collect data as recipients of contribution assistance (PBI) and non-contribution recipients (Non-PBI). This is reinforced

by the statement of the respondents in the indicator statement which states that the ease of obtaining direct costs from the government in utilizing health services (DGF3) and all health service costs is borne by the government (DGF4).

The same thing was also launched for the private sector engaged in the manpower sector through wage earner assistance programs and non-wage earner assistance programs for employees or company workers (BPJS Ketenagakerjaan, 2020). Efforts to support the government through Law Number 40 of 2004 which states that the government guarantees financing through the National Guarantee System (Kementerian Kesehatan RI, 2004). The National Security System is referred to through health insurance, old age insurance, education insurance, pension and death benefits as well as other social security. Supported by 52.21% expressed their opinion on the importance of the concept of health insurance which is strengthened through the statement that the head of the family and their members are always obedient to pay BPJS health dues regularly every month (HI5) and the ease of obtaining a health BJS card according to the stipulated requirements (HI2), including when using health care facilities (HI7).

Considering that health insurance still focuses on insurance that is social / compulsory, with the average being borne by the government or independent for those who can afford it, it is necessary to support other financing patterns through financing from government organizations and cooperation from abroad. According to this financing pattern, it is focused on certain cases or diseases that have become different trends in a region or country, both endemic and pandemic. The statement was conveyed almost 49.20% of the importance of financing from government organizations and cooperation from abroad. This is evidenced by the statement that there is financial assistance for families waiting at health service facilities (GOE2), both for supporting examinations, recovery and family care costs after returning home (GOE1,4,5) supported by financing patterns from the private sector. Although it is a complement to compulsory / social insurance coverage, it also has an impact on the system of financing patterns.

The smallest pattern of financing is the pattern of direct financing from the patient's pocket (44.00%), related to income. This is reinforced by the statement that there are objections to paying for health services in cash (OOP4), because it cannot be ascertained the amount of costs that must be prepared after using health service facilities (OOP6).

The fact of the results of this study shows that of the various health financingpatterns launched by the Jambi Provincial Government, it turns out that funding from the community is the most popular with the characteristics and characteristics that service management is in accordance with the agreement of the community / community who are members of a (small) group because of similarities and characteristics. Disease characteristics are almost the same (Dewi et al, 2018). The fact is that in choosing the pattern of health financing, nothing is perfect, but each of them has advantages and disadvantages in its implementation. In Indonesia what has happened so far is that the most ideal pattern to be implemented is health insurance with the consideration that there is a guarantee for every citizen to access health services, provided that those who can afford to pay themselves, while those who cannot afford subsidies are given contribution assistance recipients. , including for wage earners currently managed by BPJS Kesehatan and BPJS Ketenagkagakerjaan. The principle of providing assistance is also supported by direct financing from the government through a pattern of direct funding from thegovernment.

This is supported by research Murauskiene et al (2017) in Lithuania, Research Achoki et al (2016) on Universal

Health Coverage, both from the role of the private and government sectors, is strengthened by research Ryan, Thomas et al (2009) in Ireland, which states that in the health care system the health financing system depends on the pattern of health financing, the tendency to use the health insurance system has been chosen by several countries, both NHS and SHI. This research sharpened by Cavagnero (2008) which states that government-run insurance is very beneficial for the poor.

The effect of health financing methods on the ability to purchase health services. Categorized into two categories, namely the method of payment before or after service which is incorporated in the 7 indicators. Financing indicators based on disease diagnosis occupy the highest average distribution (52.86%). This indicates that this method is often chosen by the community so that there is clarity in health financing as evidenced by the indicator statement that the respondent and their family are served by a diverse team of medical officers by systematically utilizing the interpol or inter-unit information system (DR1) by optimizing services using good information systems and techniques (DR4).

The capitation system health financing method ranks second with 52.63% agreeing to use the capitation system. It is reinforced by the respondent's statement in the indicator, namely that families and their members are given information on the importance of prevention efforts before getting sick when they come to health service facilities (K1) and there is family support to pay fees at the beginning of each month (K5). The monthly salary received by health workers is also part of the health financing method, so that almost half of the respondents (50.52%) stated that this method was chosen, with certainty of income so that the respondent felt the service directly from the statement on the indicator which stated that the services provided were only are routine in nature by health workers (GBL5), however, they are still served with good cooperation between health workers (GBL1).

When viewed from the respondent's statement on the method of health financing, especially those carried out after services consisting of direct financing after service and replacement of prepayments showed unfavorable results marked 43.92% agree to use fee for services which allows the availability of costs in each.family. Fee for service is very attractive to health workers, considering in concept and in theory there is a direct payment after health workers provide services to patients, but many patients and families do not make this option. This is reinforced by the statement in the indicator that families are served optimally with a customer satisfaction orientation (FFS1) and families are always asked for their opinion after using health services (FFS7).

Along with direct financing after service and reimbursement of prepayments, only 46.55% of respondents were willing, while the remaining 53.45% refused to use this system. This is reinforced by the statement contained in the indicator that the head of the family and their members must immediately contact the insurance company about the cost of health services (PR4), even though at first they feel comfortable with paying part of the costs in advance, to submit a claim to a third party / insurance agency (PR1).

In fact, based on the theory, it is stated that in choosing the method of health financing, nothing is perfect, but each has advantages and disadvantages in its implementation. In Indonesia what has happened so far is that the most ideal method to be implemented is capitation (advance payment based on the number of people served) with the consideration that there is certainty in the number of people served in a certain area by health workers in accessing health services. With this capitation method, it is hoped that an approach will be made in the form of

efforts to implement a healthy lifestyle through a healthy paradigm, prevention is better thancure. Meanwhile, the health financing method with direct payments must be prepared by the community or the head of the family to complement the funding from the capitation system. This direct payment is directly related to the amount of income or income of each head of the family, so that the family and family members are able to access health service facilities. It is common in several countries that the proportion of direct payments is greater among poor or developing countries compared to developed countries, even though the fact is that the availability also shows different resources.

Research result of Feng, et al (2020) in China expressed support in the payment method of health care costs, through cost sharing, including research from Cuadros et al (2020) from the University of Arkansas Colombia also stated that the need for cost sharing in efforts to finance health, especially for groups of informal workers who are not well detected by the government. In the United States research results of Angrisani et al (2018) that the importance of medicare financing is because it is better patterned when compared to the risk of uncertainty about the occurrence of illness. Research DeLeire *et al.* (2017) in the United States, also states that the Affordable Care Act (ACA) provides assistance to low-income communities through premium subsidies and reduced cost sharing (CSR).

The influence of family socioeconomic status on the ability to purchase health services through the health financing pattern. Aspects of the socioeconomic status of the respondent's family with an average income of Rp. 3,144,155 per month turned out to be more than the provincial minimum wage income (UMP) Jambi Province in 2020 amounting to Rp. 2,630,162, so that there is the ability to buy health services as evidenced by an income of more than 2 million of 63.9%. Whencompared with the UMP for each district / city where the research was located, it turns out that in 4 districts (Batanghari, Bungo, Merangin, and Sungai Penuh City) the UMP value is the same as the UMP Jambi Province of Rp. 2,630,162, while 2 districts that differ above the provincial minimum wage, namely West Tanjab Regency Rp. 2,865,000 and Jambi City Rp. 2,900,000.

If it is related to work, it turns out that 19.3% need attention with the work of casual daily laborers, or income engaged in the informal sector with an average monthly income of Rp. 1,729,194. This includes work in agriculture, forestry and fisheries (Rp. 1,508,698), mining and quarrying (Rp. 2,485,594), industry and processing (Rp. 2,411,289), in the field of procurement of waste, water, waste recycling (Rp. 2,088,111), and the construction sector (Rp. 2,199,968). (BPS, 2021) The fact of the results of this study shows that of the various health financing patterns launched by the Jambi Provincial Government, it turns out that this variable (collaboration with 6 variables) mediates the relationship between family socio- economic status and the ability to purchase health services. This is supported by research results Thakur *et al.* (2018) in India, Thoa *et al.* (2013) in Vietnam, and Ku Y C *et al.* (2019) in Taipei Taiwan.

The effect of the family's social economic status on the ability to purchase health services through the health financing method. Aspects of the socioeconomic status of the respondent's family with an average income of Rp. 3,144,155 per month turned out to be more than the provincial minimum wage income (UMP) Jambi Province in 2020 amounting to Rp. 2,630,162, so that there is the ability to buy health services as evidenced by an income of more than 2 million of 63.9%. When compared with the size of the UMK (City / Regency Minimum Wage) for each district / city where the study was located, it turns out that in 4 districts (Batanghari, Bungo, Merangin, and

Sungai Penuh City) the UMK value is the same as the UMP Jambi Province of Rp. 2,630,162, while the 2 districts that are different above the Provincial Minimum Wage, namely West Tanjab Regency Rp. 2,865,000 and Jambi City Rp. 2,900,000. If associated with the job it turns out that needs to get 19.3% attention with freelance day labor jobs, or incomes engaged in the informal sector with an average monthly income of Rp. 1,729,194. This includes agricultural, forestry and fishery work (Rp. 1,508,698), mining and quarrying (Rp. 2,485,594), industrial and processing (Rp. 2,411,289), waste procurement, water, recycled waste (Rp. 2,088,111), and construction sector (Rp. 2,199,968) (BPS, 2021).

The fact of the results of this study shows that of the various health financing methods that have been implemented by the Jambi Provincial Government, it turnsout that this method variable, which consists of 7 variables, namely 5 before service and 2 after service is able to mediate the relationship between family socioeconomic status and purchasing ability. health services. This is in line with the study in the form of research conducted by Hsiao (2007), research Raeesi *et al.* 2018) in Iran, research Schieber *et al.* (2007).

Novelty (Research Novelty), First Previous research only measured the socioeconomic status variable on the ability to buy health services from the variable health financing pattern or partial health financing method, while the research I conducted was from 770 respondents by combining health financing patterns and methods on the ability to buy health services in Jambi Province. **Second**, the average income of the head of the family based on this study in Jambi Province was Rp. 3,144,155., it is in a higher position when compared to the Jambi Provincial Minimum Wage (UMP) in 2020 of Rp. 2.630.162.-, so that the head of the family has the ability to buy health services depending on the process of selecting patternsand methods of health financing in accessing health services. **Third**, The average length of schooling in this study reaches 12 years with equal high school education, but in fact the average National education in 2019 has only reached 8.34 years, while in Jambi Province it has only reached 8.45 years as evidenced by the Development Index indicator Humans of 2019. **Fourth**, specifically for financing sourced from the community as a form of mutual cooperation in health financing, it is carried out by exploring local wisdom which is used for non-chronic types of diseases, especially in informal communities, such as motorcycle taxi drivers, traders and other informal workers in accordance with the agreement of the group, especially in Jambi Province.

Conclusion

Conclusion: (1) the socioeconomic status of the family has a direct effect on the ability to purchase health services, (2) the pattern of health financing has a direct effect on the ability to purchase health services, (3) the method of health financing has a direct effect on the ability to purchase health services, (4) social status family economy has an indirect effect on the ability to purchase health services through the health financing pattern and (5) the socioeconomic status of the family has an indirect effect on the ability to purchase health services through the health financing method.

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