

## Health Insurance Ownership and Factors Related to the Utilization of Health Services in Blitar, East Java, Indonesia

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### ABSTRACT

**Background:** Blitar City, Indonesia, aims to achieve 99.74% universal health coverage (UHC) by 2024. However, public health services are only accessible to 34.6% of the population. Utilization of services for non-communicable diseases such as hypertension remains below 20%. The aim of this research was to analyze the relationship between health insurance ownership, predisposing factors, and supporting factors on the utilization of health services.

**Subjects and Method:** This was a cross-sectional study design and involved 405 respondents in Blitar City, East Java, Indonesia. Data collection was conducted using a structured questionnaire instrument measuring demographic characteristics, socioeconomic status, health status, health insurance ownership, and psychological behavioral aspects (self-efficacy, attitude, and intention) rated on a Likert scale. Data were analyzed using a structural equation modeling (SEM) approach for path analysis.

**Results:** Path analysis revealed five main factors that significantly influenced healthcare utilization. Directly, gender ( $b=0.15$ ; CI 95%=0.05 to 0.26;  $p=0.005$ ), marital status ( $b=0.13$ ; CI 95%=0.02 to 0.24;  $p=0.017$ ), and behavioral intention ( $b=0.07$ ; CI 95%=0.03 to 0.12;  $p=0.003$ ) had a significant positive effect. Indirectly, self-efficacy was the most dominant positive predictor of behavioral intention ( $b=0.54$ ; CI 95%=0.49 to 0.59;  $p<0.001$ ), followed by behavioral attitude ( $b=0.09$ ; CI 95%=0.02 to 0.15;  $p=0.009$ ).

**Conclusion:** Self-efficacy, gender, marital status, attitudes, and intentions are dominant factors. The government needs to simplify digital systems, optimize men's health programs, and transform service quality to keep pace with the high pace of UHC achievement.

**Keywords:** health insurance, health services, path analysis

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## BACKGROUND

In 2015, the global development agenda underwent a significant shift from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs), with targets to be achieved by 2030 (United Nations, 2015). Among the 17 new goals agreed upon, Goal 3 plays a central role (World Health Organization, 2015). This goal focuses on ensuring healthy lives and promoting well-being for all people at all ages (United Nations, 2015). One key target under Goal 3 is Target 3.8: achieving Universal Health Coverage (UHC) (World Health Organization, 2015).

Indonesia implements the global UHC commitment through the National Health Insurance (NHI) program managed by the Social Security Administering Agency Health (Mboi et al., 2018). This program recorded very significant membership growth at the national and regional levels so that many regions succeeded in achieving UHC status (Blitar City Health Office, 2024a). Although the quantitative achievement is relatively high, field implementation still faces major challenges, such as geographical barriers in accessing health facilities, disparities or inequalities in the quality of health services between regions, problems with the program's financial sustainability, especially related to contribution management and optimization of regional levies (Ismainar et al., 2024; Marissa et al., 2026), and the need for periodic service quality improvements for all NHI participants (Mboi et al., 2018; Alayda et al., 2024). These conditions encourage local governments to continue to formulate optimal strategies to support, strengthen, and improve the implementation of the NHI program in their respective regions (Health Development Policy Agency, 2024a).

Data from the Central Statistics Agency (BPS) and the 2023 Indonesian Health Survey (SKI) show that approximately 71.3% to 72% of the Indonesian population is covered by

health insurance (Statistics Indonesia, 2023; Health Development Policy Agency, 2024b). This figure underscores the urgency of health financing within the national system. However, there are striking geographic disparities in insurance ownership rates in urban areas reaching 75.9% and rural areas lagging behind at 64.8% (Health Development Policy Agency, 2024b).

Various analyses of National Socio-economic Survey data consistently find that insurance ownership, particularly under the National Health Insurance program, is positively and significantly correlated with actual health service utilization (Marissa et al., 2026). This system integration has been shown to reduce financial barriers in accessing outpatient and inpatient care (Alayda et al., 2024). Individuals with government-managed insurance have a higher tendency to utilize primary health care and hospital care compared to the uninsured group (Pramesti et al., 2022).

Real data shows a major contradiction between the administrative status of health insurance membership and the realization of the utilization of medical facilities in Blitar City. NHI membership achievement in 2024 reached 99.74%, exceeding the average of East Java Province which is at 94.53% (Blitar City Health Office, 2024c; East Java Provincial Health Office, 2024). Realization of service access only accessed by 34.6% of the total city population (Blitar City Health Office, 2024c). Chronic disease screening at the level of service utilization for non-communicable diseases (such as hypertension) is still below 20% of the total estimated sufferers (Blitar City Health Office, 2024c).

The high number of NHI card ownership does not necessarily increase visits to formal health facilities due to the following structural and behavioral obstacles: the policy of mass deactivation of Contribution Assistance Recipients by the central government,

many residents have NHI cards administratively, but their status is inactive when used (Mboi et al., 2018), low level of public knowledge regarding the flow of the NHI tiered referral system (Amayu, 2024), there is a negative perception of the quality of service at referral Health Service Facilities (Mboi et al., 2018; Alayda et al., 2024), and the people of Blitar City have a much higher preference for seeking treatment from independent doctor practices compared to Community Health Centers (Blitar City Health Office, 2024b).

The causality analysis results from this study are intended to provide tactical recommendations. The goal is to transform the UHC program, which is currently only a numerical success on paper, into one that is effective, inclusive, and truly beneficial to all levels of society.

## SUBJECTS AND METHOD

### 1. Study Design

The scope of this study covers the city of Blitar. This study used a quantitative approach with primary data and was conducted in March 2026. The researchers employed a cross-sectional study design. A cross-sectional study design is a type of observational research, meaning it does not involve intervention. This cross-sectional design measures data at a single point in time. The aim of this study was to determine the utilization of health services and influencing factors based on the Theory of Planned Behavior (TPB) (Ajzen, 2020) and the behavioral model of health services utilization (Andersen, 2005).

### 2. Population and Sample

The population in this study comprised residents of Blitar City who utilized Integrated Service Posts during the study period. A proportional stratified random sampling technique was employed to ensure proportional representation across the three sub-districts: Kepanjenkidul, Sananwetan, and Sukorejo. By randomly selecting samples from each stratum relative to its size in the total

population, this method enhanced demographic representativeness, maximized statistical accuracy, and minimized sampling variability.

The initial sample size was determined to be 400 respondents using the Slovin formula. To safeguard data validity and anticipate potential dropouts, the researchers added a 10% buffer (40 respondents), adjusting the total recruitment target to 440 respondents. This oversampling strategy was implemented to mitigate technical risks, such as incomplete questionnaires or respondent withdrawal mid-study. Following a proportional distribution based on the population size of each sub-district, the targeted sample was allocated as follows: 125 respondents from Kepanjenkidul, 164 from Sananwetan, and 151 from Sukorejo.

The inclusion criteria for the participants required them to be permanent residents of Blitar City (verified by a Blitar ID card), aged 17–65 years (encompassing the productive and decision-making age range), and willing to participate in the study. Out of the targeted sample, 35 questionnaires were declared invalid due to incomplete responses. Consequently, a final sample of 405 valid respondents was retained for data analysis.

### 3. Research Variables

Independent variables: socio-demographics, including age, gender, marital status, education, and transportation costs. Psychological factors, including attitudes, subjective norms, self-efficacy, and behavioral intentions. Supporting factors include economic level and health insurance ownership. Need factors, including health status.

Dependent variable: health service utilization.

### 4. Operational Definition

**Age** of respondents at the time of the interview.

**Gender** refers to the differences in human biological characteristics and functions.

**Marital status** refers to the respondent's marital status

**Education** refers to the highest educational status completed by the respondent.

**Transportation cost** refers to transportation costs incurred by respondents from home to health facilities

**Attitude** refers to the respondent's positive or negative assessment of their behavior in utilizing health services

**Subjective norm** refers to the respondent's perceptions of social pressure or expectations of others (family, friends, society) to perform or not perform health service utilization behaviors

**Self-efficacy** refers to the respondent's perceptions of ease or difficulty in performing a behavior reflect beliefs about the availability of resources and opportunities

**Behavioral intention** refers to the respondent's strong commitment or tendency to perform a behavior

**Economic level** refers to total average family income per month compared to the Minimum Wage of Blitar City

**Health insurance ownership** refers to respondents are registered as social health insurance holders

**Health status** based on respondents' subjective perceptions when utilizing health services

**Health service utilization** refers to utilization of health services by respondents during the last 1 year

## 5. Study Instruments

Data for all variables were collected using a structured questionnaire adapted from the Theory of Planned Behavior (Ajzen, 2020) and Andersen's Behavioral Model of Health Services Utilization (Andersen, 2005). The instrument integrated four main theoretical components: attitudes toward behavior, subjective norms, perceived behavioral control (measured as self-efficacy), and behavioral intentions, which collectively

predict actual health service utilization and facility access.

To ensure measurement quality, the questionnaire underwent rigorous validity and reliability testing. All items were evaluated using a 4-point Likert scale to eliminate neutral responses and enhance statistical variance. The constructs for behavioral attitude, subjective norm, and self-efficacy were each operationalized using 4 items, resulting in a total summated score ranging from 4 to 16 for each variable. Meanwhile, the behavioral intention construct was measured using 3 items, yielding a total summated score scale ranging from 3 to 12.

## 6. Data Analysis

Quantitative analysis included descriptive statistics (frequency, percentage, mean, and SD) for respondent characteristics. The direct and indirect associations between variables were analyzed by path analysis. The path analysis proceeded in steps including model specification, model identification, model fit, parameter estimation, and model re-specification (if necessary). Prior to testing, multicollinearity statistical assumption tests were conducted. All tests were  $\alpha = 0.05$  significance level and processed using Stata version 17.0 software.

## 7. Research Ethics

The study has obtained ethical approval from the Health Research Ethics Committee STIKes Patria Husada Blitar, Indonesia No. 06/PHB/KEPK/384/03.26, on March 12, 2026. All participants were provided with complete information regarding the study's objectives, anonymity, data confidentiality, participant rights, and signed an informed consent prior to participation.

# RESULTS

## 1. Sample Characteristics

The data used in this study is primary data. Respondents included residents of Blitar City who had or had not used health facilities in

the past year. A total of 405 respondents answered the questionnaire asking about their health insurance coverage and health

services utilization. Of these respondents, 297 (73.33%) had health insurance and had used health services in the past year.

**Table 1. Sample Characteristics**

| Characteristics                    | Frequency | Percentage |
|------------------------------------|-----------|------------|
| <b>Age</b>                         |           |            |
| Adult (18-59 years)                | 316       | 78.02%     |
| Elderly (60-65 years)              | 89        | 21.98%     |
| <b>Gender</b>                      |           |            |
| Men                                | 76        | 18.77%     |
| Women                              | 329       | 81.23%     |
| <b>Marital status</b>              |           |            |
| Not married                        | 76        | 18.77%     |
| Married                            | 329       | 81.23%     |
| <b>Education</b>                   |           |            |
| Lower                              | 48        | 11.85%     |
| Middle                             | 216       | 53.33%     |
| Higher                             | 141       | 34.81%     |
| <b>Transportation cost</b>         |           |            |
| Not affordable                     | 3         | 0.74%      |
| Affordable                         | 402       | 99.26%     |
| <b>Economic level</b>              |           |            |
| Low                                | 266       | 65.68%     |
| High                               | 139       | 34.32%     |
| <b>Health insurance ownership</b>  |           |            |
| Not owning                         | 16        | 3.95%      |
| Own                                | 389       | 96.05%     |
| <b>Health status</b>               |           |            |
| Sick                               | 266       | 65.68%     |
| Healthy                            | 139       | 34.32%     |
| <b>Health services utilization</b> |           |            |
| No                                 | 100       | 24.69%     |
| Yes                                | 305       | 75.31%     |

Based on the descriptive data presented in the characteristics table, a total of 405 respondents participated in this study, displaying a diverse distribution across various profiles. In terms of demographic characteristics, the majority of the respondents fall into the adult age group, accounting for 316 individuals (78.02%). Interestingly, the distribution based on gender and marital status shows identical figures, the sample is highly dominated by women at 329 individuals (81.23%). Similarly, married respondents constitute 329 individuals (81.23%). Looking at the

educational background, more than half of the respondents have completed middle-level education (216 individuals or 53.33%).

Regarding socio-economic factors and accessibility, an overwhelming majority of the respondents report that transportation costs to healthcare facilities are affordable, representing 402 individuals (99.26%). In contrast, when evaluated by economic level, the majority of the respondents are categorized into the low-income group, totaling 266 individuals (65.68%). Despite the predominantly low economic status, health insurance ownership among the

respondents is exceptionally high, with 389 individuals (96.05%) owning health insurance.

Lastly, looking at the health profile and healthcare utilization behavior, the data show an identical numerical distribution between the current health status and the economic level. The majority of the respondents

had subjective perceptions as sick when utilizing health services, totaling 266 individuals (65.68%). Aligning with the high percentages of health status, the actual utilization of health services is also remarkably high. A total of 305 respondents (75.31%) utilized health services.

**Table 2. Univariate Analysis**

| Variables                                            | Mean      | SD        | Min.    | Max.       |
|------------------------------------------------------|-----------|-----------|---------|------------|
| Age (years)                                          | 42.02     | 14.49     | 18      | 65         |
| Number of household members                          | 3.62      | 1.25      | 1       | 9          |
| Average monthly household income (rupiah)            | 2,731,785 | 2,262,071 | 250,000 | 30,000,000 |
| Time required from home to health facility (minutes) | 9.38      | 5.28      | 0.4     | 40         |
| Attitude                                             | 14.08     | 1.97      | 8       | 16         |
| Subjective norm                                      | 13.72     | 1.96      | 5       | 16         |
| Self-efficacy                                        | 13.11     | 2.15      | 4       | 16         |
| Behavioral intention                                 | 9.85      | 1.60      | 3       | 12         |

Based on the descriptive statistics for the continuous variables presented in the table, the respondents exhibit varied demographic, socioeconomic, and behavioral characteristics. The average age of the respondents is 42.02 years ( $SD = 14.49$ ), with ages ranging widely from a minimum of 18 years to a maximum of 65 years. In terms of household characteristics, the mean number of household members is 3.62 persons ( $SD = 1.25$ ), ranging from single-member households to large families with up to 9 members. Socioeconomically, the average monthly household income is reported at Rp 2,731,785. However, a very high standard deviation ( $SD = \text{Rp}2,262,071$ ) indicates substantial income inequality within the sample, where the lowest recorded monthly income is just Rp250,000, while the highest reaches Rp30,000,000. For geographic accessibility, the average time required to travel from home to the nearest healthcare facility is relatively short at 9.38 minutes ( $SD = 5.28$ ), with some respondents living exceptionally

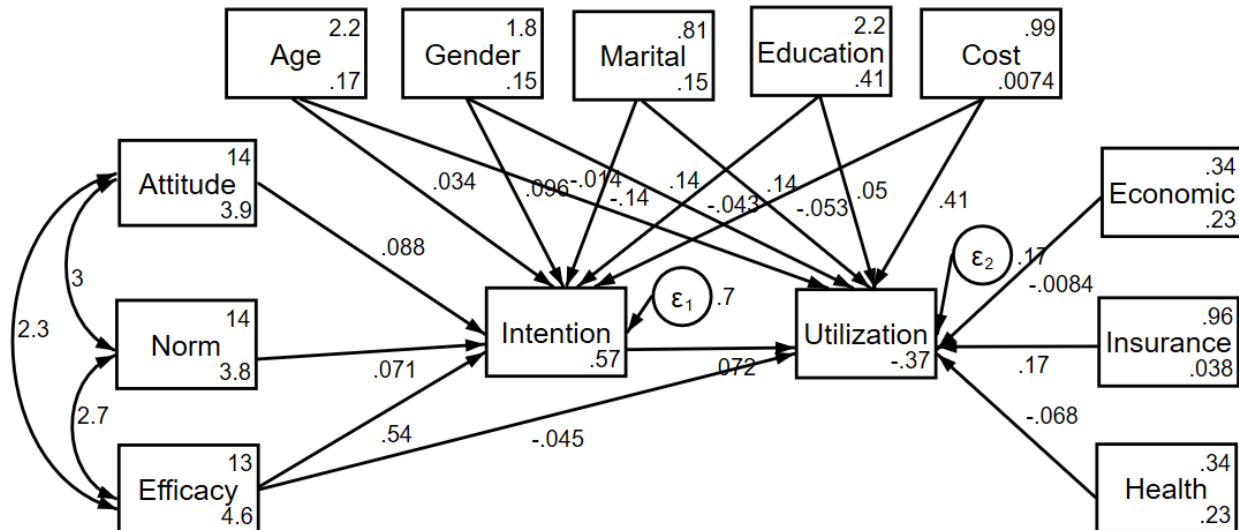
close (0.4 minutes) and others living up to 40 minutes away.

Regarding the psychological constructs based on the Theory of Planned Behavior (TPB), the respondents generally show positive tendencies across all measured variables. The mean score for attitude toward the behavior is high at 14.08 ( $SD = 1.97$ ), with individual scores ranging from 8 to a maximum of 16. Similarly, the subjective norm variable shows a strong average score of 13.72 ( $SD = 1.96$ ), spanning from a minimum score of 5 to a maximum score of 16. For self-efficacy, the respondents recorded a mean score of 13.11 ( $SD = 2.15$ ), with scores distributed between a minimum of 4 and a maximum of 16. Finally, the behavioral intention to utilize health services shows an average score of 9.85 ( $SD = 1.60$ ), with individual responses ranging from a minimum score of 3 to a maximum score of 12, reflecting a strong overall inclination among respondents to utilize healthcare services.

## 2. Path Analysis

In the path analysis model used in this study, the independent and dependent variables do not simply stand alone in a linear fashion, but form a series of cause-and-effect relationships. Based on health behavior theory

(Theory of Planned Behavior and Andersen's Health Care Utilization Model), the path analysis model with estimation is shown in Figure 1.



**Figure 1. Path Analysis Model: Theory of Planned Behavior and Andersen's Health Care Utilization Model**

**Table 3. The Results of Path Analysis**

| Dependent Variables        | Independent Variables        | b     | 95% CI      |             | p      |
|----------------------------|------------------------------|-------|-------------|-------------|--------|
|                            |                              |       | Lower Limit | Upper Limit |        |
| Direct effect              |                              |       |             |             |        |
| Health service utilization | ↵ Behavioral intention       | 0.07  | 0.03        | 0.12        | 0.003  |
|                            | ↵ Self-efficacy              | -0.01 | -0.03       | 0.01        | 0.569  |
|                            | ↵ Age                        | -0.01 | -0.12       | 0.10        | 0.836  |
|                            | ↵ Gender                     | 0.15  | 0.05        | 0.26        | 0.005  |
|                            | ↵ Marital status             | 0.13  | 0.02        | 0.24        | 0.017  |
|                            | ↵ Education                  | 0.05  | -0.02       | 0.12        | 0.198  |
|                            | ↵ Transportation cost        | 0.41  | -0.07       | 0.88        | 0.094  |
|                            | ↵ Economic level             | -0.01 | -0.10       | 0.08        | 0.857  |
|                            | ↵ Health insurance ownership | 0.17  | -0.04       | 0.38        | 0.113  |
|                            | ↵ Health status              | -0.07 | -0.15       | 0.02        | 0.118  |
| Indirect effect            |                              |       |             |             |        |
| Behavioral intention       | ↵ Attitude                   | 0.09  | 0.02        | 0.15        | 0.009  |
|                            | ↵ Subjective norm            | 0.07  | 0.00        | 0.14        | 0.053  |
|                            | ↵ Self-efficacy              | 0.54  | 0.49        | 0.59        | <0.001 |
|                            | ↵ Age                        | 0.03  | -0.18       | 0.25        | 0.755  |
|                            | ↵ Gender                     | 0.10  | -0.12       | 0.31        | 0.373  |
|                            | ↵ Marital status             | -0.14 | -0.36       | 0.07        | 0.189  |

| Dependent Variables | Independent Variables | b     | 95% CI      |             | p     |
|---------------------|-----------------------|-------|-------------|-------------|-------|
|                     |                       |       | Lower Limit | Upper Limit |       |
|                     | ← Education           | -0.04 | -0.18       | 0.09        | 0.530 |
|                     | ← Transportation cost | -0.05 | -1.00       | 0.90        | 0.914 |

N observation= 405  
Log likelihood= -3,949.5841

The path analysis results across 405 respondents revealed the factors that directly influenced health service utilization and those that indirectly affected it through behavioral intention. Based on the direct effect analysis, three independent variables demonstrated a statistically significant and positive influence on whether individuals utilized health services. Gender emerged as the strongest direct predictor ( $b = 0.15$ ; 95% CI= 0.05 to 0.26;  $p = 0.005$ ), indicating that women were 0.15 units more likely to utilize health services than men. This was followed by marital status ( $b = 0.13$ ; 95% CI= 0.02 to 0.24;  $p = 0.017$ ), which showed that married individuals had a higher likelihood of utilizing health services by 0.13 units compared to those who were not married. Additionally, behavioral intention exerted a significant direct effect ( $b = 0.07$ ; 95% CI= 0.03 to 0.12;  $p = 0.003$ ), meaning that every one-unit increase in an individual's intention directly boosted health service utilization by 0.07 units.

Conversely, other variables including self-efficacy ( $b = -0.01$ ; 95% CI= -0.03 to 0.01;  $p = 0.569$ ), age ( $b = -0.01$ ; 95% CI= -0.12 to 0.10;  $p = 0.836$ ), education ( $b = 0.05$ ; 95% CI= -0.02 to 0.12;  $p = 0.198$ ), transportation cost ( $b = 0.41$ ; 95% CI= -0.07 to 0.88;  $p = 0.094$ ), economic level ( $b = -0.01$ ; 95% CI= -0.10 to 0.08;  $p = 0.857$ ), health insurance ownership ( $b = 0.17$ ; 95% CI= -0.04 to 0.38;  $p = 0.113$ ), and health status ( $b = -0.07$ ; 95% CI= -0.15 to 0.02;  $p = 0.118$ ) did not show statistically significant direct effects on health services utilization.

Regarding the indirect effects examining predictors of behavioral intention, self-

efficacy stood out as the most dominant variable in the entire research model. It exerted a highly substantial and significant positive effect ( $b = 0.54$ ; 95% CI= 0.49 to 0.59;  $p < 0.001$ ), which meant that every one-unit increase in an individual's self-confidence drastically drove their behavioral intention to utilize health services upward by 0.54 units. In addition to self-efficacy, attitude was also found to significantly and positively influence behavioral intention ( $b = 0.09$ ; 95% CI= 0.02 to 0.15;  $p = 0.009$ ), where a one-unit increase in positive attitude improved intention by 0.09 units. On the other hand, subjective norm ( $b = 0.07$ ; 95% CI= 0.00 to 0.14;  $p = 0.053$ ) along with all other sociodemographic characteristics such as age ( $b = 0.03$ ; 95% CI= -0.18 to 0.25;  $p = 0.755$ ), gender ( $b = 0.10$ ; 95% CI= -0.12 to 0.31;  $p = 0.373$ ), marital status ( $b = -0.14$ ; 95% CI= -0.36 to 0.07;  $p = 0.189$ ), education ( $b = -0.04$ ; 95% CI= -0.18 to 0.09;  $p = 0.530$ ), and transportation cost ( $b = -0.05$ ; 95% CI= -1.00 to 0.90;  $p = 0.914$ ) failed to show any significant impact on shaping behavioral intention.

## DISCUSSION

### 1. Demographic Variables

The path analysis of 405 respondents in Blitar City showed that female gender and marital status had a significant direct impact on increased utilization of health service. Positive community attitudes and high self-efficacy indirectly influenced health service utilization, with both factors playing a strong role in shaping individual intentions (Sulaeman, 2025). Self-efficacy emerged as the most dominant factor, confirming that confidence

in accessing systems (such as online registration) and mental intention were the primary drivers of health-seeking behavior in Blitar City (Blitar City Health Office, 2024b; Sulaeman, 2025).

The results of the path analysis indicate that socio-demographic factors have a significant direct influence on the behavior of utilizing health service. First, the gender variable is proven to have a direct positive and significant effect ( $b = 0.15$ ; 95% CI = 0.05 to 0.26;  $p = 0.005$ ) which indicates that female residents in Blitar City have a higher level of health service utilization than men. This is driven by a stronger awareness of prevention, a high number of health complaints, and the fulfillment of women's reproductive roles such as pregnancy checks, family planning, and child immunization (Ramli, 2022). Second, marital status also has a direct, positive, and significant effect on the action of utilizing health services ( $b = 0.13$ ; 95% CI = 0.02 to 0.24;  $p = 0.017$ ).

The presence of a partner in the household functions spontaneously as a social safety net and emotional support. When a family member is sick, the spouse acts directly as a quick decision maker to seek medical treatment, so that the referral process to a health facility occurs instantly without having to go through a long phase of contemplation or forming an intention (Akhriansyah et al., 2023).

## 2. Psychological Aspects

Based on the Theory of Planned Behavior (TPB) framework, psychosocial factors have been shown to have a crucial role in shaping health service utilization behavior in Blitar City. Attitude variables were found to have a positive and significant effect on public intention ( $b = 0.09$ ; 95% CI = 0.02 to 0.15;  $p = 0.009$ ), where this positive evaluation arose from public satisfaction with the quality of government services, such as guaranteed drug availability, cleanliness of facilities, and clarity

of free referral channels based on Universal Health Coverage (UHC) (Laksono et al., 2024). On the other hand, self-efficacy or self-confidence did not show a direct effect on actual actions ( $b = -0.01$ ; 95% CI = -0.03 to 0.01;  $p = 0.569$ ), but had the most dominant positive effect on the formation of intention ( $b = 0.54$ ; 95% CI = 0.49 to 0.59;  $p < 0.001$ ).

This perfect mediation phenomenon confirms that resident's confidence in mastering operational aspects (such as online registration via Mobile NHI or the online queuing system) does not automatically drive them to health facilities, but must first be converted into a mental commitment in the form of intention (Kumala et al., 2025). Furthermore, intention acts as the main predictor with a direct, positive, and significant influence in bridging attitudes and self-efficacy into actual visits ( $b = 0.07$ ; 95% CI = 0.03 to 0.12;  $p = 0.003$ ). However, the strength of this influence of intention is moderate due to the existence of a behavioral gap (intention-behavior gap) triggered by situational obstacles in the field, such as bad weather, lack of transportation, or sudden work matters (Sheeran and Webb, 2020).

## 3. Socioeconomic Status and Insurance Ownership

From the perspective of the health behavior model, financial-structural factors classified as enabling factors actually showed statistically insignificant results in Blitar City. The economic level variable was proven not to significantly influence the utilization of health service ( $b = -0.01$ ; 95% CI = -0.10 to 0.08;  $p = 0.857$ ). This indicates that low- and high-income groups have equal opportunities and utilization patterns. This equality is supported by a well-targeted health cost subsidy policy and the strategic spatial planning of Blitar City, where the distribution of health service centers is evenly distributed and geographically accessible across three administrative areas, namely Sananwetan, Kepanjenkidul,

and Sukorejo sub-districts (Blitar City Health Office, 2024b). In line with this, the variable of health insurance ownership was also not proven to have a significant direct influence ( $b = 0.17$ ; 95% CI =  $-0.04$  to  $0.38$ ;  $p = 0.113$ ).

This insignificance arises because Blitar City has successfully achieved the Universal Health Coverage (UHC) target of nearly 100% of the population (Health Development Policy Agency, 2024a; Blitar City Health Office, 2024b). The highly homogenous nature of the data (where nearly all residents are actively participating in health insurance) causes this variable to lose its distinguishing variance, so that a person's reason for visiting a health facility is no longer determined by insurance card ownership, but rather by other motivational factors (Pramesti et al., 2022).

#### 4. Health Status

The results of the path analysis on the influence of health status variables on the utilization of health services in Blitar City indicate that health status as a need factor is statistically proven to have no significant direct influence on the behavior of utilizing health services ( $b = -0.07$ ; 95% CI =  $-0.15$  to  $0.02$ ;  $p = 0.118$ ). This negative coefficient value indicates the phenomenon of treatment delay, where a decline in physical condition does not immediately increase visits to health facilities because people tend to choose to self-medicate as long as the symptoms of the disease are still considered mild (Tumangger and Airlangga, 2022). Conceptually, the physical condition of illness requires a psychological mediation role in the form of conversion through psychological evaluation first, namely in the form of triggers of intention ( $b = 0.07$ ; 95% CI =  $0.03$  to  $0.12$ ;  $p = 0.003$ ) and self-efficacy ( $b = 0.54$ ; 95% CI =  $0.49$  to  $0.59$ ;  $p < 0.001$ ) so that patients are truly motivated to visit health facilities (Ajzen, 2020; Pramesti et al., 2022).

Based on these findings, the Blitar City Health Office is recommended to immediately

shift from passive service methods to proactive outreach programs (such as strengthening Integrated Service Posts (*Posyandu*), intensive monitoring of non-communicable diseases, and home care services to detect early declines in community health status before conditions worsen due to delays in treatment.

The results of this analysis confirm a shift in the main challenges at health services utilization in Blitar City, where the main problem has now shifted from financial barriers to internal motivational barriers for residents. The solution to health financing in this region can be said to be complete because the achievement of Universal Health Coverage (UHC) in Blitar City has almost 100%, so that the issue of costs is no longer a concern for the community when seeking treatment. This condition requires a new focus in public policy, campaigns to raise new membership are no longer relevant. Program priorities must be shifted to maintaining the active BPJS/NHI card and improving the comfort of services at health facilities. Based on this empirical map, the most effective form of intervention going forward is educating the community to understand the health administration flow and simplifying service waiting times, which have been proven to have a far more significant impact than providing direct economic incentives.

Overall, this series of findings concludes that the primary challenge to utilizing health services in Blitar City has shifted significantly from financial-structural barriers to motivational barriers internal to the community. The Blitar City Government's success in achieving equitable distribution of facilities and Universal Health Coverage (UHC) has meant that cost is no longer a major barrier for residents seeking treatment. As a follow-up step, the Blitar City Health Office is recommended to shift its intervention focus to two main strategies. First, simplifying access

to information, improving digital literacy, and streamlining administrative processes to maintain and enhance community self-efficacy in utilizing digital technology-based health services. Second, ensuring the certainty of doctor schedules, improving the quality of staff friendliness, and optimizing the efficiency of waiting times to ensure that patients' established intentions and motivation are not weakened by technical obstacles during in-person visits to health facilities.

#### **AUTHOR CONTRIBUTION**

All author actively participated in all stages of the study, including study design, data collection, data analysis, and manuscript preparation.

#### **CONFLICT OF INTEREST**

There are no conflicts of interest

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