IMPACT OF THE ELIMINATION OF THE NATIONAL HEALTH INSURANCE (BPJS HEALTH) SERVICE CLASSES ON ACCESS AND QUALITY OF HEALTHCARE IN INDONESIA: A SYSTEMATIC REVIEW

Daniel Pradana Andrian Wicaksono

Faculty of Medicine, Duta Wacana Christian University, Yogyakarta, Indonesia

ABSTRACT

This study aims to analyze the impact of eliminating BPJS Health classes and implementing the Standard Inpatient Class (KRIS) in Indonesia, focusing on healthcare access, service quality, financial sustainability, and governance. The policy was introduced to promote social equity and reduce disparities in healthcare delivery. A systematic literature review was conducted using databases such as Google Scholar, PubMed, and Scopus, covering studies published between 2019 and 2024. The selected literature met inclusion and exclusion criteria to ensure relevance and quality, and a narrative synthesis was applied to identify major patterns and policy implications.The findings indicate that KRIS can improve fairness in healthcare access and simplify administrative processes. However, significant challenges remain, especially regarding hospital preparedness in less developed regions, where overcrowding, longer waiting times, and potential declines in service quality are likely to occur. The transition from a classbased system to a standardized model also raises financial concerns, particularly about sustainability and equity in funding. In addition, governance weaknesses and limited policy communication have led to uncertainty and public hesitation.Overall, KRIS reflects a progressive step toward healthcare equity but demands careful implementation. Sustainable financing, improved hospital capacity, effective governance, and active public participation are essential for ensuring its success. Future studies should continue exploring financial mechanisms and regional readiness to guide more inclusive and sustainable policy development.

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Corresponding author
Daniel Pradana Andrian Wicaksono
✉
41210613@students.ukdw.ac.id
Faculty of Medicine, Duta Wacana Christian University, Yogyakarta, Indonesia

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Highlights:

1. The elimination of BPJS Health classes through the Standard Inpatient Class (KRIS) aims to improve healthcare equity but raises concerns about hospital capacity, financial sustainability, and service quality.
2. Effective governance, sustainable funding, and phased implementation are crucial to ensuring KRIS successfully enhances healthcare access without compromising service quality.

INTRODUCTION

The National Health Insurance System (*Jaminan Kesehatan Nasional* (JKN)), managed by Indonesia's National Health Insurance agency (BPJS Health), was established to provide universal health coverage for all citizens[1]. Since its implementation in 2014, BPJS Kesehatan has applied a classbased inpatient system that divides participants into Classes I, II, and III according to their financial capacity. Recently, the government has introduced a major reform by proposing the removal of these classes and the adoption of a Standard Inpatient Class (*Kelas Rawat Inap Standar* (KRIS)). This change aims to promote fairness in healthcare access so that every patient receives equal treatment standards, regardless of socioeconomic background. The reform has farreaching implications for hospital financing, service delivery, and patient satisfaction.

Healthcare policy plays a crucial role in shaping access and the overall quality of medical services[2]. The decision to eliminate BPJS Kesehatan classes raises important questions about its practicality, potential benefits, and possible drawbacks. Supporters believe that a uniform inpatient system will foster equality and reduce social stigma between patients. On the other hand, critics are concerned that the reform may reduce service quality, lengthen waiting times, and increase the financial burden on hospitals. Understanding these issues is vital to ensure that the new system supports the goals of Universal Health Coverage (UHC) while maintaining hospital sustainability. Therefore, this study reviews current literature to analyze the policy's potential impact and offer recommendations for its effective implementation.

While previous studies have examined BPJS Kesehatan's success in expanding access to healthcare, only a few have explored the broader consequences of eliminating classbased inpatient services[3]. This review seeks to fill that gap by discussing how the policy change affects different groups patients, healthcare providers, and policymakers. By integrating findings from empirical research, policy documents, and expert opinions, this paper offers a more comprehensive perspective on the challenges and opportunities involved in transitioning to a standardized system.

Moreover, this study contributes to ongoing discussions about health system reform in Indonesia by highlighting critical areas that require policy attention. Specifically, it evaluates how the elimination of BPJS Kesehatan classes influences access across various socioeconomic levels, impacts service quality factors such as waiting time, bed availability, and patient satisfaction, and identifies the main challenges in implementing KRIS. The findings are expected to guide policymakers, healthcare practitioners, and researchers in navigating

the complexities of this reform. Ultimately, the transition toward KRIS is expected to support the national objective of achieving equitable and sustainable healthcare for all Indonesians.

MATERIALS AND METHODS

This study used a systematic literature review to analyze the impact of eliminating BPJS Health service classes on healthcare access and service quality in Indonesia. The systematic review method was chosen to ensure that all relevant studies were reviewed thoroughly and objectively, allowing conclusions to be drawn based on reliable scientific evidence. This approach involved identifying, selecting, and synthesizing literature that met specific inclusion criteria established before the review process.

The search process was carried out comprehensively through several academic databases, including Google Scholar, PubMed, Scopus, and other online journal platforms. Specific keywords were used, such as “BPJS Health class elimination,” “Universal Health Coverage in Indonesia,” “healthcare access,” “standardized inpatient class,” and “health policy impact.” Boolean operators (“AND,” “OR,” and “NOT”) were also applied to refine the search results. The scope of the search included studies published between 2019 and 2024 to ensure that the data analyzed reflected recent and relevant findings.

To maintain the quality of the review, strict inclusion and exclusion criteria were applied. Studies were included if they examined the effects of BPJS Health class elimination on access to and quality of healthcare, used qualitative, quantitative, or mixed methods, and were published in either English or Indonesian between 2019 and 2025. Conversely, studies were excluded if they did not discuss BPJS class elimination, lacked empirical data, or were unrelated to healthcare access or quality.

After the selection process, data from each study were extracted, covering research design, sample characteristics, policy impacts, financial implications, and main findings. The collected data were then analyzed using a narrative synthesis approach to identify emerging themes and variations across the studies. This method provided a deeper understanding of how the elimination of BPJS Health classes may influence healthcare access in Indonesia. The selection process is summarized in the PRISMA flow diagram below.

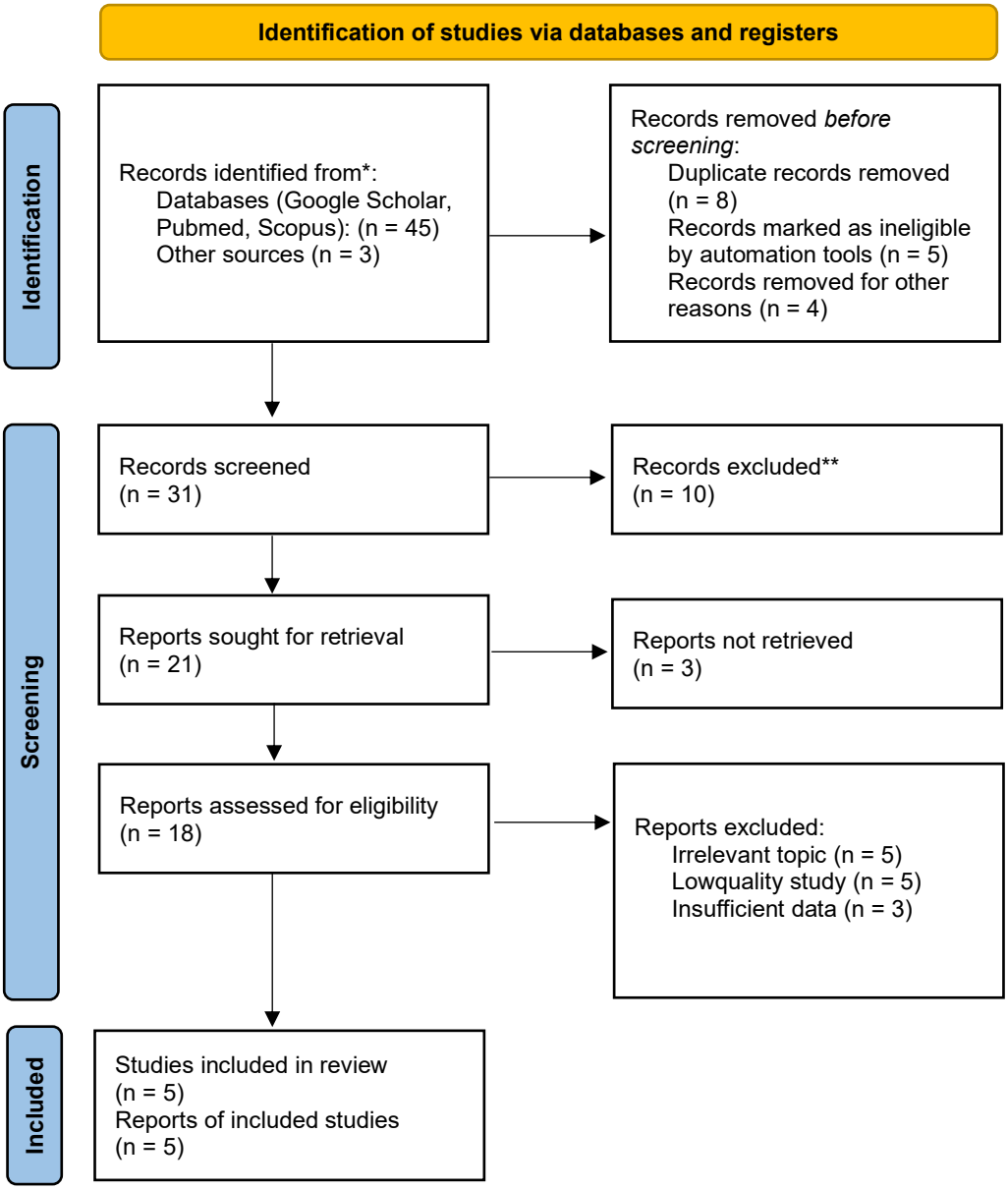

Figure 1. PRISMA diagram.

RESULTS

This section summarizes five journal articles that discuss the effects of eliminating BPJS Health service classes and the introduction of the Standard Inpatient Class KRIS policy in Indonesia. Each study explores different dimensions of the reform, including policy implications, public perception, governance challenges, and financial sustainability. An overview of the main findings from each publication is presented in the table below.

The first study, *Kebijakan Penyetaraan Kedudukan Sosial Masyarakat melalui Penghapusan Kelas dalam BPJS Kesehatan* by Merintha Suryapuspita, analyzes the BPJS Health program as a national health insurance system aimed at providing equitable and affordable healthcare for all Indonesian citizens[4]. Despite its initial objective, the system's classbased structure (Class I, II,

and III) has created inequalities in facilities, even though medical services remain the same across classes. This research evaluates the impact of abolishing these class distinctions on social equality using a normative juridical approach supported by a qualitative analysis of laws, regulations, and case studies.

The study shows that the policy is backed by several key legal frameworks, including the *UndangUndang Dasar 1945*, *UndangUndang No. 40/2004* on the National Social Security System, and *UndangUndang No. 24/2011* on BPJS, which formalized the transition from *Jamkesmas* to BPJS Kesehatan[5]. Removing class distinctions is intended to create uniform access to healthcare services for all participants.

Suryapuspita's analysis identifies both positive and negative implications. On the positive side, this reform promotes social equality, simplifies administrative procedures, and expands access to lowincome populations. However, potential drawbacks include higher premiums, greater workload for hospitals, and possible declines in service quality if supporting infrastructure is insufficient. To address these issues, the government introduced the KRIS model, which replaces the old classification with standardized criteria divided into KRIS A (for subsidized participants) and KRIS B (for nonsubsidized participants). The KRIS standards specify minimum room size, bed limitations, and service quality parameters, as stated in *Peraturan Presiden* No. 54/2020, which aims for gradual implementation starting in 2022[6].

Overall, the study suggests that removing BPJS class distinctions could promote equality and administrative efficiency but highlights the need for sufficient hospital readiness, adequate workforce capacity, and sustainable financial support. The success of KRIS depends on the government's ability to balance these factors through clear regulations and strategic investments in healthcare infrastructure[7].

The second article, Perspectives of BPJS Health Users on the KRIS Policy by Pramana and Chairunnisa Widya Priastuty, focuses on public responses to the KRIS policy implementation. BPJS Health was created to ensure fair and equal access to healthcare, but its previous threetier system resulted in facility disparities despite offering similar medical services[1]. The new KRIS system seeks to eliminate such differences by standardizing inpatient facilities for all participants, regardless of their socioeconomic background. However, this major shift has sparked public debate over whether the system truly meets users' expectations and financial capacities.

Using a qualitative case study approach, the research was conducted in Klaten Regency and the Special Region of Yogyakarta (DIY). Data were collected through indepth interviews with four participants selected through purposive sampling, representing the three BPJS classes. The data were analyzed following the Miles and Huberman model, which involves data reduction, presentation, and conclusion drawing, with triangulation applied to ensure validity.

Findings reveal a mix of opinions among BPJS users. Class III participants generally supported the KRIS policy, expecting improvements in hospital facilities, although they worried about possible increases in premiums. Conversely, Class I and II participants were less supportive, arguing that the previous classbased structure better reflected income

differences. Concerns were also raised regarding premium affordability, hospital capacity, and the limited public awareness campaigns about KRIS[8].

The study concludes that while KRIS represents an important step toward achieving social equality in healthcare, its success requires careful planning and gradual implementation. The authors recommend more extensive public socialization, pilot testing in selected hospitals to assess readiness, and regular policy evaluations to ensure smooth adaptation. Without these steps, the policy could inadvertently create new challenges instead of solving existing inequities.

The third study, Justice in *BPJS* Reform: Rawls' Theory and a Critical Review of the Standard Inpatient Class Policy by Hajar Imtihani and Muhammad Nasser, provides a critical analysis of Presidential Regulation No. 59 of 2024, which mandates the replacement of Indonesia's tiered BPJS Kesehatan inpatient class system with the KRIS[9]. The main objective of this policy is to eliminate economicbased disparities in healthcare access so that every BPJS participant receives the same quality of inpatient services, regardless of financial capacity. However, the reform has sparked broad public discussion, particularly around its financial sustainability, the quality of healthcare services, and its practical implementation.

To examine these issues, the authors adopted a normative juridical approach combined with Critical Legal Studies (CLS), which explores how law and policy can reinforce power dynamics that tend to favor certain groups while disadvantaging others. The study also applies John Rawls' Theory of Justice, particularly the difference principle, which states that social and economic inequalities are acceptable only if they benefit the least advantaged members of society[10].

The findings indicate that although KRIS promotes healthcare equity in theory, its success heavily depends on the readiness of hospital infrastructure and the consistency of policy enforcement. One major concern is the ability of hospitals in remote and underdeveloped regions to meet the 12 KRIS criteria, which include requirements such as minimum room size, adequate ventilation, inroom bathrooms, proper bed spacing, and sufficient oxygen supply[11]. Without enough financial and logistical support, these hospitals may find it difficult to comply with the standards, potentially leading to service reductions or downgraded facilities outcomes that could actually reduce access rather than improve it.

The study also highlights resistance from hospitals and highincome groups, who may view KRIS as a loss of exclusivity or worry about decreased revenue if wealthier patients move to private insurance.[12] Another key issue lies in the policy's financial model: while equalizing healthcare access demands fair and sustainable funding, achieving this balance is complex. The researchers advocate for a progressive contribution system where higherincome participants contribute more to subsidize lowerincome groups. Yet, this approach presents challenges in verifying income levels and maintaining efficient administration. Without proper oversight, inequities could persist or even deepen if wealthier individuals withdraw from BPJS, leaving lowerincome populations dependent on an already strained public health system.

In conclusion, Imtihani and Nasser emphasize that while KRIS embodies a

major step toward social justice in healthcare, its effectiveness will rely on strong infrastructure investment, equitable resource allocation, and firm policy enforcement. The government must ensure continuous monitoring and adjustment to prevent marginalized areas from being left behind.

The fourth article, The Correlation between Public Misconceptions about the Class Abolishment of BPJS Health and the Weakness of the Good Governance System by Christina Natalia, explores how misinformation regarding the elimination of BPJS classes reflects broader governance weaknesses[12][13]. Since early discussions about merging BPJS's threetier inpatient system into KRIS began in 2020, public communication has been inconsistent. Statements from the Ministry of Health, BPJS Kesehatan, and the National Social Security Council (DJSN) often conflicted, causing confusion among the public and healthcare stakeholders. Initially, the government announced that KRIS would be implemented by 2022, yet later statements denied any fixed timeline, which further undermined public confidence.

Through a literaturebased analysis of news reports, academic publications, and legal frameworks, Natalia concludes that this confusion stems from failures in transparency, responsiveness, and coordination among government institutions. The absence of clear, accessible information violated the principle of good governance, which requires that policy decisions be openly communicated and easily understood by citizens. In addition, shifting responsibilities among BPJS, DJSN, and the Ministry of Health created inefficiencies that delayed implementation and eroded trust[13][14].

The study argues that for BPJS Kesehatan to retain public credibility, it must improve its commitment to good governance practices including transparent communication, interagency collaboration, and timely responses to public concerns. Natalia recommends that the government strengthen accountability measures, launch proactive public information campaigns, and ensure that communication about KRIS is consistent and factual. Without these improvements, misinformation will continue to spread and could weaken public confidence in Indonesia's efforts to achieve Universal Health Coverage (UHC)[14][15].

The fifth study, Internal and External Factors of Community Readiness for the BPJS Class Standardization Policy by Rahmi Fajarwati, Nurmiati Muchlis, and Andi Surahman Batara (2023), examines how internal and external factors influence public readiness for the transition to KRIS[16]. Conducted at the Regional General Hospital Labuang Baji in Makassar, this quantitative study involved 194 BPJS inpatients selected through stratified proportional random sampling. Using chisquare and logistic regression analyses, the study evaluated relationships between readiness and variables such as perceived healthcare needs, expectations, awareness, and accessibility.

Results show that public readiness for KRIS is strongly associated with expectations and accessibility but not with perceived healthcare needs or awareness. The authors found that most respondents (94.8%) already felt that their medical needs were adequately met under the current system. Thus, readiness for KRIS is driven more by optimism for improved services rather than dissatisfaction with the existing model. Expectations and environmental accessibility were both

significant predictors of readiness individuals who expected better services or lived closer to healthcare facilities were more willing to accept KRIS.

These findings suggest several policy implications. First, since awareness does not strongly affect readiness, the government must strengthen its communication and education strategies to help people understand the purpose and benefits of KRIS. Second, accessibility gaps must be addressed by investing in healthcare infrastructure, especially in remote regions. Third, a gradual implementation process should be applied, supported by pilot programs and continuous evaluation. Financial management must also be handled carefully to avoid burdening lowincome participants, possibly through a tiered contribution scheme that allows crosssubsidization.

The following table summarizes the five journals reviewed in this study:

Table 1. Summary of Reviewed Journals on the BPJS Kesehatan Class Elimination Policy and KRIS Implementation.

No.	Author(s), Year	Study Location	Sample Size / Source	Methodology	Validity / Quality Notes	Key Statistical Findings / Results
1	Suryapuspita, 2024[4]	Literature & legal review	Not applicable (normative juridical)	Qualitative analysis of legal docs and case studies	Reviewed legal frameworks; valid for legal analysis	Social equality improved; risk of service burden & premium increase
2	Pramana & Priastuty, 2023[1]	Klaten & Yogyakarta	4 informants (BPJS Class 1–3 users)	Qualitative (indepth interviews)	Triangulation applied; peer debriefing used	Mixed responses; Class 3 supports KRIS, others fear premium increases
3	Imtihani & Nasser, 2024[9]	Theoretical nationwide scope	Not applicable	Normative juridical, Critical Legal Studies	Based on Rawls' theory, relevant legal references used	KRIS promotes equity, but requires significant investment and oversight
4	Natalia, 2021[1513]	Nationwide (mediabased)	Not applicable	Literature review of media & legal docs	Validity is limited to secondary data	Weak governance & miscommunication increased public skepticism
5	Fajarwati et al., 2023[16]	RSUD Labuang Baji Makassar	194 respondents	Quantitative (crosssectional survey, chisquare, logistic regression)	Strong statistical method; OR and pvalues reported	Expectations (p=0.043, OR=4.6) and access (p=0.012, OR=3.3) affect readiness

DISCUSSION

This study explored the implications of eliminating BPJS Health service classes and implementing the Standard Inpatient Class (KRIS) on healthcare accessibility, service quality, and policy feasibility in Indonesia[17]. Findings from the literature review suggest that, while the policy is grounded in a strong equitybased rationale, its success will depend on how effectively key challenges are managed particularly hospital readiness, financial sustainability, public perception, and governance consistency. The shift from a tiered inpatient system to a standardized model represents a major transformation with farreaching consequences for healthcare providers, patients, and policymakers alike. This discussion further analyzes the benefits and risks of the KRIS reform, considers its ethical implications, and draws insights from the experiences of

other countries with universal healthcare systems.

The central motivation behind KRIS lies in its commitment to reducing disparities that arise from the existing classbased BPJS system[17]. Under the previous structure, differences in room facilities, comfort, and waiting times created visible inequalities between patient classes, even though medical treatment itself remained largely similar. By introducing a single, standardized inpatient class, the government seeks to promote fairness and ensure that economic background no longer determines the quality of care received. This goal is particularly relevant in Indonesia, where socioeconomic gaps remain substantial and access to quality healthcare has historically been unequal.

However, translating this policy into practice is not without obstacles. Its effectiveness in promoting healthcare equity depends heavily on the readiness of hospitals and the availability of adequate resources[18]. Several studies have shown that urban hospitals, particularly large referral centers, are generally better equipped to meet the KRIS infrastructure standards. In contrast, facilities in rural and remote regions face significant challenges in fulfilling the 12 KRIS criteria such as minimum room size, ventilation, bathroom facilities, and patient capacity per room. These standards often require costly upgrades and renovations that may be beyond the capacity of hospitals operating with limited budgets. Without targeted funding and government support for infrastructure development, the policy could unintentionally widen existing regional disparities rather than closing them.

For instance, hospitals in underdeveloped areas frequently struggle with basic facility requirements, such as maintaining adequate room ventilation or spacing between patient beds. In such settings, the implementation of KRIS could lead to service downgrades or capacity reductions if hospitals are forced to comply with strict standards without receiving sufficient support. As a result, patients in these regions may continue to face unequal treatment compared to those in more developed provinces.

In addition to infrastructure concerns, the reform raises questions about whether KRIS will genuinely enhance service quality. Critics caution that standardizing hospital facilities without proportional increases in funding or medical staffing may cause overcrowding, longer waiting times, and additional strain on healthcare workers[19]. Evidence from other countries with universal healthcare systems shows that abolishing classbased care can indeed foster equality, but it may also increase patient demand potentially creating bottlenecks in service delivery if not matched with adequate resource expansion.

These findings underline the need for a balanced and contextsensitive approach. Policymakers must consider whether applying the same standards across all hospitals is realistic in a country as geographically diverse as Indonesia. Flexibility in implementation such as allowing phased adaptation based on regional capacity may help prevent new inequalities from emerging.

A comparative perspective provides valuable insights into how Indonesia might navigate the challenges of implementing KRIS. For instance, Thailand’s Universal Coverage Scheme (UCS) demonstrates that

while a standardized system can significantly expand healthcare access, it also brings early implementation challenges such as doctor shortages, overcrowded hospitals, and funding constraints[20]. Indonesia faces similar risks if hospital capacity and workforce readiness are not strengthened prior to nationwide rollout[21]. Policymakers should therefore assess hospital preparedness, recruit additional medical personnel, and allocate resources strategically to prevent service degradation. Moreover, the transition toward KRIS may require new training and professional development programs to help healthcare workers adapt to standardized protocols and patient management systems.

Despite its equity oriented objectives, the standardization of inpatient care could also produce unintended consequences. Under the previous tiered BPJS system, revenue from higherpaying Class I and II patients often helped subsidize services for Class III participants. The removal of these classes eliminates a key source of crosssubsidization. Hospitals especially private ones may therefore face reduced income, forcing them to scale back services or withdraw from BPJS partnerships altogether. Such outcomes could place greater pressure on public hospitals, which are already struggling with limited budgets and high patient loads.

Ensuring financial sustainability thus emerges as one of the most pressing challenges in KRIS implementation. The transition from a multitiered contribution system to a uniform one requires a restructured funding model. Without alternative revenue mechanisms, hospitals may experience financial strain, particularly those that relied on premium contributions from highertier participants to support lowertier patients. To address this, several strategies can be considered: introducing a progressive contribution scheme similar to Japan's National Health Insurance system, increasing state subsidies to offset lost revenues, and expanding public–private partnerships (PPPs) to manage patient overflow while maintaining quality. Financial planning must also incorporate inflation and rising healthcare costs to ensure longterm viability.

Another concern relates to participant behavior. If higherincome groups perceive KRIS as a downgrade in service quality, they may opt for private insurance, reducing BPJS's overall revenue base. This could create a negative cycle lower revenue leading to declining service quality, which in turn drives more participants to leave the system. Hence, policymakers must strike a careful balance between promoting equity and maintaining both service standards and financial stability.

Governance quality is another critical factor that will determine KRIS's success. Previous studies have pointed out that poor coordination, inconsistent policy communication, and unclear timelines have contributed to public skepticism. Transparent governance is essential to build and maintain trust. The government must provide consistent and accurate information about KRIS's goals, implementation schedule, and expected outcomes. Regular public updates through official websites, press briefings, and digital platforms can help dispel rumors and ensure accountability. Importantly, involving healthcare professionals, hospital administrators, and patient advocacy groups in policy discussions will create a sense of shared ownership and reduce resistance during implementation.

From an ethical standpoint, KRIS aligns with the principles of justice and fairness by ensuring equal treatment regardless of economic background. However, ethical challenges persist. Wealthier participants who previously benefited from premium services might view the reform as a loss of privilege, leading some to exit the BPJS system. This potential withdrawal could worsen funding challenges and contradict the policy's equity goals. Therefore, policymakers must maintain an ethical balance ensuring fairness for lowerincome participants without alienating those in higher income brackets.

Public perception also remains a decisive factor. While lowincome groups generally welcome the policy as a step toward equality, middle and upperincome citizens often express concerns about declining service quality. If not addressed properly, this perception gap could lead to greater reliance on private care, undermining Indonesia's pursuit of Universal Health Coverage (UHC). Thus, maintaining quality and patient dignity within standardized care environments is essential, which can be achieved through continuous staff training and patientcentered service delivery.

Healthcare providers themselves face ethical and operational burdens. The shift toward a standardized system demands additional responsibilities, particularly in rural and underresourced regions. The government must ensure that these providers receive sufficient financial support and capacitybuilding opportunities. Failure to do so could lead to overwork, burnout, and declining morale among healthcare professionals, ultimately affecting the quality of patient care.

Comparative experiences from other countries offer important lessons for Indonesia. The United Kingdom's National Health Service (NHS), one of the most wellestablished standardized systems, guarantees universal access but continues to struggle with long waiting times and funding constraints[22]. Indonesia should learn from these challenges by ensuring adequate resource allocation and efficient service delivery to prevent similar bottlenecks. Japan's healthcare model provides another useful reference its incomebased contribution system successfully maintains universal coverage while ensuring financial sustainability. Adopting a similar progressive contribution structure could help Indonesia balance fairness with fiscal stability.

Thailand's UCS model further illustrates the importance of gradual implementation. The Thai government initially introduced its universal system through pilot projects in select regions before expanding nationwide. This phased approach allowed time to identify logistical issues and refine policy execution. Indonesia could benefit from adopting a similar strategy rolling out KRIS first in regions with stronger infrastructure before expanding to more remote or resourcelimited areas.

Based on the findings and comparative insights, several key policy recommendations emerge. First, the implementation of KRIS should be gradual and regionspecific, beginning with urban areas where hospitals are better equipped to meet infrastructure standards. Second, Indonesia should adopt a progressive contribution scheme and allocate additional state funding to ensure financial sustainability. Third, efforts to expand the healthcare workforce through recruitment,

training, and incentives should be prioritized, particularly in rural regions. Fourth, comprehensive public communication strategies must be strengthened to prevent misinformation and ensure that citizens clearly understand the policy and its benefits. Fifth, the government should allocate targeted funds to upgrade hospital facilities in underdeveloped areas to meet KRIS standards. Finally, establishing an independent monitoring and evaluation body will be essential to ensure transparency, assess progress, and allow for realtime policy adjustments.

By implementing these strategies, Indonesia can facilitate a smoother transition toward KRIS while preserving its goals of equity, quality, and financial stability[21]. A well managed and transparent reform process will not only enhance public trust but also move Indonesia closer to realizing the broader vision of Universal Health Coverage where every citizen, regardless of income or geography, has access to quality healthcare.

Strengths and limitations

This article offers several notable strengths that make it a valuable contribution to understanding the implications of eliminating BPJS Health classes and introducing the Standard Inpatient Class (KRIS). One of its primary strengths lies in its relevance and timeliness, given the ongoing transformation of Indonesia's healthcare system under this new policy. The topic is highly pertinent to current national discussions on healthcare equity, financial sustainability, and governance reform.

The study is supported by a comprehensive and uptodate literature review that utilizes multiple academic databases, including Google Scholar, PubMed, and Scopus, covering research published between 2019 and 2024. This wide scope ensures that the review reflects the most recent developments and diverse academic perspectives. Another key strength is its multistakeholder approach, which considers the viewpoints of patients, healthcare providers, and policymakers. This provides a more holistic understanding of the policy's potential impact, both from an operational and social perspective.

From a methodological standpoint, the study applies clear inclusion and exclusion criteria to ensure the selection of highquality and relevant literature. The use of a narrative synthesis approach allows the identification of recurring patterns and emerging themes across studies, helping to connect evidence from various sources into a coherent analysis. Moreover, the paper effectively discusses both the positive and negative implications of the KRIS policy recognizing its potential to improve equity in healthcare access, while also addressing legitimate concerns related to hospital readiness, financial capacity, and governance issues. The inclusion of practical policy recommendations, such as phased implementation, improved financial planning, and strategic infrastructure investment, enhances the study's usefulness as a reference for policymakers and stakeholders involved in health reform.

However, this article also has several limitations that should be acknowledged. The most significant limitation is the absence of primary data. Since the analysis relies solely on secondary sources, such as journal articles and policy documents, it lacks direct field validation through interviews, surveys, or empirical case studies. As a result, the findings may not fully capture ontheground

realities or the perspectives of frontline healthcare workers and patients.

Additionally, while the systematic literature review is wellstructured, the paper does not provide a detailed explanation of the quality assessment procedures used to evaluate the selected studies. This omission may introduce the possibility of selection bias, as the robustness of included sources cannot be fully verified. Another limitation is the lack of regional comparison. The study discusses national implications but does not explore variations between urban and rural healthcare systems an important consideration, given Indonesia's diverse geography and differing regional capacities to implement KRIS.

The economic discussion within the article also remains limited. While financial sustainability is acknowledged as a concern, the study does not present detailed projections or models related to premium adjustments, budget allocations, or longterm funding mechanisms. Furthermore, although governance and communication challenges are highlighted, the paper stops short of proposing concrete frameworks or strategies to enhance transparency, accountability, and interagency coordination. Lastly, the focus on the KRIS model excludes consideration of alternative policy approaches that could similarly promote healthcare equity while preserving service quality.

Addressing these limitations in future research would provide a more comprehensive understanding of the policy's broader implications. Incorporating primary data collection, regional analyses, and more robust financial modeling could help produce evidencebased recommendations that better inform policymakers. Strengthening these areas would not only enhance the academic rigor of future studies but also support the development of more effective and sustainable healthcare policies in Indonesia.

CONCLUSION

The implementation of KRIS has the potential to promote healthcare equity by reducing discrimination and improving access, particularly for lower-income groups. However, its success relies heavily on hospital readiness, sustainable financing, and transparent policy communication. Key challenges include potential financial strain, hospital capacity limitations, and risks of declining service quality. To address these issues, phased implementation, adequate infrastructure investment, financial safeguards, and strong public engagement are essential. Overall, KRIS can support Indonesia's goal of universal health coverage, provided that governance and funding mechanisms are carefully managed.

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CONFLICT OF INTEREST

The authors declared there is no conflict of interest.

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AUTHOR CONTRIBUTION

The first author was responsible for conceptualizing the research framework, designing the methodology, and conducting the systematic literature review. Data collection and synthesis of relevant studies from various academic databases were carried out collaboratively by all authors, ensuring a comprehensive and unbiased review. The analysis of findings, identification of key themes, and formulation of policy recommendations were led by the author themselves, providing academic rigor. The drafting of the manuscript, including structuring the introduction, methodology, results, and discussion sections, was primarily undertaken by the first author, who provided critical revisions, editorial suggestions, and additional insights to strengthen the arguments presented. The author participated in reviewing and approving the final version of the manuscript, ensuring that it accurately represents the research objectives and findings.

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