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Original Research Paper

A study on the impact of the Standard Inpatient Class (*KRIS*) policy on private hospitals in Central Jakarta

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Abstract
Presidential Regulation No. 59 of 2024 on the National Health Insurance (*JKN*), Article 103B, the government mandated the full implementation of the Standard Inpatient Class (*KRIS*) policy by 2025. This regulation is expected to impact the public broadly and has generated a range of perceptions. Existing research remains fragmented, lacks focus on private hospitals, and is qualitative in nature. This study aims to evaluate the readiness and vulnerabilities of private hospitals in Central Jakarta in implementing the *KRIS* policy. A mixed-methods approach was used to analyse the policy's impact on bed capacity, hospital revenue, and the challenges hospitals faced in meeting the 12 *KRIS* criteria. The findings indicated that the *KRIS* policy could lead to a 21% reduction in the number of beds in private hospitals, potentially worsening the issue of healthcare access, recorded as the main complaint by Health Security Administering Body *(Badan Penyelenggara Jaminan Sosial Kesehatan*, abbreviated as *BPJS)* participants in 2021. An estimated budget of IDR 16 billion is required for *KRIS* compliance in private hospitals across Central Jakarta, with a projected monthly revenue loss of approximately IDR 10.8 billion. Criteria 8, 9, and 11 pertain to room density, partitions, and bathroom facilities. This study recommends adjusting the KRIS policy to account for the unique characteristics of private hospitals, which do not receive financial assistance from the government. Specifically, it suggests aligning the implementation timeline with each hospital's capacity and readiness. In addition, the government must ensure equitable access to healthcare for all *BPJS* participants.

Keywords: Central Jakarta; National Health Insurance; private hospitals; social security administering body; standard inpatient class

1. Introduction

The Standard Inpatient Class (*KRIS*) policy was first introduced in Law No. 40 of 2004 on the National Social Security System (*SJSN*), Article 23, Paragraph 4, which states: "In the event that participants require inpatient care at a hospital, the service class shall be provided based on a standard class" (Undang-Undang (UU) Nomor 40 Tahun 2004 Tentang Sistem Jaminan Sosial Nasional, 2004). However, the absence of a detailed legal framework regarding *KRIS* has led to multiple interpretations (Sulistyorini & Huda, 2022). Policymakers believe there should be a single standard class, while others argue that the existing three-tiered system, based on premium payment ability, already fulfills the law's mandate, as it does not explicitly require a unified service class (Dharmayanti et al., 2023; Susanti, 2024).

In the 2012–2019 National Health Insurance (*JKN*) Roadmap, the government declared that both medical and non-medical benefits should be equal for all. However, in 2021, a government regulation mandated the implementation of standard inpatient services by no later than January 1, 2023 (Peraturan Pemerintah (PP) Nomor 47 Tahun 2021 Tentang Penyelenggaraan Bidang Perumahsakitan, 2021). In

2024, a Presidential Regulation required all hospitals to implement *KRIS* by June 30, 2025, based on specific standards (Peraturan Presiden (Perpres) Nomor 59 Tahun 2024 Tentang Perubahan Ketiga Atas Peraturan Presiden Nomor 82 Tahun 2018 Tentang Jaminan Kesehatan, 2024). One of these standards requires that each room contain a maximum of four patients.

There are twelve *KRIS* criteria that hospitals must meet in order to be reimbursed by the Health Security Administering Body (*Badan Penyelenggara Jaminan Sosial Kesehatan*, abbreviated as *BPJS*). Implementing all 12 *KRIS* standards may increase operational costs and place a burden on hospitals, especially private hospitals, which do not receive financial support from the government. Yet private hospitals are a backbone of the *JKN* service delivery in Indonesia. As of July 2024, there were 3,130 hospitals partnered with *BPJS* nationwide, nearly half of which (44%) were private hospitals (Zakaria, 2024).

As of March 31, 2024, *JKN* coverage had reached 96% of the Indonesian population (269.5 million people), making *BPJS* the largest and fastest-growing social insurance provider to achieve universal health coverage—reaching this milestone in just ten years (Dewan Jaminan Sosial Nasional, 2023) However, policies that significantly alter the scope of benefits can affect user satisfaction and impact the quality of care. *KRIS* implementation may reduce bed capacity (Meidiawaty, 2024), further straining access to healthcare facilities and increasing patient density and waiting times for inpatient or surgical care (Meidiawaty, 2024; Mukti, 2022; Nola, 2024).

Numerous studies have examined hospital readiness to implement the 12 *KRIS* standards. According to a 2024 systematic review, only one in five hospitals was fully ready, while two others were 80% and 85% ready; the remaining hospitals were only 10% and 30% ready, respectively (Azura Arisa et al., 2023; Kuraini et al., 2023; Mz et al., 2023). Most of these studies used qualitative methods, and no publication has yet addressed the specific challenges of meeting each criterion or the long-term financial impact on hospitals (Defityanto, 2022). Furthermore, much of the research has focused on individual hospitals rather than private hospitals as a sector, despite the fact that they are among the most affected.

Central Jakarta is home to 32 hospitals, 15 of which (46.8%) are private (Novelia, 2024). This study aims to examine the vulnerabilities and financial sustainability of private hospitals in Central Jakarta using both qualitative and quantitative analyses. It assesses changes in bed capacity, revenue, and the degree of difficulty in meeting the 12 *KRIS* criteria. In addition, the study evaluates the economic impact of the policy on the long-term financial viability of private hospitals.

2. Research Methods

This study used a mixed-method embedded design, combining both quantitative and qualitative research. The qualitative data served to complement the quantitative data. The quantitative research utilized a survey, inviting respondents to complete an online questionnaire. The sample was purposively selected, with inclusion criteria covering all CEOs or managing directors of private hospitals in Central Jakarta that provide inpatient services for *BPJS* patients. The exclusion criteria were positions other than CEO or managing director and hospitals that do not serve *BPJS* inpatient patients. The researcher did not impose any limitations on the respondents' experience, tenure, or the type of hospital. The minimum sample size was calculated using the finite population formula (with a 95% confidence level and a 10% margin of error), resulting in 11 samples from 12 private hospitals in Central Jakarta.

The questionnaire was designed based on 12 *KRIS* criteria. It consisted of short-answer open-ended questions, multiple-choice questions, rating scales, and long open-ended questions. Prior to the study, the questionnaire was validated by 12 CEOs of private hospitals in DKI Jakarta to ensure clarity, relevance, and accuracy in measuring the research variables. The validation results showed that the questionnaire met reliability and validity standards.

All quantitative data were presented descriptively and with frequency distributions. The Shapiro-Wilk normality test was conducted on the short-answer and multiple-choice responses, followed by an independent T-test to assess the significance of the hospital type's impact. The classification of hospital types was based on Government Regulation No. 47 of 2021 and Minister of Health Regulation No. 3 of 2020 (Peraturan Menteri Kesehatan Nomor 3 Tahun 2020 Tentang Klasifikasi Dan Perizinan Rumah Sakit, 2020; Peraturan Pemerintah (PP) Nomor 47 Tahun 2021 Tentang Penyelenggaraan Bidang Perumahsakitan, 2021). A Chi-square test was performed on the multiple-choice responses to examine the relationship between hospital type and the average loss experienced. The results of the rating questions were presented descriptively, and the Kruskal-Wallis test was used to assess the significance of differences across the criteria. In addition, mean ranks were calculated using the Friedman test to determine the order of the criteria considered most challenging. All quantitative tests in this study were conducted using IBM SPSS Statistics 30.0.0 software.

The qualitative research used open-ended questions in the questionnaire. A good qualitative sample is achieved when data saturation is reached, typically with 6-12 participants (Hennink et al., 2017). In this study, all hospital directors were asked to answer the questions. Data were extracted deductively using thematic analysis. The report included quotes to support the findings.

3. Results and Discussion

3.1. Basic Criteria of the Sample

In Central Jakarta, there are 15 private hospitals that cooperate with *BPJS*, 12 of which provide inpatient services and are potentially affected by the *KRIS* policy. A purposive approach was used to invite respondents to fill out the questionnaire, with one respondent declining to participate. Data collection took place from October 4 to 15, 2024. The basic criteria from 11 respondents are presented in Table 1. Of these, 45% are type B hospitals, and 55% are type C hospitals. There were no type A or D hospitals included in the sample.

Table 1. Basic Criteria of the Sample

Indicator	Statistical Analysis			
	Number (n)	Percentage (%)	Mean	SD
Hospital	**11**			
Type A	0	0		
Type B	5	45		
Type C	6	55		
Type D	0	0		
Total Class I, II, III, & Intensive Beds			129.45	65.50
<75	2	20		
75-149	5	50		
150-225	2	20		
>225	1	10		
Total Class I Beds			37.18	26.95
0-24	5	45		
25-49	4	36		
50-74	0	0		
75-100	2	18		
Total Class II Beds			25.00	14.41
<13	3	27		

Indicator	Number (n)	Statistical Analysis		
		Percentage (%)	Mean	SD
13-25	3	27		
26-38	2	18		
>39	3	27		
Total Class III Beds			45.36	26.51
<25	2	18		
25-49	6	55		
50-75	1	9		
>75	2	18		
Total VIP Beds			22.27	18.84
<17	7	64		
17-33	1	9		
34-50	2	18		
>50	1	9		
Total Intensive Beds			21.91	13.48
<18	5	45		
18-35	5	45		
36-54	0	0		
>54	1	9		
Monthly *BPJS* Revenue			Rp 6,563,636,363,-	Rp 6,721,945,064,-
<5M	8	73		
5-9.99M	0	0		
10-20M	2	18		
>20M	1	9		

Source: Primary Data, 2024

Based on the hospital bed data, 50% of the hospitals had a capacity ranging from 75 to 149 beds, with an average of 129.45 and a standard deviation of 65.50. About 20% of hospitals had fewer than 75 beds, while another 20% had between 150 and 225 beds. Only 10% of the hospitals had more than 225 beds. Although 45% of hospitals had fewer than 25 beds in Class I, the distribution of beds in other classes showed more variation. The average number of VIP beds was 22.27, with 64% of hospitals providing fewer than 17 VIP beds. This suggests that the services were more focused on general and *BPJS* patients. The average revenue from *BPJS* was IDR 6.56 billion, with 73% of hospitals earning less than IDR 5 billion.

3.2.Reduction in Bed Capacity, Estimated Budget, and *BPJS* Revenue Loss

As shown in Table 2, the total reduction in bed capacity reached 294 units. Compared to the initial total bed capacity of Class I, Class II, and Class III, the implementation of *KRIS* would result in a 21% decrease in bed capacity in private hospitals in Central Jakarta. On September 1, 2024, DKI Jakarta had a total of 17,074 non-intensive beds, with the Ministry of Health estimating a reduction of 1,753 beds (10.27%) (Direktur Pelayanan Kesehatan Rujukan Kementerian Kesehatan Republik Indonesia, 2024). Our findings suggest that the estimated percentage derived from a smaller population may be higher than the government's prediction. This indicates the possibility that the reduction in bed capacity in

government-run vertical hospitals is more stable, which could balance the decrease in bed capacity in private hospitals.

Table 2. Reduction in Bed Capacity, Estimated Budget, and *BPJS* Revenue Loss

Indicator	Number	(%)	Statistical Analysis			
			Mean	SD	p-value	Sig (2-tailed)
Total Decrease in Beds	**294**	**100**	**26.73**	**37.24**	**0.001**	**0.075**
Type B	242	82	48.40	47.38	0.073	
Type C	52	18	8.67	10.80	0.013	
***KRIS* Implementation Budget**	**Rp 16,000,000,000,-**	**100**	**Rp 1,454,545,454,-**	**Rp 1,369,389,379,-**	**0.015**	**0.267**
Type B	Rp 4,650,000,000,-	29	Rp 930,000,000,-	Rp 827,345,151	0.789	
Type C	Rp 11,350,000,000,-	71	Rp 1,891,666,666,-	Rp 1,642,685,808	0.091	
Estimated *BPJS* Revenue Loss	**Rp 10.687.500.000,-**	**100**	**Rp 971.590.909,-**	**Rp1,118,035,259,-**	**0.016**	**0.131**
Type B	Rp 7,687,500,000,-	72	Rp 1,537,500,000,-	Rp 1,473,463,182,-	0.724	
Type C	Rp 3,000,000,000,-	28	Rp 500,000,000,-	Rp 419,523,539,-	0.154	

Source: Primary Data, 2024

The decrease in bed capacity is split as 82% from type B hospitals and 18% from type C hospitals, with average reductions of 48.40 and 8.67, respectively. However, the T-test results indicate that there is no significant effect between hospital types and the reduction in bed capacity (p = 0.075). The *BPJS* 2021 report noted that 69.4% of *BPJS* participants are in Class 3, which is predominantly composed of low-income individuals (Dewan Jaminan Sosial Nasional, 2022). The Central Statistics Agency of DKI Jakarta (2023) reported that the number of poor people in Central Jakarta reached 42.78 thousand (4.68%) in 2023. The impact of this reduction in access will significantly affect the low-income population, while the middle and upper classes have the option to seek non-*BPJS* services when access is unavailable.

In terms of the budget allocation for implementing *KRIS*, the total allocated budget is IDR 16 billion, with 71% used by type C hospitals and 29% by type B hospitals. Although type C hospitals allocate more, there is high variability in expenditures among hospitals of each type. Nonetheless, the T-test results indicate no significant difference in budget allocation between the two hospital types (p = 0.267). This finding is consistent with previous studies indicating that the implementation of *KRIS* requires a specific allocation of funds for certain hospitals (Lubis et al., 2024).

The total estimated decrease in *BPJS* revenue in this study amounts to IDR 10.7 billion, with type B hospitals contributing 72%. The average reduction per type B hospital is IDR 1.5375 billion, while type C hospitals experience a reduction of only IDR 500 million. The T-test results show similar financial risks related to the decrease in *BPJS* revenue for both types (p = 0.131). This suggests that the financial management strategies and budget allocations in hospitals do not vary significantly by type, likely due to national regulations that affect both hospital types equally.

The implementation of *KRIS* in private hospitals affects both budget management and *BPJS* Health revenue. *KRIS* implementation creates an imbalance between increased costs and decreased *BPJS*

revenue in private hospitals. It increases budget expenditures due to the expansion of resources for more complex specialist services without government assistance. *KRIS* also reduces hospital revenue from *BPJS* because of decreased claims for Class I and II services and the lack of available beds.

3.3. Analysis of Bed Capacity Reduction Percentage and Revenue

According to Table 3, approximately 18% of hospitals did not experience any reduction in the number of beds, while 27% reported a reduction of 1-5%. A reduction of over 25% was reported by 18% of hospitals. This data indicates a fairly even distribution in the percentage of bed reductions, with a small proportion of hospitals facing more significant impacts, which will likely lead to reduced service capacity or operational restructuring.

Table 3. Analysis Results of Bed Capacity and Revenue Reduction Percentages

Indicator	Number	Statistical Percentage Analysis	Chi-Square Sig.
Percentage of Bed Capacity Reduction			0.279
0	2.00	18%	
1-5%	3.00	27%	
5%-10%	2.00	18%	
10-15%	0.00	0%	
15-20%	1.00	9%	
20-25%	1.00	9%	
>25%	2.00	18%	
Percentage of Revenue Reduction			0.081
0	0.00	0%	
1%-10%	3.00	27%	
11%-20%	3.00	27%	
21%-30%	2.00	18%	
31%-40%	2.00	18%	
41%-50%	0.00	0%	
>50%	1.00	9%	

Source: Primary Data, 2024

In terms of revenue percentage decline, all hospitals reported a decrease, with the majority (27%) experiencing a drop of less than 20%. Meanwhile, 9% of hospitals saw a revenue reduction of more than 50%. This indicates that certain hospitals are more financially vulnerable, possibly due to a high dependency on specific income sources such as *BPJS*. The Chi-Square test showed no significant relationship between hospital type and the decrease in either bed capacity ($p = 0.279$) or revenue ($p = 0.081$). External factors such as *BPJS* policies and regulatory changes may have a greater impact than internal hospital factors.

3.4. Difficulty Level of Each *KRIS* Criterion

In type B hospitals, Criterion 11 (bathroom accessibility) emerged as the main challenge. The next most difficult requirement to meet was Criterion 10 (in-room bathrooms in inpatient wards). The third most challenging was Criterion 8 (number of beds), where limited space often makes it difficult to maintain the ideal distance between beds. As a result, hospitals are required to invest heavily in infrastructure, which also leads to a reduction in bed capacity. Previous research found that only 50% of hospitals met the required room area per bed, and only 59% fulfilled the requirement for at least 1.5

meters of space between beds (Hinu, 2022). Furthermore, only 55% of hospitals were able to comply with the maximum number of beds per ward (Dharmayanti et al., 2023).

These three criteria are closely interrelated. Reducing the number of beds per room necessitates an increase in the number of rooms, which in turn requires building additional bathrooms that meet accessibility standards. This reflects a significant challenge for hospitals, particularly older and larger facilities that are accustomed to traditional large-ward layouts. The difficulty level experienced by hospitals may be influenced by their current infrastructure and the age of the facility, with older hospitals having been established before the implementation of government regulations.

Table 4. Kruskal-Wallis Analysis Results Based on the 12 *KRIS* Criteria

Criterion	Number	Percentage (%)	Mean Rank	Kruskal-Wallis
Criterion 1: The building components used do not have a high level of porosity.			**7.05**	**0.849**
Not Difficult	4	36	Type B: 6.90	
Slightly Difficult	3	27	Type C: 7.17	
Moderately Difficult	3	27		
Very Difficult	1	9		
Criterion 2: Air ventilation meets the requirement of at least six air exchanges per hour in regular care rooms.			**7.05**	**0.922**
Not Difficult	2	18	Type B: 5.90	
Slightly Difficult	5	45	Type C: 8.00	
Moderately Difficult	4	36		
Very Difficult	0	0		
Criterion 3: Artificial room lighting meets the standard criteria of 250 lux for general lighting and 50 lux for sleep lighting.			**6.50**	**0.338**
Not Difficult	2	18	Type B: 4.70	
Slightly Difficult	7	64	Type C: 8.00	
Moderately Difficult	2	18		
Very Difficult	0	0		
Criterion 4: Availability of two power outlets and a nurse call at each patient bed.			**4.09**	**0.294**
Not Difficult	8	73	Type B: 5.00	
Slightly Difficult	1	9	Type C: 3.33	
Moderately Difficult	2	18		
Very Difficult	0	0		
Criterion 5: Availability of a bedside cabinet for each patient bed.			**3.32**	**0.409**
Not Difficult	8	73	Type B: 3.30	
Slightly Difficult	3	27	Type C: 3.33	
Moderately Difficult	0	0		
Very Difficult	0	0		
Criterion 6: The room can maintain a temperature between 20 and			**5.18**	**0.827**

Criterion	Number	Percentage (%)	Mean Rank	Kruskal-Wallis
26 degrees Celsius.				
Not Difficult	7	64	Type B: 5.00	
Slightly Difficult	0	0	Type C: 5.33	
Moderately Difficult	4	36		
Very Difficult	0	0		
Criterion 7: Rooms are separated based on gender, age, and type of illness (infectious and non-infectious).			**7.23**	**0.924**
Not Difficult	3	27	Type B: 6.20	
Slightly Difficult	4	36	Type C: 8.08	
Moderately Difficult	3	27		
Very Difficult	1	9		
Criterion 8: Inpatient room density is a maximum of four beds, with a minimum distance of 1.5 meters between the edges of beds.			**8.55**	**0.507**
Not Difficult	2	18	Type B: 8.50	
Slightly Difficult	4	36	Type C: 8.58	
Moderately Difficult	2	18		
Very Difficult	3	27		
Criterion 9: Curtains/partitions are installed using embedded ceiling tracks or are suspended.			**7.68**	**0.925**
Not Difficult	3	27	Type B: 7.50	
Slightly Difficult	3	27	Type C: 7.83	
Moderately Difficult	3	27		
Very Difficult	2	18		
Criterion 10: An en-suite bathroom is available in the inpatient room.			**6.91**	**0.072**
Not Difficult	4	36	Type B: 8.70	
Slightly Difficult	2	18	Type C: 5.42	
Moderately Difficult	3	27		
Very Difficult	2	18		
Criterion 11: The bathroom complies with accessibility standards.			**7.68**	**0.058**
Not Difficult	4	36	Type B: 9.90	
Slightly Difficult	2	18%	Type C: 5.83	
Moderately Difficult	2	18%		
Very Difficult	3	27%		
Criterion 12: Availability of an oxygen outlet.			**6.77**	**0.849**
Not Difficult	3	27%	Type B: 6.40	

Criterion	Number	Percentage (%)	Mean Rank	Kruskal-Wallis
Slightly Difficult	4	36%	Type C: 7.08	
Moderately Difficult	3	27%		
Very Difficult	1	9%		

Source: Primary Data, 2024

The three criteria most easily met by Type B hospitals were Criterion 6 (room temperature control), Criterion 3 (lighting arrangements), and Criterion 5 (bedside cabinets)—all of which had the lowest mean ranks (see Table 5). These criteria generally do not require large investments or significant structural changes, making them easier to fulfill.

For Type C hospitals, the most challenging criteria were Criterion 8 (inpatient room density compliance), Criterion 7 (porosity), and Criterion 2 (ventilation). In contrast, the easiest to fulfill were the same as in Type B hospitals—Criterion 6 (temperature control), Criterion 3 (lighting), and Criterion 5 (bedside cabinets). This suggests that Type C hospitals generally have fewer difficulties meeting basic infrastructure requirements that do not involve major modifications. This may be due to the fact that Type C hospitals tend to have smaller and newer buildings compared to Type B hospitals.

Overall, Criterion 8 (number of beds), Criterion 9 (curtains and partitions), and Criterion 11 (bathroom accessibility standards) were the three most difficult criteria for both types of hospitals to meet. The findings for Criteria 8 and 11 are consistent with previous studies conducted in both public and private hospitals, which also identified these as unmet standards (As'ady, 2025; Natsir, 2024). On the other hand, the easiest criteria to fulfill overall were Criterion 6 (room temperature), Criterion 4 (power outlets), and Criterion 5 (bedside cabinets), indicating that low-cost infrastructure components tend to be more easily implemented and met across hospital types.

Table 5. Difficulty Levels of the 12 *KRIS* Criteria by Hospital Type

Rank	Type B Criteria (mean rank)	Type C Criteria (mean rank)	All Types Criteria (mean rank)
1	Criterion 11 (9.90)	Criterion 8 (8.58)	Criterion 8 (8.55)
2	Criterion 10 (8.70)	Criterion 7 (8.08)	Criterion 9 (7.68)
3	Criterion 8 (8.50)	Criterion 2 (8.00)	Criterion 11 (7.68)
4	Criterion 9 (7.50)	Criterion 3 (8.00)	Criterion 7 (7.23)
5	Criterion 1 (6.90)	Criterion 9 (7.83)	Criterion 2 (7.05)
6	Criterion 12 (6.40)	Criterion 1 (7.17)	Criterion 1 (7.05)
7	Criterion 7 (6.20)	Criterion 12 (7.08)	Criterion 10 (6.91)
8	Criterion 2 (5.90)	Criterion 11 (5.83)	Criterion 12 (6.77)
9	Criterion 4 (5.00)	Criterion 10 (5.42)	Criterion 3 (6.50)
10	Criterion 6 (5.00)	Criterion 6 (5.33)	Criterion 6 (5.18)
11	Criterion 3 (4.70)	Criterion 4 (3.33)	Criterion 4 (4.09)
12	Criterion 5 (3.30)	Criterion 5 (3.33)	Criterion 5 (3.32)

Source: Primary Data, 2024

The Kruskal-Wallis analysis in Table 4 revealed no statistically significant differences in the difficulty levels of each criterion based on hospital type ($p > 0.05$). However, the study targeted a relatively small population, suggesting that results may yield significant differences in a larger sample. These findings indicate that, despite differences in capacity and service class, both hospital types face

relatively similar challenges in meeting infrastructure standards. The most significant barrier to implementing *KRIS* standards is the cost of infrastructure upgrades (Meidiawaty, 2024). This is evident from Table 5, where the criteria with the highest mean ranks were those that require the greatest financial investment for compliance.

3.5.The Impact of *KRIS* on Private Hospitals

Table 6 identifies three major themes that emerged as key concerns for private hospitals in facing the *KRIS* Policy: financial impact, facility capacity and space, and service quality. Among these, the decline in hospital revenue was the most prominent concern under the financial impact theme.

Table 6. Thematic Analysis Results

Theme		Sub-theme
Financial Impact	1.	Decrease in hospital revenue
	2.	Increase in renovation and operational costs
	3.	Financial losses due to the implementation of single-class tariffs
Capacity and Facility Space	1.	Decrease in bed capacity
	2.	Lack of space to meet the two-bedroom standard
	3.	Increase in patient referrals
Service Quality	1.	Employee layoffs due to reduced capacity and revenue
	2.	Dissatisfaction among Class I patients with the service

Source: Primary Data, 2024

Survey responses showed that "declining income and rising costs" were central issues, accompanied by concerns about "financial losses" due to the implementation of a uniform class tariff without adjustment. This was further exacerbated by the need for extensive renovation costs, requiring private hospitals to undertake "infrastructure fulfillment hindered by significant financial constraints." The financial burden is further worsened by the heavy reliance on *BPJS*, which may jeopardize hospital sustainability.

In terms of capacity and facility space, hospitals reported significant difficulties in providing adequate space to meet *KRIS* standards. For instance, Class 3 inpatient rooms often contain 8–12 beds with shared bathrooms located outside the room, well above the ideal *KRIS* standard (Meidiawaty, 2024). Several respondents noted a "lack of space to meet the standard of 2 or 3 beds per room" or mentioned that "due to limited room availability, a 2-bed room must serve as a *KRIS*-compliant room," indicating that some hospitals may need to reduce inpatient capacity. In some cases, this issue forces hospitals to "refer patients to other institutions" due to space constraints.

Service quality was another major theme. While *KRIS* aims to improve care quality, some hospitals reported being forced to lay off staff due to decreased capacity and income, reflecting the financial challenges in retaining healthcare workers. One respondent stated, "the burden on human resources, especially nursing, will increase," indicating that *KRIS* may lead to service degradation.

In addition, the removal of class stratification results in "*BPJS* participants from Class 1 to 3 occupying the same room, disadvantaging some participants," while others described the issue as a "downgrade in class," which could reduce patient satisfaction, especially among those accustomed to Class I services. *BPJS* has acknowledged that this shift may negatively affect the perceived quality of service and patient satisfaction levels. Dissatisfaction is not limited to patients but also affects doctors, who feel they cannot meet the expectations of higher-class patients, potentially impacting the overall quality of care (Mukti, 2022; Yazid et al., 2024). This dissatisfaction stems from the reduced value of services despite the same fee structure. If this trend continues, it may lead to an increase in *BPJS* arrears and inactive members. As of July 2024, the number of inactive *BPJS* participants in Indonesia and

Central Jakarta reached 56.1 million and 222,331, respectively (Dewan Jaminan Sosial Nasional, 2024; Novelia, 2024).

The implementation of *KRIS* should avoid setting a uniform deadline for all private hospitals, as these institutions typically do not receive government funding. Previous studies suggest that a five-year implementation timeline is feasible (Kurniawati et al., 2021). Without financial support, a one-size-fits-all policy could overburden private hospitals, which often have fewer resources compared to public hospitals. The government could consider providing soft loans to private hospitals to ensure they can maintain service accessibility.

4. Conclusion

This study concludes that the implementation of *KRIS* without time adjustments may reduce bed capacity and increase operational burdens for private hospitals in Central Jakarta, ultimately worsening healthcare access. Type B hospitals were found to be more vulnerable in terms of sanitation and accessibility, while Type C hospitals faced greater challenges with room density. It is recommended that *KRIS* implementation be carried out gradually, taking hospital capacity into account, and allowing flexibility for private hospitals that do not receive subsidies. Implementation should balance patient needs without compromising accessibility. Government support, such as soft loans, is crucial to help private hospitals meet the infrastructure demands. Future *KRIS*-related policy planning should be evidence-based and informed by implementation challenges. Further studies should explore *KRIS* implementation in other regions of Indonesia with larger sample sizes for more representative findings.

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