



Standard Inpatient Class Financing from the Perspective of Equity and Financial Sustainability

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Abstract

Background: The implementation of the Standard Inpatient Class (*Kelas Rawat Inap Standar*/KRIS) under Presidential Regulation No. 59 of 2024 represents a major reform of Indonesia's National Health Insurance (JKN) system aimed at improving equity in inpatient healthcare services. However, challenges remain, including disparities in hospital readiness, persistent variations in service delivery, and concerns regarding the long-term financial sustainability of the health financing system.

Objective: This study aims to examine KRIS financing from the perspectives of equity and financial sustainability and to propose a financing model that balances these two principles.

Methods: This normative legal study employed statutory, conceptual, and comparative approaches. The analysis was supported by policy evidence, including data on National Health Insurance Fund performance, hospital readiness, and compliance with KRIS service standards. A functional comparison was conducted with Germany's social health insurance system and tax-funded financing models, focusing on risk pooling, entitlement, strategic purchasing, and fiscal responsibility.

Results: The findings indicate that KRIS has not yet fully achieved substantive equity because access to standardized inpatient services remains influenced by differences in hospital capacity and readiness. Moreover, the infrastructure requirements associated with KRIS place additional financial pressure on the sustainability of health financing. This study proposes the Single Standard Inpatient Financing Model, which integrates ability-to-pay principles, need-based benefits, national risk pooling, strategic purchasing, and shared fiscal responsibility.

Conclusion: The proposed model positions the Single Standard Inpatient Class as the foundation for equitable inpatient healthcare delivery by improving access, financing efficiency, and the long-term sustainability of Indonesia's National Health Insurance system.

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INTRODUCTION

The right to health is a constitutional right of every Indonesian citizen, as regulated in Article 28H paragraph (1) of the 1945 Constitution of the Republic of Indonesia (*UUD 1945*), which states: "Every person has the right to live in physical and spiritual prosperity, to have a place to live, and to obtain a good and healthy living environment and has the right to obtain health services." This provision places health not merely as an individual need but as a constitutional

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right that must be fulfilled by the state, thereby imposing a positive obligation on the state to respect, protect, and fulfill the right to health through the provision of a fair, accessible, high-quality, and sustainable health service system. This obligation is further reinforced by Article 34 paragraphs (2) and (3) of the *UUD 1945*, which affirm that the state shall develop a social security system for all people and is responsible for the provision of adequate health service facilities and public services. In this context, fulfillment of the constitutional right to health depends not only on the formal availability of services but also on a financing design that distributes access fairly while remaining fiscally and actuarially sustainable within the *Jaminan Kesehatan Nasional* (JKN) system.

As a manifestation of this constitutional mandate, the Government of Indonesia administers the National Health Insurance (JKN) program, which was officially launched on January 1, 2014. This program is managed by the Social Security Administering Body for Health (*Badan Penyelenggara Jaminan Sosial Kesehatan* or BPJS Kesehatan) based on the principles of social insurance and equity, as regulated by Law Number 24 of 2011 concerning BPJS and Presidential Regulation Number 82 of 2018 concerning Health Insurance, as amended by Presidential Regulation Number 64 of 2020 and Presidential Regulation Number 59 of 2024. Since its inception, the JKN system has grown into one of the world's largest single-payer health insurance schemes, with membership coverage exceeding 98% of the Indonesian population. This extensive coverage demonstrates the success of expanding access to health services (Azeri et al., 2025). However, this condition must also be accompanied by increasing complexity in financing management, as the system must be able to guarantee broad access to health services without compromising the financial sustainability of the Health Social Security Fund. The expansion of JKN membership therefore creates a dual policy obligation: extending coverage while ensuring that contribution revenue, government subsidies, risk pooling, and claims expenditure remain sufficient to finance the benefits promised to participants.

The expansion of JKN membership coverage has been accompanied by increasing complexity in health service financing needs (Amalia, 2026; Marada, 2026). This condition is reflected in the 2025 Program Management Report and Financial Report of BPJS Kesehatan, which indicates limited fiscal space within the Health Social Security Fund to anticipate the increasing burden of health service expenditure (BPJS Kesehatan, 2024). Although this condition does not necessarily indicate failure of JKN financing, the trend indicates that financial sustainability is a crucial issue that must be considered in every health reform policy. KRIS links this financing challenge directly to service standardization because hospitals that have not yet met the twelve standards may require additional investment in facilities and infrastructure. The financing question is therefore not limited to benefit payments; it also concerns how transition and infrastructure costs are allocated without weakening the sustainability of the JKN financing system.

Any policy that has the potential to increase the need for health service financing or investment in service standards, including the implementation of KRIS, must be designed by considering the balance between fulfilling the principle of equity and maintaining financial sustainability. Without an adequate financing design, improvements in service standards may increase pressure on the Health Social Security Fund and reduce the capacity of the JKN system to guarantee sustainable health services (Andjani et al., 2026).

One of the important reforms in the administration of JKN is the implementation of the Standard Inpatient Class (*Kelas Rawat Inap Standar* or KRIS) through Presidential Regulation Number 59 of 2024. This policy aims to establish minimum standards for inpatient services for all JKN participants through the fulfillment of 12 (twelve) criteria that must be met by hospitals (Yanti, 2025). Normatively, this policy is directed at reducing disparities in service quality and strengthening the principle of equity in the administration of JKN. Nevertheless, this study argues that KRIS has not fully represented the principle of equity. Presidential Regulation Number 59 of 2024 does not, in itself, eliminate all distinctions in inpatient service arrangements but establishes standardized minimum requirements for inpatient rooms and services. Thus, the KRIS policy is more appropriately understood as a standardized inpatient service framework rather than as a single undifferentiated inpatient class. Consequently, distinctions in service and financing

arrangements may remain and have the potential to perpetuate fragmentation. This condition shows that the KRIS issue cannot be sufficiently resolved through facility standardization alone but requires a financing design capable of ensuring the sustainable fulfillment of service standards ([Hardianto et al., 2022](#)). A close reading of Presidential Regulation Number 59 of 2024 is therefore required to distinguish the objective of standardized inpatient services from any remaining differentiation in contributions, benefits, or service arrangements. Equity is assessed here not merely as formal access to JKN but also in terms of whether comparable inpatient needs are met through materially comparable standards across facilities.

This issue is ultimately linked to the debate regarding the meaning of justice in the national health insurance system. On the one hand, the principle of mutual cooperation (*gotong royong*) in social security requires participant contributions to be determined in accordance with applicable contribution rules and capacity to pay, while health service benefits are provided according to participants' health needs. On the other hand, the existence of class differentiation has historically indicated a relationship between contribution levels and the facilities received by participants ([Thaha, 2021](#)). Therefore, justice in health services should not be measured solely by the uniformity of facilities for all participants but also by the guarantee of access to appropriate, high-quality, and nondiscriminatory health services. This principle must be analyzed from the perspective of financing capacity to ensure that reform through KRIS does not place additional pressure on the sustainability of the JKN system.

In this context, several alternative financing policy designs can be considered, including increasing participant contributions, increasing government contributions through the State Budget (*Anggaran Pendapatan dan Belanja Negara* or APBN), or adopting a mixed financing model through a combination of contributions and taxes ([Nugraheni, 2025](#)). Each of these alternatives has different implications for the accessibility of health services, the community's ability to pay, the distribution of the financing burden, and the long-term sustainability of the JKN system ([Nurul Hakiki et al., 2025](#)). These alternatives address individual financing levers but do not, by themselves, resolve the combined problems of class differentiation, uneven facility readiness, and the allocation of transition costs. The proposed reconstruction is therefore assessed as an integrated financing design rather than as a simple adjustment to tariffs or participant contributions.

This condition ultimately raises issues concerning the relationship between the principle of equity, the principles of social security, and the demands of financial sustainability in the administration of JKN. On the one hand, the principle of equity requires that every participant receive fair health services according to their medical needs. On the other hand, the social security principle places participant contributions within a framework based on ability to pay and mutual cooperation, while the sustainability of JKN also demands a balance between revenue and expenditure within the Health Social Security Fund ([Silalahi & Fitri, 2025](#)). In practice, these three principles do not always operate harmoniously, thus requiring a financing policy design capable of balancing equity, social security, and financial sustainability. For this study, financial sustainability is assessed through four policy parameters: the relationship between financing inflows and benefit expenditure, the capacity of risk pooling to redistribute health care cost risk, the additional investment burden associated with KRIS readiness, and the ability of purchasing and payment arrangements to control expenditure without reducing necessary access.

Research on KRIS to date has focused more on hospital readiness, fulfillment of facility standards, and policy implementation aspects ([Adnyani, 2026](#); [Tomalima, 2026](#)). Meanwhile, studies that specifically integrate the analysis of equity and financial sustainability into the reconstruction of KRIS financing remain very limited. As a result, there is no established conceptual model explaining how KRIS financing can be designed to ensure equitable services while maintaining the sustainability of the JKN system. Unlike previous studies, this article offers the Single Standard Inpatient Financing Model as a reconstruction of KRIS financing. This model is based on the elimination of inpatient class distinctions and the strengthening of a single national service standard, incorporating the principles of ability to pay, need-based benefits, single national risk pooling, strategic purchasing, and shared fiscal responsibility between BPJS Kesehatan and the government. This model is intended to harmonize the principles of equity and

financial sustainability in the administration of JKN. The limitation of the existing literature is that hospital-readiness studies primarily explain implementation capacity, whereas financing studies tend to examine contribution or payment sustainability separately. The present study integrates these dimensions by examining how equity in standardized inpatient benefits interacts with risk pooling, facility investment, and expenditure control.

METHOD

Legal materials were selected based on their direct relevance to JKN, KRIS, benefit standardization, and health-financing authority, while policy documents were used to contextualize implementation and financing pressures. The analysis proceeded through statutory interpretation, conceptual evaluation of equity and financial sustainability, functional comparison of financing systems, and synthesis of the proposed financing model. Equity indicators include uniformity of inpatient standards and facility readiness, while sustainability indicators include the balance between revenues and expenditures, risk pooling, transition investment, and purchasing efficiency.

This study employs a doctrinal legal research method aimed at analyzing the reconstruction of Standard Inpatient Class (KRIS) financing from the perspective of equity and financial sustainability in the administration of National Health Insurance (JKN). Doctrinal research was chosen because the primary object of this study is the body of legal norms governing the administration of JKN, particularly the regulation of KRIS under Presidential Regulation Number 82 of 2018, as last amended by Presidential Regulation Number 59 of 2024, and its conformity with the principles of equity and financial sustainability within the national health insurance system.

The research employs a statutory approach, a conceptual approach, and a comparative approach. The statutory approach is used to examine the regulation of KRIS within the framework of the Indonesian health-law system; the conceptual approach is used to analyze the concepts of equity, social health insurance, risk pooling, strategic purchasing, and financial sustainability; and the comparative approach is used to compare the characteristics of financing in social health insurance-based and tax-funded health systems as a basis for developing a KRIS financing model that is better aligned with the characteristics of the JKN system in Indonesia.

The legal materials used consist of primary, secondary, and tertiary legal materials. Primary legal materials include the 1945 Constitution of the Republic of Indonesia; Law Number 40 of 2004 concerning the National Social Security System; Law Number 24 of 2011 concerning the Social Security Administering Body; Law Number 17 of 2023 concerning Health; and Presidential Regulation Number 82 of 2018 concerning Health Insurance, as amended, particularly by Presidential Regulation Number 59 of 2024. Secondary legal materials include books, scientific journal articles, reports from the World Health Organization, the Organisation for Economic Co-operation and Development (OECD), the World Bank, and other literature discussing health financing, equity, and the sustainability of health insurance systems (*Dewan Jaminan Sosial Nasional, 2024*).

To contextualize the normative analysis, this study uses BPJS Kesehatan program-management and financial reports and official policy documents cited in the manuscript. These materials are not treated as primary empirical observations; rather, they are used to identify reported financing trends, implementation constraints, and institutional responsibilities relevant to the legal analysis.

Legal materials were analyzed qualitatively using a prescriptive-analytical method. The analysis begins by identifying the conformity of KRIS regulations with the principle of equity in the fulfillment of the right to health, followed by an evaluation of the financing implications of KRIS based on the financial condition of the Health Social Security Fund and the readiness of hospitals to meet KRIS standards. Furthermore, the results of this analysis provide the basis for reconstructing the KRIS financing model through the proposed Single Standard Inpatient Financing Model, which integrates the principles of ability to pay, need-based benefits, single national risk pooling, strategic purchasing, and shared fiscal responsibility as an effort to establish a fairer and more financially sustainable financing system.

RESULTS AND DISCUSSION

Results

Health Service Financing Models in the Health Insurance System

Health financing is one of the fundamental functions of the health system that determines a country's capacity to achieve Universal Health Coverage (UHC) (OECD & WHO, 2024). From a modern perspective, health financing is no longer understood merely as a mechanism for collecting funds to finance health services, but also as a public policy instrument that functions to ensure equitable access to health services, redistribute health risks, and protect the public from financial hardship due to illness. Thus, the success of a health financing system is measured not only by the amount of available health funding, but also by its ability to create a balance among equity, efficiency, and financial sustainability in the provision of health services.

The World Health Organization (WHO) emphasizes that the main goal of health financing is to ensure that all people obtain the health services they need without experiencing financial hardship (WHO, 2010; World Health Organization, n.d.-a). Within this framework, WHO identifies three main health financing functions: revenue collection, risk pooling, and strategic purchasing. These three functions constitute an integrated whole and serve as the main foundation for the administration of health insurance systems in various countries.



Figure 1. Health Financing Functions

Source: (WHO, 2010; Kutzin, 2013)

a. Revenue collection, namely, the mechanism for collecting health financing resources, which may come from taxes, social insurance contributions, private insurance premiums, or out-of-pocket payments. The revenue collection mechanism determines the degree of equity in the distribution of the health financing burden. Systems that rely more heavily on direct payments by patients tend to increase the risk of catastrophic health expenditure (CHE), a situation in which health care costs paid out of pocket are so large that they disrupt a patient's ability to meet basic

living needs relative to their capacity to pay. Meanwhile, systems based on taxes or mandatory contributions allow the financing burden to be distributed according to the economic capacity of the population (ability to pay). Therefore, the revenue collection mechanism is a starting point for realizing a more equitable health financing system.

b. Risk pooling, namely, the mechanism that distinguishes health insurance systems from individual health financing arrangements. Through this mechanism, health risks that were originally borne by individuals are transformed into collective risks, so that the costs of health services are no longer the sole responsibility of patients who become ill but are shared among participants through the principle of social solidarity. WHO and Kutzin emphasize that the larger and more integrated the risk pool, the greater the system's capacity to redistribute funds and strengthen financial protection. Conversely, fragmentation of financing pools reduces the effectiveness of cross-subsidization, making the goal of equitable health services more difficult to achieve. Risk pooling has an equity function because contributions and fiscal transfers are combined so that access to benefits is not determined solely by an individual participant's contemporaneous health expenditure. Redistribution occurs across risk groups and, depending on contribution design and subsidies, across income groups; the equity question is therefore whether pooled resources finance comparable inpatient services according to medical need.

c. Strategic purchasing, namely, the mechanism for using collected funds to purchase quality health services effectively and efficiently. This function is not only related to the selection of payment methods for health facilities, such as capitation or case-based payment, but also concerns the system's ability to control health care costs while encouraging improvements in service quality. Thus, strategic purchasing becomes an important instrument for maintaining a balance between improving service quality and ensuring the financial sustainability of the health insurance system.

Based on the explanation of the three main health financing functions above, it can be understood that the success of a health financing system is not determined by the amount of available funds, but rather by a country's ability to integrate revenue collection, risk pooling, and strategic purchasing mechanisms. Therefore, health financing is a system that must be able to maintain a balance between equity and financial sustainability simultaneously. This conceptual framework serves as the basis for the analysis in this study to evaluate whether the financing design of the Standard Inpatient Class (KRIS) is aligned with the health financing functions developed by WHO. This paragraph sets out the conceptual criteria used for evaluation; the subsequent analysis applies those criteria to KRIS by examining whether revenue collection, pooling, and purchasing arrangements support standardized access without creating unmanaged expenditure or transition burdens.

For comparative purposes, the manuscript groups health financing arrangements into two broad ideal types—Social Health Insurance (SHI) and predominantly tax-funded systems—while recognizing that actual national systems may combine elements of both.

Table 1

Comparison of Characteristics of Social Health Insurance-Based and Tax-Funded Health Financing Systems

Aspect	Social Health Insurance	Tax-Funded System	Health	Implications for Equity
<i>Revenue Collection</i>	Mandatory contributions based on ability to pay.	Taxes collected by the government.	by the	Financing burden is distributed according to economic capacity.
<i>Risk Pooling</i>	Funds are pooled in one or more social security funds.	Funds are managed directly by the government (e.g., State/Regional Budget).	by the	Integrated pooling mechanisms, greater redistribution capacity.
<i>Strategic Purchasing</i>	Conducted by the social insurance administering body.	Conducted by the government.	by the	Determines efficiency of fund utilization and service quality.
<i>Benefit</i>	Based on medical	Based on citizen rights.		Guarantees equitable

	needs (need-based benefits).		access to health services.
Challenges	Contribution compliance and actuarial balance.	Fiscal capacity and budget priorities.	Determines system financing sustainability.

Source: Analysis from ([Kutzin, 2013](#); [OECD, 2023](#); [WHO, 2010](#); [Wagstaff, 2009](#))

The Social Health Insurance (SHI) model builds health financing through mandatory contribution mechanisms paid by workers, employers, and the government according to the economic capacity of participants (ability to pay). The collected funds are then pooled through a risk pooling mechanism so that health service costs can be distributed collectively based on medical needs (need-based benefits). This characteristic allows for cross-subsidization between healthy and sick participants, higher- and lower-income participants, and working-age and older participants. Thus, Social Health Insurance places social solidarity at the core of health financing arrangements.

In contrast to contribution-based SHI arrangements, predominantly tax-funded systems finance a larger share of health services through general public revenues. The comparison is used here to examine differences in revenue collection, pooling, and public fiscal responsibility, not to imply that every system conforms to a pure model.

One country that implements Social Health Insurance is Germany through its Statutory Health Insurance (*Gesetzliche Krankenversicherung*). Health insurance funds are collected through income-based mandatory contributions and subsequently redistributed among sickness funds through a risk adjustment mechanism. This system allows insurers to contract with hospitals and other health care providers based on service quality and efficiency considerations. Another country that implements Social Health Insurance is Japan, which maintains universal health coverage through a combination of participant contributions and government subsidies, thereby supporting financing sustainability amid an aging population. The OECD shows that Social Health Insurance systems can provide flexibility in the strategic purchasing of health services, thereby encouraging efficiency in the use of health resources ([OECD, 2023](#)). Germany is used as a functional comparator because statutory insurance links compulsory coverage, pooled funds, and regulated purchasing. The comparison focuses on these institutional functions and does not assume that Germany's contribution structure or provider arrangements can be transplanted to Indonesia.

Contribution compliance can be a financing challenge in systems with large informal sectors. Cross-country generalisations, however, require country-specific evidence; the comparison in this study is therefore limited to financing functions supported by the cited literature.

In tax-funded health systems, an advantage lies in their ability to guarantee universal health service coverage without linking the right to receive services directly to individual contribution payments. People have access to services, while financing comes primarily from tax revenues. This model reflects the principle that health services are a public good as well as a basic right of citizens, so the risk of exclusion due to an inability to pay contributions can be minimized. In addition, the administration of tax-based systems may be relatively simpler because it does not require a contribution collection mechanism from each participant, as is the case in Social Health Insurance.

This model is applied by the United Kingdom through the National Health Service (NHS), whose primary financing comes from tax revenues. Similarly, Sweden and Denmark rely substantially on public financing through national and regional taxes to provide universal health services. The OECD shows that countries with tax-based systems generally have very high population coverage and provide financial protection to residents ([OECD, 2023](#)). In addition, the gatekeeping mechanism through primary health care, which is widely applied in tax-based systems, can help control health service costs while improving care coordination.

However, a major challenge for tax-based systems is their dependence on government fiscal capacity. When tax revenues decline because of economic downturns or increasing pressure

on the public budget, this can reduce the government's ability to expand or maintain health service capacity. This challenge was observed in the UK's NHS in the post-COVID-19 period, when increasing health service needs were not fully matched by budget growth. The OECD affirms that most countries face increasing fiscal pressure due to population aging, the increasing prevalence of chronic diseases, inflation, and rising health technology costs (OECD, 2023). Therefore, the sustainability of a tax-based system depends substantially on the government's ability to maintain adequate fiscal space so that health services can remain financially sustainable.

Ultimately, Social Health Insurance and tax-funded health systems have different institutional mechanisms, but both are designed to achieve the same overarching goal, namely Universal Health Coverage. Therefore, the effectiveness of a health financing system is not determined by the model choice alone, but by a country's ability to establish effective risk redistribution mechanisms, efficient service purchasing systems, and financing governance capable of supporting the sustainability of health services. In other words, the debate on health financing models should not stop at the question of whether a country uses Social Health Insurance or a tax-based system, but should also consider the extent to which the selected arrangements can realize equity and financial sustainability simultaneously.

KRIS Financing Problems in the JKN System

Indonesia implements Social Health Insurance (SHI) through the administration of the National Health Insurance (JKN) program under Law Number 40 of 2004 concerning the National Social Security System and Law Number 24 of 2011 concerning the Social Security Administration Agency (BPJS). However, the financing characteristics of JKN are not entirely identical to the classical SHI model applied in Germany or Japan. The JKN system in Indonesia is built through a combination of participant contributions, government subsidies for Contribution Assistance Recipient (PBI) participants, and state fiscal support for the administration of health services. This condition shows that JKN financing is more appropriately understood as a hybrid social health insurance arrangement, namely, a social insurance system strengthened by government fiscal intervention to expand membership coverage and protect vulnerable groups. The term "Social Health Insurance" is used here as an analytical category for contribution-based compulsory pooling arrangements; Indonesia's JKN nevertheless has hybrid features because public subsidies and fiscal transfers also support participation and financing.

Table 2

Characteristics of the JKN Financing System in Indonesia for 2024 and 2025

Indicator	2024	2025	Change
JKN Participant Total	278,096,343 people	282,739,458 people	+ 4,643,115 people
Social Security Revenue	Rp165.34 trillion	Rp176.72 trillion	+6.88%
Social Security Expenditure	Rp173.00 trillion	Rp193.85 trillion	+12.05%
Difference (Revenue – Expenditure)	- Rp7.66 trillion	- Rp17.13 trillion	Deficit increased by Rp9.47 trillion (an increase of 123.6%)
Revenue-to-Expenditure Ratio	95.57%	91.16%	Decreased by 4.41 percentage points

Source: BPJS Kesehatan, Programme Management Report and Financial Statements of the Social Health Insurance Fund (Jakarta: BPJS Kesehatan)

The BPJS financial materials cited in this study are used to identify the direction of financing pressure rather than to establish a causal decomposition of expenditure growth. Higher expenditure may reflect changes in utilization, service prices or tariffs, case mix, coverage, and other factors; the available documentary data do not permit this study to attribute the increase to a single cause.

With respect to KRIS, the existing problem is not solely related to the establishment of 12 service standard criteria, but also to a service design that continues to maintain differentiation

among inpatient classes. Conceptually, this condition creates a potential discrepancy between the goal of service standardization and the principle of equity, which requires health service benefits to be provided according to medical needs rather than the economic capacity of participants. If inpatient service standards are intended to be uniform, the financing design also needs to move toward a more integrated mechanism so that the relationship among contributions, risks, and benefits does not reproduce service stratification. Within the health financing framework, this integration can be strengthened through broader risk pooling, simplification of the benefit package, and optimization of strategic purchasing.

Therefore, increasing service standards without an adequate financing design has the potential to increase pressure on the sustainability of the Health Insurance Fund. Thus, KRIS needs to be understood not merely as a policy for standardizing inpatient facilities, but also as a service reform with implications for the long-term financing design of JKN.

On this basis, the analysis of KRIS financing needs to begin by examining policy evidence regarding the capacity of health facilities to meet the established standards. The level of hospital readiness provides an overview of the resources that still need to be provided to achieve KRIS standards nationally. This data is important because it shows that KRIS financing needs are determined not only by the amount of service benefits paid through JKN, but also by the investment needs required to ensure that all participants can actually obtain the service standards that have been established normatively.

Based on this framework, the level of hospital readiness in fulfilling the twelve KRIS criteria becomes an initial indicator for assessing the financing consequences of the policy. The greater the gap in standard fulfillment, the greater the investment and operational adjustment needs that must be addressed. Accordingly, readiness is treated as a transition-cost indicator rather than as a direct measure of long-term JKN solvency: a larger readiness gap implies a greater need to identify who finances facility adjustments and how those costs interact with pooled benefit expenditure.

Table 3

Hospital Readiness Data in Fulfilling KRIS Standards and Its Implications for Financing

Indicator	Level of Readiness
Number of hospitals that have filled out the RS Online KRIS form	2,816 hospitals
Hospitals meeting all 12 KRIS criteria	1,713 hospitals (60.83%)
Hospitals meeting 9–11 criteria	640 hospitals (22.72%)
Hospitals meeting 5–8 criteria	328 hospitals (11.64%)
Hospitals meeting 1–4 criteria	46 hospitals (1.63%)
Hospitals not yet meeting KRIS criteria	89 hospitals (3.16%)

(Source: Ministry of Health RS Online Data, July 15, 2026)

The data in Table 3 show that KRIS implementation still faces a readiness gap among hospitals. Of the 2,816 hospitals that reported their fulfillment of KRIS standards through the RS Online application, only 60.83% had met all twelve KRIS criteria, while the remaining 39.17% were at various levels of readiness. This data shows that the transition toward KRIS still requires a significant adjustment process, particularly for hospitals that have not yet met all service standards.

Table 4

Data on Fulfillment of 12 KRIS Criteria in 2,816 Hospitals

KRIS Criteria	Fulfillment
Bedside patient call button	98%
Room density	98%
Room allocation	97%
Bathroom inside the room	97%

Non-porous building materials	96%
Air ventilation	95%
Room temperature	95%
Room lighting	94%
Non-porous curtains/partitions	90%
Wheelchair-accessible bathroom	90%
Oxygen outlet at every bed	89%
Nurse call at every bed	84%

(Source: Ministry of Health RS Online Data, July 15, 2026)

Table 4 shows that many of the criteria with lower levels of fulfillment are important components supporting medical services for patients, such as nurse call systems, oxygen outlets, curtains/partitions, and bathroom accessibility. Thus, the main challenge in KRIS implementation is not solely related to changes in standards, but also to the need for health facility investment that has direct implications for financing.

This data further serves as a basis for assessing equity and financial sustainability. From the perspective of equity, the uneven readiness of hospitals shows that the standards normatively intended for all JKN participants have not yet fully resulted in equal service experiences. Meanwhile, from the perspective of financial sustainability, this gap indicates the need for investment and additional financing that must be addressed so that service standardization can be implemented comprehensively. Thus, the KRIS issue lies at the intersection of participants' rights to obtain equitable services and hospitals' ability to meet the required facility standards.

From the perspective of health financing, fragmentation of financing pools is one of the main obstacles to achieving optimal risk redistribution. WHO emphasizes that the more fragmented the risk pooling mechanism, the more limited the system's ability to redistribute funds among participant groups, thereby reducing efficiency and equity in financing (World Health Organization, n.d.-b). Conversely, the formation of larger risk pools allows cross-subsidization mechanisms to operate more effectively, strengthens financial protection, and increases the system's capacity to maintain financing sustainability.

If KRIS is reconstructed as a single standard inpatient class, the JKN financing mechanism would conceptually move toward a single national risk pool that no longer distinguishes service benefits according to inpatient class. All participant contributions, whether from individual contributions or government subsidies, would be pooled into a common fund to finance health services based on medical needs (need-based benefits). This model is consistent with the principle of social solidarity that characterizes Social Health Insurance, whereby healthy participants help finance care for sick participants, higher-income participants help finance care for lower-income participants, and lower-risk participants help finance care for higher-risk participants, without distinguishing the quality of services received on the basis of class.

From the perspective of equity, implementation of a single standard class would provide a framework for reducing class-based differences in inpatient service access. Equity is not only interpreted as equality of access to health services, but also as the fair distribution of health resources according to health needs rather than ability to pay (Whitehead, 1992). Therefore, if all participants are required to receive the same standard of inpatient services, a financing arrangement that maintains benefit differentiation could create a discrepancy between the principle of service equity and its financing mechanism. Conversely, unification of financing through a single risk pool would strengthen the principle of mutual cooperation because all participants collectively contribute to the financing of health risks without benefit separation based on class.

From the perspective of financial sustainability, the unification of standards under a single national inpatient class could potentially simplify JKN financing administration. A unified benefit package allows for administrative simplification, harmonization of payment mechanisms for health facilities, and strengthened strategic purchasing because BPJS Kesehatan would no longer need to manage benefits according to multiple service-class categories. In addition, a larger risk pool can increase the system's capacity for cross-subsidization, allowing financial risks to be

distributed more broadly.

Therefore, the reconstruction of KRIS financing should move beyond the concept of a standardized class toward the formation of a Single Standard Inpatient Class, namely, a single national inpatient class with one service standard for all JKN participants. This model allows for strengthening the single national risk pool, optimizing cross-subsidization mechanisms, and administering financing in a manner more consistent with the principles of equity, social solidarity, and financial sustainability.

Reconstruction of a Fair and Sustainable KRIS Financing Model

JKN financing is often understood as a consequence of the participant contribution mechanism managed according to social insurance principles. This approach is consistent with the character of JKN as social health insurance. With respect to KRIS, Presidential Regulation Number 59 of 2024 introduces KRIS as an inpatient service standard for JKN participants. However, this policy has not fully eliminated class differentiation, so the KRIS provisions primarily regulate standardization within inpatient classes rather than eliminating service-class classification.

The results of the analysis in the previous section show that KRIS implementation still faces two main problems: substantive equity has not been fully achieved because hospital service standards are not uniformly fulfilled, and there is increasing pressure on the financial sustainability of the National Health Insurance program. At the same time, KRIS implementation continues to maintain the inpatient class structure even though the policy direction emphasizes service standardization. This condition shows that the KRIS issue cannot be resolved solely through improvements in health facility standards, but requires reconstruction of its financing design.

Based on these findings, this study proposes the Single Standard Inpatient Financing Model as a financing model that integrates the principles of equity and financial sustainability. This model is built on five main parameters, as presented in Table 5. The proposed model differs from class-differentiated arrangements by combining a single inpatient service standard with contributions calibrated to ability to pay, need-based access to benefits, a unified national risk pool, strategic purchasing, and explicitly allocated transition responsibilities. Its distinctiveness lies in linking service-standard equity to financing architecture rather than treating hospital readiness and contribution policy as separate problems.

Table 5

Parameters for Reconstruction of KRIS Financing in the JKN System

Parameter	Function	Conceptual Basis	Objective
Ability to Pay	Determining participant contributions	Social Insurance	Vertical equity
Need-Based Benefits	Determining service benefits	Equity	Horizontal equity
Single National Risk Pool	Combining all risks	WHO	Cross-subsidization
Strategic Purchasing	Service purchasing	WHO	Efficiency
Shared Responsibility	Distribution of financing	UUD 1945 and BPJS Law	Sustainability

The five parameters are interrelated in forming a financing system that is more consistent with the goals of JKN administration. Ability to pay ensures that participant contributions continue to reflect economic capacity so that the principle of social solidarity is maintained. Conversely, service benefits are no longer determined by the amount of contributions but are based on medical needs (need-based benefits). The integration of these two principles is then strengthened through a single national risk pool, so that all participant contributions are collected within a unified financing mechanism that allows for more effective risk redistribution. Furthermore, the effectiveness of fund utilization is supported through strategic purchasing, while the investment needs associated with fulfilling KRIS standards become a shared

responsibility between the government and JKN administrators under the principle of shared fiscal responsibility. Shared fiscal responsibility refers to the statutory roles of the central government, relevant regional governments, and BPJS Kesehatan as the JKN administrator, with health care facilities responsible for implementation within applicable financing and service rules. The model therefore requires an explicit allocation of transition and infrastructure obligations rather than an undefined transfer of costs to providers.

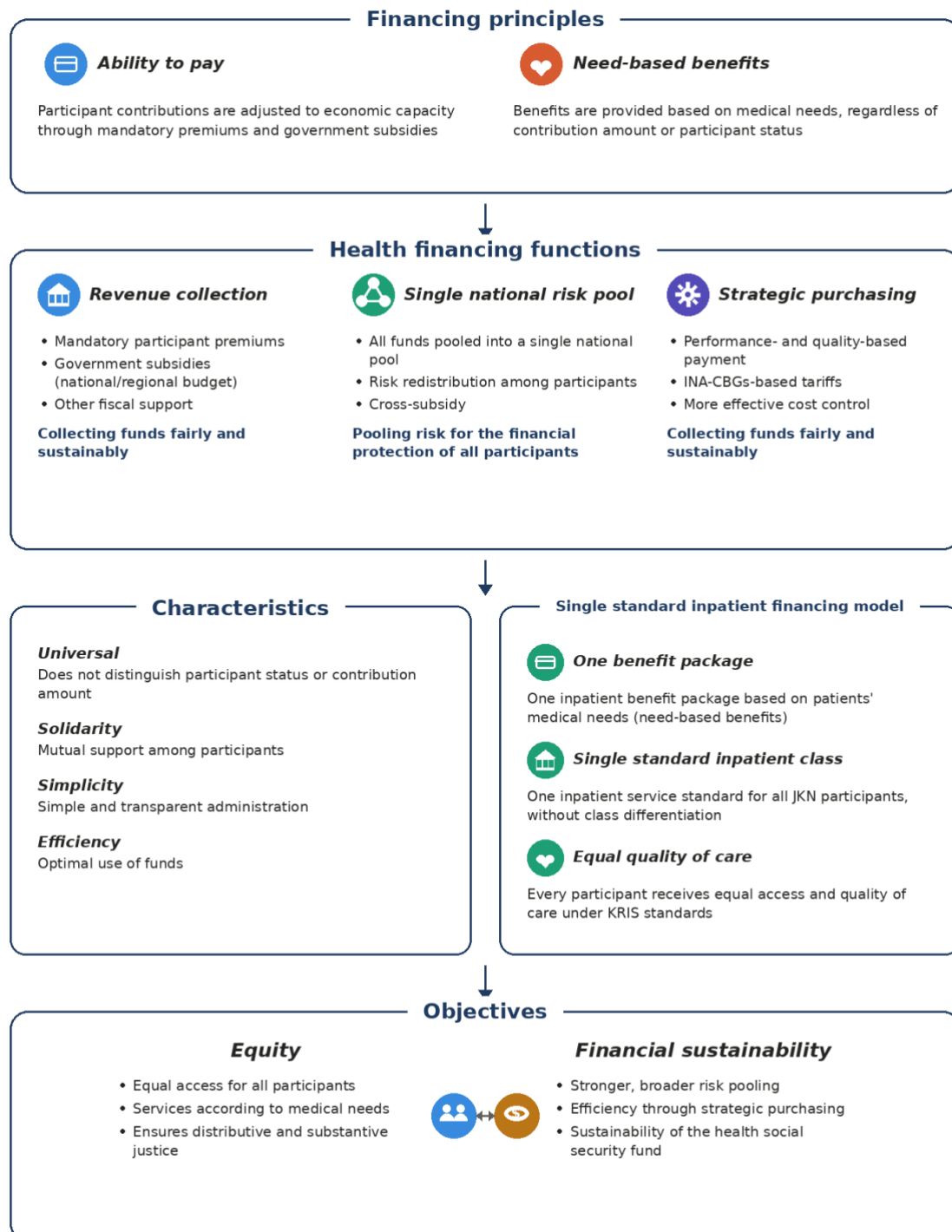


Figure 2. Framework for Reconstruction of KRIS Financing Based on Equity and Financial Sustainability

The Single Standard Inpatient Financing Model places service standardization as the main

basis for JKN financing administration. In this model, all participants receive a single standard of inpatient services based on medical needs, while the contribution mechanism maintains the principle of ability to pay through participant contributions and government subsidies. Thus, service standards become uniform without eliminating the solidarity mechanism in fund collection.

Table 6

Comparison of Existing KRIS Model and Single Standard Inpatient Class

Existing KRIS	Proposed Model
Standardized Class	Single Standard Inpatient Class
Benefit still segmented	One Benefit Package
Pooling still class-oriented	Single National Risk Pool
More complex administration	Simpler administration
Equity only partially realised	Stronger equity
Sustainability pressured	Improved sustainability

The comparison of the Existing KRIS Model and the Single Standard Inpatient Class in the table above shows that the reconstruction proposed in this study is not merely about changing hospital facility standards, but about transforming the relationship between services and financing in the JKN system. Service standardization is accompanied by benefit standardization so that the relationship between contributions and benefits is no longer based on class classification, but on participants' medical needs. At the same time, unification of the risk pooling mechanism strengthens risk redistribution and can simplify financing administration through consolidation of the benefit package and optimization of strategic purchasing.

The model is normatively designed to strengthen equity by separating the standard of needed inpatient care from the amount of an individual participant's contribution. Its effect on financial sustainability, however, cannot be established without actuarial and fiscal simulation; the present study therefore identifies design conditions and testable expectations rather than claiming a demonstrated improvement in sustainability.

Discussion

The findings of this study show that the KRIS financing issue cannot be separated from the three main health financing functions formulated by WHO, namely revenue collection, risk pooling, and strategic purchasing (Kutzin, 2013). These three functions are interrelated and provide a framework for assessing whether a health financing policy can balance equity and financial sustainability. In the context of KRIS, Presidential Regulation Number 59 of 2024 essentially establishes minimum standards for inpatient services without completely eliminating class differentiation. This condition indicates that KRIS is more appropriately understood as a standardized inpatient service arrangement rather than, by itself, a single inpatient class, so service and financing differentiation may persist.

Hospital readiness data reinforce this argument. Of the 2,816 hospitals that reported through RS Online, only 60.83% met all 12 KRIS criteria, while the remainder were at various levels of readiness (Ministry of Health RS Online Data, July 15, 2026). The criteria with lower levels of fulfillment include crucial components of inpatient care—nurse call systems, oxygen outlets, and bathroom accessibility—that have direct implications for service delivery, rather than merely administrative aspects. From an equity perspective, this gap indicates that the normatively established right to health services under Article 28H paragraph (1) and Article 34 paragraphs (2)–(3) of the UUD 1945 has not yet been fully realized in practice, because participants' actual access to standardized services remains partly dependent on the readiness of the health facility in which they receive care.

At the same time, pressure on financial sustainability is increasingly evident. Data from the BPJS Kesehatan Program Management Report and Financial Report show that the difference between revenue and expenditure for the JKN health insurance program increased from a deficit of Rp7.66 trillion in 2024 to Rp17.13 trillion in 2025, with expenditure growth (12.05%)

exceeding revenue growth (6.88%). This finding is consistent with Wagstaff (2009) view that social health insurance systems may require government fiscal intervention to sustain the principle of solidarity, and it is relevant to the experience of the UK's NHS in the post-pandemic period, which faced pressure associated with population aging and rising health technology costs (OECD, 2023).

Based on the framework of Mathauer et al. (2019) on pooling arrangements, the larger and more integrated the risk pool, the greater the system's capacity to redistribute funds. This principle forms the basis for the argument that reconstructing KRIS toward a Single Standard Inpatient Class with single national risk pooling is conceptually consistent with an equity-oriented financing architecture. This is also consistent with the findings of Mathauer et al. (2020), which indicate that fragmentation of primary health care financing can hinder equitable, people-centered services. The proposed Single Standard Inpatient Financing Model, with five parameters—ability to pay, need-based benefits, a single national risk pool, strategic purchasing, and shared fiscal responsibility—is intended to address the gap between the normative objective of service standardization and the practical constraints associated with fiscal capacity and facility readiness, as also discussed in the study by Sininta et al. (2025) on the effectiveness of KRIS in promoting equitable access to health services.

CONCLUSION

The study concludes that KRIS raises a combined equity and financing issue: standardized inpatient benefits cannot be assessed independently of uneven facility readiness, class-related differentiation, risk pooling, and the allocation of transition costs. The proposed Single Standard Inpatient Financing Model responds by linking a uniform service standard with ability-to-pay contributions, need-based benefits, unified pooling, strategic purchasing, and defined fiscal responsibility. This is a normative design proposition, not evidence that financial sustainability has already improved.

The academic contribution of this study is an integrated framework for evaluating KRIS through both substantive equity and financing sustainability. Future research should test the proposed model through actuarial simulation, facility-level costing, and empirical analysis of participant access before conclusions are drawn regarding its fiscal effects or nationwide implementation.

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AUTHOR CONTRIBUTION STATEMENT

Azhar Jaya contributed to the conceptualization, research design, legal analysis, and manuscript preparation. Retno Saraswati contributed to the development of the theoretical framework, statutory analysis, and critical review of the manuscript. Nabitatus Sa'adah contributed to the comparative legal analysis, interpretation of health financing policies, and refinement of the research discussion. Syifa Ulhadira contributed to literature review, data interpretation, manuscript editing, and final revision. All authors discussed the results, reviewed the manuscript critically, and approved the final version of the manuscript.

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