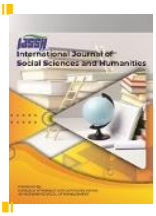

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Political Contestation in the Implementation of Presidential Regulation No. 59 of 2024 concerning Standard Inpatient Classes (KRIS)

Islam Manda Manggar Bumi Suharto[1]

Corresponding Author's e-mail: *manggar23manda@gmail.com*

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Abstract

The implementation of the Standard Inpatient Class (KRIS) through Presidential Regulation Number 59 of 2024 represents an important reform in Indonesia's National Health Insurance (JKN) system, aimed at promoting equitable health services for all participants. However, this policy has generated political resistance and contestation among the government, hospitals, workers' organisations, and civil society groups. This study analyses the dynamics of political contestation in KRIS implementation using the Advocacy Coalition Framework (ACF) and Argumentative Discourse Analysis (ADA). It employs an interpretive qualitative method based on policy documents, government reports, minutes of parliamentary meetings, media publications, and supporting documents related to KRIS implementation during 2024 to 2025. The findings show that contestation occurs through three main dimensions: discourse struggles between welfare-state and market logics, negotiation and compromise within institutional arenas, and delay politics with quiet resistance at the implementation level. The shift towards a compromised three-class inpatient system reflects a negotiated agreement caused by the inability of any coalition to fully dominate the policy process. This study confirms the relevance of ACF in explaining health policy change and highlights that public policy implementation is shaped by ideas, interests, and power relations among actors.

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[1] University of Indonesia

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Introduction

Health development is one of the main pillars of national development because it is directly related to the quality of human resources and community welfare. Within the framework of the Sustainable Development Goals (SDGs), health is not only seen as a development goal, but also as a prerequisite for the achievement of various other development goals. Therefore, various countries are trying to build a health system that is able to ensure access to fair, quality, and sustainable health services for all citizens. One of the approaches that is widely adopted is Universal Health Coverage (UHC), which is a system that ensures that all residents get the health services they need without facing excessive financial hardship (World Health Organization, 2023). The implementation of UHC not only requires adequate fiscal capacity, but also requires policy governance that is able to accommodate the various interests of the actors involved in the health system.

Indonesia is one of the countries that has adopted the UHC principle through the implementation of the National Health Insurance Program (JKN) since 2014. This program is an important milestone in national health reform because it has succeeded in significantly expanding public access to health services. By 2025, the number of JKN participants will have reached more than 98 percent of Indonesia's population, making it one of the largest social health insurance systems in the world. This success shows the state's commitment to ensuring the health rights of citizens as mandated in Article 28H and Article 34 of the 1945 Constitution of the Republic of Indonesia. However, various evaluations show that the JKN system still faces challenges in the form of inequality in service quality, disparity in health facilities, and fiscal pressures that continue to increase as the number of participants and health service costs increase.

One of the issues that has received a lot of attention in the implementation of JKN is the difference in inpatient facilities based on the class of participation. The class 1, class 2, and class 3 systems that have been implemented are considered to create service differentiation that has the potential to be contrary to the principles of social justice in national health insurance. The difference in the number of beds, room area, ventilation, and various other facilities causes participants to gain different service experiences even though they are in the same health insurance system. This condition encourages the government to carry out reforms through the implementation of the Standard Inpatient Class (KRIS) stipulated in Presidential Regulation Number 59 of 2024 concerning the Third Amendment to Presidential Regulation Number 82 of 2018 concerning Health Insurance.

Normatively, KRIS is designed as an instrument to reduce the gap in health services through standardization of inpatient facilities for all JKN participants. This policy departs from the assumption that health services are a universal right that must be given equally to all citizens regardless of economic ability or membership category. In the perspective of the welfare state, the state has the responsibility to ensure that the distribution of health services takes place fairly and equitably (Esping-Andersen, 1990). Therefore, the implementation of KRIS is positioned as a strategic step in strengthening the principles of social solidarity and distributive justice in the national health insurance system.

Despite having progressive goals, the implementation of KRIS does not run smoothly. Since the passage of Presidential Regulation Number 59 of 2024, various interest groups have expressed objections to the policy. The Association of Private Hospitals of All Indonesia (ARSSI), the Association of Hospitals of All Indonesia (PERSI), and the Association of Regional Hospitals (ARSADA) highlighted the high investment costs that hospitals must incur to meet the twelve criteria of KRIS. On the other hand, worker groups and civil society organizations are worried about the potential increase in JKN contributions as a consequence of changes in the service system. These differences of views

show that the implementation of KRIS is not only a technical health issue, but also a political arena that involves a battle of interests, resources, and different belief systems.

In public policy studies, the phenomenon can be explained through the Advocacy Coalition Framework (ACF) developed by Sabatier and Jenkins-Smith. This framework explains that the policy process takes place through the interaction of various advocacy coalitions consisting of actors from various organizations that have similar belief systems and seek to influence the direction of policy according to their interests. ACF differentiates actors' beliefs into three levels, namely deep core beliefs, policy core beliefs, and secondary aspects. Policy change occurs when there is a policy-oriented learning process, negotiation, or external pressure that changes the configuration of power between coalitions (Sabatier & Jenkins-Smith, 1993).

In addition to being influenced by the battle of interests, policy implementation is also greatly influenced by the battle of meaning built through discourse. Hajer (1995) explained that public policy is basically a discursive arena where various actors build narratives to gain legitimacy for the positions they are fighting for. In the Argumentative Discourse Analysis (ADA) approach, language and narrative are not only tools of communication, but also instruments of power used to shape public perception of a policy. Therefore, it is not enough to analyze the implementation of KRIS through an institutional approach alone, but it is also necessary to consider how actors construct and contest various storylines in the public space and the formal policy arena.

Previous studies have shown that health system reform often creates a conflict between the goal of equitable distribution of services and the economic interests of health care providers. Greer et al. (2022) found that health policy changes in different countries generally face resistance from groups that feel disadvantaged by resource redistribution. Similar findings were put forward by Abimbola et al. (2019) which showed that the successful implementation of health reform is greatly influenced by the government's ability to build strong policy coalitions and gain legitimacy from stakeholders. In the Indonesian context, research on JKN generally focuses on aspects of financing, service quality, and fiscal sustainability, while studies that specifically examine KRIS as an arena for political contestation are still relatively limited.

The limitations of the study show that there is an important research gap to fill. Most previous studies have viewed the implementation of health policies as administrative and managerial issues, while the political dimension behind the implementation process has not received much attention. In fact, various dynamics that emerged during the implementation of KRIS show that health policy changes cannot be separated from the battle of ideas, interests, and political strategies carried out by various actors. Therefore, this study seeks to fill this gap by examining the implementation of KRIS through the perspective of the Advocacy Coalition Framework and Argumentative Discourse Analysis.

This study aims to analyze the forms of political contestation that occurred during the implementation of Presidential Regulation Number 59 of 2024 concerning Standard Inpatient Classes (KRIS), map the advocacy coalitions formed, identify the storylines produced by each coalition, and explain the negotiation and compromise mechanisms that affect policy direction. Theoretically, this research is expected to enrich the development of health policy studies in Indonesia through the integration of ACF and ADA perspectives. Practically, the results of the research are expected to be input for the government in designing health policies that are more inclusive, implementive, and able to accommodate various stakeholder interests without sacrificing the goal of equitable distribution of health services.

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Methods

This study uses an interpretive qualitative approach with a *policy study design* to understand the dynamics of political contestation in the implementation of Presidential Regulation Number 59 of 2024 concerning Standard Inpatient Classes (KRIS) in the National Health Insurance (JKN) system. This approach was chosen because the focus of the research is related to the construction of meaning, inter-stakeholder interactions, conflicts of interest, and the process of policy negotiation that cannot be adequately explained through quantitative approaches. The analysis is directed at identifying actors, mapping advocacy coalitions, constructing discourses, and policy change mechanisms that develop during the implementation of KRIS in the 2024–2025 period. This approach is relevant considering that the implementation of health policy is basically a political process involving state institutions, professional organizations, interest groups, and civil society that have different goals and belief systems (Sabatier & Weible, 2014).

The research data consists of primary data and secondary data. Primary data were obtained through semi-structured *in-depth interviews* with selected informants using *purposive sampling techniques* based on direct involvement in the implementation of KRIS and representation of actors involved in the policy arena. The informants included representatives of the Ministry of Health of the Republic of Indonesia, the National Social Security Council (DJSN), BPJS Kesehatan, the Association of Private Hospitals of All Indonesia (ARSSI), the Association of Hospitals of All Indonesia (PERSI), the Association of Regional Hospitals (ARSADA), labor and labor organizations, and BPJS Watch as representatives of civil society. Meanwhile, secondary data was obtained from various relevant documents, including Presidential Regulation Number 59 of 2024, Presidential Regulation Number 82 of 2018 and its amendments, official BPJS Kesehatan report, DJSN document, Ministry of Health report, minutes of the Commission IX meeting of the House of Representatives of the Republic of Indonesia, evaluation report on the implementation of KRIS, national media publications, scientific articles, and various other supporting documents related to the KRIS policy.

Data analysis was carried out by integrating two theoretical frameworks, namely *the Advocacy Coalition Framework* (ACF) and *Argumentative Discourse Analysis* (ADA). ACF is used to identify advocacy coalitions, map the belief *system* of each actor, and explain the dynamics of policy changes that occur during the implementation process. According to Sabatier and Jenkins-Smith (1993), policy actors tend to form coalitions based on shared values and beliefs to influence policy direction through various political and institutional strategies. Meanwhile, ADA is used to analyze how actors construct narratives (*storylines*), frame policy issues (*policy framing*), and produce and distribute discourse in various policy arenas as an instrument of obtaining political legitimacy (Hajer, 1995). The analysis was carried out through the stages of data reduction, *thematic coding*, interpretation based on ACF and ADA concepts, and drawing conclusions through the synthesis of various research findings. To ensure the validity of the data, the research applied source triangulation and theoretical triangulation, as well as member *checking* key informants to ensure the suitability of the interpretation with the reality of the policy implementation being studied.

Results and Discussions

1. Establishment of an Advocacy Coalition in the Implementation of KRIS

The implementation of the Standard Inpatient Class (KRIS) through Presidential Regulation Number 59 of 2024 shows that health policy changes do not take place in a neutral space, but rather in a political arena involving various actors with different interests and belief systems. Based on the

perspective of the Advocacy Coalition Framework (ACF), actors who share similar beliefs and goals tend to form advocacy coalitions to influence the direction of public policy (Sabatier & Weible, 2014). In the implementation of KRIS, this study identifies three main coalitions that interact and compete with each other in determining the direction of inpatient service system reform. The first coalition is the Standardization Support Coalition, which consists of the Ministry of Health, the National Social Security Council (DJSN), and BPJS Kesehatan. This coalition has a basic belief that health services are a universal right that must be guaranteed equally by the state. Therefore, the existence of an inpatient class system is seen as inconsistent with the principles of social justice and the goal of Universal Health Coverage (UHC). These findings are in line with research by Greer et al. (2022) which states that health reform in countries with social security systems is generally driven by the orientation of equitable access and reduction of health service inequality.

On the other hand, the Coalition Against Standardization consists of the Association of Private Hospitals of All Indonesia (ARSSI), the Association of Indonesian Hospitals (PERSI), the Association of Regional Hospitals (ARSADA), and worker and labor groups. This coalition does not directly reject the goal of equitable distribution of health services, but questions the implementation mechanism which is considered to burden hospitals without adequate financing support. According to Cairney (2019), resistance to policy reform often arises when implementer actors view that the cost of change outweighs the benefits obtained. The third coalition is the Civil Society Group represented by BPJS Watch. Unlike the previous two coalitions, this group occupies a relatively hybrid position. They support the principle of equality in health services, but at the same time are concerned about the impact of the implementation of KRIS on the sustainability of the JKN system and the potential increase in participant contributions. This position suggests that the preferences of actors in policy subsystems are not always dichotomous, but can be on a more complex spectrum according to the interests being fought for (Weible et al., 2020).

These findings show that the implementation of KRIS meets the basic assumption of ACF which places the policy process as an arena for interaction between coalitions that have different belief systems. These differences are not only related to the technical aspects of health services, but also concern normative debates about the meaning of justice, efficiency, and state responsibility in the provision of health services.

2. The Battle of Frames between the Logic of the Welfare State and the Logic of the Market

One of the most prominent forms of contestation in the implementation of KRIS is the battle of frames. In the perspective of Argumentative Discourse Analysis (ADA), public policy is a discursive arena where actors construct certain narratives to gain legitimacy for the positions they are fighting for (Hajer, 1995). Therefore, the debate about KRIS is not only related to the technical aspects of health, but also concerns how the policy is interpreted and represented to the public. The coalition of standardization supporters has consistently built a narrative that KRIS is an instrument for equitable distribution of health services that is in line with the mandate of the constitution. The government has placed this policy as an effort to eliminate discrimination in service facilities based on the economic status of JKN participants. Within the framework of the welfare state, this kind of policy is seen as a necessary redistribution mechanism to reduce social inequality in access to health services (Esping-Andersen, 1990). The narrative strengthens the moral legitimacy of the government by placing KRIS as a symbol of social justice.

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Instead, the hospital coalition built a different framing. They view KRIS as a policy that has the potential to disrupt the sustainability of health services because it requires large investments in hospital infrastructure renovation. This perspective emphasizes the importance of economic efficiency and organizational sustainability in the delivery of health services. According to Exworthy et al. (2019), health reform often brings together two opposing logics, namely the logic of social equity and the logic of economic efficiency. The tension between the two logics is evident in the debate over the implementation of KRIS. Workers' groups and civil society are also building their own narratives. They are worried that service standardization could be a justification for the government to increase JKN contributions in the future. These concerns reflect the distributive dimension of health policy, namely how the costs and benefits of reform are distributed to various groups of people. According to Béland and Howlett (2016), public perception of the distribution of benefits and policy burdens is often an important factor determining the level of support for social policy reform. The contestation of this discourse shows that the success of policy implementation is not only determined by the quality of the substance of the policy, but also by the ability of actors to build narratives that gain public support. In the context of the KRIS, the battle between the logic of the welfare state and the logic of the market is a factor that greatly determines the direction of policy development during the implementation period.

3. Negotiation and Compromise in the Institutional Arena

In addition to taking place in the public space, the KRIS implementation contest also takes place in the institutional arena through working meetings of the House of Representatives of the Republic of Indonesia, policy consultation forums, and various inter-institutional coordination mechanisms. In the perspective of the ACF, policy change generally does not occur through the absolute victory of one coalition, but rather through a negotiation process that results in compromises on certain aspects of the policy (Jenkins-Smith et al., 2018). The results of the study show that the government initially targeted the full implementation of KRIS by 2025. However, various objections submitted by hospitals and professional organizations prompted the emergence of various negotiation forums involving the House of Representatives of the Republic of Indonesia, the Ministry of Health, BPJS Kesehatan, DJSN, and hospital organizations. In the forum, the main issues that were debated were the readiness of hospital infrastructure, the certainty of service rates, and the fiscal impact on the JKN system.

The role of the House of Representatives in this process is very important because it acts as a policy broker that bridges the interests of various coalitions. According to Nohrstedt and Weible (2010), policy brokers have a strategic function in reducing conflicts between coalitions and encouraging the achievement of agreements that can be accepted by various parties. In the case of KRIS, THE HOUSE OF REPRESENTATIVES seeks to encourage evaluation of implementation before the policy is fully implemented. The negotiation process ultimately resulted in various adjustments to the initial design of the policy. One form of compromise that emerged was the retention of a three-class system with a certain minimum standard as an alternative to the original idea of a single class. This compromise suggests that policy changes do not necessarily change the core beliefs of each coalition, but more often occur on the technical aspects of implementation that are considered more flexible to negotiate (Sabatier & Weible, 2014).

4. BPJS Health Deficit as an External Shock

The findings of the study show that the dynamics of the implementation of KRIS cannot be separated from the financial condition of BPJS Kesehatan which continues to face fiscal pressure. In

the perspective of ACF, external factors such as economic changes, fiscal crises, or political pressures can serve as external shocks that affect the configuration of power in the policy subsystem (Weible et al., 2009). The deficit faced by BPJS Kesehatan is one of the main arguments used by various coalitions to strengthen their position. For the government, service standardization through KRIS is seen as one of the efforts to improve the efficiency of the health service system and reduce various forms of inefficiency that arise due to the fragmentation of service classes.

This perspective is in line with the findings of the OECD (2023) which shows that standardization of health services can improve the efficiency of the use of health resources if accompanied by the right financing mechanism. On the contrary, the hospital views BPJS's fiscal pressure as a reason to delay the implementation of KRIS. They argue that the unstable financial condition of the JKN system actually makes hospitals face greater risks if they have to make infrastructure investments in a short period of time. The argument suggests that fiscal data can be used differently by actors with different interests and beliefs. Meanwhile, civil society groups linked the issue of deficit to the possibility of increasing participant contributions. These concerns suggest that health reform is not only influenced by technical considerations, but also by public perceptions of the fairness of policy cost distribution. In this context, the BPJS deficit serves as an issue that strengthens contestation while encouraging policy negotiations.

5. The Politics of Delay and Quiet Resistance in the Implementation of KRIS

The findings of the study show that one of the most dominant forms of resistance in the implementation of KRIS is the politics of delay and quiet resistance. In contrast to open rejection, this strategy is carried out through implementation delays, requests for additional regulations, and various forms of partial compliance with policies. According to Lipsky (1980), policy implementers have the capacity to influence policy outcomes through various forms of discretion in program implementation. In the context of KRIS, hospitals take advantage of the unclarity of derivative regulations and the uncertainty of financing schemes as a basis for postponing various necessary infrastructure adjustment steps.

This strategy results in a considerable implementation gap between policy objectives and the reality of implementation on the ground. This phenomenon is in line with the findings of Pressman and Wildavsky (1973) who stated that implementation failures are often not caused by weak policy objectives, but by the complexity of inter-agency coordination and low compliance of implementers. The politics of delay in the implementation of KRIS shows that delays are not always a consequence of limited capacity, but can be a political strategy used to influence policy direction. By slowing down the implementation process, implementer actors gain room to push for policy changes that are more in line with their interests.

6. Negotiated Agreement and Change in KRIS Policy Direction

The overall analysis shows that the implementation of KRIS ends in the form of a negotiated agreement that reflects the results of compromise between coalitions. No single coalition has managed to fully dominate the policy process. Instead, each coalition gains some of its stakes through various adjustments to the initial policy design. The coalition of supporters succeeded in maintaining the principle of standardization of health services as the main goal of the reform. However, the hospital coalition has also succeeded in pushing for various adjustments that reduce implementation pressure on health facilities. Meanwhile, civil society groups have the space to continue to monitor the impact of policies on JKN participants.

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These findings reinforce ACF's argument that policy change generally occurs through a process of learning and negotiation that takes place over the long term, rather than through rational decisions that are entirely determined by governments (Jenkins-Smith et al., 2018). In the context of the KRIS, the emerging compromises show that the success of health reform is highly dependent on the government's ability to build consensus and manage conflicts of interest between stakeholders. Overall, the results of the study indicate that the implementation of KRIS is a clear example of how health policy has become a complex arena of political contestation. Health service reform not only requires good policy design, but also requires a governance strategy that is able to integrate various interests, build public legitimacy, and create a constructive negotiation space for all actors involved.

Conclusion

The implementation of the Standard Inpatient Class (KRIS) in the National Health Insurance (JKN) system shows that health policy reform is a process full of political dynamics, not just administrative and technical changes in services. This study found that there are three main coalitions involved in the implementation of KRIS, namely the government coalition as a supporter of service standardization, a coalition of hospitals and workers' groups as parties critical to implementation, and civil society groups who are in a moderate position. Contestation occurs through a discourse battle regarding the meaning of justice and efficiency of health services, negotiations in the institutional arena, and various forms of implementation resistance manifested through the strategy of *politics of delay* and *quiet resistance*. These findings show that differences in belief systems and interests between actors are the main factors that shape the direction of the implementation of the KRIS policy.

Furthermore, this study shows that the change in the direction of KRIS policy does not occur through the dominance of one coalition, but through a negotiation and compromise process that results in *a negotiated agreement*. BPJS Kesehatan's fiscal pressure, the readiness of hospital infrastructure, and concerns about the sustainability of services are important factors that affect the process. From a theoretical perspective, the results of the study reinforce the relevance of *the Advocacy Coalition Framework* and *Argumentative Discourse Analysis* in explaining health policy changes that involve complex interactions between interests, power, and discourse construction. Therefore, the successful implementation of health reform in the future requires an approach that not only pays attention to technical and regulatory aspects, but is also able to build consensus, strengthen communication between stakeholders, and accommodate the various interests that are developing in the health policy subsystem.

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in Indonesia and become a consideration in the formulation and implementation of a more fair, inclusive, and sustainable National Health Insurance policy.

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