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Institutional Readiness of Baubau City Regional General Hospital in Implementing the Standardised Inpatient Care Class Policy

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ABSTRACT

The Standardised Inpatient Care Class (KRIS) is a national policy within the National Health Insurance (JKN) programme in Indonesia that mandates hospitals to fulfil 12 technical criteria to ensure equitable inpatient services for all BPJS Kesehatan participants. This study evaluated the institutional readiness of Baubau City Regional General Hospital in implementing KRIS as mandated by Presidential Regulation (No.59/2024). A convergent mixed-methods design was employed, involving four key informants with direct authority over the implementation process. Data were collected through in-depth interviews, readiness assessments based on the 12 KRIS criteria, direct field observations, and document reviews. Qualitative and quantitative data were analysed separately and integrated during interpretation using SWOT and fishbone analyses. The findings indicated that the hospital had not yet achieved readiness to implement KRIS, particularly in infrastructure standards, clinical-support facilities, and service system requirements. Major barriers included limited regional fiscal capacity, disparities in governance authority between local and centrally managed hospitals, and weak inter-unit coordination. These constraints may affect policy implementation effectiveness and equitable service delivery. The study concludes that Baubau City Regional General Hospital remains institutionally unprepared for full KRIS implementation. A phased PDCA (Plan–Do–Check–Act) approach is recommended to strengthen infrastructure readiness, coordination mechanisms, and institutional implementation capacity.

Keywords: Standardised Inpatient Care Class (KRIS), Hospital Readiness, Institutional Capacity, Health Policy Implementation, National Health Insurance

INTRODUCTION

The Standardised Inpatient Care Class (KRIS) represents the baseline standard for inpatient services under Indonesia's National Health Insurance (JKN) programme, established through Presidential Regulation No. 59/2024 [(1)]. However, the implementation of KRIS within Indonesia's decentralised health system and broad geographical diversity continues to face challenges in achieving equitable access and quality of healthcare services across regions [(2)]. By abolishing the class-based tiering of hospital wards, KRIS mandates that all BPJS Kesehatan participants receive uniform, dignified care regardless of socio-economic background [(3)]. This commitment is based on distributive justice principles, particularly Rawls' framework of equitable access, which emphasises fairness in the distribution of social goods, including healthcare infrastructure and service quality. Within the KRIS policy, these principles are reflected in efforts to standardise inpatient facilities and reduce disparities in healthcare access across hospitals and regions through 12 technical readiness criteria spanning infrastructure, human resources, and supporting facilities [(1,3–5)].

Hospital preparedness for KRIS implementation is still quite inconsistent throughout Indonesia, according to empirical data. Joint evaluations by BPJS Kesehatan and the Ministry of Health indicate substantial regional disparities, with some hospitals achieving readiness levels of 75–85%, while others face persistent deficits in physical infrastructure, room density, and patient-support systems [(6–8)]. Importantly, these disparities are not random, but are associated with differences in hospital governance capacity, regional fiscal limitations, and uneven infrastructure preparedness across public hospitals in Indonesia [(9,10)]. Infrastructure adequacy has been consistently identified as a pivotal determinant of healthcare service quality and patient satisfaction, particularly in district-level institutions where capital investment from regional budgets remains limited and unpredictable.

However, previous studies on KRIS preparedness still have several limitations. A study at RSUP dr. Tadjuddin Chalid Makassar found that inadequate infrastructure was the main obstacle to KRIS implementation, but the study was conducted in a centrally managed tertiary hospital setting, which may differ from the conditions faced by district-level hospitals [(4)]. Similar financial limitations and inadequacies in inpatient infrastructure were reported in studies conducted at RSUD Batu Bara. However, these studies relied on single-site descriptive methods without investigating the governance mechanisms that underlie those situations [(6)]. The majority of current research treats implementation constraints as site-specific rather than as outcomes of larger governance

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and financial systems, despite the fact that these studies collectively demonstrate that regional hospitals face structurally unique challenges.

While extant research highlights KRIS policy's potential to enhance accessibility and quality of JKN services through standardisation of inpatient facilities [11–13], successful implementation remains contingent upon institutional readiness, cross-sectoral collaboration, and community engagement [14–17]. It should be noted that only a few studies have offered clear and structured improvement strategies for regional hospitals with limited resources. As a result, a gap remains between identifying problems and providing solutions that can be replicated in other settings.

There are still gaps in the literature despite mounting evidence of implementation inequalities. Few studies have looked at how institutional readiness is mediated by governance asymmetries between regional and central hospitals, and previous research has not suggested formal improvement frameworks based on implementation theory. Additionally, KRIS preparedness research continues to underrepresent eastern Indonesia, where administrative capacity and resource constraints are more severe. In addition to providing a contextually relevant case for analyzing KRIS preparedness in resource-constrained regional settings, Baubau City Regional General Hospital, a Class C district hospital servicing the Buton Islands region, is an example of these structural issues.

Therefore, this study aims to assess the institutional readiness of Baubau City Regional General Hospital in implementing KRIS against the 12 criteria established by BPJS Kesehatan, to analyse the fiscal, governance, and coordinative factors shaping such readiness, and to propose strategic directions for accelerating full compliance. Unlike prior descriptive KRIS readiness assessments, this study integrates institutional readiness evaluation with governance-oriented analysis and strategic diagnostic tools to generate context-sensitive recommendations for regional hospitals. By integrating SWOT analysis and fishbone diagnosis within a qualitative framework, this study provides a structured assessment of KRIS readiness. It also extends beyond descriptive inventory by examining the systemic roots of implementation gaps in regional hospital settings.

MATERIALS AND METHODS

This study used a convergent mixed-methods design, combining quantitative readiness scores and qualitative data from interviews [18]. Both types of data were collected at the same time, analysed separately, then brought together at the interpretation stage. This approach was chosen because assessing KRIS readiness requires both measurable compliance figures and an understanding of why gaps exist, which a single method alone could not fully capture. The study was carried out at RSUD Kota Baubau, Southeast Sulawesi, between December 2024 and February 2025. Participants were chosen purposively, meaning they were selected because of their direct involvement in hospital management, not randomly. To be included, a participant had to be currently working at RSUD Kota Baubau, hold a supervisory or management role related to inpatient services, planning, nursing, or facilities, and agree to participate voluntarily.

Four key informants were recruited: the Hospital Director, the Head of Medical Services, the Head of Nursing, and the Head of Infrastructure and Facilities. This selection was considered sufficient to represent institutional readiness across the principal domains of KRIS compliance governance, clinical services, nursing workforce, and physical infrastructure consistent with purposive sampling principles in qualitative research where informant depth and relevance are prioritised over sample size. As Creswell et al. (2011) note, what matters in purposive sampling is not how many people participate but whether the right people are included. Informants were approached directly after being identified from the hospital's organisational chart, and all four agreed to participate. Interviews continued until no new themes came up, which suggested saturation had been reached.

Data were collected in four ways. Interviews were conducted one-on-one with each informant using a guide that covered five areas: understanding of KRIS regulations, infrastructure conditions, staff capacity, budget and planning, and coordination between units. Each interview was recorded and transcribed. A readiness questionnaire based on the 12 KRIS criteria was also given to each informant, with each item answered as either met or not met. On top of that, two researchers independently observed the inpatient wards using a checklist that looked at room size, ventilation, bathroom access, nurse call systems, and bed arrangements. The percentages in Table 1 come from these observations. The denominator for all percentages in Table 1 was the total number of inpatient room observations assessed for each KRIS criterion (n = 105). Finally, hospital documents reviewed to check and add context to what informants said. To increase confidence in the research results, a second researcher not involved in data collection was asked to review the analysis process and thematic categories to reduce potential bias.

For analysis, interview transcripts were read inductively to identify recurring themes. Observation and questionnaire data were turned into percentages per criterion. SWOT analysis was done as a team, using observation and questionnaire results for the internal factors and documents and interviews for the external ones. Fishbone analysis helped map out why implementation barriers exist, looking at human resources, infrastructure, policy, finance, and coordination. In the final step, the qualitative and quantitative findings were brought together to give an overall picture of readiness.

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To check the consistency of findings, results from all four data sources were compared for each KRIS criterion. When sources agreed, the finding was treated as solid. When they did not match, the team went back to the documents or followed up with the relevant informant. Triangulation across both sources and methods was used to make the findings more trustworthy Creswell et al. (2011). Ethical approval was obtained from the Pelamonia Institute of Health Sciences Research Ethics Committee (No. Rek/014/KEPK-IIKP/II/2025). All participants gave written consent before the study began, and their identities were not disclosed at any point.

RESULTS

Institutional Understanding Of KRIS Policy

Based on indepth interviews with several informants at Baubau City Regional General Hospital, this study explored the hospital's understanding and readiness toward the implementation of the Standardised Inpatient Care Class (KRIS). Informants generally understood KRIS as a policy requiring the fulfilment of infrastructure, facilities, and service standards according to the 12 criteria established by BPJS Kesehatan. One informant stated,

> *"I believe that standard inpatient care as defined by KRIS requires adequate facilities, such as complete medical equipment. So far, the class requirements at Baubau City Hospital are determined solely by the number of patients, not by medical equipment or medications, and we at the hospital will certainly strive to ensure this KRIS is implemented." (Informant 1*)

This statement indicates that healthcare workers primarily associate KRIS readiness with the adequacy of infrastructure and medical equipment. It also reflects awareness regarding the need to fulfil several technical KRIS standards related to inpatient facilities. Another informant explained,

> *"I think the information about KRIS was announced about a year ago through a Zoom socialization. However, regarding its implementation, we have to wait for the regulations. We have also been inspected by BPJS Kesehatan to check the inpatient rooms based on the 12 criteria mentioned." (Informant 2)*

This statement demonstrates that the hospital has undergone an external assessment process by BPJS Kesehatan as part of the KRIS preparation phase. Several participants reported that the hospital had established a KRIS planning team to support implementation preparation:

> *"At this hospital, we've heard about KRIS. We are still working to implement it, especially since it's still new. We've already formed a planning team, especially a KRIS planning group. We, as a service, are definitely ready for KRIS. There shouldn't be much change." (Informant 3)*

This finding indicates institutional commitment and managerial readiness for future KRIS implementation of KRIS. However, another informant reported that several KRIS standards had not yet been fulfilled:

> *"I have heard about KRIS; we at the hospital are still working towards KRIS readiness, but there are several criteria we have not yet met and some rooms are not yet fully equipped. We have also been checked directly by BPJS, and we are still fixing what is missing in the hospital." (Informant 4)*

This statement highlights the gaps in several infrastructure-related KRIS criteria. Specifically, ventilation system, accessible bathrooms, and oxygen outlets demonstrated very low readiness levels, consistent with the findings presented in Table 1.

Compliance Status With The 12 KRIS Criteria

To assess the hospital's compliance with the 12 KRIS criteria established by BPJS Health, a readiness survey was conducted at Baubau City Regional General Hospital. The results are presented in Table 1. Readiness percentages in Table 1 were calculated based on the proportion of inpatient rooms that fulfilled each KRIS criterion during observation. A total of 105 inpatient rooms across all inpatient wards were assessed in this study. The readiness percentages indicate varying levels of compliance across the 12 KRIS criteria. A score of 100% indicates full compliance, while 0% indicates that the criterion has not yet been fulfilled. The hospital demonstrated high readiness in the arrangement of inpatient rooms based on gender, age, and type of illness (100%), as well as the availability of bedside tables (92%). These findings suggest that some non-structural service standards have already been implemented effectively.

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However, several infrastructure-related criteria showed very low readiness levels. Air ventilation, room lighting, accessible bathrooms, bed specification completeness, and oxygen outlets all recorded 0% readiness. These findings indicate major infrastructural limitations that may hinder full KRIS implementation. The low readiness in room temperature regulation (14%) and bed accommodation density (41%) further suggests that substantial physical renovation and facility improvement are still required.

Table 1. Survey Results on KRIS Readiness Based on 12 BPJS Health Criteria

No	KRIS Criteria	Total KRIS Readiness Criteria
1	Construction materials in hospitals do not have high porosity.	79%
2	Air ventilation	0%
3	Room lighting	0%
4	Bed specification completeness	0%
5	Bed with bedside table	92%
6	Room temperature 20-26℃	14%
7	Rooms are arranged based on gender, age, and type of illness (infectious, non-infectious, maternity)	100%
8	Bed Quality and Accommodation Density	41%
9	Bed curtains	78%
10	En-suite bathroom	75%
11	Accessible bathroom	0%
12	Oxygen outlet	0%

Root Causes of Implementation Barrier

To further identify the underlying factors influencing these readiness levels, a fishbone analysis was developed, as shown in Figure 1. This analysis explores the root causes of the hospital's limited readiness in achieving full KRIS compliance across five main dimensions: human resources, methods, materials, facilities, and financial resources.

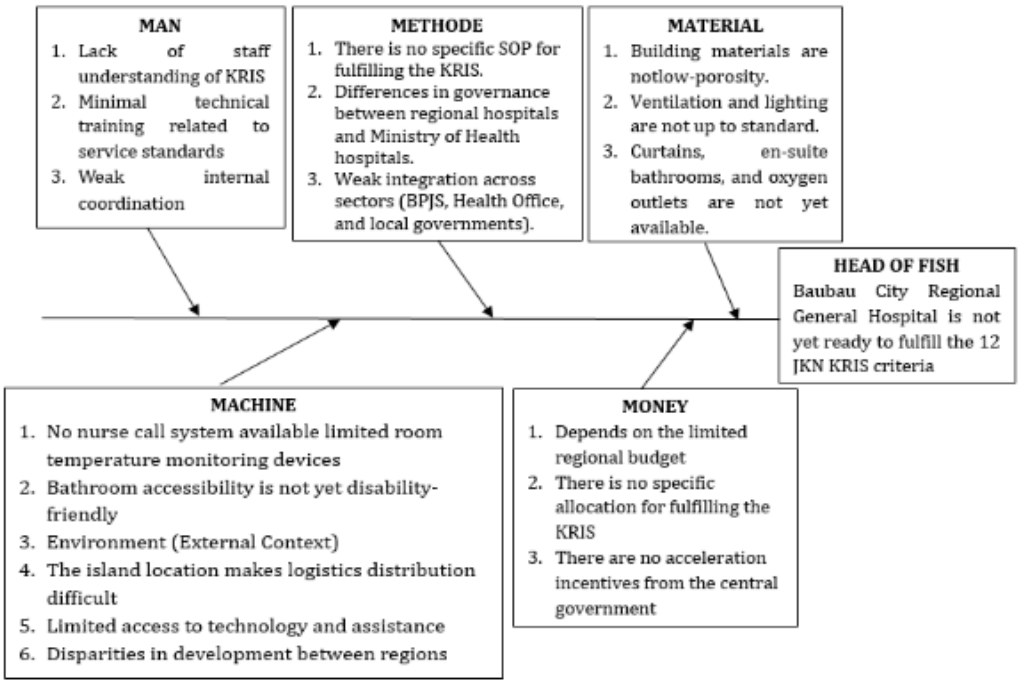

Figure 1. Fishbone Diagram

The fishbone analysis revealed that financial constraints constituted the primary barrier to KRIS implementation. Limited regional and BLUD budgets restricted the hospital's ability to renovate inpatient rooms and procure supporting medical equipment. Infrastructural limitations were also identified as major contributing factors, particularly related to ventilation systems, lighting, accessible bathrooms, and oxygen outlet availability. These findings correspond with the low readiness percentages shown in Table 1, especially for Criteria 2, 3, 11,

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and 12, which all recorded 0% readiness. Additionally, the implementation process was constrained by the need for gradual adaptation to new national standards and incomplete fulfilment of technical facility requirements.

Strategic Positioning and Improvement Strategies

Table 2. SWOT Analysis of Baubau City Hospital's KRIS Readiness

Internal	**STRENGTHS** **1.** A special KRIS planning team has been formed, tasked with developing strategies and implementation steps. **2.** Visits and inspections from the BPJS Kesehatan demonstrate their attention and support in the transition to KRIS.	**WEAKNESSES** **1.** Many inpatient rooms do not meet the 12 KRIS criteria. **2.** Limited budget for renovations and procurement of medical equipment to support KRIS standards.
External	**S-O Strategy (Strengths-Opportunities)**	**W-O Strategy (Weaknesses-Opportunities)**
OPPORTUNITIES **1.** With relatively better preparedness compared to other hospitals in the Buton Islands region, Baubau City Hospital has the opportunity to become a referral hospital as well as a model in implementing the 12 KRIS criteria, both from a technical, managerial and infrastructure perspective. **2.** Improving its strategic position as a referral hospital for the island region, more advanced readiness provides Baubau City Hospital with the opportunity to strengthen its position as a primary referral hospital, particularly in providing quality inpatient services that meet national standards.	1. Utilize the KRIS planning team to develop the Baubau City Regional General Hospital as a regional referral hospital. 2. Collaborate with the BPJS and the Ministry of Health to establish the Baubau City Regional General Hospital as a KRIS hospital in Baubau City.	1. Submit a proposal for renovation funding assistance to the Ministry of Health or BPJS by branding it as a referral hospital for the Islands.
THREATS **1.** The limited budgets of regional governments and Public Service Agencies have not yet been sufficient to cover all physical renovation requirements and the procurement of medical equipment that meet KRIS standards.	**S-T Strategy (Strengths-Threats)** 1. Optimize the KRIS planning team to develop a phased and efficient financing scheme within budget constraints. 2. Strengthen synergy with the Social Security Agency (BPJS) and local governments to obtain special budget allocations related to the national KRIS program.	**W-T Strategy (Weaknesses-Threats)** 1. Prioritize inpatient room renovations based on urgency. 2. Develop a medium-term plan for the procurement of supporting medical equipment using a phased procurement system.

The SWOT analysis reveals a fundamental tension between institutional readiness and resource constraints. The formation of a dedicated KRIS planning team and regular BPJS Kesehatan supervision reflect genuine organizational commitment, suggesting that the hospital's leadership has begun treating KRIS as a structural reform rather than a mere procedural obligation. However, these managerial strengths have yet to translate into physical readiness. Persistent infrastructure gaps particularly in ventilation, lighting, accessible bathrooms, and oxygen outlets reflect a structural mismatch between policy ambition and fiscal capacity that managerial effort alone cannot resolve.

Externally, the hospital's comparatively advanced preparedness within the Buton Islands region presents a strategic opportunity: positioning itself as a regional model for KRIS implementation could serve as

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leverage to attract prioritized funding from the Ministry of Health and BPJS Kesehatan. Yet this opportunity remains contingent on proactive advocacy, given that limited local government funding continues to pose a systemic threat beyond the hospital's internal control.

Overall, the qualitative and quantitative findings converged to indicate that hospital personnel demonstrated adequate awareness of KRIS requirements and institutional commitment through the establishment of a dedicated planning team. Nevertheless, substantial gaps remained in physical infrastructure readiness. Quantitative assessment identified deficiencies in ventilation systems, lighting, accessible bathrooms, and oxygen outlet availability. These findings were consistent with qualitative reports indicating that budget limitations and ongoing renovation processes constituted major barriers to achieving full compliance with KRIS standards.

DISCUSSION

The findings indicate that Baubau City Regional General Hospital is not yet fully prepared to implement the Standardised Inpatient Care Class (KRIS) as mandated by Presidential Regulation No. 59 of 2024. While certain criteria, such as room segregation based on gender, age, and disease type and the provision of bedside tables, have been met, several infrastructural and facility-related standards remain unfulfilled. These results align with the study's objective to assess hospital readiness and highlight specific areas requiring improvement prior to the national implementation deadline.

In terms of facilities and infrastructure, although the use of building materials in intensive care units meets cleanliness and safety requirements, weaknesses persist in general treatment rooms. Air ventilation and room lighting fail to comply with standards due to the absence of air quality and light intensity measuring devices. These deficiencies are not merely technical oversights; they carry direct implications for infection control, patient recovery outcomes, and hospital accreditation standing. The absence of environmental monitoring instruments further reflects a governance failure in proactive patient safety management, as the hospital lacks the capacity to detect and respond to environmental health risks before they escalate into clinical harm.

The use of natural ventilation in this study aligns with the findings of As'ady et al, who highlighted that air ventilation can be optimised through the installation of secure and adequately sized windows to enhance air exchange within rooms an essential factor in maintaining patient comfort and health. In addition to natural ventilation, Wava Husada Hospital in Malang also employs a mechanical ventilation system to ensure proper air circulation throughout the facility. Regular inspections of the ventilation system are conducted using specialised equipment to maintain air quality within the hospital environment [(19)].

Regulatory requirements further underscore the need for compliance. According to the Regulation of the Minister of Health Number 40 of 2022, hospital service capacity must be supported by buildings, infrastructure, and medical equipment that meet technical standards. In addition, inpatient room density is not ideal, as some rooms still contain more than four beds with inter-bed distances of less than 1.5 metres [(7)]. Other criteria such as the availability of bed dividers, en-suite bathrooms, and room temperature regulation are partially fulfilled but not yet compliant with KRIS indicators. The convergence of deficits across sanitation, accessibility, emergency response, and environmental control systems including nurse call systems, accessible bathrooms, and oxygen outlets remains below required standards [(8)]. Rather than treating these unmet criteria as isolated deficiencies, they collectively reflect a systemic pattern of deferred capital planning and fragmented infrastructure governance, indicating that KRIS readiness gaps at RSUD Kota Baubau are structurally rooted and require coordinated institutional responses.

These infrastructural gaps carry direct implications for patient safety and should not be interpreted merely as administrative shortcomings. Arisa et al. noted that optimally functioning nurse call systems can reduce delays in nurses' emergency response, while accessible bathroom designs prevent accidents and support the mobility of patients with disabilities [(7)]. Substandard ventilation and inadequate oxygen outlets similarly elevate clinical risk, particularly for patients with respiratory conditions. Fulfilling KRIS standards must therefore be understood as a critical component of healthcare risk management rather than a bureaucratic obligation.

Budget constraints are the primary factor hindering compliance with KRIS standards, compounded by the absence of integrated planning for infrastructure renovation [(20)]. These findings are consistent with previous studies showing that local government hospitals face challenges in adapting to new regulations due to limited financial and infrastructural capacity [(21)]. The findings of this study are consistent with those reported in Sudrajat et al, which examined the implementation of the KRIS–JKN policy at Bandung City General Hospital. The study highlighted that the main barrier to successful implementation was budget constraints, as the funding from the hospital's BLUD scheme was insufficient to finance the infrastructural renovations required to meet the twelve KRIS criteria [(22)]. While Bandung and Jakarta hospitals benefit from larger fiscal envelopes, Baubau's constraints highlight the need for differentiated implementation pathways for eastern Indonesia, where fiscal capacity, infrastructure baseline, and geographic remoteness present compounding challenges that uniform national timelines fail to accommodate.

From a governance perspective, BLUD autonomy requires hospitals to generate own-source revenue, yet KRIS infrastructure investments substantially exceed short-term revenue capacity suggesting a structural

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mismatch between policy expectations and institutional financing mechanisms. This mismatch is particularly acute for Class C regional hospitals in fiscally constrained regions, where the assumption of revenue self-sufficiency embedded in the BLUD model is fundamentally at odds with the scale of capital investment that KRIS compliance demands. Without transitional central government bridging grants or earmarked fiscal transfers, the burden of compliance falls disproportionately on hospitals least equipped to absorb it an outcome that paradoxically undermines the very equity objectives that KRIS is designed to advance.

Gunawan et al. found that local government hospitals often encounter difficulties in disseminating and operationalising policy directives [21]. A pattern similarly observed at Baubau City Hospital, where technical components such as ventilation, lighting, and oxygen outlets were not prioritised in annual work plans. These findings reflect broader challenges in public policy implementation. Sabatier and Mazmanian argue that gaps between policy design and operational execution are often shaped by institutional capacity, resource availability, and inter-governmental coordination [23].

This situation highlights a gap between national policy expectations and the realities observed in regional healthcare facilities. In Jakarta, eleven of twenty-nine regional hospitals (38%) have achieved full compliance with Standardised Inpatient Care Class (KRIS). The least satisfied criteria involve bed facility completeness and room density, mainly due to space limitations, inadequate budgeting, and delays in renovation approvals. Effective KRIS–JKN implementation requires strong coordination among central and local governments and hospital management [24]. Another study on private hospitals found that approximately 40% of hospital beds were allocated to KRIS rooms, each accommodating between two and four patients. The most challenging standards to meet were criteria 8, 9, 11, and 12. Implementation was financed through hospital operational budgets and accompanied by continuous monitoring and evaluation. Following implementation, hospitals reported higher bed occupancy rates, increased revenue, and improved patient satisfaction [25]. These contrasting experiences reinforce that readiness is not solely a function of regulatory willingness but of institutional capacity a dimension that national implementation frameworks must explicitly address.

To bridge these gaps, a phased PDCA (Plan–Do–Check–Act) approach is proposed as an operationally feasible pathway for KRIS compliance at RSUD Kota Baubau. In the Plan phase, the hospital should conduct systematic audits of ventilation systems, lighting infrastructure, and oxygen outlets to establish a compliance baseline and prioritise renovation needs. In the Do phase, pilot renovations should be initiated in one inpatient ward to test implementation feasibility within existing budget constraints. In the Check phase, compliance outcomes and patient feedback should be monitored systematically to evaluate the effectiveness of interventions. In the Act phase, successful interventions should be scaled across remaining wards with support from the Provincial Health Office, including coordination for central government funding mechanisms and technical assistance.

The implementation of KRIS aims to ensure equitable healthcare services, improve service quality, and enhance patient safety for National Health Insurance participants [4]. Theoretically, this study reinforces Rawls's principle of distributive justice, which asserts that every individual deserves equal access to healthcare services without discrimination [5]. The partial readiness observed at Baubau City Hospital underscores a disparity between normative policy expectations and the structural realities of regional public hospitals a disparity that is not merely operational but fundamentally a question of social justice.

The findings of this study affirm that without differentiated fiscal support and adaptive governance mechanisms, KRIS risks deepening rather than reducing inequities in healthcare access between western and eastern Indonesia. The implementation of KRIS should therefore be understood not as an administrative endpoint but as a long-term investment in strengthening public trust and realising distributive justice in the national health system. Evidence from low- and middle-income countries indicates that favourable health outcomes remain achievable under resource-constrained settings when health systems prioritise governance quality, equity, and adaptive implementation strategies. Such contexts are characterised by effective governance and political commitment, bureaucratic learning and institutional memory, and adaptive capacity to innovate under constraints, alongside responsiveness to population needs and system resilience to political, economic, and environmental shocks [26].

CONCLUSION AND RECOMMENDATIONS

This study reveals that Baubau City Regional General Hospital is not yet fully prepared to implement the Standardised Inpatient Care Class (KRIS) as mandated by Presidential Regulation No. 59 of 2024. This study found that Baubau City Regional General Hospital is not yet fully prepared to implement the Standardised Inpatient Care Class (KRIS) as mandated by Presidential Regulation No. 59 of 2024. Although several indicators have been fulfilled, including the provision of bedside tables and the segregation of inpatient rooms based on gender, age, and disease type, several infrastructural criteria such as air ventilation, lighting, bed completeness, accessible bathrooms, and oxygen outlets remain below KRIS standards. The findings also indicate that budget limitations and the absence of integrated infrastructure planning are the primary barriers to full KRIS compliance.

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Based on these findings, a phased implementation strategy is recommended to improve hospital readiness. Priority should be given to infrastructure renovation planning, strengthening governance, and gradually fulfilling critical KRIS indicators. Additional financial support and stronger coordination between hospital management, local government, BPJS Kesehatan, and the Ministry of Health are also needed to support sustainable KRIS implementation. The future studies should consider multi-site comparative research across other Class C regional hospitals, particularly in eastern Indonesia, to identify whether these infrastructural challenges are systemic across the region. Additionally, longitudinal evaluations are needed to assess the effectiveness of KRIS once it is fully operational.

AUTHOR CONTRIBUTIONS

This A.Y.B.R.T contributed to the conceptualisation, study design, data interpretation, and manuscript writing. R.D.P. contributed to the methodology, data analysis, and manuscript review. M.A. contributed to data collection, validation, and manuscript editing. A.A.N. contributed to supervision, critical review, and final approval of the manuscript. J.B. contributed to field data collection and operational implementation of the study.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest in this study.

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REFERENCES

1. Kemenkes RI. Keputusan Direktur Jenderal Pelayanan Kesehatan Nomor HK.02.02/I/1811/2022 tentang Petunjuk Teknis Kesiapan Sarana Prasarana Rumah Sakit dalam Penerapan Kelas Rawat Inap Standar Jaminan Kesehatan Nasional. Jakarta; 2022.
2. Agustina R, Dartanto T, Sitompul R, Susiloretni KA, Suparmi, Achadi EL, et al. Universal Health Coverage In Indonesia: Concept, Progress, and Challenges. Lancet (London, England). 2019 Jan;393(10166):75–102. 10.1016/S0140-6736(18)31647-7.
3. Imtihani H, Nasser M. Keadilan dalam Reformasi BPJS: Teori Rawls dan Kajian Kritis Terhadap Kebijakan Kelas Rawat Inap Standar. Syntax Idea. 2024;6(9):3832–42. doi:10.46799/syntax-idea.v6i9.4447.
4. Lubis PA, Barus MB, Hafidzah F, Gurning FP. Analisis Perpres No 59 Tahun 2024 Tentang Penerapan Kelas Rawat Inap Standar Di Rumah Sakit Umum Daerah (RSUD) Batu Bara. J Inov Kesehat Adapt. 2024;6(7):11–6. Available from: https://jurnalhost.com/index.php/jika/article/view/1381/1641.
5. Zanariyah S, Sulistiyono A, Imanullah MN, Suryono A. Optimization of social justice principles in health insurance by the health social insurance administration agency (BPJS) in Indonesia. Multicult Educ. 2021;7(8). doi:10.5281/zenodo.5294967.
6. Natsir RTP, Ahri RA, Rusydi AR. Implementasi Kelas Rawat Inap Standar Jaminan Kesehatan Nasional Terhadap Sarana Prasarana di RSUP dr . Tadjuddin. J Aafiyah Heal Res. 2024;5(1):442–55. Available from: https://garuda.kemdiktisaintek.go.id/documents/detail/4530781.
7. Kuraini SN, Anggraini AN, Ariagita AP, Hapsari MS, Anggraini SD. Kajian Kesiapan RSUD Kota Salatiga Dalam Menghadapi Kebijakan Kelas Rawat Inap Standar (KRIS). J Manaj Kesehat Yayasan RS Dr Soetomo. 2023;9(2):311–20. doi: 10.29241/jmk.v9i2.1552.
8. Arisa A, Purwanti S, Diaty R. Kesiapan RSUD Dr. H. Moch Anshari Shaleh Banjarmasin Menghadapi Regulasi PP No 47 2021 Tentang Implementasi Kelas Rawat Inap Standar (KRIS) JKN di Tahun 2022. J Kesehat Qamarul Huda. 2023;11(1):264–70. doi:10.37824/jkqh.v11i1.2023.451.
9. Putri MS, Chalidyanto D. Hospital Challenges in Implementing the Standard Inpatient Class Policy: A Literature Review. Media Gizi Kesmas. 2025 Nov 27;14(2):323–31. 10.20473/mgk.v14i2.2025.323-331.
10. Rusydi AR, Palutturi S, Noor NB, Pasinringi SA. The Implementation Of Good Corporate Governance (GCG) At Public Hospital In Indonesia: A Literature Review. Enfermería Clínica. 2020;30:145–8. 10.1016/j.enfcli.2019.10.057.
11. Hakiki BA, Soegijapranata K, City S. Analysis of the Review of the Standard Inpatient Class Policy (KRIS) as a Replacement for the BPJS Health Class System in Improving Health Service Equity Based on Presidential Regulation Number 59 of 2024. Int J Soc Welf Fam Law. 2025;2(1):33–46. doi:

ISSN : 1907-8153 (Print)
e-ISSN : 2549-0567 (Online)

10.62951/ijsw.v2i1.157.
12. Rizky W, Afriyanto DF, Shoffiyatunisaak NA. An Overview of the Readiness of Regional General Hospital Infrastructure (RSUD) Karanganyar Regency in Implementing the National Health Insurance Standard Inpatient Classes. Indones J Bus Anal. 2024;4(1):181–92. doi:10.55927/ijba.v4i1.8269.
13. Mz MQ, Pane M, Hutajulu J, Tarigan FL. Analisis Kesiapan Rumah Sakit Bhayangkara Tk II Medan Terhadap Pelaksanaan Kelas Rawat Inap Standar (KRIS). J Kesehat Tambusai. 2024;4(2):1893–911. Available from: https://journal.universitaspahlawan.ac.id/index.php/jkt/issue/archive/2.
14. Adelia N, Sukma A, Sembiring P, Gurning FP. Studi Literatur : Tantangan dan Strategi Pelayanan Kesehatan dalam Implementasi Kebijakan Kelas Rawat Inap Standar (KRIS) di Indonesia. J Kolaboratif Sains. 2025;8(7):4318–26. doi:10.56338/jks.v8i7.7827.
15. Rachmanda NA, Kusbaryanto. Analysis Of Implementation Readiness For Standardized Inpatient Class (KRIS) Using A Mixed Methods Approach At A Private Hospital In Yogyakarta, Indonesia. TPM – Testing, Psychom Methodol Appl Psychol. 2025 Sep;32(S6):575–9. Available from: https://tpmap.org/submission/index.php/tpm/article/view/1774.
16. Fauzi FZ. The Evolution Of National Health Insurance In Indonesia: Policies, Progress, And Challenges. J Kebijak Pemerintah. 2025 Oct;8(1 SE -):67–78. doi:10.3389/ijph.2024.1606810.
17. Situmorang TE, Darmawan ES. Kesiapan Rumah Sakit Dalam Menghadapi Kelas Rawat Inap Standar (KRIS) A Systematic Literature Review. J Kesehat Masy Inov. 2025;8(5):31–8. doi:10.33701/jkp.v8i1.5559.
18. Creswell JW, Klassen AC, Plano Clark VL, Smith KC. Best Practices For Mixed Methods Research In The Health Sciences. Bethesda Natl Institutes Heal [Internet]. 2011;2013(2011):541–5. Available from: https://obssr.od.nih.gov/sites/g/files/mnhszr296/files/Best_Practices_for_Mixed_Methods_Research.pdf
19. As'ady BJA, Yogiyopranoto M, Purwadhi P, Widjaja YR. Implementasi Kelas Rawat Inap Standar Jaminan Kesehatan Nasional Terhadap Sarana Prasarana di RS Wava Husada Malang. Innov J Soc Sci Res. 2025;5(1):4230–40. doi:10.31004/innovative.v5i1.16881.
20. Raafiana M, Andriani H, Indonesia U, Raafiana M, Andriani H. Kesiapan Rumah Sakit Dalam Implementasi Kebijakan Kelas Rawat Inap Standar (KRIS) JKN : Literature Review. Syntax Lit J Ilm Indones. 2025;10(1):435–44.
21. Gunawan AN, Hanafi RA, Hanifa NI, Husnus K, Farahany S, Saragih TR, et al. Analisis Hambatan Administrasi terhadap Akses Pelayanan Kesehatan di Puskesmas Desa Securai Kecamatan Babalan Kabupaten Langkat. J Kesehat Masy. 2024;8(3):6502–10. doi:10.36418/syntax-literate.v10i1.54936.
22. Sudrajat AS, Rahayu RH. Implementasi Kebijakan Kelas Rawat Inap Standar Jaminan Kesehatan Nasional (KRIS-JKN) di RSUD Kota Bandung. J Gov Innov. 2025;7(1):372–91. doi:10.31004/prepotif.v8i3.36485.
23. Sabatier P, Mazmanian D. The Implementation Of Public Policy: A Framework Of Analysis. Policy Stud J. 1980 Jan 1;8(4):538–60. doi:10.36636/jogiv.v7i1.5256.
24. Ilmansyah VD, Basabih M. Analisis Kesiapan Implementasi Kebijakan Kelas Rawat Inap Standar Jaminan Kesehatan Nasional Rumah Sakit Umum Daerah DKI Jakarta. J Locus Penelit dan Pengabdi. 2025;4(4):1598–608. doi:10.58344/locus.v4i4.4101.
25. Desria K, Novita A, Hendarwan H. Evaluasi dalam Implementasi Kebijakan Kelas Rawat Inap Standar Jaminan Kesehatan Nasional (KRIS-JKN) pada Rumah Sakit Swasta. J Ilmu Kesehat Masy. 2025;14(3):201–17. doi:10.33221/jikm.v14i03.3355.
26. Balabanova D, Mills A, Conteh L, Akkazieva B, Banteyerga H, Dash U, et al. Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening. Lancet [Internet]. 2013 Jun 15;381(9883):2118–33. doi:10.1016/S0140-6736(12)62000-5.