IJSSR
International Journal of Social Service and Research

Vol. 4, No. 11, November 2024
e-ISSN: 2807-8691 | *p*-ISSN: 2807-839X

THE STANDARD INPATIENT CLASS (KRIS) POLICY IN HOSPITALS AND ITS IMPACT ON THE DECLINE IN BED AVAILABILITY FOR BPJS

Fusia Meidiawaty
Universitas Borobudur, Indonesia
*e-mail: meiuchie23@gmail.com

Keywords
BPJS Patient, Hospital, Standard Inpatient Class

ABSTRACT

The Standard Inpatient Class (KRIS) policy introduced by BPJS Kesehatan aims to enhance equitable healthcare quality by standardizing hospital inpatient facilities in Indonesia. However, its implementation has raised concerns due to its significant impact on hospital bed availability, particularly in facilities with limited capacity, leading to challenges in service accessibility and quality. This study aims to examine the implications of the KRIS policy on bed capacity and healthcare service standards, as well as the obstacles faced by hospitals in maintaining service quality for BPJS participants. Employing a normative juridical method, the research systematically analyzes legal materials, including Presidential Regulation Number 59 of 2024, alongside relevant secondary literature. The findings reveal that the policy, while intended to improve service equity, has resulted in a notable decline in bed capacity, increased waiting times, and heightened workloads for medical personnel, particularly in resource-constrained hospitals. Hospitals in remote areas face additional challenges in meeting infrastructure requirements due to budget limitations. The study concludes that balancing the policy's quality standards with resource availability remains a critical issue, necessitating sustainable financial strategies, capacity-building programs, and innovative resource management solutions to ensure equitable healthcare access for all BPJS participants. Future research should focus on comparative assessments, patient satisfaction, and alternative strategies to optimize policy outcomes.

INTRODUCTION

In its role as the protector of the public interest, the law is tasked with achieving a number of key objectives. The fundamental purpose of law is to establish an orderly society, ensure the enforcement of rules, and maintain equilibrium. In the context of Indonesia as a state governed by the rule of law, all actions, whether undertaken by citizens or leaders, must be subject to the applicable legal framework. The Indonesian Constitution requires that the principle of a state of law be consistently applied. Despite the fact that the law exists to regulate and organise social life, its implementation frequently encounters obstacles and does not always proceed in an optimal manner (D. Hidayat & Hainadri, 2021).

Health is a fundamental right for every individual, family, and community, so everyone has the right to get protection for their health so that there is justice for every community (Amelia & Budi, 2021). The government is responsible for ensuring this right is fulfilled by optimally regulating and protecting public health rights. This responsibility is realised through the provision of adequate health facilities and services that are easily accessible to all levels of society, regardless of social or economic status (Isriawaty, 2015). In the medical context, this right can also be referred to as the right to health or the

right to achieve an optimal level of health, which is the obligation of the state to fulfil for all its citizens (R. Hidayat, 2016). The guarantee of obtaining health services is as stated in the legal basis for the administration of the Indonesian government, article 28H paragraph (1) of the 1945 Constitution which reads 'Everyone has the right to live in physical and mental prosperity, to have a place to live, and to get a good and healthy living environment and the right to obtain health services.

It is the responsibility of the state to provide quality healthcare facilities. Presidential Regulation Number 59 Year 2024 was issued as the third amendment to Presidential Regulation Number 82 Year 2018 regarding health insurance. This regulation introduces substantial alterations to the standards governing inpatient wards in hospitals, consequently impacting the number of available beds. Enacted on 8 May 2024, this Presidential Regulation comprises 24 articles that have undergone changes, additions, and deletions (Abbas, 2008). One of the primary objectives of this Perpres is the regulation of Basic Health Needs (KDK), which encompasses essential services for the maintenance of health and the saving of lives. In this context, inpatient service facilities must adhere to specific standards, including the number of beds and the availability of medical equipment. The Standard Inpatient Class (hereinafter referred to as KRIS) serves as a reference for the services that must be provided by hospitals.

The implementation of new standards for inpatient care has a considerable effect on the capacity of hospital beds. The elevated standards necessitate that hospitals allocate additional space for each admitted patient. One consequence of this policy is a reduction in the number of beds that can be made available to BPJS patients. The World Health Organisation (WHO) has set an ideal standard for the number of beds in hospitals, which is one bed for every 1,000 population. In contrast, the ratio of available beds in hospitals serving BPJS Kesehatan participants is approximately one bed for every 1,100 residents. This discrepancy can be attributed to the necessity for hospitals to adjust their capacity to align with the class standards set by the KRIS policy, which consequently affects the arrangement and distribution of beds across inpatient classes.

In hospitals with limited capacity, this policy may result in a significant reduction in the availability of beds, leading to prolonged waiting periods for BPJS patients seeking inpatient services. The reduction in bed capacity may result in BPJS patients encountering greater challenges in securing a hospital bed, particularly in referral hospitals that are already operating at full capacity. Furthermore, although the objective of implementing this regulation is to enhance the quality of health services, the decrease in bed capacity may lead to overcrowding in the ward, which could ultimately compromise the quality of care provided to patients (Nola, 2024).

One significant challenge encountered by healthcare facilities is the challenge of maintaining service standards in accordance with the KRIS while simultaneously ensuring sufficient bed capacity for all BPJS patients. Hospitals frequently encounter a predicament when attempting to allocate scarce resources, including beds, medical personnel, and other facilities, while patient demand continues to rise. Furthermore, the reduction in the number of beds for BPJS participants results in an increase in workload for medical personnel and a lengthening of patient waiting times. This has a detrimental impact on the hospital's operational efficiency and the quality of services provided. Patients who require immediate treatment may be delayed due to limited bed availability, which disrupts their recovery and creates dissatisfaction among the public.

This study examines the impact of the Standard Inpatient Class (KRIS) policy on the availability of hospital beds for BPJS Kesehatan patients and explores the challenges hospitals face in maintaining healthcare service quality under the policy. By evaluating the operational and quality implications of the KRIS policy, the research contributes to policy evaluation literature, provides insights into managing resource constraints, and supports healthcare policymakers with practical recommendations. It also enriches the discourse on Indonesia's national health insurance system by offering empirical evidence on the intersection of policy implementation and service quality.

METHODS

The research employs a normative juridical method to analyze legal issues and systems relevant to the study. This methodology focuses on examining legal materials systematically to address the research objectives. Primary legal materials used in this study include Presidential Regulation Number 59 of 2024, which amends Presidential Regulation Number 82 of 2018 on health insurance. These legal materials are analyzed to explore their implications and relevance to the research focus. Secondary materials, such as supporting literature and academic references, are also utilized to provide additional context and depth to the analysis.

RESULTS

The Implementation of the Standard Inpatient Class Policy (KRIS) on the Availability of Beds for BPJS Health Patients in Hospitals

Article 28-H of the 1945 Constitution of the Republic of Indonesia enshrines the right of every individual to live in a state of physical and mental well-being, to have a place to live, and to inhabit a good and healthy environment. Furthermore, individuals are entitled to receive health services. The right to health is an essential basic human need and is enshrined as a fundamental right of every citizen (Ardinata, 2020). Furthermore, Article 34, paragraph (3) underscores the state's obligation to ensure the provision of adequate healthcare facilities and public facilities. In accordance with Article 1, paragraph 3 of Law Number 17 of 2023 concerning Health, the definition of health services is as follows: "Health Services are all forms of activities and/or a series of service activities provided directly to individuals or the community to maintain and improve the degree of public health in the form of promotive, preventive, curative, rehabilitative, and/or palliative."

Hospitals are healthcare institutions that provide a comprehensive range of individual health services, encompassing inpatient, outpatient, and emergency care (Farlinda et al., 2017). Furthermore, hospitals serve as a location for patients to reside during the recuperation and convalescence phase of their treatment (J et al., 2015). Hospitalisation is a type of health service provided in hospitals that is not contingent on a specific structure. This service encompasses the provision of facilities and the performance of a range of private medical activities, including observation, diagnosis, treatment, care, and rehabilitation. Patients who are hospitalised are typically required to remain in the facility for a minimum of one day, based on referrals from other healthcare facilities or different hospitals (Jati, 2019). While patients are in the treatment room until they are ready to go home, they will receive various types of services, including from medical personnel, nurses, and medical support services. In addition, patients will also receive support from their neighbours and any necessary administrative or financial services.

The potential for Presidential Regulation No. 59 of 2024 on the Third Amendment to Presidential Regulation No. 82 of 2018 on Health Insurance to enhance the quality of health services is contingent upon the implementation of stricter regulatory measures governing the operations of inpatient facilities. One of the primary objectives of this Presidential Regulation is to establish minimum standards for inpatient facilities, which encompass requirements pertaining to the infrastructure, the number of beds per room, and supplementary services that must be made available in hospitals. The implementation of the revised inpatient class standards has a considerable impact on hospital bed capacity. The introduction of enhanced standards necessitates that hospitals allocate more space for each admitted patient.

The BPJS Kesehatan is a legal entity established for the purpose of managing the health insurance programme, in collaboration with health facilities in regard to financing. This process encompasses the submission of BPJS claims, whereby hospitals present the cost of care provided to BPJS participants to BPJS Kesehatan on a collective basis. These claims are subsequently billed on a monthly basis as part of the health service payment mechanism agreed between the hospital and BPJS Kesehatan (Irsan et al., 2024).

The Standard Inpatient Class (KRIS), also referred to as the Single Class, represents a policy initiative within the JKN framework, implemented through BPJS Health. The introduction of the KRIS has had a beneficial impact, including the provision of standard class services, an improvement in the quality of service and the establishment of a standard class. All BPJS participants are now entitled to the same level of care, regardless of their financial status. This ensures that the less well-off have the same entitlements as the more affluent in terms of health services (Widianto, 2024). The objective of the KRIS policy is to enhance the quality of service provided to BPJS Kesehatan participants (Kurniawati, 2021).

The government has announced its intention to replace the BPJS Health class 1, 2 and 3 system with the Standard Inpatient Class (KRIS) system. The initial phase will entail the standardisation of hospital class 3 inpatient rooms (DIY, 2023). This standardised class change has been incorporated into the National Health Insurance Law. The objective of the standardised class, as outlined in the law, is to enhance the quality of services, particularly inpatient care. There are 12 criteria for standardised inpatient classes, including (Indonesia, 2023):

1) Porosity level, it is essential that building components have a high degree of porosity to ensure optimal air circulation.

2) Air ventilation, each treatment room must meet the standard of at least six air changes per hour to maintain air quality.
3) Room lighting, artificial lighting must meet the standard of 250 lux for general lighting and 50 lux for sleeping lighting.
4) Contact box and nurse call, each bed is equipped with two contact boxes and nurse call buttons, facilitating patient communication with nursing staff.
5) Nightstand, each bed in each room must be equipped with a nightstand to store the patient's belongings.
6) Room temperature, room must be maintained between 20 and 26 degrees Celsius.
7) Patient grouping, the room must be separated by gender, age, and type of disease (infectious and non-infectious).
8) Room density, a maximum of four beds per room is permitted. The room must be equipped with a minimum distance of 1.5 metres between bed edges to ensure privacy and comfort.
9) Curtains/partition, curtains or partitions should be installed with rails attached to the ceiling or hanging to separate areas.
10) En-suite bathroom, the room must be equipped with a bathroom in the inpatient room.
11) Accessibility standards, the bathroom must meet accessibility standards for all patients.
12) Oxygen outlets, each room must be equipped with oxygen outlets for medical needs.

The primary objective of implementing the 12 KRIS criteria is to mitigate the risk of patient mortality resulting from infections acquired in overcrowded treatment rooms (Arief, 2022). In other words, this standard is designed to ensure that hospital accommodation facilities adhere to enhanced safety standards in order to protect patient health. One of the changes implemented is the stipulation of a maximum of four beds in a room, with bathroom facilities located within the room for every four patients. This is in stark contrast to the current situation, where class 3 inpatient conditions are usually far above the ideal standard, which has between six and ten beds per room, with bathrooms located outside the room (Publik, n.d.). The KRIS initiative represents an effort to enhance the quality of services and patient safety, including those provided to BPJS patients. As an illustration, numerous hospitals offering class 3 services continue to have 8 to 12 beds in a single treatment room, with separate bathrooms situated outside the inpatient room. This regulation will establish a maximum of 4 beds in a treatment room and a bathroom in each room.

The BPJS Kesehatan institution offers two distinct interpretations of the definition of KRIS. The initial interpretation is in accordance with the stipulations set forth in Law No. 20/2014 on Standardisation and Conformity Assessment (SRRI) (Undang-Undang Nomor 20 Tahun 2014 Tentang Standarisasi Dan Penilaian Kesesuaian, n.d.). From this interpretation, it can be seen that KRIS covers inpatient classes 1, 2, and 3, which must fulfil the Standardisation of Inpatient Rooms (SRRI). This includes patient safety standards, medical equipment standards, infrastructure standards, amenities standards, and the number of beds, which vary from class 3 to presidential suites. Meanwhile, the second interpretation considers KRIS as a class standard in terms of the number of inpatient room classes, either one class or two class.

The stipulation of a maximum of four beds in one room introduces a challenge regarding bed availability, given that the initial BPJS class 3 beds can accommodate up to 12 patients. The KRIS and the determination that there will only be four beds raises concerns about how hospitals can provide optimal care if the number of beds for patients is reduced. One of the groups that will be most affected by this decision are patients who use BPJS. The reduction in hospital bed capacity will have a significant impact on BPJS Kesehatan patients, who will experience a number of direct consequences. These include limited access to health services provided in hospitals, as well as greater difficulties in securing a bed, particularly in referral hospitals that already have limited capacity. This can lead to increased waiting times for necessary treatment, which in turn can affect their health and well-being.

The suboptimal implementation of the KRIS may impede BPJS participants from accessing quality and standardised healthcare services at hospitals. The lack of standardised class inpatient rooms for BPJS participants represents a significant concern. At present, only 50% of hospitals are able to comply with the stipulated room area per bed, while the distance between bed edges, which should be a minimum of 1.5 metres, is only met by 59% of hospitals (Hinu, 2022). Furthermore, the maximum number of beds per room was only met by 55% of facilities. The provisions regarding inpatient room density are not novel; they are derived from the 2012 technical guidelines for hospital buildings that pertain to classes 2 and 3. Nevertheless, it would seem that hospitals have not fully implemented the

guidelines. Modifications to these provisions have the potential to reduce the number of beds available in existing inpatient rooms (Dharmayanti et al., 2020)

This presents a considerable challenge, particularly in emergency situations where the necessity for medical attention is immediate. Patients registered with BPJS frequently have to wait longer or seek alternative hospitals, which may not always possess the requisite financial resources to meet their needs. The lack of certainty regarding the availability of an appropriate bed can result in elevated stress and anxiety levels among patients and their families, particularly in cases where the patient's condition necessitates intensive care. A reduction in bed capacity can also exert increased pressure on medical and hospital personnel, as staff are compelled to manage a larger number of patients under more challenging circumstances. This could potentially lead to a decline in the quality of healthcare services provided to patients, contributing to a less satisfactory experience for BPJS Kesehatan patients.

Prior to the implementation of the Standard Inpatient Class Policy (KRIS), the class system in BPJS Kesehatan services was divided into classes 1, 2, and 3, which indirectly created a hierarchy based on participants' financial capabilities. Those with the financial means to pay higher premiums are able to access superior health facilities in classes 1 and 2, whereas those with more limited financial resources are confined to the more restricted class 3 facilities. This system serves to reinforce social inequality in health services, whereby those with stronger financial resources are able to enjoy superior quality facilities, while those in lower economic groups tend to receive less adequate services (Pramana & Priastuty, 2023).

Despite the implementation of classes 1, 2, and 3, difficulties in accessing hospital rooms persist. The advent of KRIS, which has the potential to reduce the number of beds available for BPJS participants, has undoubtedly given rise to concerns regarding the sufficiency of beds for patients. As the capacity of the BPJS is increasingly constrained, patients may encounter greater difficulty in securing a bed, particularly in referral hospitals that are already operating under significant capacity pressure. Furthermore, the introduction of KRIS has resulted in significant challenges in accessing health services. This is largely due to the considerable queues and extended waiting times that patients experience when KRIS is operational.

The KRIS provision that limits a maximum of four beds per room has a direct impact on hospital revenue, as the number of available beds is reduced. While there are several disadvantages associated with this reduction in beds, it is important to consider the positive aspects of the implementation of KRIS in hospitals. This policy aims to improve the quality of service and accessibility for patients participating in BPJS Kesehatan. It represents a strategic step to align health services with the needs of the community, particularly in the context of national health insurance.

It is crucial to acknowledge that the KRIS policy is an integral component of a larger initiative to enhance the national health system. Nevertheless, the realisation of this objective will necessitate adjustments and assistance from a number of stakeholders. For instance, the government must allocate greater financial resources and support to hospitals, enabling them to meet the standards set out in the KRIS policy without compromising the availability of beds for BPJS patients. Ultimately, the successful implementation of KRIS hinges on the capacity of hospitals to innovate and enhance operational efficiency. Hospitals must be able to demonstrate an enhanced capacity to manage existing resources and identify innovative solutions to address the issue of bed availability. This may entail collaboration with other health facilities, enhancement of out-of-hospital health services, or the development of technology to optimise care processes. Consequently, the implementation of KRIS has a considerable impact on the availability of beds for BPJS Kesehatan patients in hospitals. While the objective is to enhance the quality of care, the challenges that emerge must be addressed with due diligence. It is hoped that collaborative endeavours and appropriate support will facilitate improvements in healthcare accessibility for BPJS patients, without compromising the quality of care they receive.

The Obstacles and Challenges Faced by Hospitals in Maintaining the Quality of Health Services for BPJS Health Participants After the Implementation of the Standard Inpatient Policy

Health is a fundamental necessity and a human right that regulated in law. As a fundamental human right, the realisation of health is contingent upon the provision of an array of health services to the entire community, facilitated through the implementation of quality and affordable health development (Abbas, 2008). It is widely acknowledged that a healthy population is a prerequisite for economic prosperity. The enhancement of health services can be considered an investment in human capital, which is of paramount importance for the advancement of a nation. It is therefore evident that

the role of the government in providing health services is of paramount importance in order to improve public health (Khariza, 2015).

Hospitals are confronted with a multitude of challenges in providing high-quality patient services within an increasingly competitive environment. Furthermore, hospitals are required to comply with a number of accreditation standards, meet the needs and expectations of patients, maintain social and ethical values, improve health services in a sustainable manner, and attempt to reduce costs (Hafiq et al., 2017). The expectations of patients in relation to hospital services are shaped by their perceptions of the optimal standards of service. In Iran, hospitals have pledged to adhere to clinical and non-clinical standards with a view to enhancing the quality of care and guaranteeing patient safety (Vali L et al., 2020).

The implementation of KRIS is confronted with significant challenges pertaining to the availability of hospital facilities and infrastructure. As indicated by data from the Ministry of Health, approximately 30% of the 3,176 hospitals in Indonesia have not yet attained the requisite standards for compliance with KRIS. The most significant challenges pertain to the necessity for inpatient rooms that are deficient in terms of air ventilation, room lighting, en-suite bathroom facilities, and oxygen outlets. Hospitals, particularly those situated in remote locations, encounter difficulties in meeting these criteria due to the substantial financial investment required, which is not always accessible to hospitals with constrained budgets. The provision of en suite bathroom facilities and central oxygen outlets represents a significant challenge for class C and D hospitals, which are often located in areas characterised by limited infrastructure and resources (Hanri & Sholihah, 2021). For instance, the standardisation of inpatient classes is primarily intended to ensure the maintenance of service quality, rather than to compromise it. Nevertheless, the Minimum Standard Annual Report of Tadjuddim Chalid Hospital indicates a decline in satisfaction levels with regard to the inpatient installation (Nurhayani et al., 2024).

A further consequence of the introduction of KRIS is the difficulty in accessing health services, due to the high number of patients queuing and the lengthy waiting times. This situation arises because the restriction of the maximum number of beds to four per room will result in a reduction in available bed capacity, which will in turn impact on hospital revenue. Conversely, the bed occupation rate (BOR) in Regional General Hospitals (RSUD) in Indonesia is currently approaching 100% (Handayani et al., 2022).

The implementation of KRIS is hindered by several factors, including the necessity for extensive hospital renovation costs to meet the standards set forth for the standard class and the limited availability of beds within the hospital. The World Health Organisation (WHO) has established an optimal standard for hospital bed availability, which is 1 bed for 1,000 population. Meanwhile, the ratio of hospital beds available to serve BPJS Kesehatan participants is approximately 1 bed for 1,100 residents. The varying population of each region in Indonesia also results in a disparate number of beds in a given area. This will undoubtedly present challenges for participants in accessing health services in accordance with their rights (Devapriya, 2020).

Consequently, the implementation of KRIS standards necessitates significant financial outlays that frequently exceed the capacity of hospital budgets, particularly in remote locations. By 2023, BPJS Kesehatan is projected to face a budget deficit of IDR 7.9 trillion, which reflects significant challenges in funding the necessary medical facility upgrades. In order to address this issue, the government has proposed utilising the Special Allocation Fund (DAK) to assist hospitals in upgrading their facilities. The DAK is designed to support a range of sectors, including health, with a particular focus on enhancing health infrastructure and services in areas that require them most. In 2024, the national health budget is planned to be IDR 186.4 trillion, including allocations for the DAK.

From an operational standpoint, the reduction in beds also affects the efficiency of the service provided. As the waiting time for treatment increases, the workload of medical personnel also rises in direct proportion. This may result in a reduction in the quality of care provided to patients. In some cases, patients are compelled to wait longer for the treatment they require, which can result in more serious health complications. Another challenge that hospitals face is the limited resources available to them. Many hospitals lack sufficient medical facilities and equipment that meet KRIS standards. This not only affects bed capacity, but also the hospital's ability to provide quality care. Consequently, hospitals must identify ways to adapt to this policy while still meeting the needs of patients.

The primary challenge in this case is the hospital's preparedness for implementing the KRIS standardisation, as it must undergo modifications or renovations to align with the KRIS standardisation requirements. The current challenge pertains to the implementation of standardisation in Class 3,

necessitating adjustments to the number of patients or beds per room from the previous standard of 6-10 individuals per room. In this instance, the provision of a single bathroom for four beds is a pertinent example. The provision of panels for oxygen outlets, sockets, bells and other such items also presents a challenge. The elimination of classes 1-2-3 in BPJS Kesehatan has resulted in participants from class 1 and class 2 being afforded the same facilities as those who pay less. In response to this, the KRIS was developed as a road map that commenced with a trial. From this initial stage, it is evident that adjustments require a significant time frame, including the calculation of bed occupation rate capacity. Furthermore, the issue of patients remains a concern if renovations result in class 3 closures in a hospital.

With regard to the financing of Classes 2 and 1, it should be noted that there has been no alteration to the benefits received thus far. The benefits received by Class 1 and Class 2 participants remain unchanged, as the contributions required are 150,000 per month for Class 1 and 100,000 per month for Class 2. The rights of these participants remain unchanged. Consequently, Class 1 participants may continue to receive a room for two, while Class 2 participants may still obtain a room for three. The Ministry of Health is currently prioritising the implementation of Class 3. With the implementation period extending until 30 June 2025, there is sufficient time to complete this phase. The adjustments for Class 1 and Class 2 represent the final stage of the process and will continue to be discussed, including in relation to further benefits, contributions and other arrangements.

The implementation of this policy in its entirety will inevitably give rise to a number of challenges, the most significant of which will be the dissatisfaction of the community. This dissatisfaction will arise from a number of factors, the first of which is the potential for an increase in contribution rates. Furthermore, there is a possibility that the facilities available to participants who were previously classified as Class I will be reduced. Finally, there is a risk that the health services that can be covered by BPJS will be reduced. It is probable that participants who were previously in Class I will experience dissatisfaction. This may result in a preference to switch to other hospitals that do not cooperate with BPJS (private). A further challenge is the potential inability of many hospitals to comply with the standardisation requirements due to the significant costs involved in rearranging their infrastructure in accordance with the standards set out in the KRIS policy.

CONCLUSION

The Standard Inpatient Class (KRIS) policy implemented by BPJS Kesehatan has resulted in a decline in bed availability, especially in hospitals with limited capacity. This has led to increased waiting times, workload for medical personnel, and reduced service efficiency. The policy aims to improve the equitable quality of care, but challenges remain in balancing quality standards with treatment capacity. Hospitals face limited facilities and infrastructure, such as bed restrictions and en-suite bathrooms, which must meet KRIS standards. Budget constraints in remote areas exacerbate these difficulties. Limited medical resources and health workers make it difficult to upgrade necessary facilities, potentially leading to participant dissatisfaction with services. Future research could explore the impact of KRIS policy in diverse settings, alternative strategies for balancing quality and capacity, policy evaluation on BPJS budget sustainability, patient satisfaction and healthcare equity, and capacity-building programs for remote hospitals.

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